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# Practitioner or Patient—Who's in Charge?

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*Traditionally, the sociological concept of the relationship between practitioner and patient has been the sick role, in which the physician as practitioner is in charge, and the patient is obligated to cooperate with the physician's prescribed regimen. More recently, this power relationship has been redefined by some from a consumerist perspective, in which physician and patient bargain over the terms of the relationship. Although each brings different resources to the encounter, neither participant is automatically in charge. Data from a sample of 466 members of the public and 86 physicians are used to assess the extent of reported public attitudes and behaviors that challenge the physician's traditional power, as well as physicians' reported response to such attitudes and events, as evidence of the public's propensity to a consumerist relationship and physicians' willingness to accept it. Among both the public and physicians, substantial minorities express beliefs and report actions congruent with this consumerist perspective. However, different demographic and health belief variables emerge in the two groups as explanatory factors. Doctor-patient power relationships are seen to depend on characteristics of the actors as well as on the illness situation.*

Social control in health care manifests itself and can be analyzed at various levels—social, institutional, and individual. At the individual level, the dynamics of control are played out between practitioners—physicians, nurses, support staff—and patients, often including their family-member surrogates. This interpersonal level has been selected as the focus of this paper, with the discussion limited to the physician as practitioner.

Physician-patient interaction is rooted in a power relationship; in this respect it serves as one example of a general class of professional-client relationships. Traditional sociological theory on professions awards power to the professional based on the command of an esoteric body of knowledge, acquired through academic training and leavened by a service orientation toward the client. It is the profession's monopoly of knowledge not

easily accessible to the public and its claims to a public service outlook that legitimate professionals' command over the practitioner-client relationship, and institutionalize client obligations to trust professionals and comply with their prescriptions (e.g., Goode, 1961; Moore, 1970).

This model of professional power over clients has been incorporated in that central concept in medical sociology, the sick role. Viewing the ill person as deviant and the medical practitioner as an agent of social control (Parsons, 1951) implies this power relationship. Indeed, the obligation of the sick to seek expert help in order to get well explicitly involves deferring to professional authority in receiving and accepting information and instructions on how to end a deviant status (Coe, 1970).

Authority classically is defined as the *right* to influence and direct behavior, such right having been accepted as valid and legitimate by others in the relationship. In the medical context, authority is defined as the patient's grant of legitimacy to the physician's exercise of power, on the assumption that it will be benevolent. The relationship is asymmetrical: The patient is in a dependent, and the physician in a superordinate, position (Suchman, 1965). Although the degree of dependence may

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vary by the patient's health condition (Szasz and Hollender, 1956), social status (Arluke et al., 1979), or ethnicity (Segall, 1976), both parties supposedly accept this asymmetry as appropriate and desirable. It is the knowledge difference, the "competence gap," between doctor and patient that justifies both the professional's assumption of authority and the client's trust, confidence, and norm of obedience (Parsons, 1975). Indeed, information control (maintaining the "competence gap") has been posited as the mechanism used to preserve the professional's dominance (Stimson and Webb, 1975; Waitzkin and Stoeckle, 1976).

Although the sick-role concept has been widely criticized from a number of perspectives (e.g., Freidson, 1961; Kassebaum and Baumann, 1965; Twaddle, 1969), this earlier work tended to accept the power paradigm as given. However, in the last decade or so, a competing model of the relationship between doctor and patient has begun to gain some currency—one based on consumerism and authority challenges rather than authority acceptance (Haug and Sussman, 1969; Reeder, 1972), and involving bargaining and negotiations (Hayes-Bautista, 1976; Danziger, 1978).

A consumerist stance clearly constitutes a challenge to physician authority. It focuses on purchaser's (patient's) rights and seller's (physician's) obligations, rather than on physician rights (to direct) and patient obligations (to follow directions). Caveat emptor, "let the buyer beware," rather than trust in the seller's goodwill, characterizes the transaction. In a consumer relationship, the seller has no particular authority; if anything, legitimated power rests in the buyer, who can make the decision to buy or not to buy, as he or she sees fit.

Patient consumerism, furthermore, implies at least a belief in a narrowed competence gap between the sick person and the care-giver. Instead of the assumption that peers—other physicians—alone are trained and sufficiently knowledgeable to judge the quality of the product (Freidson, 1975), now the consumer can make the assessment (Lebow, 1974; Haug, 1980), presumably on the basis of knowledge acquired through experience, patient education, or the media. One indicator of the current phenomenon is the spate of do-it-yourself

health books in recent years (e.g., Boston Women's Health Collective, 1973; Sehnert and Eisenberg, 1975; Vickery and Fries, 1976), implying that self-care is appropriate, and that physicians are not necessary for handling all symptoms and attendant ailments. In short, consumerism is incompatible with the sick-role model of the dependent patient and the doctor authority figure; a doubting consumer does not fit the Parsonian picture.

Moreover, physicians themselves are increasingly recognizing the changing model of the patient interactions in which they engage. A professor of medicine recently observed at Yale that "the traditional conceptions of professional authority are being challenged by a more educated and more egalitarian society" (Pellegrino, 1977, p. 10), and a Harvard Medical School physician, in an address entitled "Patient Power," has criticized "traditional physician paternalism and patient submission," urging more patient participation in clinical decision-making (Slack, 1977).

Finally, the implication flowing from patients' consumerist perspective and physicians' recognition of this stance is that the doctor-patient interaction itself may have changed. In certain instances it may now be based more on a bargaining than on a dominance model. Early suggestions of such a model appeared in Roth's (1963) study of doctor-patient relationships in a TB hospital, and in the work of Katz and colleagues (1969) dealing with an exchange conceptualization of the interplay between professionals and clients in the Israeli Health Service. More recently, negotiation as an approach to understanding how doctors and patients deal with each other has been explored at Massachusetts General Hospital (Lazare et al., 1978) and with respect to urban Chicana patient behavior in San Francisco (Hayes-Bautista, 1976).

From the bargaining perspective, each party to the interaction brings different resources to the encounter, and is prepared to negotiate an acceptable set of terms for the relationship, which may include agreements on both diagnosis and treatment. Thus neither participant is automatically in charge. Physicians can bring to bear not only their store of knowledge and experience but also their institutionalized role of gatekeeper to desired services and medications, and a tradition of authority (Haug, 1978).

Patients also have resources, including their own fund of knowledge and experience (Stimson and Webb, 1975), the threat (overt or implied) to take their business elsewhere (Freidson, 1961), and their institutionalized right to "informed consent" before any invasive procedures are instituted (Carleton, 1978). The outcome of a particular encounter will depend on the unique mix of resources, as well as needs and motivations, brought into play.

Testing the extent to which patients are currently adopting a consumerist approach in their encounters with doctors, rather than the more submissive stance implied by the sick role, would best be done by systematic observation of a sample of interactions between the participants. In the absence of such data, findings from interviews make it possible at least to assess the extent of reported public attitudes and behaviors that challenge the physician's traditional authority, as well as physicians' reported response to such attitudes and events. Such findings can be interpreted as offering preliminary evidence of the public's propensity to a consumerist relationship and physicians' willingness to accept it.

A recent survey of the public and of primary-care physicians provides empirical data of this type. Specifically, the study addressed the following research questions: (1) What is the extent of medical consumerism, as expressed by public challenge of physician authority; (2) what is the physician's response to such challenge; and (3) what variables explain a consumerist outlook on the part of the public and its acceptance by physicians?

Before we proceed to the results of the study itself, it is well to lay to rest two misconceptions about the concept of challenge to physician authority. First, it should be noted that authority, a structural characteristic involving the *right* to direct action, must be differentiated from authoritarianism, an intrapsychic phenomenon, or style of exercising that right. Persons in authority may or may not invoke their rights in an authoritarian way. Persons who are authoritarian in their attitudes may or may not be in positions of authority.

Second, it is necessary to distinguish non-compliance, a frequently studied phenomenon in medicine (e.g., Davis, 1967, 1968; Marston, 1970), from rejection of physician authority. As we have noted elsewhere (Haug and Lavin,

1979), patients who fail to follow a recommended regimen may nevertheless recognize their practitioners' right to take charge, and indeed feel guilty about their noncompliance. Others may recognize the right, but fail to comply as an act of medical sabotage, an undercover assertion of autonomy and independence (Marshall, 1981). Conversely, compliance with a regimen may be the result of having persuaded a physician to advise the treatment plan that the patient had in mind and sought to have confirmed when making the health care visit (Hayes-Bautista, 1976). In short, the relationship between compliance and acceptance of physician authority is equivocal. Studies of the one may or may not have a bearing on the other.

## METHODS

### *Sample*

The public sample was selected, using random multistage methods, from noninstitutionalized persons 18 years of age or older in three communities in a Midwestern state—a major metropolitan area, a medium-sized industrial city, and a small semirural town. In the metropolitan area a subset of persons randomly selected from the membership of a prepaid medical group plan was also included. Primary-care physicians in active practice were randomly sampled from the same broad geographic areas, as well as from within the prepaid plan. The overall response rate was 82.5% for the public and 67% for the physicians. Since the physician sample included only two black members, the analysis in this report is limited to white physicians and therefore to whites only among the public.

### *Measures*

*Dependent variables.* The dependent variables tap consumerism in terms of the authority dimension of the doctor-patient relationship. In order to measure the concept two indices were devised: one attitudinal, the other behavioral.

The attitudinal variable, challenging MD authority, which is operationalized in the same way for both the public and physicians, indicates belief in patient responsibility for medical

decisions. This belief is assessed through agreement with four statements concerning patients relying on their own judgment, patients raising questions about the doctor's advice, patients preferring greater discussion of treatment issues, and physicians taking the patient's views into account. The items were adapted from submissiveness statements in the Adorno F. Scale (Robinson and Shaver, 1973). Scores are summed, and the scale is standardized to range from 10 (low challenge/low consumerism) to 20 (high challenge/high consumerism).<sup>1</sup> (Individual items in this scale and in the other multi-item attitudinal scales and behavioral outcome measures described below are listed in the Appendix.)<sup>2</sup>

Behavioral challenge among the public is measured by self-reports of having changed doctors because of dissatisfaction, or having directly told a doctor that what he or she advised was too difficult, too costly, not necessary, or not in keeping with the respondent's own or another's opinion. This index has a range from 0 to 4, with 4 the maximum occurrence of behavioral challenge.<sup>3</sup>

Because the physician behavioral variable assesses response to challenge, it is operationalized differently. Reported actions in the face of real or imaginary challenge situations in which patients stated that medical recommendations were too difficult, not necessary, or too costly, can range from outright rejection of such patients, through efforts to persuade them to accept the physician's point of view, to accommodation to the patient's perspective. Index scores range from 0 to 6, with the latter indicating high accommodation to challenge.<sup>4</sup>

The meaning of low and high values on these two outcome measures merits emphasis. Members of the public adopting attitudes and behaviors congruent with the obedience assumed by the sick role would score low on both, indicating a nonchallenging approach to physicians. On the other hand, persons who tend to a consumerist outlook on relationships with physicians would score high on the challenge variables. It is thus possible to refer to a sick-role, as opposed to a consumerist, type of response with respect to challenge of MD authority on the part of the public. Similarly, physician respondents scoring low on the attitude scale can be said to expect patients to

adopt the sick role, while those scoring high are amenable to a consumerist relationship. Also, physicians scoring low on accommodation with respect to their actions in response to patients' behavioral challenge are dealing with patients from a sick-role perspective, since they have rejected those who raise questions, and those scoring high have responded by engaging in negotiating behavior consistent with an acceptance of consumerism as an appropriate perspective. Middle values on this last measure have a distinct meaning: They indicate that physicians have attempted to persuade patients to their point of view. Mid-scores on the attitude measure, in contrast, indicate ambivalent or mixed views.

*Independent variables.* The rationale for the selection of independent variables for the analysis is rooted in the power paradigm underlying the study, the factors chosen being expected to affect obedience to authority in general and thus to authority in the doctor-patient relationship.

Since earlier research has suggested that younger, better educated, and more affluent persons are more likely to question physician authority (Haug, 1976), age, education, and income are included. Possible differences in obedience to rules and acceptance of authority by gender provide the rationale for including sex as a variable; the likelihood of greater sophistication, and thus more skepticism toward authority, in urbanized areas is the basis for including level of urbanization of community. Respondent's age is measured by actual chronological age, education is categorized in seven levels from 1 (seventh grade or less) to 7 (postgraduate education), and level of urbanization is scored from 1 for small town to 3 for metropolitan area.

Since the consumerist concept turns on a narrowed "competence gap" between physician and patient, variables suggesting patient expertise are central to the study. Thus, for the public, level of health knowledge and prior experience of medical error are included, and among physicians a measure of belief in the patient as knowledgeable is relevant. Level of health knowledge is operationalized by combining scores indicating the accuracy of definition of six medical terms—antibiotic, glucose, sutures, electrocardiogram, hemoglobin, and serum cholesterol—with those indicating the

correctness of information as to whether four ailments—diabetes, polio, tuberculosis, and anemia—are catching or not. Total scores for health knowledge range from 0 (low) to 16 (high). To measure physicians' perception of patients as knowledgeable, an index is derived by combining scores on three items assessing differences between past and current patients in level of health knowledge and respect for the professional's knowledge. Scores range from an image of patients as less knowledgeable (10) to highly knowledgeable (50).

For both the public and practitioners, indices of belief in the patient's rights to information and to make decisions are used as assessments of the patient's right to take responsibility for specific health care decisions. Statements from the American Hospital Association's Bill of Rights (Annas, 1975, p. 235) were used to evolve these indices. The level of agreement or disagreement produces scales that range from 10 (no belief in patient's right to information or to make decisions) to 50 (strong belief in these two rights).

Since patients' power as consumers has been posited to vary depending on whether clients are paying directly for care, as in a fee-for-service arrangement, or are in a prepaid system (Freidson, 1975; Bloom and Wilson, 1979), membership/nonmembership in the prepaid group is included as an explanatory factor.

On the grounds that persons in better health might be more willing to adopt a consumerist stance, health status is used as a variable. This rationale is directly applicable to the public, but is less obviously relevant to physician response to patient consumerism. The variable is nevertheless included in the physician analysis because of the likelihood that it is related to practitioners' doubts about the efficacy of their professional services, a view that in turn would make patient challenges more understandable and perhaps acceptable. Health status is measured by an index comprising a self-assessment of health in the prior month, an evaluation of the respondent's degree of healthiness on a 7-point scale ranging from "sickly" to "healthy," and the presence or absence of chronic illness. The overall index scale ranges from 3 (poor health) to 11 (excellent health).

Because public attitudes and behaviors concerning physicians are clearly related to the extent of their medical experience, utilization

of physicians' services in the past year is included as a dichotomous variable, scored as use/nonuse.

Respondents' evaluation of physicians' fulfillment of the professional role that accords them the right to authority is measured by belief in their competence as well as belief in their dedication to serving the patient. Belief in the competence of physicians is operationalized by six items covering physician error and extent of knowledge, and belief in physicians' dedication to service is measured by three items assessing the degree of physicians' personal concern for patients. Both scales were adapted from an earlier measure created by Zyzanski and colleagues (Zyzanski et al., 1974). In addition, specialty is included as a physician variable on the grounds that even among primary-care practitioners, there are likely to be differences in expertise between general practitioners, family physicians, pediatricians, and internists.<sup>5</sup>

Finally, since a tendency to reject authority in general might express itself in challenging physician authority in particular, a measure of such a tendency is inserted for both the public and physicians as an explanatory variable. An overall attitude that denies the legitimacy of authority is conceptualized as a relatively stable trait, resulting from early socialization processes. It is therefore treated as affecting authority relations with physicians, rather than the reverse. Although a reciprocal, reinforcing relationship between the two variables is a possibility, it is considered unlikely and not so treated in the analysis. The tendency to reject authority in general is assessed through agreement with the same four statements used in measuring the attitudinal challenge to MD authority variable, but in this instance the referents in the statements are parents and children rather than physicians and patients.

## FINDINGS

The white segment of the public sample used in this report ( $N = 466$ ) ranges in age from 18 to 91, with an average age of 49 years. This subsample is 73% of the total public respondents, who number 640. It is divided about equally between males and females. Thirty-one percent have some college education, and 34% graduated from high school. Median annual

earnings are \$10,000. The group is thus somewhat older and better educated than the adult white population as a whole, but claims to earn somewhat less than the average. The respondents in this subsample view their health as very good or excellent—54% have ratings with these meanings.

The physician sample ( $N = 86$ ) ranges in age from 29 to 89, with a mean of 52. Only two of these white physicians are female. As expected, all have education beyond college, and their median family income is \$45,000. In short, this sample seems reasonably typical of the medical profession. Two-thirds consider their health good or excellent.

With respect to the first question posed in this research, the extent of consumerism in medicine, the findings show that 60% of the public sample have scores of 17 to 20 on the attitudinal scale of challenging MD authority (Table 1), indicating by their self-reports a propensity to adopt a consumerist perspective in medical encounters. As for physicians, they, too, report attitudes congruent with the consumerism phenomenon. Indeed, 81% claim views that question physician authority, a higher percentage than the public evidences on the same index.

In attitudinal terms, then, a substantial portion of the public takes a consumerist position, claiming the right, if not to be in charge, at least to take some responsibility for medical decision-making instead of leaving it entirely in the physician's hands. The physicians themselves express a willingness to abrogate at least some measure of their authority and control.

**TABLE 1. Consumerism as Attitudinal Challenge to MD Authority: The Public and the Physician**

Score	Willingness to Question MD Authority	
	Public %	Physician %
Low 10-12	4	0
13-14	11	4
15-16	26	16
17-18	39	47
High 19-20	21	34
Total	101	101
N	463 <sup>a</sup>	86

<sup>a</sup> The difference from the total number of cases, 466, is due to missing data.

The public's self-reports of actual instances of challenging behavior exhibit a different pattern (Table 2): Fewer than half indicate they have ever taken an action that questioned the doctor's authority. Clearly, such action is dependent on opportunity; persons who do not visit a doctor, or if visiting find themselves in agreement with a recommended regimen, do not have occasion to challenge. Thus the fact that 30% report a single instance of confrontation, and 17% report two or more such episodes, indicates that the traditional authority of the medical profession is indeed being challenged by many in actual behavior, as well as attitudes.<sup>6</sup>

In contrast, only 8% of the physicians score at the high point of the scale measuring behavioral accommodation to patients' challenging action, meaning that only a few actually claim to accept patient demands for participation in decision-making. Forty-nine percent score at the midpoint or above, indicating at least reported past use of persuasion when challenged instead of relying on traditional authority. However, it is noteworthy that persuasion implies that the physician is attempting to remain in control of the situation.

Not unexpectedly, distributions for both the public and physicians on attitudes fail to correspond to their behavioral reports. This is another example of the disjuncture between propensity to act and realized actions, often

**TABLE 2. Consumerism as Behavioral Challenge to MD Authority: Public Action and Physician Response**

Behavioral Challenge by the Public	Accommodation to Patients' Behavioral Challenge by the Physician		
	Challenge Instances	%	
None	53	Low 0	8
One	30	1	18
Two	12	2	25
Three or more	5	3	25
Total	100	4	16
N	462 <sup>a</sup>	High 5, 6	8
		Total	100
		N	85 <sup>b</sup>

<sup>a</sup> The difference from the total number of cases, 466, is due to missing data.

<sup>b</sup> The difference from the total number of cases, 86, is due to missing data.

noted in the literature. Although the rationale for attitude-behavior differences can take a number of forms, both theoretical and methodological, variations in the situational context in which any behavior occurs are usually considered the most likely explanation. (For a thorough discussion of this complex issue, see Schuman and Johnson, 1976.) In this study, it should be noted that challenging behavior on the part of the public is incumbent on persons having the opportunity to take such action as a result of contact with a physician whose recommendations do not fit their wishes. Such limitations are less likely to apply to physicians, since they interact with patients almost daily. In their case, the attitudes they report may reflect adherence to socially acceptable democratic and nonauthoritarian tenets, whereas their actions reflect the pressures of patient management. Furthermore, the training of physicians lays heavy stress on their taking responsibility for their patients, which would seem to require the authority to be in charge and, if necessary, to take control in order to carry out that responsibility despite patient objections.

Answers to the question of what explains the public's consumerism and the physicians' responses to this phenomenon were explored in four path models, covering both attitudinal and behavioral aspects among both groups. The demographic variables of age, income, and urban location were included as exogenous independent variables for both groups, as well as level of health status and views about authority in general. Sex and education were added for the public analysis, along with use/nonuse of physician services in the prior year. (Sex and education were omitted from the physician analysis because only 2 of the 86 physicians are female, and education is constant for the group.) First-level endogenous variables in both public and physician analyses were belief in MD competence, belief in MD service, patients' right to make decisions, patients' right to information, and method of payment. For the public analyses, health knowledge and experience of medical error were also included; for the physician analyses, specialty and image of current patients as knowledgeable were added. Finally, attitudinal challenge was inserted as a second-level endogenous variable for both groups in the path models for behavioral chal-

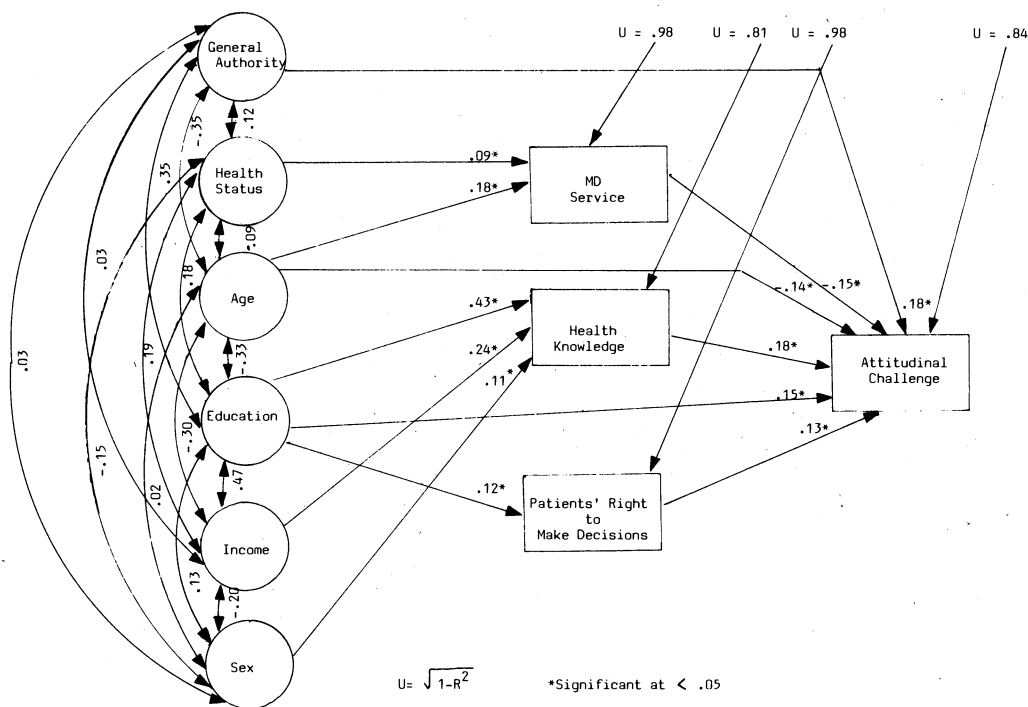
lenge. After fully saturated models with all these variables were calculated, paths not significant at the .05 level were eliminated, resulting in some variables being dropped from the models. The models were then recalculated, leading to the pruned versions presented in Figures 1-3.

The exogenous variables with a direct effect on the public's consumerist stance in relating to physicians are age, education, and general views on authority (Figure 1). The younger ( $B = -.14$ ), better educated ( $B = .15$ ) who tend to reject authority in general ( $B = .18$ ) are most likely to challenge a physician's authority, thus evidencing a consumerist attitude rather than one based on sick-role expectations. Furthermore, both better health status and older age relate to a belief in physicians' service orientation, and this variable is negatively related to the outcome measure ( $B = -.15$ ). Not surprisingly, those who doubt a physician's goodwill are more likely to adopt a consumerist attitude. Moreover, greater health knowledge, which is related to higher education, higher income, and female sex, exhibits one of the strongest effects on attitudinal challenge ( $B = .18$ ). Finally, those who believe in patients' right to make decisions (these respondents tend to be the better educated) are also likely to adopt a consumerist attitude ( $B = .13$ ). In all, 30% of the variance in attitudinal challenge is explained by the model. It is noteworthy that urban residence, belief in physician competence, method of payment for services, and belief in patients' right to information do not survive this path analysis, nor do experience of medical errors and prior year utilization.

The public's consumerist behavior exhibits a different explanatory pattern (Figure 2). The only exogenous variables with a direct effect on behavior are age and the respondent's health status. Younger persons ( $B = -.11$ ), and those who claim worse health ( $B = -.14$ ), are more apt to have engaged in consumerist than sick-role actions. However, experience of medical error has the strongest impact ( $B = .27$ ): Those who have endured negative episodes are more likely to have exhibited behavioral challenge. Seeing oneself in worse health is also related to claims of medical error, as are younger age and higher education. Furthermore, those reporting better health are more likely to believe in physician compe-



**FIGURE 1. The Public: Path model of factors affecting attitudinal challenge to MD authority (pruned version)**



**FIGURE 2. The Public: Path model of factors affecting behavioral challenge to MD authority (pruned version)**

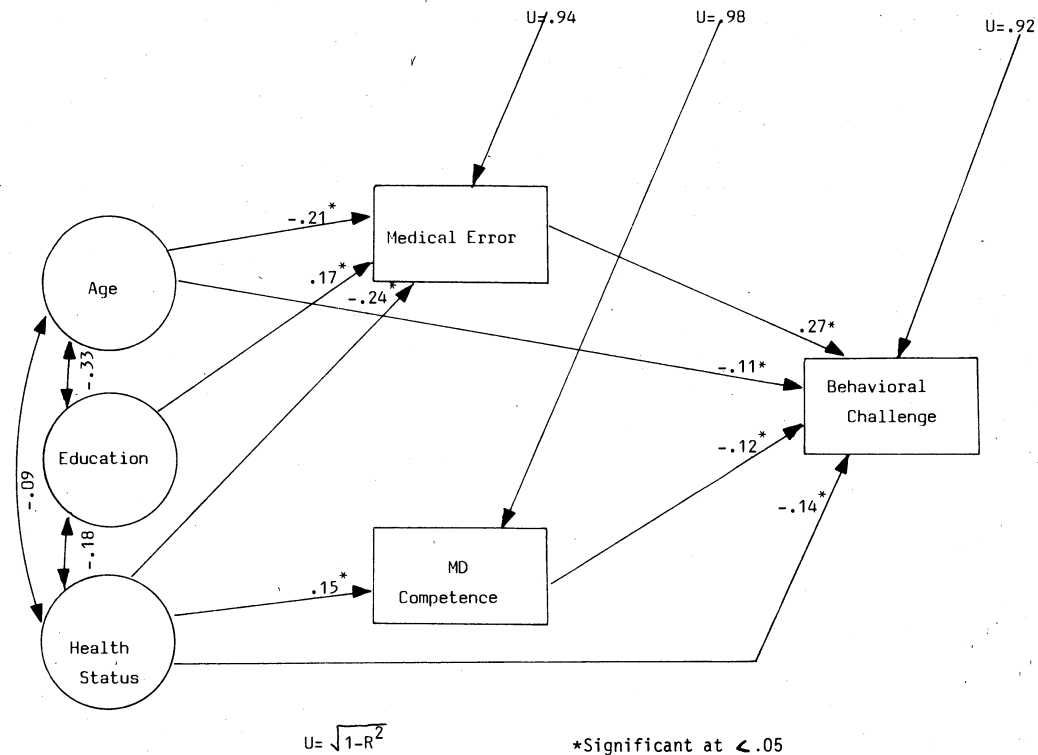
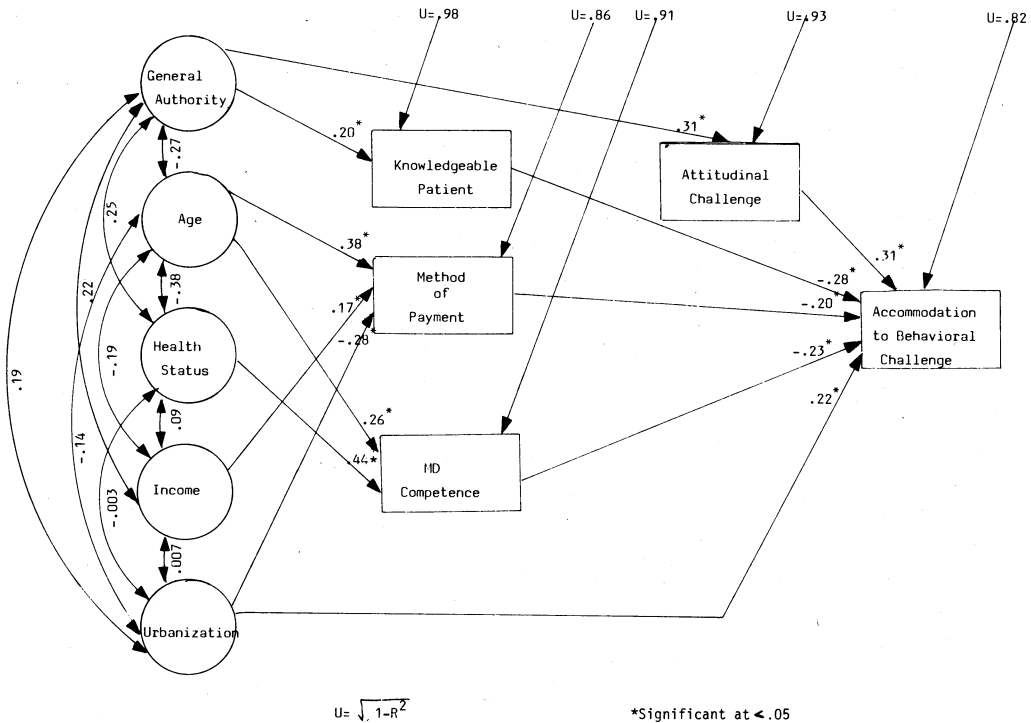


FIGURE 3. The Physician: Path model of factors affecting response to behavioral challenge (pruned version)



tence; but this latter variable is negatively related to challenging behavior ( $B = -.12$ ). In all, 15% of the variance in consumerist actions is explained. Notably, belief in physician service orientation, health knowledge, income, and urbanization of residence all drop from the model, as do the two indicators of patient rights, method of payment, and prior year utilization. Perhaps most significantly, a challenging attitude fails to affect behavior sufficiently to survive in the model.

The model for physician attitudes toward their own authority is simple indeed, and requires no illustrative figure. Among all the variables, only views on authority in general have an effect on attitudes toward physician authority. The more liberal on one, the more liberal on the other ( $B = .31$ ). All other variables drop from the model, which explains only 10% of the variance.

Physicians' reported behavioral response to patient consumerism exhibits a more complex pattern (Figure 3). However, among the exogenous variables only level of urbanization has a direct effect. Big-city dwellers are more apt to accommodate to challenge ( $B = .22$ ).

Practitioners who doubt physician competence are more likely to accept consumerism ( $B = -.23$ ), but the competence variable is itself positively related to older age and better health status: Older physicians in good health are less likely to question physician competence. Those who believe current patients are more knowledgeable, a factor related to general belief in authority, are *less* likely to accommodate to challenge ( $B = -.28$ ). A possible explanation for this anomalous finding is given below. Among physicians, attitudinal challenge, whose only antecedent is attitude to authority in general, has the most marked effect on behavior ( $B = .31$ ). The method of payment variable, which is affected by age, income, and level of urbanization, also helps to explain accommodation to patient challenge. Physicians in a prepaid plan are more likely to be accommodating ( $B = -.20$ ). In all, 33% of the variance is explained.

Tables 3 and 4 provide data on the direct and indirect effects in the models for attitudes and behavior among both physicians and the public. All indirect effects have been calculated to exclude spurious and joint associations so that

**TABLE 3. Direct and Indirect Effects on Consumerism in Terms of Attitudinal and Behavioral Challenge to Physician Authority: Public Sample**

	Attitudinal Challenge			Behavioral Challenge		
	Direct <sup>a</sup>	Indirect <sup>b</sup>	Intervening Variables	Direct	Indirect	Intervening Variables
<i>Exogenous Variables</i>						
Age	-.14	-.03	MD service	-.11	-.06	Medical error
Sex	None	.02	Knowledge	None	None	
Education	.15	.09	Knowledge, decisions	None	.05	Medical error
Health status	None	-.01	MD service	-.14	-.08	Medical error, MD competence
Income	None	.04	Knowledge	None	None	
Urbanization	None	None		None	None	
General rejection of authority	.18	None		None	None	
Prior year utilization	None	None		None	None	
<i>Endogenous Variables</i>						
MD competence	None	None		-.12	None	
MD service	-.15	None		None	None	
Medical error	None	None		.27	None	
Health knowledge	.18	None		None	None	
Method of payment	None	None		None	None	
Right to information	None	None		None	None	
Right to make decisions	.13	None		None	None	
Attitudinal challenge	—	—		None	None	
	R <sup>2</sup> = .30			R <sup>2</sup> = .15		

<sup>a</sup> Direct effects are path coefficients (standardized beta weights). The only effects reported are those significant at the .05 level or better.

<sup>b</sup> The indirect effects reported are calculated to exclude spurious or joint association.

**TABLE 4. Direct and Indirect Effects on Consumerism in Terms of Attitudinal and Behavioral Challenge to Physician Authority: Physician Sample**

	Attitudinal Challenge			Behavioral Challenge		
	Direct <sup>a</sup>	Indirect <sup>b</sup>	Intervening Variables	Direct	Indirect	Intervening Variables
<i>Exogenous Variables</i>						
Age	None	None		None	-.14	Method of payment, MD competence
Health status	None	None		None	-.10	MD competence
Income	None	None		None	-.03	Method of payment
Urbanization	None	None		.22	.06	Method of payment
General rejection of authority	.31	None		None	.04	Attitudinal challenge, knowledgeable patients
<i>Endogenous Variables</i>						
MD competence	None	None		-.23	None	
MD service	None	None		None	None	
Specialty	None	None		None	None	
Method of payment	None	None		-.20	None	
Right to information	None	None		None	None	
Right to make decisions	None	None		None	None	
Knowledgeable patients	None	None		-.28	None	
Attitudinal challenge	—	—		.31	None	
	R <sup>2</sup> = .10			R <sup>2</sup> = .33		

<sup>a</sup> Direct effects are path coefficients (standardized beta weights). The only effects reported are those significant at the .05 level or better.

<sup>b</sup> The indirect effects reported are calculated to exclude spurious or joint association.

the sum of the reported direct and indirect effects is the causal component of the association between variables (Alwin and Hauser, 1975). For the public sample (Table 3), sex, health status, and income have only indirect effects for attitudinal challenge, and these effects are small. Education has only indirect effects on behavioral challenge, and again the amount mediated by other variables is minimal. In the case of the physician sample (Table 4), with respect to behavior the effects of age, health status, income, and a general rejection of authority are limited to an indirect relationship. Of these, the largest is age ( $B = -.14$ ).

## SUMMARY AND DISCUSSION

What do these findings mean in terms of the research questions investigated? Is consumerism in medicine a contemporary phenomenon, and if so, what explains it? Certainly the data indicate that the traditional asymmetrical relationship based on the competence gap, with the physician in charge as an agent of social control, does not hold universally. Substantial percentages of both the public and physicians espouse a consumerist perspective attitudinally, although the extent of adherence drops when behavior is assessed.

Furthermore, the findings have uncovered a possible group of the public—younger, more knowledgeable, more rejecting of authority in general, skeptical of physicians' service orientation, and convinced of their right to make health care decisions—who at least believe that physicians should not always be in charge. How these types of persons will actually behave when confronting a practitioner is not clear. Consumerist attitudes are not explanatory of consumerist behavior. Instead, negative experiences dominate the causal pattern. Those who claim to have challenged a physician's authority tend to be younger, believe that medical errors occurred in their care and that physician competence leaves something to be desired, and perceive their health as poorer. These characteristics certainly describe facets of a typical consumer-oriented individual—younger, more knowledgeable, and perhaps one who has experienced an unsatisfactory transaction in the past. This type is likely to resist having a physician solely in

charge in the doctor-patient relationship, at least in those episodes where he or she is well enough to resist.

What of the other actor in the encounter? Physicians' views on their authority vis-à-vis patients are influenced only by their point of view on authority in society in general. When it comes to their reported behavior, very few are willing to accommodate to patient demands; at best, they will attempt to remain in charge through persuasion. Their attitudes have some effect on their behavior: Those less committed to the idea of physician authority are more likely to persuade or accommodate. These respondents are apt to be in the larger city, to be in a prepaid plan, to have some doubts themselves about physician competence, and, finally, to consider patients as not particularly knowledgeable and thus perhaps in need of the education implied by the use of persuasion.

Although direct comparisons between causal models for physicians and public are not appropriate because of necessary differences in the explanatory factors postulated as relevant for each, it is intriguing to contrast the varying effectiveness of the models in the two groups. Among the public, attitudes were better explained (30%) than behavior (15%), whereas the opposite holds for the physicians. Only 10% of their attitudinal variance is explained, as against fully 33% of the variability in their behavior.

Do these findings reveal a new model of the doctor-patient relationship that relegates the sick role to the sociological history books? Such a claim would be exaggerated for a number of reasons. In the first place, the linkages between the challenge measures and consumerism, as well as between consumerism and rejection of the sick role, are based on logical and theoretical considerations, rather than on empirical demonstration. Moreover, the data are derived from self-reports and recall rather than from observation of the actual actions of the sick. It is more accurate to argue for the possibility of two competing models that apply differentially, depending on the characteristics of the actors, their orientation to power and dependence, and the circumstances under which they meet.

For example, from the patient perspective, the sick-role model is most likely to characterize a situation in which an older person, who

has been socialized to accept a physician's authority and goodwill, suffers from a rare, serious, disabling condition and is interacting with an established specialist in treating the condition. Conversely, the consumerist model may well be applicable to the situation in which a younger person, socialized to question anyone's authority, even that of a physician, has contracted a common ailment and is interacting with a physician who is a stranger and whose specific qualifications are unknown. Between these polar opposites, any mixtures of characteristics, orientations, and situations are possible. An older person with a long-standing chronic ailment can be so familiar with symptoms and treatments that he or she is quite willing to take a consumerist stance with any physician. A young person who is extremely ill may abandon a consumerist stance and accept the doctor's control in a desperate need to get well. In short, as Szasz and Hollender (1956) suggested 25 years ago, the power relationship between patient and doctor is strongly affected by the situational factor of the nature of the illness.

Clearly, the findings of this study have not fully tested these propositions. Very sick people are not available for interview in a survey. However, the findings do suggest the possibility of such competing or, more accurately, alternative models, whose applicability depends on a variety of situational factors. And they do reveal that the answer to the question—practitioner or patient, who's in charge?—is, it depends on who the doctor is, who the patient is, and why they have met.

An intriguing set of cross-relationships, admittedly speculative, is also suggested by these findings (Table 5). When the consumerist patient meets the physician who wants to take total responsibility, the outcome is conflict. In the ideal case, the patient will either find a

more congenial doctor on his or her own or be told to go elsewhere. If the consumerist patient finds a consumerist physician who is willing to negotiate acceptable terms on diagnosis and treatment, the parties will tend to stay together and will very probably develop trust.

When the patient who prefers dependent relationships meets a physician who feels it appropriate to be in charge, a happy congruence of controller and controlled should follow, and perhaps a long-term relationship. When this "do-me" patient meets a physician who prefers not to use an authority-based approach, both may be uncomfortable. The relationship can decay into the physician's taking charge, as the patient prefers, or the patient may seek a more "take-charge" practitioner.

These speculations ignore the extent to which structural and situational constraints would modify the pattern of relationships. For example, the consumerist patient confronted with a take-charge doctor may not have the economic flexibility to make a change, just as the doctor may not be able to afford to alienate such a patient. The same pair could be bound together by the fact that the patient has an unusual condition in which only the particular physician is expert in the community. Organizational imperatives, as well as illness characteristics, add new dimensions to the social-psychological model of doctor-patient relationships.

Another structural factor, on the other hand, may facilitate patient consumerism. There is some evidence of change in the value system of the society with respect to the appropriate relationship between doctor and patient. For example, a recent flyer from the Information Office of the National Institute on Aging, Department of Health and Human Services, addressed to older persons, declared, "Remember that you are a consumer, entitled to

**TABLE 5. The Dynamics of Who's in Charge**

Patient Orientation	Physician Orientation	
	Take Charge	Persuade or Accommodate
Consumerist	Conflict. Patient will get or be told to get a new doctor.	Bargaining to agreement, perhaps leading to developing mutual trust.
Dependent	A happy congruence of controller and controlled.	An uncomfortable disjuncture. May decay into doctor being in charge, or patient may try to find a more "take-charge" doctor.

ask questions when selecting a doctor, and to expect reasonable satisfying answers, not age-worn cliches. A good doctor/patient relationship is based upon respect, open communication and collaboration, and is, in essence, *a contract of equals* between physician and patient."

#### NOTES

1. Test-retest reliability for this attitudinal outcome variable, using 320 adult student responses, equaled .60.
2. Further details on measurement of variables will be supplied by the authors upon request.
3. Occurrence of behavioral challenge is measured on the basis of all past experience, and appears unrelated to recent physician exposure. The correlation between utilization of physician services

in the past year and reported behavior challenge is .10; use thus explains only 1% of the challenge variable.

4. Physicians were first asked what their behavior had been when faced with these patient actions. If they claimed never to have had the experience, they were asked what they would have done in such circumstances; many were then able to report actual instances of patient challenge and their response to the event.
5. Differences in expertise would occur because of variations in type and length of training during residencies, as well as in professional expectations such as board certification.
6. These findings are congruent with the results of a more recent study on challenge and utilization (Haug and Lavin, 1980) in which a random sample of the public (N = 1,509) indicated very similar attitudinal and behavioral challenge levels.

#### APPENDIX

##### Major Multi-Item Scales and Their Distributions

Variable Name and Description	Scale Items	Scale Categories	Percentage of Cases		
			Public	Physicians	
<i>Attitudinal Challenge to MD Authority</i> (Developed from 4 items, each consisting of alternative opinions, scored 1 for submissive, and 2 for challenging, attitude to physician authority. The scores were summed, divided by the number of responses, and multiplied by 10 to avoid fractional values. Starred items were coded as challenging responses.)	1. Obedience and respect for what doctors tell you is most important.	Low challenge			
		10-12	4	0	
		13-14	11	4	
	*Relying on your judgment and making your own decisions about what doctors tell you are most important.	15-16	26	16	
		17-18	39	47	
		High challenge	19-20	21	34
				N = 463	N = 86
	2. If doctors would discuss less with patients and tell them straight out what to do, everybody would be better off.				
	or				
	*If doctors would discuss matters more with patients before acting, everybody would be better off.				
3. *In making health decisions, the doctor ought to take a patient's opinion into account.					
or					
The doctor ought to have the main say-so in deciding what to do about a person's health problems.					
4. *It's all right for people to raise questions with doctors about anything they tell you to do.					
or					
Every person should have complete faith in doctors and do what they tell you without a lot of questions.					

APPENDIX (Continued)

Variable Name and Description	Scale Items	Scale Categories	Percentage of Cases	
			Public	Physicians
<p><i>Behavioral Challenge to MD Authority (The Public)</i>                      (Weighted scale developed from 7 items. Five items, reporting challenges to doctor's advice, were coded 1 for no challenge, and 2 for challenge, then summed, divided by number of responses, and multiplied by 10 to avoid fractional numbers. A value of 10, indicating no advice challenge, was scored 0; 11 or 12, indicating one such episode, was scored 1; 13 to 20, indicating more than one instance of challenge, was scored 2. Added to these values were items 6 and 7, which were scored 1 for each reported behavior.)</p>	Have you ever told a doctor that:	No		
	1. What he advised was too difficult or too much trouble?	challenges 0	53	
	2. You didn't think what he advised was necessary for your condition?	One 1	30	
	3. You had advice from friends or family which seemed to make more sense?	Two 2	12	
	4. What he advised cost too much?	Three or four 3	5	
	5. His advice did not fit what you read about or saw on TV?			N = 462
	6. Have you or your family ever gone to a second doctor to get his opinion about some condition without telling your first doctor?			
<p><i>Accommodation to Patients' Behavioral Challenge to the Physician (The Physician)</i>                      (A summated value derived from 3 items, each consisting in the face of patient challenge: rejection, scored 0; persuasion, scored 1; accommodation, scored 2.)</p>	7. (Elicited from question asking "What were the most important reasons for changing doctors?" and coded 0 for never changed and 1 for reasons reflecting changing for dissatisfaction.) Changing physicians because of any of several types of dissatisfaction.			
	1. The last time a patient suggested what you advised was too difficult or too much trouble, what did you do?	Low accommodation		
	2. How about the last time a patient told you what you advised was not necessary for his/her condition?	0	8	
	3. What did you do the last time a patient told you that what you were suggesting cost too much?	1	18	
		2	25	
		3	25	
		4	16	
	High accommodation 5, 6	8	N = 85	
<p><i>Belief in Patient's Right to Information</i>                      (Developed from 3 items with Likert-type scale, scored 1 for no belief in patient's right to information to 5 for strong belief in this right. Agreement with an item indicated belief in the right. The scores were summed, divided by the number of responses, and multiplied by 10 to avoid fractional values.)</p>	1. If a patient asks to read his own medical records, they should be given to him.	Low belief		
	2. Doctors should be required to explain the reasons for any treatment or prescription they recommend to a patient.	13-20	1	4
	3. Doctors should make completely clear to a patient the risks for any treatment or operation.	21-30	3	27
		31-40	35	38
		41-49	37	19
		High belief 50	23	13
				N = 465
			N = 86	

## APPENDIX (Continued)

Variable Name and Description	Scale Items	Scale Categories	Percentage of Cases	
			Public	Physicians
<i>Belief in Patient's Right to Make Decisions</i> (Developed from 3 items with Likert-type scale, scored 1 for no belief in patient's right to make decisions to 5 for strong belief in this right. Agreement with the statement indicated belief in the right. The scores were summed, divided by the number of responses, and multiplied by 10 to avoid fractional values.)	1. If no contagious disease is involved, a patient should be allowed to leave the hospital even though his doctor does not agree. 2. A patient should make the final decision whether to go along with the doctor's advice even if the decision is to refuse treatment. 3. When a person is in the last stages of a terminal illness that cannot be cured, the patient or his family should decide if further treatment should be continued.	Low belief		
		13-20	7	4
		21-30	28	18
		31-40	50	36
		41-49	11	21
		High belief	3	22
			N = 465	N = 86
<i>Belief in MD Competence</i> (Developed from 6 items, each coded on Likert-type scale, and scored so that the higher value indicated a positive evaluation of physicians' competence, a lower value a negative evaluation. A weighting factor, developed by Zyzanski et al. (1974), was multiplied by each item value, and then a summated score was formed from all items. Starred items were recoded so that a high score consistently indicated high belief in physicians' competence.)	1. *People do not know how many mistakes doctors really make. 2. Today's doctors are better trained than ever before. 3. *No two doctors will agree on what is wrong with a person. 4. Doctors will do everything to keep from making a mistake. 5. *Many doctors just do not know what they are doing. 6. *Doctors are put in a position of needing to know more than they possibly can.	Low belief		
		21-30	1	1
		31-40	8	3
		41-50	40	22
		51-60	46	48
		High belief	6	26
		N = 464	N = 86	
<i>Belief in MD Service</i> (Developed from 3 items, each coded on Likert-type scale, and scored so that a higher value indicated a positive evaluation of physicians' concern for patients, a lower value a negative evaluation of their concern. A weighting factor, developed by Zyzanski et al. (1974), was multiplied by each item value, and then a summated score was formed from all items. Starred items were recoded so that a high score consistently indicated high belief in physicians' service orientation.)	1. *Doctors act like they are doing you a favor by treating you. 2. *Many doctors treat the disease but have no feeling for the patient. 3. Most doctors take a real interest in their patients.	Low belief		
		8-16	6	17
		17-22	16	45
		23-28	32	37
		29-34	35	0
		High belief	11	0
		N = 464	N = 86	



APPENDIX (Continued)

Variable Name and Description	Scale Items	Scale Categories	Percentage of Cases		
			Public	Physicians	
<i>General Rejection of Authority</i> (Developed from 4 items, each consisting of alternative opinions, scored 1 for submissive, and 2 for challenging, attitude to authority in general. The scores were summed, divided by the number of responses, and multiplied by 10 to avoid fractional values. Starred items were coded as challenging responses.)	1. *In making family decisions, parents ought to take the opinion of the children into account.	Low challenge			
		10-12	4	5	
		13-14	16	13	
		15-16	33	20	
	or				
	Parents ought to have the main say-so in deciding what to do about a child's problem.	17-18	30	29	
		High challenge	19-20	17	34
	2. Obedience and respect for authority are the most important things children should learn.			N = 462	N = 86
	or				
	*Relying on their own judgments and making their own decisions are the most important things children should learn.				
3. *It's all right for people to raise questions about even the most sacred matters.					
or					
Every person should have complete faith in some supernatural power whose decision he obeys without question.					
4. If people would talk less and work more, everybody would be better off.					
or					
*If people would discuss matters more before acting, everybody would be better off.					

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## Expecting Sick-Role Legitimation and Getting It

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*In this paper we examine the relationship of individual expectations for and receipt of sick-role legitimation. Specifically, in two stages we identify and contrast the background, attitudinal, behavioral, and health-services-utilization characteristics of four analytic groupings of individuals in the ambulatory care setting: (1) those who expect sick-role legitimation (i.e., expecters) versus those who do not (i.e., nonexpecters); and (2) those who expect sick-role legitimation and get it (i.e., winners) versus those who expect it but do not get it (i.e., losers). Data from a 1978 regional survey of 500 respondents demonstrate that those who expect sick-role legitimation are members of older cohorts who typically have lower socioeconomic status characteristics and are more likely to need sick-role legitimation as a function of their perceived physiological deterioration. Those who expect sick-role legitimation and get it (i.e., winners) are more likely to be less educated, and to have a regular doctor whom they see more often, than those who do not get sick-role legitimation (i.e., losers). Finally, we speculate on the impact that these findings may have in light of changing American values and social structure regarding physician authority, doctor-shopping, and the relationship between the sick role and "lower class behavior."*

It has been said that Parsons' (1951, 1958, 1975) conceptualization of the sick role is the

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single most important contribution to the sociology of health because it offers the most systematic and consistent framework for analyzing the socially necessary behavior of sick individuals in American and other Western societies (see Fox, 1979; Wolinsky, 1980). Indeed, although the literature criticizing Parsons' concept of the sick role continues to grow (see Berkanovic, 1972; Blackwell, 1967; Callahan et al., 1966; Chalfant and Kurtz, 1971; Denzin and Spitzer, 1966; Erikson, 1957; Gallagher, 1976; Goldstein and Dommermuth, 1961; Gordon, 1966; Kassebaum and Baumann, 1965; Lipman and Sterne, 1969; Mechanic, 1959; Mechanic and Volkart, 1961; Petroni, 1969a, 1969b, 1969c, 1972; Phillips, 1965; Roman and Trice, 1968; Rosengren, 1962a, 1962b; Segall, 1976; Sobel and Ingalls, 1964; Suchman, 1964, 1965a; Thomas, 1966), there is general agreement that Parsons' contributions have been both profound and of