PROFESSIONAL INDIVIDUALISM VS. COLLECTIVISM:
PHYSICIAN IDENTITY IN A LABOR CONTEXT

BY
KERRY L. SCOTT

THESIS
Submitted in Partial Fulfillment of the Requirements for the Degree of
Master of Arts
Sociology

The University of New Mexico
Albuquerque, New Mexico

May, 2002
DEDICATION

I dedicate this thesis to my family and friends whom I neglected while working on this project, especially my nephew Erik.
ACKNOWLEDGMENTS

I wish to thank Dr. Beverly Burris, my advisor and committee chair, for her theoretical insight, thoughtful feedback, and guidance. I also wish to thank committee members Dr. Richard Coughlin and Dr. Felipe Gonzales, for their input and advice throughout this project.

I am grateful for the support and encouragement from my colleague Warren Wylupski who has been a wonderful sounding board.

I thank my neighbors Chris, Jared, Jerry, Marcus, Pito, and Tasha for on many occasions providing dinner as well as reminding me that community is extremely important and valuable.

I also would like to thank the physicians for graciously taking time out of their busy schedules to be interviewed.
PROFESSIONAL INDIVIDUALISM VS. COLLECTIVISM:
PHYSICIAN IDENTITY IN A LABOR CONTEXT

By

Kerry L. Scott
B.A., Criminal Justice, University of New Mexico, 1988
M.A., Sociology, University of New Mexico, 2002

ABSTRACT

This study compares two subject groups (N=33) of physicians in the southwestern United States. Subjects from both groups were interviewed to obtain data regarding physician identity and unionization. From within a framework of professional identity, questions addressed the conditions of the healthcare environment, reasons behind unionization, goals of unionization, and elements of class consciousness.

The findings suggest that managed care practices carried out through bureaucratic and technocratic processes essentially reduce physicians’ autonomy, authority, and financial independence. The subjects from the group of organized physicians are concerned with all of these factors, but point to financial concerns as being the most pressing and urgent issue. Conversely, the subjects from the group of non-organized physicians are less concerned with all areas, and most noticeably less concerned than the organized physicians are regarding income. However, when efforts to unionize were
previously occurring at the corporation employing the non-organized physicians, subjects reported that at that time both reduced autonomy and the fear of a reduction in income were of great concern.

The employer corporation management had necessary access and, therefore means, to effectively appease the discontent physicians with little expenditure. The insurance companies have no established structure from which to appease non-employee physicians without much expenditure. The structural ability or inability of the employer/insurance company to appease the physicians seems directly related to whether or not the subjects express sentiments of discontent or exhibit characteristics of class consciousness. The non-organized physicians are less likely to be class conscious as management has co-opted their effort and therefore inducted the physicians into the corporate team. The organized, self-employed physicians are more likely to be class conscious as the insurance company has no means, nor desire to appease them, nor necessity to induct them into their team.
### TABLE OF CONTENTS

**LIST OF FIGURES** ................................................................................................................................. x

**LIST OF TABLES** ........................................................................................................................................ xi

**CHAPTER 1: INTRODUCTION and LITERATURE REVIEW** ................................................................. 1

Introduction .................................................................................................................................................. 1

Literature Review ......................................................................................................................................... 4

  Professionalism ......................................................................................................................................... 4

  Bureaucracy and Technocracy ...................................................................................................................... 6

  Collectivism through the AMA .................................................................................................................. 12

  Collective Organization Goals .................................................................................................................. 13

  Class Consciousness ................................................................................................................................. 21

  Managed Care’s Effect on the Physician .................................................................................................... 23

  Conclusion .............................................................................................................................................. 32

**CHAPTER 2: RESEARCH METHODS and FINDINGS** ........................................................................ 34

Research Methods ......................................................................................................................................... 34

Validity ......................................................................................................................................................... 35

Findings ......................................................................................................................................................... 36

  Background – Group A and Group NA ......................................................................................................... 38

  General Demographics .............................................................................................................................. 39

  Reasons for Organizing and Goals ............................................................................................................. 40

    Work Environment – Group A ................................................................................................................... 40

    Industry Response to Alliance Presence – Group A ................................................................................. 47

    Physician Opportunity to Communicate – Group A ................................................................................ 48
Work Environment – Group NA ........................................ 49
Management Response to Threat of Union – Group NA ....... 58
Physician Opportunity to Communicate – Group NA .......... 59
Reasons for Organizing and Goals – Summary.................. 59
Class Consciousness ........................................................................ 61
Commonality with other Physicians ........................................ 62
  Group A ........................................................................ 62
  Group NA .................................................................... 64
Commonality with other Professionals............................... 66
  Group A ........................................................................ 67
  Group NA .................................................................... 68
Commonality with other Workers ....................................... 69
  Group A ........................................................................ 70
  Group NA .................................................................... 71
Commonality with Administration/Management .......... 72
  Group A ........................................................................ 73
  Group NA .................................................................... 76
Impact of Work Satisfaction on Daily Life......................... 79
  Group A ........................................................................ 79
  Group NA .................................................................... 80
Commitment to Collective Action................................. 81
  Group A ........................................................................ 81
  Group NA .................................................................... 82
LIST OF FIGURES

Chart 1. Alliance Union Domain with Desired Changes in Work ........................................47
Chart 2. Non-Alliance Union Domain with Desired Changes in Work ..........................58
Chart 3. Managed Care’s Maintenance of Resources ..........................................................105
LIST OF TABLES

Table 1-a. Specialty Levels........................................................................................................37
Table 1-b. Subjects’ Overall Demographics.............................................................................39
Table 2. Alliance Subjects’ Desired Change in Work Environment .......................................46
Table 3. Alliance Subjects’ Union Domain Specification.........................................................46
Table 4. Non- Alliance Subjects’ Desired Change in Work Environment .........................57
Table 5. Non- Alliance Subjects’ Union Domain Specification.............................................57
Table 6. Commonality with Others .........................................................................................79
Table 7. Effect of Work Satisfaction on other Areas of Life................................................80
Table 8. Subjects’ Position on Unions .....................................................................................84
CHAPTER 1: INTRODUCTION and LITERATURE REVIEW

INTRODUCTION

The medical profession has undergone tremendous change in the last century. Science and rationalism led to increased bureaucracy. Increased governmental bureaucracy, the corresponding expectations of governmental responsibility for medical care, and rising governmental expenditures for healthcare caused officials to search for a more efficient healthcare system. Many argued for nationalized healthcare; others characterized this as socialism and sought other solutions (Starr 1982). The notion of the Health Maintenance Organization (HMO) first arose as a way for the government to systematize, and make more efficient, the services to Medicare patients (Starr 1982). However, in the 1970s federal incentives were offered to private industry for revamping their organizations to better accommodate government insurance plans and healthcare in general (Reagan 1999). The private HMO was developed in the name of efficiency. Bureaucratic management within HMOs has essentially reduced the power and autonomy of the professional through the control of time, tasks, and hierarchy (see Reagan 1999). The primary elements of physician professionalism - authority (Haber 1991, Starr 1982), autonomy (Collins 1979, Haber 1991, Hoffman 1989, Larson 1977, Starr 1982), and esoteric knowledge (Hoffman 1989, Starr 1982) - have been compromised. A few sociologists have conceptualized this process as "deprofessionalization" or "proletarianization" (Haug and Oppenheimer in Freidson 1984, Starr 1982, Ritzer and Walczak 1988).

The professional associations' inability to garner strength enough (Starr 1982) to combat the detrimental effects of commercialism, bureaucracy, and technocracy poses a
unique dilemma for the professional. Because physicians believe managed care operates to the detriment of patient care, they have begun to organize in order to regain their control over the medical profession (Keating 1999).

Some physicians, along with other professionals and semi-professionals, have collectively organized outside of the professional association in the effort to protect their professional interests. Some of these new organizations, though under the umbrella of the AFL-CIO, are not labor unions by name and scope of authority due to anti-trust legislation. Although they have faced legal battles, others have officially formed labor unions as the members are employees of a company, thereby falling within National Labor Relations guidelines.

Physicians who are in private-practice are not protected by National Labor Relations law, and therefore they are treated as any other entity doing business. As a result, federal antitrust laws prohibit them from collective bargaining with insurance companies (Thompson 2001). Although efforts to repeal antitrust limitations have succeeded at the state level in several states, federal legislation has not been enacted. Still, even if legislation is passed allowing non-employed physicians to unionize, will advantage be taken of this opportunity? Similarly, will employed physicians begin organizing in greater numbers if collective organizing among doctors is supported on different legal fronts? Is the individual, competitive character of the physician antithetical to something so similar to unionization?

Sociology has yet to fully understand the dynamics of professional collectivism in a bureaucratized, corporate environment. Firstly, how does bureaucracy affect
historically autonomous professionals? Secondly, how do typically individualistic professionals respond to challenges on their autonomy?

I interviewed two sample groups of physicians in the Southwest region of the United States; one of these groups is comprised of individual private-practice physicians who are collectively organized into an organization that is similar to a union; the other group is comprised of non-organized physicians employed by a staff-model HMO. The non-organized physicians had considered organizing in the late 1990s, but did not follow through with the voting process.

This study addresses the following questions: 1) What specific issues prompted individual physicians to get involved in collective organizing?, 2) Are the organized physicians more likely than the non-organized physicians to identify with the working class and/or working class consciousness?, and 3) Are the organized physicians' goals that of traditional labor union members (financially oriented) or are they of a more intrinsic nature? These questions are addressed in relation to whether or not, and if so how, physician responses to these issues are congruent with our understanding of professionalism.¹

¹The import of this study becomes more apparent as we consider the growing trend of more occupations adopting professionalized standards and requirements. From a recent internet search for professional associations, I found myriad organizations such as the following: The Professional Ski Patrol Association, Association of Professional Genealogists, Professional Insurance Marketing Association, Massachusetts Association of Professional Foresters, Association of Professional Piercers, Professional Association of Resume Writers & Career Coaches, Professional Roofing, and The Association of Professional Astrologers. These associations promote "professionalism" in occupations not typically considered professional. The web-site for The Association of Professional Astrologers (www.professionalastrologers.org) provides information on obtaining insurance, advancing skills, an annual conference, in addition to outlining a code of ethics and membership requirements. As more occupations become professionalized, the characteristics of professionals, and perception of professionals in relation to other workers will likely have a greater bearing on the workplace environment. I anticipate that the professionalization of more and more occupations will have much impact on class consciousness and labor organizations.
The rise of rationalism and scientific development in the nineteenth century had a profound effect on work previously considered to be crafts or ordained occupations, such as the physician's work (Collins 1979, Haber 1991, Hoffman 1989, Mills 1951, Starr 1982). Although particular occupations had established guilds since medieval times, these occupations had little on which to base their prestige and credibility other than mysticism and apprenticeship (Collins 1979). In the case of medicine, the advancement of knowledge through science rationalized the mystical (Haber 1991), and elevated the complexity, and, thus, prestige of the training; although the former change is fairly evident, the latter is more involved. Scientific knowledge, unavailable or incomprehensible to the layperson, mystified and gave control to the physician in secular ways rather than sacred (Haber 1991). Whereas the public had previously regarded these craftsmen as receiving their knowledge from God or from wise-persons, now the knowledge was based on tangible evidence. This dynamic gave a different kind of prestige to this scientific occupation. Additionally, the increase in knowledge necessarily led to increased training in both time and complexity.

As only the relatively affluent were financially able to dedicate more time to training prior to earning a living, they were the ones to inherit this newly characterized occupation (Haber 1991). Collins (1979:139) summarizes the physician's status compared to other medical occupations: "Physicians alone claimed genteel status because of their learning and their role as dignified consultants who stood above commercial pursuits." Additionally, Collins asserts that a genteel persona for the doctor was a social
imperative even in medieval times in order for the physician to attract and have the respect of his genteel clientele. Together, the affluent status of the physician, which also connoted social authority and social distance, and the credibility of science set this occupation apart from others. The physician became a modern professional. Begun and Lippincott state, "the term 'profession' refers to an occupation which has achieved societal recognition of its elevated status over the other occupations" (in Roth 1980:58).

Credibility and the benefits of affluence are the foundation for the elements of professionalism; these translate into what we consider esoteric knowledge, the means for autonomy from direct task control and market control (Starr 1982, see Larson 1977 on market creation and control), and authority over the profession and the clientele (Haber 1991, Starr 1982). Esoteric knowledge was augmented by education, licensure, and other methods prescribed by medical societies that had organized to buttress the autonomy of the professional (Collins 1979, Haber 1991, Larson 1977, Starr 1982). Soon a more developed monopoly than even the guilds was established. The inequitable nature of authority, and monopolized knowledge and access, combined with further rationalism and democratization, would become the basis for future challenges to the professionalism of the physician (Freidson 1994, Hoffman 1989).

In a cyclical relationship, the broader elements of professionalism (esoteric knowledge, autonomy, and authority) provide the legitimization for manifest expressions of these elements, which in turn reify the more general elements; many theorists define these manifest expressions themselves as elements of professionalism. Several theorists (Abbott 1983, Fitzgerald 1946, Foote 1953, Freidson 1984, Wilensky 1964) define professionalism in terms of the exclusive receipt of specialized training, often of a
technical quality, or knowledge. Some argue that a profession serves the public interest (Abbott 1983, Collins 1979, Fitzgerald 1946). Professionalism is further institutionalized through colleague associations. Andrew Abbott (1983:856) states that the professional internalizes normative controls "embodied outwardly in canons of professional ethics." Abbott relegates the monitoring of these norms to the autonomous self-regulation of associations in addition to state specification of ethical jurisdiction, in other words the licensing of professionals (see also Pavalko1971). Not surprisingly, it was the associations who petitioned the states to assist in regulating licensure. Fitzgerald assigns to the associations the regulation of the "discipline," "recognizable standards," and "criteria" (1946:196-197). This is of course opposed to regulation through traditional management hierarchy. The associations also contribute to the "brotherhood" of professionals (Langerock 1915). Moreover, associations ostensibly regulate by instilling a sense of autonomy and responsibility in the professional (Pavalko 1971).

BUREAUCRACY AND TECHNOCRACY

C. Wright Mills (1951:79) writes: "Descriptively, bureaucracy refers to a hierarchy of offices or bureaus, each with an assigned area of operation, each employing a staff having specialized qualifications. So defined, bureaucracy is the most efficient type of social organization yet devised." Though bureaucracy developed in conjunction with the industrial revolution (Burris 1993) for purposes of efficiency, the impact on the medical profession prior to the rise of science was relatively low and served a positive function for physicians.

With the formalization of medical education in the late eighteenth century,
medical societies sought state control of physician licensing to further their stronghold on the profession. Though many states did regulate licensing in response to the medical societies' lobbying, these laws were soon retracted in response to the effects of democratization during the Jeffersonian and Jacksonian eras. At the same time alternative medical fields were growing (Starr 1982), such as Christian Science. Medical schools were becoming abundant, thereby, reducing the power of established physicians. The American Medical Association (AMA), formed in 1847, began efforts to regain the physician's stronghold over medicine.

With the rise in scientific discoveries in the late nineteenth century, the physicians were able to regain their status by asserting that they were now experts; the AMA was successful in convincing legislatures to reinstate licensing requirements (Collins 1979, Haber 1991). This occurred in tandem with the transformation of bureaucracy, as scientific discovery bolstered rationalism and together increased the faith in the notion of experts. An early example of technocracy - rationalized rule by experts (Burris 1993) - is the Flexner Report. Andrew Flexner, a proponent of reforming the educational system, acting on behalf of the Carnegie Foundation, evaluated the existing medical schools and argued that 124 of the 155 schools should be shut down. Eventually most of these schools did shut down and accordingly increased the power and prestige of physicians and the AMA (Collins 1979). The monopoly of the medical profession by physicians was reinforced, at least for the time being.

Following the development of the physician as expert and modern professional, several events took place in the first half of the twentieth century that had significant impact on the professionalism of the physician. For multiple reasons, hospitals rather
than the home became the center of care (see Mills 1951, Starr 1982). Additionally, these hospitals changed from charitable to profit-making organizations (Burris 1993). The federal government encouraged the proliferation of the hospital. Health insurance was offered to companies and labor unions, and federal health care in the form of Medicare was established (Reagan 1999, Starr 1982). During this time, healthcare was becoming more bureaucratized. Not only were rules constructed for government payment on claims for Medicare, but also doctors' access to hospital use became formalized.

With the federal government spending tremendous amounts of money, the debate soon began concerning the efficacy of care (Starr 1982). In 1970, during the Nixon administration, the term Health Maintenance Organization (HMO) was coined by Dr. Paul Ellwood and the HMO was proposed as the answer to the government's call for efficient medical care to avoid a national health care system (Starr 1982). The HMO was intended to reduce costs for government programs such as Medicare; it entailed the organization of governmental programs, but not the corporate enterprise. However, in 1973 President Nixon offered incentives for private medical organizations to regiment their systems in general and reduce costs using different methods of payment for care, such as capitation (a portion of insurance premiums allotted to physicians per patient rather than payment for each service) (Reagan 1999).

The health rights movement in the late 1960s and early 1970s questioned the efficacy of services and the lack of access to services by the disenfranchised (Starr 1982). The desirability of the physician's expert role in relation to organizations and in relation to the patient was questioned (Roth 1980, Starr 1982). Soon corporations adopted the HMO system of care; the independent physician could not compete very well in this new
market. Professionals who did not own their practice began to undergo much transformation in the 1970s and 1980s with the rationalized, bureaucratic incorporation of technical advances and the associated ideology. More and more physicians began to work for large corporations or organizations (Freidson 1994).

Though some view bureaucratization as a structure providing opportunity for promotion, etc., most would agree that because the bureaucratic and micro-management orientation of the HMO regulates physicians, whereas previously physicians regulated themselves, the physicians' autonomy is decreased (Macdonald 1995). In Remaking Health Care In America (Shortell et. al. 1996:105), the authors prescribe methods to influence and manipulate the physician's acceptance of a medical organization's prerogatives: "As we will discuss, the leader's job in such a situation is to make physicians uncomfortable, then manage that discomfort and channel the anxieties and fears into constructive action: a challenging task." The physician would now have to navigate through organizational environments he and the AMA had previously avoided.

The management occupation adopted some of the characteristics of modern professionalism such as specialized, expert knowledge (Mills 1951). The democratization of education and the computer revolution opened access of knowledge to management, lay persons, and the consumer (Freidson 1994). Medical knowledge became more accessible to people in general and the monopoly of the physician's esoteric knowledge was compromised (Freidson 1994). Soon HMO management and insurance companies would, as stated above, micro-manage what procedures physicians could perform under what circumstances, what drugs may be prescribed, and how they would be paid, among other formalizations (Reagan 1999). Although Freidson argues that
physicians are adept at getting around these formalizations, because management impinges on the physician’s autonomy and consumers demand a more direct role in their healthcare the physician's authority is diminished.

Several theorists explore this erosion of the elements of professionalism. Although he disagrees with their characterization of the "deprofessionalization" (the loss of exclusive control and prestige, etc.) and "proletarianization" (the hierarchical relationship between labor and management) of the profession (as does Starr 1982), Freidson summarizes their views. According to Freidson (1984:6), theorists such as Haug and Oppenheimer assert that antitrust law, political pressure to control the medical profession, consumer demand for better care, and organizational accountability are causing professional organizations to exert more control over their members, thereby, reducing the physicians’ ability to “follow the dictates of their individual judgments as in the past.”

Burris (1993) discusses these issues within the framework of professional/bureaucratic conflict. She explains that bureaucracies impose constraints on professionals in various manners and to varying degrees, all of which is mitigated by standards of professionalism.

Externally sanctioned expertise (credentials and recognition by professional organizations) gives professionals some countervailing power within the bureaucratic hierarchy, power that enables professionals to exercise expanded autonomy and discretion in the pursuit of professional goals. Professionals are segregated from other members of the bureaucracy and enjoy special privileges. However, bureaucratized professionals also must modify their traditional client orientation so as to incorporate bureaucratic goals of efficiency and profit maximization (in corporate settings), and they also tend to focus upon more specialized skills rather than the broader mystique of traditional professionalism. (Burris 1993:82)

According to Haug (Burris 1993:114), increasing levels of education for the
general public and greater access to information through technological developments has caused deprofessionalization. Similarly, others (Burris 1993, and Larson 1977) explain that professionals are undergoing “proletarianization.” These theorists characterize proletarianization as creating “a more narrow and rigid division of labor,” increasing caseloads and the volume of work, as well as delegating professionals’ tasks to “less educated workers and computers” (Burris 1993:115). They also explain that in this corporate environment, management uses strategies “to keep professionals satisfied include[ing] organizational segregation, relative autonomy, and the retention of considerable discretion over one’s work…” (Burris 1993:116). Burris points out, however, that although the professionals are subordinated, they are not actually deskilled. However, in this study, I will also address the extension of this dynamic into the self-employed medical arena that has also been infiltrated by bureaucracy and technocracy through third-party entities such as insurance companies.

Gloria Engel and Richard Hall (1973) interestingly point out that “[p]rofessionals who are employed in bureaucratic organizations are freer from economic pressures, and …they are therefore more likely to focus on service and altruism” (Burris 1993:118). However, altruism is sometimes compromised; some theorists assert that in this environment patients are seen as a burden in that they increase the workload (Burris 1993, Mizrahi 1986). To summarize, “the health care system is changing in that it is becoming more integrated, more centralized, and more dominated by a corporate ethos” (Burris 1993: 124). Indeed, in this study I will explore the relationship between employment status in an organizational setting, financial stability, and intrinsic opportunities.
COLLECTIVISM THROUGH THE AMA

The American Medical Association (AMA) organized to protect the interests of the physician by means of exclusionary tactics utilizing educational standardization, licensure, and codes of ethics, has experienced oscillating periods of success and failure. In addition, the membership has not necessarily been representative of physicians in general. Starr summarizes the problems that underlie the difficulties of the AMA:

The failure of physicians to generate strong collective organization reflected a deeper structural weakness in the profession. It is all to easy to assume, as some analysts do, that because doctors, or any other group, share some imputed interest, say, in obtaining a monopoly, they will act coherently to support and defend that interest. Yet any number of factors -- competing loyalties; internal conflicts; the inability of the members of a group or class to communicate with one another; the active hostility of the state, church, or other powerful institutions -- can prevent the effective articulation of common interests. At a minimum, collective action requires some mechanism for inducing individuals to lay their private affairs aside and devote effort, time, and resources to the group. (1982:92)

The AMA and physicians in general solicited and supported government intervention in medical care when it came to measures (such as licensure and government payment for medical care) that would protect their market (Larson 1977) or maintain their standard of living. However, they were adamantly opposed to a national health care system that would threaten their market autonomy (Haber 1991); such national systems were declared socialist. Ironically, the intrusive and controlling HMO system is an outgrowth of the governmental health programs the AMA once supported. Progressive physicians and some of the federations within the AFL-CIO supported a national health care system (Starr 1982); other physicians viewed them as socialists (which some in fact were) and a threat to the physician's market.

Another aspect of the changing profession is that bureaucratic rationalism has divided the physicians into specialties (Burris 1993, Stewart 1995, Mills 1951) and,
thereby, has further stratified physicians' prestige. Though physicians have always been competitive with one another in relation to market share, the proliferation of specialties took this to a higher level (De Santis in Roth 1980). No longer were physicians a homogenous group (Freidson 1994). The AMA proved to be relatively ineffective at mediating inter-specialty conflict within the profession (De Santis in Roth 1980). For the most part, heterogeneous physicians are at best represented by specialty associations and are at worst individual actors without representation at all. Due to the physician's individualism, as expressed in market competition and specialty hierarchies, efforts to collectively organize seem bleak. Hierarchy confuses negotiations because

a system of negotiations among equals, as opposed to a hierarchical decision-making structure, is consistent with the independence and individualism inherent in medicine's sense of professionalism .... What is most remarkable, from a sociological point of view, is that the medical realm is not ruled by a single unifying organizational structure, but by a powerful competitive process. (De Santis in Roth 1980:231)

Physicians' loss of market control by means of incorporation into the managed care system, loss of autonomy regarding tasks and time, loss of exclusive knowledge, and the rise in heterogeneity makes for a compromised profession. The AMA seems unable to either unify the profession or protect its interests in a corporate environment. In response, some physicians have turned to organizations resembling labor unions.

COLLECTIVE ORGANIZATION GOALS

Recent research (see below) on job satisfaction among different classes of workers raises several questions salient to the collective organization of professionals. Firstly, given a particular occupational status, such as that of the professional, what are the worker's primary concerns or potential areas of contention within a workplace
structure? Secondly, does the category of valued issues determine the means that workers choose in the attempt to reconcile points of contention?

In their analyses of job satisfaction, Fenwick and Olson (1986), and Gruenberg (1980), delineate the concepts of extrinsic and intrinsic job valuation in their respective research. Gruenberg compares extrinsic and intrinsic reward factors against job satisfaction between workers with different educational levels and in different occupational groups. The extrinsic rewards of a job are represented by variables such as pay and job security, whereas the intrinsic rewards are represented by the aspects of labor espoused by Marx, for example, to be of critical value to the worker psyche such as creativity, control, learning, and the opportunity to use one's skills. Fenwick and Olson add autonomy and meaningful work to the intrinsic reward category. These rewards are salient to the study of physicians according to how they view the import of these rewards and how accessible they are to the doctors.

The purpose of Gruenberg's (1980) research is to evaluate the previous works of Blauner, Kahn, and others who disagree as to whether workers are predisposed to value extrinsic and intrinsic rewards differently according to their social class and associated belief systems or values.² Fenwick and Olson's (1986) research attempts to determine if non-union workers and workers who only value intrinsic rewards are the only appropriate population for management to target for workplace participation programs. They find that dissatisfaction with extrinsic conditions is more of a motivating factor for participating in workplace decision making than are intrinsic concerns. They suggest that a by-product of this participation is that worker concerns are subsequently directed
towards intrinsic rewards and away from extrinsic concerns, thus, benefiting the company. Their conclusion is that by alienating union workers from participation, both management and union organizations are missing an opportunity for furthering their goals – increased productivity for the former and increased power for the latter. This framework will be used in assessing the impact of extrinsic versus intrinsic concerns among physicians and the implications for collective organizing in efforts to redress inadequacies of either or both types of rewards.

Gruenberg (1980) finds that workers choose from the competing types of rewards to evaluate their jobs according to the availability of the reward system rather than a particular belief system or value predisposing a person to prefer one type of reward over another. Instead of class and socialization factors, he finds that, where possible, workers in general value intrinsic rewards above extrinsic. His findings augment Fenwick and Olson's (1986) position regarding workplace participation and its resulting increase in the preferred valuation of intrinsic rewards. The following clarifies Gruenberg's position:

[A]ll workers are powerfully affected in their assessment of a job by the level of intrinsic rewards it offers .... We find no evidence that workers must learn to appreciate or need intrinsic satisfaction; our data are much more compatible with the idea that workers must learn to value extrinsic rewards as sources of satisfaction from work. They do so when intrinsic rewards are relatively unavailable but remain responsive to increases in intrinsic returns .... [W]e find no lower threshold for the importance of self-realization in work; we do find an upper threshold for the importance of subsistence needs. (1980 p. 267-268)

Fenwick and Olson (1986) also refer to Maslow's\(^{3}\) concept of "self-actualization". They, like Gruenberg (1980), dispel the notion that the desire for intrinsic rewards is a matter of socialization and instead point to structural causes. For example, Maslow's "hierarchy of needs" argument implies that participation is an intrinsic reward which satisfies higher order, "self-actualizing" human needs, and thus will be sought by workers only after they have obtained extrinsic rewards which satisfy lower-order, physiological and safety needs (Gruenberg 1980:507).

Fenwick and Olson explain that according to this "hierarchy of needs" only highly skilled workers will have the ability to "seek intrinsic rewards" (1986:507). Together, Fenwick and Olson, and Gruenberg (1980) allow us to see the links between the meeting of basic needs, the ability to pursue intrinsic rewards, and the benefits to both management and workers. The theory of “hierarchy of needs” may be applicable to the physician’s value of rewards according to the structural environment in which one works. Does the relative financial stability a physician works within determine his or her orientation to value extrinsic rewards and intrinsic rewards differently? If so, do these different reward categories call for different remedies to inadequacies, such as collective organization versus working from within the system.

Like Fenwick and Olson (1986), Elden's (1981) work examines participation in the workplace. Elden is primarily concerned with socializing the general population into a more politically active body. He suggests that democratizing the workplace is the most efficient method to accomplish this task. Though he treats participation, or democratization, and job satisfaction independently, the parallels are obvious. Elden's

proposed democratic workplace design advocates group responsibility, horizontal and informal communication paths, and a job design with 1) integration, 2) variety, 3) teamwork, 4) decision making, and 5) continual learning (1981:46). He explains that the results of this design are 1) "[i]ntegrative, expressive (competence, learning, craftsmanship)," 2) an "[i]ntrinsic, collective" orientation to work, 3) "[d]ependence on self and team mates, self-reliance, [and] initiative" for learning, and 4) a high degree of self-management and self-maintenance (1981:46). He concludes that the political consequences are a high sense of political efficacy, lack of belief in fate control, and high levels of social and political participation.

The first two areas of Elden's (1981) workplace design implicitly include five of six of Fenwick and Olson’s (1986), and Gruenberg's (1980) intrinsic rewards: creativity, control, learning, opportunity to use one's skills, and autonomy. One of Elden's additions to the literature for the purpose of this study, however, is his emphasis on a team orientation, or what he refers to as group processes. This is a pertinent factor especially in consideration of its relationship to the political consequences. We could extrapolate two contradictory hypotheses from the third area of this design - the political consequences. If democratic participation in the workplace leads to increased social and political participation due to a sense of political efficacy, I assume that these individuals would be more likely to join organizations in general, and, therefore, be more likely to join a union. Conversely, in a truly democratic participatory workplace a union would not be necessary and therefore would be unsupported. However, similar to Fenwick and Olson's position on union involvement in participation, Elden states that outside of his study "contemporary efforts in other plants that are unionized suggest that union

participation in work improvement programs may be a prerequisite for democratizing change as well perhaps as authentically humanizing change!" (1981:51). Finally, Elden mostly contributes to our analysis by re-framing the connection between workplace structure and worker attitudes: "The empirical evidence is patterned exactly as one would expect if participatory workplace structures did in fact facilitate politically relevant learning" (1981:52).

In Fenwick and Tausig’s (1994) study evaluating job stress on the worker, they are primarily concerned with the effects of unemployment on worker satisfaction and stress. They categorize unemployment as an inter-related element of "job structure" along with "decision latitude" and "job demands". Interestingly, "decision latitude" (control over tasks, degree of skill, learning, creativity, and autonomy) shares many of Fenwick and Olson’s (1986), and Gruenberg's (1980) intrinsic elements. "Job demands" is comprised of workload and the presence of "conflicting job demands". Additionally, one theoretical consideration may provide much insight for my analysis. Though a large organization may be able to better absorb economic pressure and therefore the worker may be better protected from the stress of a potential layoff, larger organizations typically have higher levels of bureaucratic controls, thereby limiting intrinsic aspects of worker satisfaction such as "loss of job control, increasing isolation, powerlessness, dissatisfaction, and 'alienation'" (Fenwick and Tausig 1994:270). Fenwick and Tausig find the following:

As expected, high 1971 unemployment rates are related to lower job security and decision latitude, while workplace size presented an apparent trade-off between desirable job structures: increasing job security but reducing decision latitude...[B]oth age and years of education increased decision latitude, but also job demands. Female and non-White respondents, not surprisingly, had lower job security and decision latitude...1973 job structure variables...are almost
identical...Decision latitude increased life satisfaction and lowered stress, while job demands reduced satisfaction and increased stress. Job security increased satisfaction, but had no effect on stress .... Overall, decision latitude was the job structure most determined (largest explained variance and most direct effects) by macroeconomic and individual variables ... Job demands, in contrast,... was not predicted as well by the model ... Job security was predicted by a number of variables but had only one significant effect itself - on...satisfaction. (1994:273, 276)

In contrast to those researchers who address intrinsic rewards (e.g., Fenwick and Tausig 1994, Elden 1981), others seek to explain job satisfaction and worker response in light of more tangible extrinsic elements. Although some of the variables and structural issues are similar, the dynamics are attributed more to economic rewards rather than psychological rewards.

Leggett (1964) examines structural determinants of class consciousness. Reminiscent of Fenwick and Tausig (1994), unemployment is the independent variable in his analysis. However, Leggett looks at the dependent variable class consciousness as it is characterized by "class verbalization," "skepticism," "militancy," and "egalitarianism". Leggett defines verbalization as the expression of issues in class terms, skepticism as the belief that "wealth is allocated...to benefit primarily the middle class," militancy as the activity to "advance the interest of one's class," and egalitarianism as the support for the equal distribution of wealth (1964:228). Additionally, Leggett points to coworker proximity and channels of communication as causal factors for consciousness raising. Does the opportunity to communicate with other physicians or proximity to other physicians affect the collective efforts of doctors?

Wolman's (1936) historical analysis counter-intuitively reports that unionization increases under conditions of full employment and decreases during economic downturns. Yet, according to Leggett (1964) there is a positive relationship between
unemployment and class consciousness, the latter of which that includes "militancy" - a categorization seemingly inclusive of unionizing. Wolman's perspective differs from Leggett’s in that it is based on opportunity and power in combination with class consciousness. Wolman introduces company unions and other union-busting techniques of the employer (threats to and actual firings of union organizers, and hiring detectives to monitor unionizing activity and report those involved). Though these techniques are somewhat dated, especially the detective involvement, does the fear of the ramifications of joining a union exist today for physicians?

In current times, I would extend this approach to efforts at emphasizing participatory worker involvement as discussed in the prior section in addition to monetary and benefit bonus programs for increased production, etc. Though participatory involvement as previously discussed pertained to intrinsic rewards, I suggest this management method has been extended to the distribution of employee bonuses and benefits. Thus, we would expect a negative relationship between employee participation in management's fiscal decision making and potential union consciousness.

Coleman's (1988) work questions the stereotyped goals of labor unions. According to Coleman, United States labor unions are usually viewed as pressure groups without a sense of societal and class responsibility. He argues that this is not true. Coleman traces union activity historically and establishes ties to the Democratic Party in union efforts to promote economic social equality and democracy. Of import for this study, however, is his assessment of labor market changes. Coleman explains that unionization has decreased because the labor unions have not altered their recruiting tactics to accommodate a shift from industrial and craft work to the growing service
sector. Accordingly, we would expect to find that service sector workers are not as likely to vote for a union because unions have not attempted to include them among the defined "working-class." Would this expectation also apply to professionals such as physicians? According to some this is not necessarily true. For example, Rhoades (1998) cites the increasing collective organization of higher education faculty. Also, Budrys (1997) argues professionals are increasingly organizing.

CLASS CONSCIOUSNESS

The primary differentiation between class and class consciousness, in the Marxist perspective, is awareness of one's place and membership within the class stratification. A person can be, objectively, a member of the working class without being, subjectively, conscious of the class itself or aware of the impact of this class position within society. Marxist theory posits that the workers' struggle against "capitalist exploitation" will not be as effective if the working class does not possess a strong sense of class consciousness (Luxemburg in McLellan, 1988:109). Thus, if a person belonging to the working class does not recognize the restrictions imposed by the capitalist class upon the working class, his/her action to remedy these restrictions is stifled. In 1921, Lukacs wrote about the import of class consciousness:

For if from the vantage point of a particular class the totality of existing society is not visible; if a class thinks the thoughts imputable to it and which bear upon its interests right through to their logical conclusion and yet fails to strike at the heart of that totality, then such a class is doomed to play only a subordinate role .... They may win a few battles but they are doomed to ultimate defeat. (in McLellan 1988:254-255)

What factors can be measured to assess class consciousness? LeBlanc critiques the traditional definition of class consciousness:

21
A majority of such workers do not automatically or necessarily have a sense of themselves as being part of something called the working class. (In fact, being neither very rich nor very poor, most working people in the United States since the 1950s have tended to define themselves as middle class, with active encouragement from the mass media as well as mainstream politicians and academics.) They don't necessarily believe they can best improve their conditions by joining with other workers in the struggle against big businessmen, the capitalists, who own and run our economy. They don't automatically or necessarily see themselves as having common interests with working-class people of other countries (or even of working-class people of their own country who have different racial or ethnic backgrounds, different occupations and income levels, different sexual identities and orientations, and so on). These beliefs - (1) that there is something called the working class to which we belong, (2) that our interests are necessarily counterposed to the interests of the capitalists against whom we must struggle, (3) that we should identify with and have solidarity with all members of our class, and (4) that the working class should struggle for political power in order to bring about the socialist transformation of society - these beliefs have traditionally been seen as constituting the class consciousness of the proletariat. (LeBlanc 1996:109)

Bottomore asserts that Marx was aware that the working class has much wage differentiation between its members, and that because of this differentiation, and also the "temptations of increasing affluence," there can be a conflict between "the common interests of the whole class" and that of the "individual workers and groups of workers" (1983:80). Would we expect to find that differences in pay, status, and power among specialties within the medical profession affect orientation towards collective organization?

Differing degrees of power among physicians may be illuminated by more recently developed theory. New Class theory distinguishes between exclusive domain over knowledge and control of the use of this knowledge. Whereas previously class theorists would place physicians in the ruling class due to exclusivity of knowledge and therefore power, new class theorists introduce the effect of bureaucratization on the controlled use of knowledge. Similar to Haug and Oppenheimer (in Freidson 1984),
proletarianization and de-professionalization are referred to frequently. However, the import of new class theory is that it explains how bureaucracy has changed the class structure. Wright (1994:132) states: "If orders are followed because of formal sanctions for non-obedience rather than because of rational persuasion on technical grounds, then the social relation involved must be considered primarily a bureaucratic-authoritative one rather than one based on differences in technical knowledge." How are physicians’ sense of power and status affected by this imposition of bureaucracy and authority in spite of their traditional domain over “esoteric” knowledge?

MANAGED CARE’S EFFECT ON THE PHYSICIAN

Regardless of how the changes are framed, a new form of organization has enveloped the physician. How have doctors been affected by managed care and the corresponding changes to professional identity?

In their discussion regarding theories on doctors’ professional control, Warren et. al. state,

Curiously, these debates about the professional status of physicians have rarely been grounded in data on physicians’ assessments of their situation. Of course, these theories were developed to explain the status of medicine as a profession, not the situations of individual physicians. Nevertheless, each of these theories provides us with valuable concepts for understanding the situation of contemporary physicians. (in Cockerham et. al 2001:357)

Their study surveyed the satisfaction levels of 510 doctors. They determined that in previous studies “[a]ge and sex have not been found correlated with satisfaction.” In their study as well, age and gender differences were not significant. Overall, “[j]ust over half our respondents (56.5%) describe themselves as satisfied or very satisfied with being a physician today” (Warren et. al. in Cockerham et. al 2001:361). They acknowledge,
however, this figure is lower than other national surveys’ reports of 65-87%.

Interestingly, they found that 33% of solo practitioners were dissatisfied, whereas those physicians in groups of two to four doctors reported less dissatisfaction (29% dissatisfied) as did those in practice groups of five to ten physicians (14% dissatisfied). However, in groups of more than ten doctors, physician dissatisfaction rose to 24%. It appears that if there are very few or very many physicians, dissatisfaction is more likely. Warren and her colleagues also found that dissatisfaction was positively correlated with increases in the number of managed care patients that the physician cared for. Physicians who were paid by salary were more likely to be satisfied than those who were paid by third party insurance (Warren et. al. in Cockerham et. al 2001:361).

Those who are dissatisfied express ethical problems. In his editorial “Waving goodbye to healthcare”, Kaiser writes:

A successful and respected vascular surgeon, at the height of his career, recently quit medicine. He lamented, “I wish I had never entered medicine. Its soul is gone.”

One of the best nursing supervisors in a Southern California community hospital, after much soulsearching, quit, with the comment, ‘I can no longer look myself in the mirror. With the recent budget cuts, it is no longer possible to provide quality care for our patients,’ she told me. Stories like these are repeated every day in hospitals throughout our country.

The word is out - healthcare isn’t much fun anymore. (2000:32)

Wildes writes:

In the Hippocratic Oath the physician swears to act in the best interests of the patient according to the physician’s judgment. However, over the last 40 years we have come to understand that the physician’s view of the patient’s best interest and the patient’s view of his or her best interest may often be quite different”. (2001:9)
Do the physicians who are cognizant of these opposing views believe that the patient-consumer questions their ethics? If so, does this lack of unyielding faith from the patient cause the physician to be dissatisfied?

Others suggest that this difference may be more than simply a matter of physician-patient viewpoint. Some argue that the culture of medicine has changed. Hafferty and Light (1995) state: “Ethical principles, such as the AMA’s call for physicians to seek changes in laws that are contrary to the best interests of the patient (Clause 3 in the AMA’s Principles of Medical Ethics [American Medical Association 1994]) slip into an even greater obscurity. As the nature of clinical work is transformed, a new clinical culture is created” (in Cockerham et. al 2001:267). Similarly, Zussman argues that physicians’ considerations of financial concerns when treating patients take place “within a collective context rather than as income-maximizing individuals, [and] that their responses are mediated by the networks of physicians in which they are embedded and possibly by long-term contingencies” (1997:182-183). Zussman brings to light the changing cultural dynamics’ effect on once clear ethical mandates. Later, Zussman elaborated further on his position:

Financial incentives seem, curiously enough, to operate more as a means of institutionalizing ideas and beliefs about what constitutes appropriate practice than as a purely economic phenomenon. What becomes critical, then, to understanding the ethical implications of managed care is not so much an understanding of the intricacies of payment schemes as an understanding of the social context in which physicians make sense of and evaluate those schemes. (2000:8-9)

While it might be tempting to attribute a consensual ending to the mediation of ethics, conflict and power issues remain. Hafferty and Light (1995) point out the potential ethical ramifications of administrative influences.
...[T]here is no evidence to date suggesting that these new elites will share either a core set of values reflecting a fiduciary or service orientation. At the same time, the absence of administrative and knowledge elites within the profession renders medicine vulnerable to the incursions of “outside” experts, individuals whose agendas may be not only antagonistic to medicine but antithetical to the necessary presence of discretion in medical work. (in Cockerham et. al. 2001:269)

In addition to ethical concerns, physicians must contend with patient-consumer demands. Customer service evaluations measure patient satisfaction with both HMOs and individual doctors. Results of these evaluations can directly impact the physician. Zimmerman (1997:52-53) states: “Customer service performance by providers will increasingly be tied to monetary rewards as patient satisfaction gains in importance.”

Ethical medical care can also impact patient satisfaction as illustrated in a New Republic editorial: “Typically, the sickest patients reported the most dissatisfaction” (2001:12). Patient satisfaction is also tied to the type of healthcare structure. Shi (2000) found that those insured through organizations that paid the physician on a Fee-For-Service basis were more satisfied than those enrolled in HMOs.

Weissman (1998) states that in 1997 pharmaceutical companies spent $917 million on direct-to-consumer advertising for prescription drugs. Doctors report feeling pressure and conflict when consumers demand medications that are not in their best interest.

Some medical professionals will never be convinced that advertising is a good idea. They fear promotion may lead consumers to pressure physicians to prescribe a drug that’s wrong for them. ‘Usually it takes longer to explain why I can’t give it to them (than to write a prescription),’ says Stephen Brunton, a Greenwich, Conn. physician, who nevertheless resists the urge to prescribe. Ads also encourage the use of new drugs over existing ones -- even though the old drugs may be cheaper or more effective. ‘What is brought to the consumers’ attention,’ says Andrea Kielich, a Portland, Ore. Internist, ‘is not necessarily the best drug, but the drug that has the most money to advertise.’ (Headden and Melton 1998:57)
Similarly, consumer access to information also poses problems for physician decision making. Hardey (in Cockerham et. al. 2001:250-251) writes: “Further research is needed to understand how and whether doctors view patients’ use of the Internet as a threat to their clinical autonomy or as a resource to promote partnership in care.”

The way a doctor approaches and communicates with a patient can also impact legal and financial matters.

A significant number of physicians will be sued at least once in their career, especially if they practice in some of the more vulnerable specialties. In addition, there is some evidence that the threat of malpractice lawsuits changes the practice style of many physicians, leading to the practice of ‘defensive medicine’ and raising the total cost of health care....Physicians without malpractice claims spent more time with patients, oriented patients more frequently to the flow of the visit, and more often used humor and laughter during the encounter. (Lefevre 2000:258)

Though companies refer to malpractice claims and over-utilization by patients, only one of ten major companies reported income for the first half of 2001 as a net loss (Greenwald 2001:3-4).

At the same time, HMOs are realizing that focusing only on finances can be detrimental to other organizational issues. Revamping their approach to personnel, a medical center investigated other management styles including those of an airline and a hotel. The final result became their “Service Excellence program, an initiative designed to build morale, productivity and loyalty among staff and patients.”

In 1994 Thunderbird Samaritan merged its management with a sister hospital, and the subsequent cost cutting upset employees and patients. By 1997, fewer than 69 percent of employees rated Thunderbird Samaritan a satisfactory place to work, and there was talk of unionizing. Worse, the hospital ranked near the bottom 10th percentile in patient satisfaction, according to Press Ganey Associates, a South Bend, Ind.-based firm that measures satisfaction.... [Service Excellence] empowers employees to fix problems on the spot. Staffers are asked to anticipate, acknowledge and apologize for mistakes and are empowered to make amends through small gestures .... Last year employee satisfaction improved from a
preprogram level of 69 percent in 1997 to 82 percent. Turnover fell from 19.4 percent in 1998 to 19 percent last year for the staff as a whole and from 15.7 percent to 11 percent among registered nurses. (Reese 2000:41-42)

However, Reese’s account of Thunderbird Samaritan’s transformation does not isolate physician satisfaction as it does nursing satisfaction wherein a national shortage lies (Galloro 2001). Whether these changes address physicians’ primary measures of satisfaction, such as pay and freedom of clinical judgment (Warren et. al. in Cockerham et. al. 2001), is unknown.

Forced yielding of judgment to non-physicians does not end with management, but is also reported with other healthcare workers.

Today, the majority of babies delivered within the Kaiser system are delivered by midwives. Taken as a whole, these patterns indicate a diminished presence and role for physicians in the actual delivery of services and lessening influence over the degree to which other groups participate in delivering of services. (Hafferty and Light in Cockerham et. al 2001:262)

This coincides with Schenck’s (1995) prediction that managed care will shift toward allied health workers, causing a decrease in market demand for doctors.

In addition to allied health workers assuming physician tasks, doctors are responsible for more clerical duties. Government standards place time consuming responsibilities upon doctors.

All that paperwork exacts a big toll in terms of time, resources and -- most disturbingly -- patient care. The AHA’s recent study, Patients or Paperwork? The Regulatory Burden Facing America’s Hospitals, found that providers spend at least 30 minutes on paperwork for every hour of patient care. In emergency departments, the ratio is one hour of paperwork for every hour of care. (Sarudi 2001:29)

Both governmental and non-governmental bureaucracy (Wild and Hill 1998), and micro-management (Mechanic 1996) consume doctors’ time as well as limit their
There appears to be a somewhat analogous situation emerging in this country as third-party payers, corporate purchasers of health care, and the state itself become more aggressive in attempting to influence resource availability and conditions under which clinical services are delivered. Examples include the use of formularies that dictate a specific and limited number of medicines available for prescribing, tighter scheduling of patient visits, in-home referral requirements, requirements for prior authorizations, and the hotly debated linkage of physician reimbursement to lower resource utilization by patients. Thus, while it would remain at least true literally that physicians retain the legal right to order any test they might deem appropriate or to treat the patient in the manner they deem “best,” it is also true that the threat of review along with the threat of nonreimbursement, effectively limits the number of clinical practice options. In these ways, HMOs, managed care plans, and related practice arrangements leave the physician in charge of clinical decision making, but do so within a range of incentives (positive and negative) that are intended to alter at least the terms and conditions under which medicine is practiced. (Hafferty and Light in Cockerham et. al. 2001:266-267)

Warren et. al. (1998) found that physicians who experience less control over their schedule are more likely to express dissatisfaction, though not statistically significant. Those who rely on managed care contracts to get patients also are more likely to report dissatisfaction, as are physicians who believe a third party has great impact on how they are able to treat their patients. Those physicians who believe their patients lack confidence in them are much more likely to be dissatisfied (47% versus 18%). Doctors whose patients have more medical knowledge are less likely to be dissatisfied. Control over others also bears on satisfaction, as those who write orders that non-physicians follow are less likely to express dissatisfaction. Warren and her colleagues write: “Our research suggests as well that retaining dominance is critical to physician satisfaction ... and, indeed, our research suggests that clinical autonomy plays an important role in physician satisfaction” (in Cockerham et. al. 2001:237).

Attempts by HMOs and other organizations to improve physician satisfaction
Some changes have been implemented to accommodate physician requests.

...[P]ayers are striving to cut administrative costs while improving relations with members, providers and physicians. ‘All the plans are trying to drastically reduce the amount of perceived micromanagement’ to win docs’ support, say Peter Kongstvedt, M.D., co-author of a recent report on managed care by Cap Gemini Ernst & Young. ‘There’s a lot of experimentation here’....To get there, payers are eliminating rigid reviews of medical decisions, winnowing the number of procedures that require precertification from a few thousand to a few hundred, Kongstvedt says ... ‘Cigna has developed new products that no longer require the authorization of a primary care ‘gatekeeper’ for specialist referrals. And United Healthcare eliminated precertification for most procedures.’ .... In a related area, while trying to educate consumers about plans better, health plans similarly are searching for ways to gain cooperation from physicians, whose support is critical for cost-cutting to work.... Economist Mark Pauley, an industry expert at the University of Pennsylvania’s Wharton School agrees that addressing the physician backlash is critical. ‘There is no way to let doctors do whatever they please and still hold down health care costs,’ he says. (Carpenter 2001:20)

An administrative director advocates another approach by offering rewards secondary to structural change. In his outline for recruitment strategies geared towards future retention, Scott suggests:

Mutual expectations should be discussed during the interview and confirmed before an offer is made. Discussions should cover patient load; work and call schedules; committee responsibilities; teaching responsibilities, if applicable; and ramping up their practice. Ramping up the practice means initially establishing a lower number of patients per day and gradually increasing this number over a six-month period until the physician is meeting the practice’s benchmark work load. This procedure gives new physicians an opportunity to acclimate to the practice’s paperwork requirements and policies and procedures.... One cost-effective tool for retaining physicians is to offer them additional benefits that put little financial strain on the organization. Such benefits include discounted auto and home insurance, a payroll deduction plan, a dry-cleaning pick-up service, a photo drop off service, an on-site automatic teller machine, sick-child day care subcontracted to a local day care center, discounts on fitness center memberships, and no-cost smoking cessation programs .... Staff physician recognition programs reward physicians for outstanding performance and boost morale. To establish such a program, a workgroup consisting of physician leaders and staff physicians should be formed to develop a practice-wide recognition program(1998:76-77)

Though many studies have shown little evidence of gender differences in
satisfaction, one analysis does indicate that demographic changes, including gender, in
the medical profession may affect practice structure choices and therefore be indirectly
correlated with satisfaction.

Emphasis on ‘traditional’ professional values such as autonomy have also made
self-employment the ideal-type employment status for professionals. The
congruence between autonomy and self-employment may have fit better with the
demographic makeup of the medical profession up to the 1970s when over 90%
of physicians were white males, usually from upper class backgrounds (Starr,
1982). It made sense to consider medicine a homogeneous profession during this
time, composed of individuals sharing similar views about their work.... The past
two decades have witnessed important new forms of stratification within medicine
due to the rising number of females, minority groups, and lower and middle class
individuals entering medical school .... Since 1970, the number of male physicians
has grown 79%, while the number of female physicians has increased 425%

Hoff (2001) questions whether the fact that women are more likely to be
employees, rather than work for themselves, may be related to structural obstacles. He
theorizes that the historically male dominated profession may prevent women from being
able to acquire clientele and referrals. He considers the same explanation for non-whites.
However, Hoff finds that race and ethnicity do not follow the same employment pattern
as gender. Rather he finds that non-whites practice in areas more highly populated by
non-whites and may therefore have access to patients without resorting to employment
status, as white male doctors also appear able to accomplish. However, Hoff’s analysis
maybe confounded, as he finds that primary care physicians are more likely to be
employed because of increased demand for generalists in HMO settings; therefore, the
likelihood or unlikelihood of women and non-whites being generalists as opposed to
specialists may be of import. Still, data that addresses the demographics of specialty
would yet leave unanswered another of Hoff’s questions - whether differences in race,
ethnicity, and gender are associated with preference for particular areas of medicine
(Hoff in Matcha 2001)? Finally, in light of Hoff’s findings, do demographics have a role in physicians’ orientation to collective organization?

CONCLUSION

Commercialism, bureaucracy, and technocracy seemingly diminish those characteristics that have historically typified the professional. Commercialism places economic concerns in opposition to social obligation and ethics. Additionally, professionals formerly allied through intellectual and creative interests are forced to compete against one another for clientele. The growing bureaucracy of management reduces the power and autonomy of the professional through the control of time, tasks, and hierarchy. Technocracy aids in the rationalization of commercialism and the control of management over the professional by redistributing the knowledge, and thus, the power, of the professional.

The inability of professional associations to combat the detrimental effects of commercialism, bureaucracy, and technocracy poses a unique dilemma for the professional. Some professionals are turning to organizations similar to labor unions to represent their interests. Labor unions have traditionally represented the "working class" rather than professionals. The concerns of labor unions have been characterized as largely economic in nature. These economic concerns are referred to as extrinsic factors. Conversely, professionals are afforded more emotive and intellectual pursuits, as some theorists refer to as intrinsic rewards. As professionals are "deprofessionalized" or "proletarianized" through loss of autonomy, control, and power, the question arises as to whether intrinsic or extrinsic values will be of greater import to them. Logically, we
could theorize that the proletarianization of the professional would yield concerns characteristic of the working class (i.e., salary, benefits, and stability). Following Gruenberg (1980), and Fenwick and Olson (1986), equally as possible we could assume that although the professional, relative to a previous status, is proletarianized, he still has obtained economic security to the point where regaining emotive and intellectual standards will be more highly sought.

There has been relatively little empirical research, yet much supposition, as to the effects of these organizational changes on physicians’ values and reactions. The present study will attempt to further illuminate the following question. As physicians have undergone changes in medical standards of practice, bureaucratization, and organizational structure, how have class formation (Wright 1994:381), class consciousness, and efforts in collective organization been affected?
CHAPTER 2: RESEARCH METHODS and FINDINGS

RESEARCH METHODS

This research project is a qualitative study of physician identity and values as it relates to membership in a collective organization. I interviewed thirty-three (33) physicians. One half (16) of the sample population was chosen from physicians who belong to an organized group of individual private-practice physicians in the Southwest. The other half (17) are non-organized doctors in another Southwest city, employed by a staff-model managed care organization, who began organization procedures but did not complete the process.

Purposeful sampling was employed to comprise a sample of twenty doctors each from both the organized group, hereafter referred to as the Alliance (group A), and the non-organized group, hereafter referred to as the Non-Alliance group (group NA). For each population group a complete list of potential subjects was used. I sorted the physicians according to specialty, years in practice, degree of prestigious education, ethnicity, and gender. I attempted to limit the study to surgeons, cardiologists, and primary care doctors. However, there were not enough willing subjects to conduct the selection in such a way. Instead, I established a hierarchy denoting status and degree of responsibility of practice area. The classifications are indicated by numerical ratings of status in four categories. Level four (4) is the highest status level reserved for specialists/surgeons. The next level, level three (3), was assigned to specialists who were not specifically surgeons, but performed surgery frequently. The next group, level two (2), was comprised of specialists who do not frequently perform surgery. The lowest status group, level one (1) was primary care doctors, including family medicine and
pediatrics. Equally as important were achieving variety in ethnicity and having diverse areas of practice represented. The former proved impossible to achieve; only three of the willing subjects were non-whites. However, a fair amount of diversity was attained regarding area of practice, years of practice, educational prestige, and gender. The two groups were demographically well matched (see table 1-b).

The semi-structured interviews were conducted in person. I explained to the subjects the nature of the research, any risks to them, steps taken to ensure anonymity, and asked their permission to tape record the conversation. The purpose of taping the interviews was only to aid the accuracy of my analysis. The tapes were transcribed and erased after the analysis. The interviews consisted of theoretically related questions and demographic questions. The theoretically related questions were drawn from four areas: structural effects on the individualist identity of the physician, collective organizing as a reaction to the transformation of identity, mechanisms for mobilization, and the temporality or permanence of any identity change (see interview questions in Appendix A). After interviewing two subjects from each of the two groups I considered the overall themes revealed and adjusted the research questions accordingly.

VALIDITY

The following addresses anticipated problems or issues concerning the validity of this study. Both data collection and analysis difficulties are considered. I tape recorded the interviews to ensure the most accurate data possible. Most of the questions were posed in an open-ended format; this, ideally, reduced the potential for leading the subject. To reduce anxiety for the interviewees and increase openness, the subjects were told that
their identity would be confidential. I assigned numbers to each person in order to keep
data separate, but only I had record of to whom the numbers corresponded. Once the data
was analyzed and I was satisfied that I would not need to follow up with any particular
subject, the records of the corresponding numbers were destroyed. Additionally, in the
findings section below, I use pseudonyms to protect the identities of the subjects.

I expected the analysis to delineate possible explanations of the dynamics of
identity/value differences among these particular subjects. Conclusions are not expanded
to other populations beyond that studied. No external generalization, to doctors in
general or to professionals in general, is suggested. Instead I submit this as a pilot study
to guide future research.

**FINDINGS**

The following section summarizes the subjects’ responses to the interview
questions. The data is divided by research question and also by subject group. The next
chapter provides a more analytical comparison and my conclusions.

The two study populations - the Alliance (group A) doctors (N=16) and the
Non-Alliance (group NA) doctors (N=17) are further categorized according to area of
practice. 4 The areas of practice were categorized and labeled according to the following
levels: 1) Primary care practitioners such as internal medicine physicians, pediatricians,
and family practice doctors, 2) Specialists who do not generally perform surgeries, but

---

4 Access difficulties hampered my intent to strictly compare surgeons, cardiologists, and family
practice doctors across the two groups of subjects. In addition to the fact that cardiologists are
contracted by the corporate organization of the group NA physicians rather than being employees
of the staff-model organization, it was also difficult finding a comparable number of doctors from
within the other two areas of practice who were willing to be interviewed.
yet have higher prestige than primary care physicians - such as radiologists and anesthesiologists, 3) Specialists who perform some surgical procedures on a regular basis such as gastroenterologists, obstetricians, etc., and 4) Specialists who are typically high in status and prestige - surgeons, cardiologists, oncologists, etc. For purposes of analysis, these categories (see table 1-a) are numerically labeled with the lowest level “1” assigned to the primary care physicians (internal medicine, pediatrics, etc.), ascending to the highest level “4” assigned to the most prestigious area of practice (surgeons, cardiologists, etc.). The subjects confirmed this stratification by prestige as they often spoke of specialists who ranked above or below them according to power and status.

Table 1-a: Specialty Levels

<table>
<thead>
<tr>
<th>SPECIALTY</th>
<th>LEVEL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care, etc.</td>
<td>1</td>
</tr>
<tr>
<td>General Specialist</td>
<td>2</td>
</tr>
<tr>
<td>Specialist with Some Surgery</td>
<td>3</td>
</tr>
<tr>
<td>High Level Specialist and/or General Surgeon</td>
<td>4</td>
</tr>
</tbody>
</table>

The interview questions (see Appendix A) are drawn from the three areas of research questions: reasons for organizing/organizational culture, identity in relation to others (physicians, workers in general, and management/administration), and goals/concerns in relation to collectively organizing. I cover the data according to each of these theoretical areas, in addition to initially considering demographic influences.

First I address the reasons for organizing in combination with the goals of organizing, as it will become apparent that the two areas of questions are related. Interviewee responses are compared according to whether the subject is group A or group NA. Where I have given numbers of subjects per type of response, the totals may or may
not equal N because some subjects did not answer all questions. Raw figures will be used throughout the findings chapter to avoid confusion. Percentages reflect the ratio to the number of physicians responding to a particular question rather than the total N.

BACKGROUND - GROUP A (ALLIANCE) and GROUP NA (NON-ALLIANCE)

The physicians in group A organized several years ago after a managed care group solicited help from a union. The group requested the help of the Alliance to remedy decreasing wages, decreasing autonomy, and decreasing authority over care. Quickly, the organization grew to represent individual physicians operating solely or in small groups.

Physicians in the subject group NA considered organizing a few years ago after experiencing difficulties with management. The staff-model HMO, the “Corporation”, was bought out by a third party insurance company. Several physicians reported that a particular member of the new management was impeding their autonomy. Physicians were facing increased monitoring of operations, threats of cutting staffing and department budgets, and becoming subject to standard employment practices such as random drug testing. However, after some investigation into unionizing, the attempt ceased before a vote was taken. There are differing accounts from the subjects as to why the unionizing effort ceased; some attribute it to management response to employee demands while others claim the effort simply ran out of steam. Both perspectives will be addressed in this and the following chapter.
<table>
<thead>
<tr>
<th></th>
<th>GROUP A N=16</th>
<th>GROUP NA N=17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>Age 60-70</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Age 50-59</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Age 40-49</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>Age 30-39</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Mean Age</td>
<td>45</td>
<td>47</td>
</tr>
<tr>
<td>Specialty 4 – High level Specialist/ General Surgeon</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Specialty 3 – Specialist with Fair Amount of Surgery</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Specialty 2 – Specialist with Infrequent Surgery</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Specialty 1 – Primary Care, etc.</td>
<td>8</td>
<td>7</td>
</tr>
<tr>
<td>Ethnicity White</td>
<td>14</td>
<td>16</td>
</tr>
<tr>
<td>Ethnicity Non White</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Non-Prestigious Education (self-reported)</td>
<td>11</td>
<td>10</td>
</tr>
<tr>
<td>Prestigious Education (self-reported)</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>Father’s Class – Professional</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>Father’s Class - Other White Collar</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Father’s Class - Blue Collar</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Income &gt; $120k (Level 3)</td>
<td>12</td>
<td>16</td>
</tr>
<tr>
<td>Income $90k-$119k (Level 2)</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Income &lt; $90k (Level 1)</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>
Purposeful sampling allowed for well matched demographic comparisons (see above table 1-b). Interestingly, demographics within each group and between the two groups did not yield any significant patterns (see Appendices B and C for demographics by subject). As the demographic influences are essentially constant, the findings will now focus on structural differences between group A and group NA.

REASONS FOR ORGANIZING AND GOALS

It appears that the reported precipitating factors to organizing, or consideration of organizing, are linked to perceptions regarding changes that the medical profession and structure has undergone. These perceptions are repeated in similar forms in response to the question of what goals are, or should be, sought from organizing efforts.

WORK ENVIRONMENT, DESIRED CHANGE, AND UNION DOMAIN – GROUP A

Most of the organized physicians in group A reported that declining reimbursement rates for services and rising staffing costs to meet insurance companies’ protocols are either unfair, or even threaten the stability of the medical profession in that highly experienced doctors are leaving the profession at an earlier age. Five (71%) of the group A subjects stated that they did not like being a doctor (see Appendix D). At an early evening interview, following a long day spent between two offices, and rounds at a nearby hospital, Dr. Brown (a group A, 50-year-old male, level 4 specialist) stated:

Not too long ago you used to have to almost break a doctor’s arm to get him to quit practicing medicine. And now as I look around, doctors my age - they’re just counting the years ‘til they can get out. They can hardly wait. And they’re not

---

5 Income results may be limited in that the coding scheme did not allow for measuring income variation over $120,000.
gonna be practicing long beyond the age of 55. Which is I guess unfortunate ‘cause ... they are probably about the smartest and [most] capable of all the doctors and that’s when they’re leaving.

Dr. Brown reported that he would like to see less red tape to free up staff time. He cited both extrinsic and intrinsic goals for the Alliance. Ideally, he would like the Alliance to have more power to negotiate with the insurance companies over contractual agreements and insurance protocol guidelines.

Dr. Dillon, (a group A, 40-year-old female, level 1 specialist, and mother) expressed her concern that her time tending to the business part of her medical practice was detracting from her time with her young child. She is hoping to be able to cut down on her hours soon and only work three days or less per week. She explained in detail the business constraints she faces.

We might be billing a $50 claim and then because of contractual agreements that we'll accept less than our usual fee - then they may be paying us two thirds of that - so we're really fighting for $27 or something like that. And so by the time the patient pays their portion, we collect ten or fifteen bucks from the patient and twenty-seven bucks from the insurance company, it's a lot of effort to try to collect that one bill. I can spend thirty minutes of my staff time - which I don't end up with much if they have to go do that.

She also pointed out that if the insurance company reimburses the office incorrectly and the mistake is not found and disputed rapidly by her staff, due to standard contractual agreements the insurance company can refuse to pay any bill that is not submitted within 60 days. Dr. Dillon also spoke of the financial ramifications of getting prior authorizations in order to be reimbursed for services.

I have one person that I pay and that's her whole position. And another person assists her, but it's like one and a third to one and a half people that their full position is authorizing things. I guess what you have to keep in mind is we do not have any revenue generated from that.
Concurring with Dr. Brown, Dr. Dillon stated that she was considering going to part time
and that "doctors are so burned out."

During many of the interviews, the notion of professional integrity and its relation
to providing care arose. During breakfast at a popular and busy restaurant, in-between
interesting philosophical tangents, Dr. Gallagher (a group A, 45-year-old female, level 3
specialist) spoke of the degradation of having her integrity questioned.

I think [of myself as] much more a healer than a processor ... I kick and scream
when I have to dictate letters to justify ... why they have to be on this medicine or
that medicine. My word isn't good enough - that bothers me ... Why [is] me
simply saying the person needs it isn't enough most of the time for a lot of things.

Dr. Gallagher believes the reasons to organize would encompass having "a better voice in
my patient's management and care."

Dr. Lutz (a group A, 60-year-old male, level 3 specialist) also expressed
dissatisfaction with the profession. He spoke of a conversation he had with a friend
whose son is in medical school and having second thoughts.

And I said why would a bright kid who could go into any other profession and do
well want to go into this. Subject himself and you to extreme expense in
education and then put up with the government, insurance companies, and all the
other crap for the rest of his life when he could do anything else - probably
engineering, law, economics.

He continued to explain how his experience with the medical field has changed.

When I went into medicine I knew I was gonna have a comfortable living. If I got
through all the schooling, the trials and tribulations of residency training and
internship, I'd find my niche in the world and settle down and work hard and I'd
be rewarded. You know it's not that - it didn't turn out that way .... It's become
too much of a business. It's forced us to become business people.

Dr. Lutz, like others, spoke of difficulties with billing. He also told of times
where patient care is affected by managed care protocol. He told a story of a woman who
had been treated by her primary physician for six months under an incorrect diagnosis.
His perception was that a specialist referral to him was delayed. He somberly stated, "I evaluated her and basically what she had was a malignant lymphoma. She died within a year." For Dr. Lutz, the reason for organizing was "a general dissatisfaction with the managed care plans" and attempting to gain negotiating power. Dr. Lutz spoke in terms of a "crisis" in medicine: a crisis in the delivery of care and the types of individuals going into medicine, in addition to an economic crisis for physician income, and an economic crisis for government.

Dr. Irving (a group A, 37-year-old male, level 1 specialist) who has also spent time practicing in another country within a nationalized healthcare system, spoke of increasing medical problems for patients. He explained that the medical industry's recent use of capitated plans and short-term goals has had tremendous ramifications on the delivery of care.

You get to the point where things get more expensive because you haven't been taking care of the problem. And that's what's happened with capitation now. It's about ten years old maybe. But, the first five years they didn't take care of the problems. They delayed it all until now. So all the actuarial numbers are based on care that wasn't being provided. So now the whole population is a little sicker in my opinion because of this problem of not being taken care of.

He explained what he would like to see the Alliance accomplish.

When the insurance is sold I think the consumer needs to be informed, 'here's how your doctor is going to be reimbursed'... I think just like cigarettes, it shouldn't be illegal to smoke them, but you should have to warn them what the consequences are. If I'm gonna buy a capitated plan, I think I have the right to know that my doctor's gonna be disincentivized in ways that might not be in my best interest .... I would like them making it legal for doctors to band together and talk about these issues together. Right now it's illegal. You run the risk of anti-trust laws.

Dr. Nelson (a group A, 36-year-old male, level 4 specialist from a prestigious school) pointed to a crisis in physician skills. Similarly, Dr. Ottman (a group A, 43-year-old male, level 1 specialist) spoke of the problem.
You're selecting out perhaps a different person going into the profession...people who are going into this now with their eyes set more on entrepreneurship and less for the concept of caring for fellow man. You're also taking people that may not be as bright or astute...The people I'm talking to now are saying 'I'm going into plastics', 'I'm going to do liposuction', 'I'm going to make several millions of dollars', 'I'm not gonna even see any HMOs'.

He suggested that the financial incentives for giving medical care would be improved if HMOs would "just set rates at the Medicare allowable and make it uniform throughout the entire United States." But he also has reservations about eliminating the anti-trust laws because they do protect against monopolies. However, Dr. Ottman does look to the Alliance as providing a "unified voice from the physician perspective."

Physicians are very much like the early colonists - that we need to band together not just to ensure our own existence, but actually we have a fiduciary to the rest of the public, if you will, to fight this concept of what's really happening - this colonialism so to speak.

Some believe that the government's economic position with medical care will lead to nationalized healthcare. Dr. Lutz stated:

I think it's gonna come. I don't think it's gonna be here for a while yet. I think what will happen is that the government's cutting down on the amount of money available and I think the insurance companies will continue to be in the field until they can't make any profit. And then they'll just bail.

During a very early morning interview, prior to a full day of appointments, Dr. Kepler (a group A, 37-year-old male, level 3 specialist) stated he does not believe that "medical care should be taken out of the private market." The outspoken avid weekend bicyclist also indicated that he doesn't believe there is a healthcare crisis from a governmental position: "If you study economics, it doesn't matter where you spend money in this country as long as it stays in this country ... the money gets re-circulated."

His responses, however, are indicative of the complexity of the healthcare structure.
I think the system is good. If they kept Medicare as your least expensive, your lowest reimbursement, and all the other insurance companies were better than that for the general public that'd be fine...But I also think that the whole system should be revamped...There's all sorts of things to help the poor out. There used to be an end - to help people get on their feet and then move forward...The reality is that you need to take care of people. And if they don't have the means we should take care of them.

Dr. Kepler went on to describe a system he has put in place for indigent patients. He gives care to these patients in return for community service hours. He suggested that all physicians should do the same.

And if everyone did that, this country'd be a better place. And that's what they should adopt on a national program. But the doctors are too damned stupid and selfish.

The ethics involved in giving care arose with several other doctors as well. In speaking about the influence of a patient's insurance plan on care, Dr. Jackson (a group A, 39-year-old female, level 1 specialist, and single mother) stated that she cannot take into consideration a patient's insurance plan when providing treatment.

For me, it's not a moral thing, it's just I can't keep track of that. Too, I think it's dangerous because if ever something went wrong because you were withholding care, one - I would feel bad. Two, I don't think it's a good position to be in. Three, I think you know you just have to practice medicine the way you practice medicine. And if you do that, you'll be fine...So you just do your job, and in the end it all evens out.

However, Dr. Jackson did cite problems with insurance reimbursement as the reason to organize: "It's hard because we're at a disadvantage I think in negotiating contracts. I think we're getting screwed in that sense...we're the little guys, we're dealing with these really big guys."

When asked what they would like to be changed about their job, many subjects listed several issues. In order to focus on the aspects most concerning to the subjects, table 2 below shows only the first issue listed by the twelve subjects who responded to
the question. Table 3 represents the issues that the subjects stated when asked what was appropriate for union domain. This table, like table two, shows only the subjects first response to the question regarding appropriate union tasks. Across the two tables the linkages between desired change and union domain are concealed. These links are displayed in chart 1.

Table 2: Alliance Subjects’ Desired Change in Work

<table>
<thead>
<tr>
<th>Desired Change</th>
<th># OF SUBJECTS IDENTIFYING ISSUE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pay</td>
<td>3 (25%)</td>
</tr>
<tr>
<td>Power</td>
<td>3 (25%)</td>
</tr>
<tr>
<td>Quality of Healthcare</td>
<td>3 (25%)</td>
</tr>
<tr>
<td>Red-tape/tasks</td>
<td>2 (16.7%)</td>
</tr>
<tr>
<td>Autonomy</td>
<td>1 (8.3%)</td>
</tr>
</tbody>
</table>

Table 3: Alliance Subjects’ Issues for Unions

<table>
<thead>
<tr>
<th>UNION DOMAIN TASKS</th>
<th># OF SUBJECTS IDENTIFYING ISSUE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Politics/Power</td>
<td>6 (37.5%)</td>
</tr>
<tr>
<td>Collective Bargaining</td>
<td>5 (31.25%)</td>
</tr>
<tr>
<td>Lobbying</td>
<td>4 (25%)</td>
</tr>
<tr>
<td>Quality of Healthcare</td>
<td>1 (6.25%)</td>
</tr>
</tbody>
</table>
The above chart shows 6.25% of the subjects stated that Quality of Healthcare is appropriate for union activity; 25% stated Lobbying, 31.25% stated Collective Bargaining, and 37.5% stated Politics/Power in general. Not only do the desired changes in the work environment fit within these union domain categories, the union domain categories overlap themselves; lobbying may be done on behalf of quality healthcare for patients or for the right to collectively bargain (changing anti-trust laws). The union could address the quality of healthcare through lobbying or collective bargaining. Power could be sought through lobbying, collective bargaining, or by other means such as consumer education.

INDUSTRY RESPONSE TO ALLIANCE PRESENCE – GROUP A

Group A subjects were asked whether they felt that the insurance companies had responded to the Alliance’s presence. Though all but one group A subject indicated that
unions are useful, there was variation in their assessment of the Alliance’s effectiveness. One subject responded that the insurance companies had partially responded to the Alliance. Only four (25%) subjects responded that the insurance companies had made any changes to appease the providers. Dr. Nelson (group A) indicated that some of the insurance companies have changed their policies regarding red tape, etc. In reference to negotiating a contract with an insurance company, another group A physician stated, “we did threaten to use [the Alliance] … so that immediately brought them to the table - as soon as we threatened that ‘if we don’t [get] this contract, you’re gonna have to talk to our third party messenger’ [Alliance representative].” Another doctor (group A) said the insurance companies are responding in that they are aware of the threat and are fighting changes to the anti-trust laws. Six (37.5%) responded that there was little to no change. Some of these in the latter group stated that the insurance companies do not have to accommodate Alliance physicians as long as some physicians succumb to the insurance industry’s demands. One physician explains how the insurance companies manage to elude Alliance pressure.

The [Alliance] has the problem that you do have individual people out here – physicians that already know they’re not allowed to collectively bargain. And because of that they just continue to scrape and scratch for every dime that they can. And so even though you know it’s a good thing not to sign the contract, reality is you got to pay your bills. And so a lot of people sign those contracts and then bitch about them everyday.

PHYSICIAN OPPORTUNITY TO COMMUNICATE - GROUP A

The physicians' opportunities for discussing these concerns about the medical profession appear to be limited. Though Dr. Gallagher has been practicing medicine for 16 years, she compared her opportunities to communicate with other physicians to her experience as a resident: "I have less time now, I think, than when I was a resident."
When asked how often he socializes with other physicians, Dr. Peters (a group A, level 4 specialist in his mid-forties), stated unhappily, "I don't socialize anymore ... I no longer have a circle of friends ... I've been consumed by the job."

Dr. Miller (a group A, 52-year-old male, level 1 specialist, and strong union supporter), while grabbing lunch between patients, responded "the doctor is so busy and so backed up they don't have time to spend." Dr. Lutz (group A) explained that most doctors "don't talk a lot anymore" and that for "the new doctors it's more of a business than it is a profession I think." Though several group A doctors did report that they socialized often with other physicians, only six (37.5%) of the doctors indicated that it had not decreased over the years or that it is not limited to pharmaceutical conferences or other similarly structured settings.

Roughly, one half (7 – 46.7%) group A subjects stated they did have adequate time to communicate with other physicians, whereas eight (8 – 53.3%) subjects indicated they did not have enough opportunity to do so; four of these eight specifically stated there wasn’t enough time. Similarly, half of those (7 subjects – 53.8%) responding to the question of whether they socialized with other physicians stated they were able to socialize regularly with other doctors, whereas six (46.2%) stated they were not able to do so.

WORK ENVIRONMENT, DESIRED CHANGE, AND UNION DOMAIN– GROUP NA

Of the group NA subjects, only two expressed like or dislike for being a doctor. This was a considerable difference in verbalization of dissatisfaction as compared to the group A doctors (5 of 7 – 71.4%).
Although the physicians in group NA had some variation in their perception of the state of the medical profession, most indicated a significant perceptual distinction between private-practice versus staff-model employment. The financial-structural differences between the two forms of practice were made apparent. Dr. Vaughn (a group NA, 47-year-old female, level 1 specialist, and a proponent of quality circles and other methods of employee participation) stated, "money isn't why I went into medicine and I think that for the people who are doing it for money the squeeze with managed care has been difficult." Dr. Vaughn reported that she is currently involved in a Quality Circle group and feels she can work within a system rather than being supportive of a unionizing effort.

Dr. Linman (a group NA, 54-year-old male, level 1 specialist), though positive regarding his work environment, expressed concern over the financial influences in private-practice.

I like the HMO better. I don't feel any conflict of interest. The profit motive is what drives a lot of doctors to do things in private practice in my opinion. And I had a real ethical concern with that .... I think that doctors in private practice have a profit motive to do things.

He went on to acknowledge that for the private practitioner, the "insurance companies have what they consider the reimbursable amount for procedures and I think that's gone down because of managed care." Along with Dr. Vaughn, Dr. Linman indicated he would not support unionization under any circumstance. Unlike Dr. Vaughn, Dr. Linman recognizes that unions can be useful; however, he stated that he would not support a union because he would not engage in a strike thereby refusing to see patients.

Dr. Underwood (a group NA, 52-year-old male, level 4 specialist) explained that having been in private-practice for almost ten years, he went to work for the Corporation
when he saw "there was more of a push towards capitation contracts and I could see that being [in] an essentially solo practice was not a viable model for the future." He also stated, "there's nothing really wrong with managed care as much as it is the finance of managed care because that's where the conflicts come." However, Dr. Underwood did clarify that these conflicts are not an issue with the Corporation. He indicated that the state of affairs with the Corporation is unique within the managed care industry.

As far as I've been able to tell, [the Corporation] is very good about providing care - not denying expensive care ... It isn't a problem here, it's a problem in most other places ... that's a matter of record.

He reported that he was fairly involved in the prior unionization effort, but that currently it would not be constructive. Dr. Underwood explained that the Corporation had become a “little bit more conciliatory” in response to the unionizing effort and that, therefore, unionizing was unnecessary at the time. He did state that should need arise again for organizing, he would surely advocate being clear that although the union's purpose would be to support employee needs, the organization would encompass professional ethics as well.

Several doctors, such as Dr. Moody (a group NA, 42-year-old male, level 4 specialist, with a humorous demeanor), reported that for him a major consideration guiding him away from self-employment was a dislike for management responsibilities such as "hiring and firing." Dr. Moody pointed out that his specialty is comprised of individuals that endured very tough "militaristic" training and are therefore unlikely to risk such a position by unionizing. He did, however, indicate that causes for organizing would be comprised mainly of quality healthcare issues.

Others, however, defined the flip side of these positive aspects of being employed
by the Corporation. Dr. Ives (a group NA, 52-year-old male, level 3 specialist, and manager within his department) stated:

The providers are not driven to provide needless care. The negative side is the potential is there for not providing necessary care. And I think it's more of a potential and a perception than reality.

He also mentioned that he believes there is "dramatic" over-utilization of services in private-practice. Dr. Ives reported that he believed no changes were necessary at the time of the union efforts, and went on to say that there are no reasons for physicians to organize in that they are in short supply, well paid, and, therefore, their jobs are not in jeopardy.

Dr. Peabody (a group NA, 50-year-old male, level 2 specialist, and mild-mannered) stated that a bad aspect of working for the Corporation is a "lack of control over certain aspects of your career - like how much money you make, and how many people you can hire and how much equipment you can buy." Yet, Dr. Peabody does not support unionization; "I think as a group, physicians probably have enough clout just to deal with issues and people that need to be dealt with without forming a union.” He went on to explain that he would feel he was giving up his “authority” and “control” by joining a union.

Oscillating between speaking of the good and bad aspects of medicine, Dr. Osborne (a group NA, 45-year-old female, level 1 specialist, with a career that she reports keeps her so busy she is still single) explained the stability of having an income that is not tied to medical decisions; however, she also stated, of the stability, "although to some degree it's artificial - if the company goes out of business then there's no paychecks.” Dr. Osborne supports unionization for several reasons: monetary, working conditions, and
patient concerns; however, she explained: "you can't push on all three fronts at once ... And so when you sort of shuffle it all away and shake it level and see what comes out, I think for the most part it usually comes down to money."

Physicians within the Corporation experience limitations to staffing. Dr. Walker (a group NA, 49-year-old female, level 3 specialist, who was very outgoing) stated during an afternoon interview at her home:

Nursing support is terrible...That's very frustrating to the doctors. We would rather that they make a little more money and be a little more professional and not bicker with each other. There's constant friction on that level ... In the hospital itself, they're going to less Rns and more lower paid staff. And the patients notice it - just in terms of patient care.

Dr. Yaeger (a group NA, early-40s male, level 1 specialist, who was very soft spoken) also claimed to have a problem with the lack of control over staffing.

It seems that every time I get someone who I work well with and understands [how to work for me], for a variety of reasons they leave or are transferred elsewhere. In a private setting you would [have control].

Unlike private-practice physicians, Dr. Yaeger doesn't have to worry much over pre-authorizations; however, although he "never once had a procedure turned down when [he's] had to go through prior authorization," he nonetheless has "resentment" for the expenditure of his time. Time is also essential to his concerns that would warrant unionization efforts: "it would be a feeling that the administration, which makes most of the financial decisions for us, has decided that we need to do more."

Other doctors cited excessive paperwork as problematic. Dr. Rivers (a group NA, 48-year-old male, level 1 specialist), the only non-white physician from group NA subjects who agreed to be interviewed, listed several tasks, in addition to much paperwork, that negatively impact him:
People interfering with the practice of medicine, [not] being able to order blood tests or being able to order certain medications without having to get approvals for them, [not] being able to get patients to specialists without jumping through hoops.

Dr. Rivers believes that staffing logistics, salaries, and hours of work are appropriate concerns for unions.

Dr. Peabody (group NA) summarized the group's perspective on the state of the medical profession's effects on the group physicians in general:

[We] do more work in less time, have less time to develop relationships with patients, more managed care. That's the negative part of it; one good thing is that it's probably forced people to be a little more [efficient].

The physicians' take on whether being a doctor is enjoyable is equally as variable as their take on the state of the medical profession. Dr. Hunter (a group NA, 43-year-old male, level 2 specialist, and proponent of unionization) was straightforward in his evaluation of the profession:

I feel empathy for everybody in this line of work. It's a bad line of work. I wouldn't recommend it. I've talked people out of it. My kids - I can tell you right now - neither of them will be doctors. They've heard me spouting off for years.

Dr. Zimmerman (a group NA, 49-year-old female, level 4 specialist) who was reticent at first to candidly discuss her perspectives during the interview, spoke of the high rate of physicians that are leaving the lower paid geographical region. She stated, "They're not stupid; if they're gonna work harder, then they're gonna go for lifestyle and get paid for it somewhere else."

One physician attributed a decline in the number of physicians practicing to stock market success over the past few years, implying that money is a necessary driving force behind the practice of medicine.
Though Dr. Walker (group NA) expressed disgust with staffing issues, she is most favorable toward her practice: "I can see doing this until I retire." She went on to explain that there are always those who are discontented, and that they eventually leave. Accordingly, Dr. Walker stated that she thought the effort to unionize was "kinda silly," and that she "just didn't think it was gonna happen."

Three of the group NA physicians expressed concern over a healthcare "crisis."

Dr. Linman stated:

We're going to eventually hit a crisis of needed care - the ability to provide care ... and the over-utilization of what we do have ... So back to the future - I think we're gonna need to take the profit motive away from providing care. I think that's the only way that things will really work.

Dr. Kelley (a group NA, 36-year-old male, level 1 specialist, who was down-to-earth) suggested that a crisis is already present.

It's already getting there. It's patients being limited on their pharmacy benefits, and that's one of the biggest problems there is currently. Also, in an HMO setting there's referral processes that have to take place that are annoying for patients. And I think they are only going to get worse.

Another physician warned that the HMOs are "ultimately not gonna be financially viable; it's not a profitable business." He explained that the government will have to take over healthcare. In addition he projects that lower quality people will pursue medicine.

As alluded to above in discussion of whether or not being a physician is desirable, physicians are encountering a decrease in respect and prestige, in addition to having their integrity questioned. Several doctors cited changes in degree of deference from patients, such as calling the physicians by their first name. Though to a lay person this may seem insignificant, physicians in both group A and group NA attest to being somewhat offended by the familiarity. One group NA physician discussed the disrespect she often
encounters.

[The patients expect to] come in, to not wait, not have to answer questions, to specify that they will have antibiotics for their child's cold, that they are being terribly inconvenienced by having to skip work and that we're the shoe-shine boys.

Another (group NA) spoke of the changes within the patient-doctor relationship.

Rather than a patient seeing me as their doctor, they see me as an employee of the health-plan that they have a contract with.

One (group NA) physician explained that he senses disapproval from both the lay public and the outside physician. He believes that the Corporation is perceived by both parties as "the big bad guy" and that the physicians "feel that [the Corporation] is stealing money from their pocket[s]" and the public believes the Corporation "is going to withhold care so that they can line their coffers with money."

The erosion of respect and integrity may be related to many of the physicians' responses to the issue of organizing in general. Several of the group NA physicians cited opposition to unionization because the element of a strike is contrary to the ethics of patient care. Only one of the group NA physicians suggested that an alternative to withholding care in the event of a strike would be for physicians to treat patients at another location.

The following table 4 shows the first responses by the subjects who stated what aspects of their jobs they would like changed. Though five of the seventeen (29.4%) subjects were clearly opposed to unionization, twelve (70.6%) could at least envision, if not fully support, causes for which a union would be appropriate. Table 5 displays the first responses they gave to the question asking what tasks fall within a union domain. The desired change for increased control over staffing and organizational logistics
appears to be linked to the corresponding appropriate union issue. The other desired changes as compared to union issues do not seem to be as clearly related. Chart 2 shows the obscured links. “Control” over logistics implies a desire for autonomy, at least in its relation to an aspect of autonomy; I clarify that this is linked in only a specific way as it is clear that autonomy can also encompass many other areas of control. Given the relationship of logistical control to autonomy and that the potential areas that collective bargaining can encompass include autonomy, I posit that logistical control is also a point of contention that could possibly be negotiated in a collective bargaining arena. Thus, with the exception of the desire for an Increase in Status of Specialty (expressed by only one group NA subject), the desired changes in work environment are reflected in the union domain.

<table>
<thead>
<tr>
<th>Desired Change</th>
<th># OF SUBJECTS IDENTIFYING ISSUE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staffing and Organizational Logistics</td>
<td>7 (53.8%)</td>
</tr>
<tr>
<td>Red-tape/tasks</td>
<td>3 (23.1%)</td>
</tr>
<tr>
<td>Autonomy</td>
<td>2 (15.4%)</td>
</tr>
<tr>
<td>Increase Status of Specialty</td>
<td>1 (7.7%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>UNION DOMAIN TASKS</th>
<th># OF SUBJECTS IDENTIFYING ISSUE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staffing and Organizational Logistics</td>
<td>5 (41.7%)</td>
</tr>
<tr>
<td>Collective Bargaining</td>
<td>3 (25%)</td>
</tr>
<tr>
<td>Autonomy</td>
<td>3 (25%)</td>
</tr>
<tr>
<td>Red-tape/Tasks</td>
<td>1 (8.3%)</td>
</tr>
</tbody>
</table>
The above chart shows 8.33% of the subjects stated that Red-tape/Tasks are appropriate for union activity; 25% stated Autonomy, 25% stated Collective Bargaining, and 41.67% stated Logistics, such as staffing, etc.

MANAGEMENT RESPONSE TO THREAT OF UNIONIZATION – GROUP NA

Was the necessity to unionize abated by management efforts to appease the workers? Group NA subjects were asked if they felt the Corporation management had responded with changes to the unionization efforts. Eleven (92%) group NA subjects, as opposed to four (36%) of the group A subjects responding to the same type of question, stated that the Corporation had implemented changes to appease the physicians. The physicians who indicated that change had taken place most frequently cited a change in management personnel, and a few mentioned the implementation of stock and bonus programs. Only one responded that there was little change.
PHYSICIAN OPPORTUNITY TO COMMUNICATE – GROUP NA

Group NA physicians reported slightly more opportunity to communicate with other doctors than did the group A subjects. Ten (66%) of the group NA physicians reported frequent opportunity to communicate with other physicians. Almost half (7 of 15 – 46.7%) stated that they were able to socialize with other physicians every month. Conversely, Dr. Moody (group NA) stated he rarely communicates with other physicians: "You also have to realize we [are] in a separate building than the rest. By being way over here we're very isolated." In fact several of the physicians in group NA who reported infrequent opportunities to socialize and communicate with other doctors work at off-site locations.

REASONS FOR ORGANIZING AND GOALS - SUMMARY

Many (31.25%) group A (Alliance members) subjects expressed dissatisfaction with being physicians. Group A subjects point to dissatisfaction with constraints on autonomy imposed by third party insurance companies. Difficulties they encounter include delayed payment for services and restrictions on patient care procedures (such as prior authorization). The subjects reported that these constraints negatively affect patient care. Additionally, commercialism and consumer demand affect workloads and erode physician status, respectively. Group A subjects collectively organized attempting to counter these deprofessionalizing factors as well as factors relevant to their income. Due to anti-trust legislation at the federal level and in most states, collective bargaining is not an option for the branch of the Alliance to which the subjects belong; as a result, many
of the subjects questioned the effectiveness of the Alliance acting on their behalf without being legally able to collectively bargain

Group NA (Non-Alliance) subjects considered collectively organizing a few years ago when they encountered a "tightening up" trend from new management. Power over the physicians was increasing as monitoring of operations increased, threats of cutting back on staffing and department budgets, and imposing standard employment practices on the physicians. However, the effort was stopped prior to an official vote. It appears these efforts were stopped as management took steps to appease the staff-model physicians; benefits such as bonuses and stock-options were implemented, as well as changes in management personnel. Although these subjects recognize difficulties associated with managed care, they are apt to show preference for their employment status versus private-practice. Subjects cite conflicts regarding profit motives in private-practice that they do not deal with as employees. Claims were made that over-utilization is a problem in the private-practice setting; it is suggested this is avoided in an HMO; one group NA doctor did state that under-utilization is a greater threat in an HMO than in a private-practice setting, but this physician speculated that this is more of a perceived potential problem than it is an actual problem. A physician in group NA also indicated that patient care is not compromised, as opposed to several group A subjects.

Group NA subjects did object to insufficient control over staffing issues, as well as an abundance of paperwork. A group NA doctor also mentioned discouraging potential medical students from the profession, as did a group A subject. However, more subjects in group A (eight – 53.3%) reported that patients did not treat them, to some degree, as professionals. Only three (17.6%) subjects in group NA stated similar beliefs.
The difference between the two structures of medical care, the staff-model versus private-practice, appears to be associated with the subjects’ perceptions of how their work is or is not made difficult, and whether or not the insurance companies (in the case of alliance members), or management (in the case of non-alliance doctors) are responsive to the physicians’ concerns. Group A subjects reported that their work is made difficult by insurance company requirements and constraints, that their ability to provide patient care is hindered, and that the insurance companies are not responsive to physician concerns. Conversely, group NA subjects were not as likely to indicate that their work is made difficult by management, nor that they believe patient care is compromised, and they do indicate that management responds to their concerns.

CLASS CONSCIOUSNESS

The final research question is addressed in the following sections. Are these organized physicians more likely to identify with the working class and/or working class consciousness?

In the first of the following sections, I provide examples of the subjects’ responses to these questions:

Do you feel you have things in common, such as work experiences or personal experiences with 1) other doctors, 2) other professionals such as attorneys, accountants, etc., 3) workers in general, and 4) with management?
COMMONALITY WITH OTHER PHYSICIANS

GROUP A

The group A subjects (94%), with the exception of one, all responded affirmatively to the first question. Though they agreed that they have things in common with other doctors, they did also mention points of contention. The commonalties dealt primarily with pressures and stress, whereas the differences were attributed to political and monetary perspectives, in addition to effects from organization structural differences.

First I will address the reports of commonality.

Dr. Peters (group A) expressed disdain for his lifestyle.

See my house - it's really clean. You know why it's so clean - nobody lives here ... I live in the car, at the clinic, at the hospital. And that's pretty true not just for me but for everybody.

By the time I met with Dr. Cage (a group A, early-30s female, level 1 specialist) at her office before 8 a.m., she had already done her rounds at a hospital nearby.

It's virtually the same - everybody. This is all we talk about. When I go to the hospital, if we're having lunch, all we talk about is the business of medicine and how everybody hates medicine. And how everybody's trying to develop some kinda gimmick to make money or to get out of the business of practicing medicine.

Though all but one of the group A subjects reported commonalties, six (37.5%) also referenced significant differences between doctors. Dr. Edmonds (a group A, 39-year-old male, level 1 specialist) recently out of residency after several other careers, discussed the differences in levels of camaraderie between specialists.

I think the higher up you get, the more specialized you get, the less close you become. You have to. If you're a brain surgeon or a heart surgeon or something like that, you have to be a pretty strong, independent person - making life and death decisions on the spur of the moment. Patients' lives are literally in your hands daily. From that you can develop a pretty good ego and a pretty good
self-worth. So why would you possibly need anybody else? So your personality and who you are can work against you. Because you have all that control and you don't need anyone else when you're in the operating room, why would you need anybody else to help tell you how to run your business.

Dr. Kepler (group A) expressed criticisms of his fellow physicians’ attitudes towards money.

[T]hey're pissed off because they want to make money. But you know I make a lot of money. I mean how much money do you need? ... I think that my philosophy, or the way that I look at other physicians has changed in general. I think a lot of them are whiners. A lot of cry-babies out there that make a lot of money and think they don't. [They] don't know what it's like to really have it hard. I know everybody works hard, and they suffered to get through school, and they this and that, but.

Similarly, Dr. Dillon (group A) spoke of her disgust toward a physician who is significantly expanding his business, hiring doctors to practice for him in exchange for his managing of the practice, and intentionally undercutting other physicians in the area. She stated, "Even if it's crummy he makes money off it; and he thinks he's gonna put everybody else out of business." Dr. Lutz (group A) spoke of an ethical change in physicians' focus.

When we used to be in the doctors' lounge at hospitals, people were talking about interesting cases and now it's talking about insurance and this planning. [To] the new doctors it's more of a business than it is a profession I think.

Dr. Miller (group A) pointed out that although his daily experiences with third parties and such are similar to those of other doctors, the impact these constraints have upon him may be less than that experienced by a young physician with large student loan debts, etc.

Dr. Miller and Dr. Gallagher (both of group A) suggested that camaraderie is affected by organizational setting. Dr. Gallagher specifically stated that private-practice is "much more isolated."
GROUP NA

Three (17.6%) of the group NA doctors reported very little to no commonality with other doctors. Dr. Nabor's (a group NA, 39-year-old female, level 1 specialist, who was rather serious) responded that "there's a wide range of how people see their job." She also reported that she believed herself to be more liberal regarding national healthcare and her career is moving from direct patient care toward administrative work. She stated, "I'm not like most doctors because I think most doctors are happy day after day to continue being in the office and seeing patients."

Dr. Simpson (a group NA, 51-year-old male, level 3 specialist) after offering me tea and sitting casually by me as opposed to formally distanced from behind his desk, cited cultural variation.

Of course you have the experience of being a doctor, and medical school experience which are pretty big things...I feel I don't have a lot in common with a lot of doctors because [they] are fairly conservative. [They] like to golf, or you know live in [wealthy areas], or something. Those things don't appeal to me very much ...doctors are not a homogenous group.

Dr. Vaughn explained that although there are commonalties regarding constraints and limitations, "some choose to bitch about it and some don't; I don't choose to bitch about it."

Overall, group NA doctors were more apt than group A physicians to qualify reports of commonalties by citing differences between doctors or by limiting the scope of similarity; this suggests a difference in solidarity. Three of the group NA doctors reported partial commonality with other physicians and linked that to shared experiences outside of the workplace such as having kids, or engaging in the same sports. Two of the group NA doctors pointed to differences between specialists and also between physicians
working in differently structured organizations such as private-practice vs. employed physicians. Conversely, all but one of the group A doctors responded that they had shared commonality with other physicians.

Several group NA doctors mentioned differences between private-practice and HMO doctors. Rather than addressing isolation, however, group NA doctors primarily pointed to financial orientation. Dr. Linman (group NA) spoke of previous experience when he frequently used the same hospital facility as private-practice doctors. He stated, "doctors in private-practice saw us as the enemy because we were taking away their patients." Speaking of those in private-practice, Dr. Underwood (group NA) similarly stated, "they're heavily invested, not just financially, but psychologically, in this entrepreneurial concept of medicine." Dr. Yaeger (group NA) reported that he perceived commonality among HMO doctors, but not private-practice doctors. He stated they "would never have anything to do with [HMOs]." He attributed this to the fact that private-practice doctors are more directly involved with billing, staffing, and patient relations.

Others, Dr. Peabody and Dr. Rivers, specified differences between specialists. Dr. Peabody (group NA) argued that generalists are likely to get to know their patients better than specialists, as generalists repeatedly provide care to the same patients. Dr. Rivers (group NA), however, alluded to a lack of camaraderie:

I think that many specialists don't have a high regard for primary care. And we just kinda get in the way. They think that they can do primary care.

Dr. Hunter (group NA), though a level 2 specialist rather than a level 1 primary care physician, corroborated Dr. Rivers’ assessment and equated generalists with mid-level providers.
They don't have to possess the same kinda physical skills that surgeons do. Frequently what has happened in medicine today is that family practitioners [and] interns have become just gatekeepers. Somebody comes in with back pain, they automatically kick them to [a specialist]... and frankly a nurse practitioner or a PA can do [that] just as well.

Dr. Zimmerman (group NA), a level 4 specialist, interpreted the mid-level provider role differently than the level 2 specialist.

They think I can be replaced by a nurse practitioner. So a nurse can be replaced by a medical assistant - not even an L.P.N. You know it's all across the profession, not just doctors. The entire profession's gone to the lowest common denominator and what you're getting is lowest common denominator behavior

Dr. Moody (group NA), a level 4 specialist, stated that commonality among physicians is increasing "because we're past the golden age of medicine". He attributed an increase in the sense of shared values and experiences to an increase in commonality between those who are going into medicine; “it's no longer the incredibly lucrative practice that it used to be and I think people are going into it with that knowledge”.

Conversely, Dr. Osborne (group NA) contended that changes in medicine have eroded the sense of commonality. She stated:

I expected it to be sort of a band of brothers type of thing - camaraderie and everybody sort of having the same goals, general principles, ethics, and priorities. And [that] everybody would at least sort of recognize that we were on a spectrum. No matter what specialty you were, what nationality, where you were trained, or whatever, that there would be a common ground that would be a strong unifying factor. In some ways there are, but in a lot of ways there aren't. And you can really find yourself talking across purposes with people. And that's getting worse because a lot of the evolution in the medical industry is divisive. And it's also not only divisive within medicine itself, but divisive when you start talking about physician extenders and nursing personnel.

COMMONALITY WITH OTHER PROFESSIONALS

Perspectives on shared experience with professionals outside of medicine yielded less variability between the two subject groups. Of all subjects, only three (9%)
expressed commonality with other professions without referring to shared experiences outside of work such as being a parent.

**GROUP A**

Several physicians referred to differences in ethical responsibility among professions. Dr. Miller (group A) explained that although there are individuals who are ethical in any field, "medicine, teaching, and priesthood - certain fields are gonna draw a certain kind of people." Others, such as Dr. Gallagher (group A), responded that professions outside of medicine do not experience the same type of pressure. She stated:

> I think probably the personal issues such as time, and time spent at home, and driving around the city, and those kind of things are probably very similar. If you're an accountant and you make a mistake you can get sued; it can cost somebody some money; it usually doesn't kill people. If you're a lawyer and you lose a case and somebody goes to jail, unless it's like the death sentence or something, but I mean even then, you're not responsible for killing the person. I think in the realm of the world and all the jobs there are, being a physician I really think that in the back of your mind everyday is "I don't want to miss something; I don't want to make a mistake, because if I do this person could die."

Many others cite differences in methods of financial remuneration and autonomy. Regarding attorneys, Dr. Cage (group A) stated, "they get what they charge, they have a retainer...[and] they don't have to wait ninety days for payment from a certain insurance plan." Dr. Lutz (group A) pulled out a code-book and explained the problem of government regulation versus autonomy.

> Look at this. Everything's by number ... I showed my attorney that, [and] my financial advisor that; they just look at me like 'oh my God'. Nobody oversees them. An attorney says 'o.k., the clock starts now and I'll do what I want'.

67
Two physicians responded that not only do other professions not share the problems that physicians encounter, but that non-physician professionals don't have empathy as well. Dr. Brown (group A) stated:

[A]ny complaints I have, most people just look at you ... and their attitude is 'shut up, do your job, and what are you complaining about'.

GROUP NA

Most of the reported differences between physicians and other professionals were attributed to ethical and responsibility issues. Dr. Moody (group NA) critiqued the legal profession.

I think attorneys are paid to be amoral - not immoral, amoral. That's really what they're paid for... regardless of what's right and wrong ...You go into things because you like it. And I think it's a different group of people.

Dr. Thatcher (a group NA, 56-year-old male, level 1 specialist), a few minutes late for the interview as he was attending a birth, defined the difference according to professional responsibility. With composure, as if he’d simply watched a birth on television as opposed to in real life, he stated, "it boils down to the Harry Truman statement, 'the buck stops here'; we are the ones who are ultimately responsible for the care that was given, and, therefore, I guess we assume a more active role in making sure it gets done."

Another group NA physician summed up the differences also in terms of dedication and responsibility.

There is no profession that shares a common experience like medicine in the amount of hours, and the amount of stress...That's probably why physicians gravitate towards one another - because they share common experience, maybe army boot-camp or something. How many people do you know that would stay up for 72 hours in a row working, which is what we used to do in residency training?
Dr. Hunter (group NA), as did several group A physicians, spoke of the pressure doctors face.

It's stressful when someone dies, whether you make a mistake or not. You're dealing with life and death decisions daily. You see a lot of suffering. You see people dying [and] there's nothing you can do...It's very stressful. I don't think people really understand that unless they've worked in health care.

Speaking of the relationship between physicians in general, rather than himself, and other professionals, one physician (group NA) mentioned differences due to remuneration constraints. He spoke on behalf of doctors in private-practice by stating that compared to other professionals, non-employee doctors do not have control over their pay.

Only two doctors found unqualified commonalities with other professions. Dr. Nabors (group NA) recognized that other professions have specialized training and are experts in their fields; he stated these as shared commonalities. Dr. Ives (group NA) explained that pressures and responsibilities are relatively experienced.

I think doctors somewhere along the line get used to the pressures. They feel just as everybody else in a profession does. So in the abstract they may be different. I make choices that people can die from. But, yet those pressures aren't any more real to me than when an accountant might have felt long ago for making sure somebody's taxes were right and they don't get audited. The pressures you live with - you get used to whatever they are - and take them for granted.

COMMONALITY WITH OTHER WORKERS

Responses to whether general workers and physicians shared experiences varied both within subject groups as well as between them.
GROUP A

Six (37.5%) group A doctors expressed perceived commonality with workers in general. Dr. Gallagher (group A) who had previously worked for a government health service, stated the following.

There were people in charge, but a government pay scale is a government pay scale. I would have sort of thought when I was there 'well what makes a doctor so much better than a brick layer, or an air conditioning specialist?' Nothing - I mean really nothing.

Dr. Kepler (group A) similarly stated:

I think we're blue collar workers that get paid a lot...[A]s long as I turn screws, I'm making money; but as soon as I stop turning screws, I don't make money.

Although one doctor (group A) differentiated between healthcare and other fields in that the responsibility for someone's health weighs heavier than other workers' responsibilities, he did find several commonalties. He explained that workers in general are working longer hours, making less money, and experiencing the same daily pressures related to keeping up with technology and consumption.

Another doctor (group A) limits commonality to other healthcare workers stating that although they may work more clearly limited shift-work, when working they do have the same pressures that doctors do.

Two physicians (group A) differentiate themselves from workers in general stating that they do not clock in and out, work nine to five, nor are they able to cognitively leave work at the workplace. Two others pointed to being more regulated than other workers. Two of the physicians found commonality with only certain groups of general workers, such as those who "solve problems." One doctor referred to teachers as an example.
Two physicians expressed a mixed viewpoint. Dr. Cage (group A) stated that although insurance companies treat her "like an indentured servant," she found specific differences between herself and general workers.

I don't have sick days; I have to come in everyday. If I mess up, somebody might die. If I mess up, I might get sued. There's not a lot of leeway for mistakes.

Similarly, Dr. Miller (group A) had a mixed perspective.

I'm not a worker. I own my own business. I'm an entrepreneur... [But] doctors are very highly paid piece workers. My dad also told me that too. He said 'don't ever get your head too big, because you are really a highly paid piece worker'...When I don't work I'm not earning any money.

**GROUP NA**

Five (29%) group NA doctors expressed commonality (with little qualification) with general workers, though four (24%) more reported some commonality within a very limited scope. Dr. Linman (group NA) responded by stating everyone is affected by an "American trend" to "do more with less." Dr. Underwood (group NA) stated that one commonality is that he is an employee. Dr. Vaughn (group NA) responded that medicine was turning into a business and "we're still supposed to turn out the widgets."

A few of the group NA physicians found similarities with only some groups of general workers. Two expressed commonality to workers only within the healthcare field. Another physician said he could relate to workers that are ethical and oriented toward problem solving such as social workers.

Two group NA physicians indicated that they differ from general workers from a cultural perspective. Dr. Kelley (group NA) complained that general workers don't understand how to respect professional boundaries in a social context; he suggested that non-professionals badger professionals about work related issues at inappropriate times.
He doesn't socialize with non-professionals. Dr. Peabody (group NA) also addressed cultural issues. He stated:

I think professional people and people who work behind the counter at Walmart, for example, just walk in different circles, just live their lives differently. [They] live in different parts of town. [Their] kids play little league in a different league because they live in a different part of town. We just don't share the same places.

Others found differences in relation to ethics and responsibility. Dr. Osborne (group NA) stated that "unless I'm out of town, I don't ever feel that I'm off work." Dr. Simpson (group NA) said that to doctors work is "more than just a job." Dr. Walker (group NA) responded that she does not have much in common with general workers as they're "punching the clock" and don't have much status at work. Two group NA physicians expressed a mixture of similarity and difference with general workers. Differences were attributed to having higher incomes and better benefits than the average worker does. One of the physicians stated that although he was in another income class, he identified with other workers as an employee in addition to sharing interests in general. The other physician also mentioned he has greater responsibility than the general worker, but, yet, as an employee is similarly vulnerable to potential abuse from management.

COMMONALITY WITH INSURANCE INDUSTRY ADMINISTRATION/HMO MANAGEMENT

The last of this set of questions addresses perceived commonality with management. Though there is variation within each subject group, the variation between subject groups is most apparent with those who perceived some shared commonality with management. Group A subjects who expressed shared perspectives (60%) mostly related
business objectives in general to entrepreneurial objectives. Group NA subjects (40%) primarily pointed to common goals for the organization as a whole.

GROUP A

Those who found little to no commonality with insurance or facility management/administration pointed to two areas of divergence: the ethically different corporate profit motive and the corporate exploitation or degradation of physicians.

Dr. Miller and Dr. Irving (group A) both stated that insurance companies look at medicine as a "commodity." Dr. Kepler (group A) clarified this perspective when he stated, "doctors aren't getting paid what they deserve; patients aren't getting the care; and the insurance [company] is getting rich." He went on to explain his understanding of insurance profit reporting. According to Dr. Kepler, figures from insurance companies reflecting losses or low earnings are those that measure expenses compared to premiums rather than taking into consideration profits from investments - the latter being the foundation of insurance financing. He stated, "this whole thing is a giant joke for the rich to get richer." Dr. Brown (group A) also questioned reports that insurance companies are losing money.

The HMOs say they're losing money. They're paying the hospitals less. They're paying the doctors less. Each year the amount they pay a doctor in the hospital goes down, [yet] premiums go up. They're collecting more money and they say they're losing money. I'm going how? Where's it all going? Well, you pay a CEO 12 million dollars a year; I guess that would take out a little bit of money.

Though it was obvious he was looking forward to having personal time after the interview, Dr. Hatch was seemingly pleased to share his thoughts on the medical field and unions. During a Saturday afternoon interview, spending yet more time away from
his family than had already been lost due to a morning office retreat, Dr. Hatch (a group A, 42-year-old male, level 4 specialist) stated that the HMOs and managed care were intended to "manage health," but yet are "really in it as a middle-man." Dr. Dillon (group A) critiqued the middle-man structure and suggested "the most logical thing is if we started doing direct contracts - doctor groups with employers; and then we'd all have common goals."

Many of the physicians had mixed perspectives on the "business" aspect of medicine. Dr. Irving (group A) alluded to an ethical difference when he stated, "I don't think medical care matters to them [insurance companies] unless it's good business." He did acknowledge that the healthcare industry has difficulty with over-utilization by patients and that this needlessly wastes resources and money. However, he also explained that the delay of care permitted because patients so frequently change health plans - and, therefore, delaying care equals savings for stakeholders - actually costs the healthcare industry in long run when medical conditions worsen from lack of treatment. However, he also stated that "nobody would say they have to take care of people in 100% of their needs because you could not afford that system." Still, he acknowledged that he could identify with management objectives in that he too is a business owner and must concern himself with "keeping costs down."

Others also reported these conflicting perspectives. Dr. Lutz (group A) suggested that the pharmaceutical companies are "right in the middle of it." He pointed out that "they're blamed for a lot, but in this country the research and development are done by private industry for the most part." He concluded that although they have considerable power and play a significant role in the high costs of care, "at least they have the drugs."
At the same time, although he acknowledged he has commonality with insurance company administration in that he is a business owner, he did differentiate between himself and corporate management by pointing out that "we're a small business."

Dr. Kepler (group A) differentiated between large corporations that produce something and corporations that serve as middle-men.

I'd rather pay a drug company that's developing a good product and is researching something that's gonna help my patients down the road than pay an insurance company [that] does nothing but make money.

Dr. Cage (group A) viewed the pharmaceutical companies differently. She claimed "they're pricing a lot of legitimate insurance companies out of business."

However, she stated one would be "astounded" by the salaries, bonuses, and stock options of insurance CEOs. When responding directly to the question of commonality with insurance management/administration she stated with disgust: "Only in the sense that I have my own business, have to learn the business, and have to manage the business - which I never thought I'd have to do in medicine."

Dr. Edmonds (group A), who did not report identifying with managers or administrators, stated,

[insurance companies] prey on the new practitioners. They think they have to sign everything and accept everything, which they do. The older guys start to weed out what they don't like.

In spite of his reference to older physicians' cautious review of contracts with insurance companies, he indicated that the corporations still maintain the power position.

Insurance companies now hold their patient population hostage ....If you don't accept it, then you won't have access to any of this.

Others also recognize the corporations' power and control. Dr. Fitz (a group A, 65-year-old male, level 1 specialist) came across as very philosophical and happy to share
his wisdom. He explained that payer organizations treat him like a "resource." He stated that he cannot even identify with the administrators who are medical doctors as "they're company men." Dr. Peters (group A) elaborated on the power and control of insurance company strategies.

By using the term 'healthcare provider' I think they unwittingly struck gold. They have down-peddled the entire visibility of physicians...They've been able to use that to somehow affect our psyche in a subconscious way. 'Well, I'm just a lowly healthcare provider. I'm a cog in the giant machine. I'm a powerless automaton and I guess I'll just go out in the back yard and eat bugs and eat bark'.

Although he is adamant that the corporations have power over the physician, he also expressed commonality. With disgust in his tone, he stated:

I've become a businessman, and I didn't want to. But, here I am. That's exactly what I am now.

Dr. Ottman (group A) explained the complexity of physicians versus business.

I don't think of myself ever as an entrepreneur. I still try to think of myself as a physician first. It is a business; I recognize that it is a business and I think we should be treated as a business in the context of management from day to day circumstances. But, we shouldn't be imposed upon so that [it] limits our ability to provide care for patients. That's the irony.

GROUP NA

Subjects in group NA tended to judge management and administration according to whether physicians' concerns were taken seriously. The majority of subjects reported that management treated them as professionals. Dr. Linman (group NA) stated that a new patient appointment process was soon to be implemented, but that it did not seem to be congruent with his needs; he explained that he had approached management with his concerns and that they told him "'we want to make it so that it will work for you.'" To him, this demonstrated that management took his concern seriously and treated him as a
professional. Dr. Peabody (group NA) stated, "they try, I think, within the constraints that they have to provide a good working environment, both from the standpoint of personnel and equipment, so that I can do the kind of job I feel like I'm supposed to do." Dr. Nabors (group NA), from a similar viewpoint, stated "I think that they value the opinion of physicians so they listen to physicians, and they do surveys to understand where physicians are at."

Dr. Peabody (group NA) explained that he has things in common with management at this particular organization because they are physicians. Several of the group NA physicians noted that the management at the Corporation are all physicians with the exception of only a couple, whereas group A physicians are apt to categorize any manager, for instance including medical directors, differently than physicians; although, as will be explained more thoroughly in the analysis, group A physicians do find a fair amount of commonality with management, they do so differently than group NA subjects, in that group A subjects find they have in common management issues such as owning a business, rather than medical issues such as care. Dr. Underwood (group NA), however, also stated that he shared with management the common interest that the organization does well. Many of these group NA physicians acknowledged the profit motive of managed care (from HMOs, insurance companies, and pharmaceuticals), but few reported that it directly interfered with their work.

Dr. Kelley (group NA), who reported that he is treated like a professional, does not find commonality with management. He responded, "I think management has their whole separate set of issues; I mean management are politicians; they're number crunchers." Conversely, Dr. Simpson, who responded that he is treated like a
professional, stated, "I think I have a reasonable amount of influence considering the size of the organization." However, he also stated that he didn't feel he had "a lot in common with them personally."

Conversely, Dr. Walker (group NA) stated that management treats her like a professional only sometimes. As far as believing her concerns are taken seriously, she stated, "it's like barking up a dead tree." Though he stated he is treated as a professional, Dr. Rivers (group NA) expressed perceptual differences between physicians and management.

Their job is completely different from mine. I mean some of these managers might be physicians, but they're not seeing patients; they don't have the pressure of seeing patients. So they're managers, they may be physician-managers, but they're not physicians.

A department chair (group NA) shared her thoughts on the impact of this perceptual rift. According to her the traditional physician worked as needed and was well compensated prior to the development of HMOs and salaried physicians.

[T]he tendency is to see yourself more as putting in a workday. I think physicians are going to be less willing to do call. They're gonna search for jobs where they work from nine to five...They're gonna look for things that improve their lifestyle. And I think they're more self-centered. They're more interested in 'what's in it for me'; that is a reaction to not being rewarded for giving more than what is owed. So there's no loyalty from the institution to the physician, nor [from] the physician to the institution.

The following table outlines the differences between the subject groups regarding commonality with others.
Table 6: Commonality with Others

<table>
<thead>
<tr>
<th>Common Physicians</th>
<th>GROUP A - AGREE &amp; PARTIALLY AGREE</th>
<th>GROUP NA - AGREE &amp; PARTIALLY AGREE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>15 of 16 (94%)</td>
<td>14 of 17 (82%)</td>
</tr>
<tr>
<td>Common Professionals</td>
<td>5 of 16 (31%)</td>
<td>7 of 17 (41%)</td>
</tr>
<tr>
<td>Common Workers</td>
<td>6 of 16 (38%)</td>
<td>9 of 17 (53%)</td>
</tr>
<tr>
<td>Common Management</td>
<td>9 of 15 (60%)</td>
<td>6 of 15 (40%)</td>
</tr>
</tbody>
</table>

**IMPACT OF WORK SATISFACTION ON DAILY LIFE**

The subjects were asked if they believed the degree of satisfaction with one's work affected one's life as a whole - regarding both family life and one's satisfaction with self. There were noticeable differences between the two subject groups.

**GROUP A**

Two (12.5%) doctors group A indicated that their degree of work-satisfaction does not affect the rest of their life. All of the other group A subjects reported that it did affect other areas of their life at least to some extent.

Dr. Cage (group A) illustrated the immense effect dissatisfaction and work-related matters have upon her.

When I get home, I'm so tired. On the weekends all I do is my laundry, clean the house, and play with my animals. I don't go out. I haven't been to a club since I was a resident. It's pretty sad [she laughs]...I guess some of it's self-imposed. I guess if I tried hard enough I could do some of those things, but I'm tired.

Dr. Allen (a group A, 50-year-old male, level 4 specialist) calmly stated:

The stresses of the office carry over into the home...I'm not home - coming home [at] 8:30 - 9 o'clock every night, working twelve hour days. There's no quality
time at home and everything's rushed.

Not all of the subjects who reported that work affects their lives in general indicated negative effects. Three group A subjects reported that being a physician positively affected their lives.

**GROUP NA**

Four (24%) subjects in group NA reported that although work satisfaction affects other areas of their lives, it does not affect their self-image. Two (11.8%) group NA physicians stated they are able to "separate" work from the rest of their lives. Of those who reported it did significantly affect their lives, five (5 of 11 – 45%) indicated it did so negatively. Their detailed elaborations were similar to those of group A.

Dr. Rivers (group NA) responded that "bad jobs make people sick." Though he stated he now is able to "disassociate" his self-esteem from his work, Dr. Hunter (group NA) explained that it "cost me being married." Another, Dr. Linman (group NA), similarly stated that it "interferes with my relationship with my wife." The following table shows the differences between the two subject groups and the impact of work upon the rest of their lives.

Table 7: Effect of Work Satisfaction on Other Areas of Life

<table>
<thead>
<tr>
<th></th>
<th>GROUP A</th>
<th>GROUP NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work Affects Life</td>
<td>15 (93.8%)</td>
<td>11 (64.7%)</td>
</tr>
<tr>
<td>Work Partially Affects Life</td>
<td>4 (23.5%)</td>
<td></td>
</tr>
<tr>
<td>Work Does Not Affect Life</td>
<td>1 (6.2%)</td>
<td>2 (11.8%)</td>
</tr>
<tr>
<td>N=16</td>
<td></td>
<td>N=17</td>
</tr>
</tbody>
</table>
COMMITMENT TO COLLECTIVE ACTION

The following reveals indications of belief in and commitment to collective action. This data was collected from the questions already referred to in this chapter. These responses were teased out as they were specifically applicable to collectivism.

GROUP A

The first emerging theme discussed concerns the threshold that, according to some group A subjects, must be crossed to necessitate collective action. Dr. Brown (group A) discussed degrees of unhappiness in describing what precipitates action.

[Why] any groups would ever want to get together and band together is because they are so unhappy over what they perceive to be problems from whoever - the insurance companies or the government. They would [have to] be so desperate as to organize together...The idea of physicians organizing as a union has been an anathema for all physicians for years. And so the litmus test about their unhappiness is their willingness to unionize...And so the more people that talk about it, you know they're more and more unhappy. And it's not just like mild unhappy, it's a desperate unhappiness - an inner anger.

What happens when this unhappiness subsides for whatever reason? Dr. Miller (group A) stated:

When doctors are in a jam, and an HMO is doing something terrible to them, they become quite responsive and communicate with the union. When it's quiet and everything's o.k., doctors go back to being individual entrepreneurs...I think it's hard to get going because getting all these entrepreneurs together is like herding cats.

Dr. Ottman (group A) suggested that "there needs to be some unified voice from the physician perspective; the AMA doesn't do it." What are the obstacles to establishing such a voice? Dr. Hatch (group A) related organizational change to an even more declining sense of collectivism.
Physicians are sort of a skittish group in that in most of our minds, we all like to see ourselves as very individualistic...Physicians do not see themselves as a collective group... think community is the operative word here; [it] has been kinda thrashed in the last five years...They've been able to divide the docs. They've put specialists against primary. They've thrown the old ideal of this collegial group of doctors out the window.

In addition to obstacles created, directly or indirectly, by organizational change, class lines also add a prohibitive element to collective action. Dr. Fitz (group A) explained that "most physicians think they're Republicans; they really don't understand; because they really want to be professional people who are above it, they don't want to get their hands dirty." Another physician, Dr. Kepler (group A), does not adhere to Dr. Fitz' view. Dr. Kepler advocated utilizing union power from different occupations so that, for example, "people don't have their trash picked up because they're screwing doctors." Dr. Kepler’s scenario provides an alternative to the following concern and doubt expressed by Dr. Fitz.

The [Alliance] doesn't have any power. It's a paper tiger. Mao Tse-tung said power comes from a barrel of a gun. And what he meant was in order to have power, you have to have a weapon. And so the weapon is a strike. So until they're able to strike, they're not gonna have any power. There's no power in talking.

Dr. Cage (group A ) interjected yet another obstacle other than recognizing potential power and avenues of power. She stated, "I know there's some other people in the [Alliance] that feel more strongly that we can make a change, but who's got time?"

GROUP NA

Doctors in the group NA shared their viewpoints on the same issues as those stated above. Some of these corresponded directly and others, especially regarding desperation and necessity, directly opposed group A subjects' perspectives.
Similar to one group A physician, Dr. Rivers (group NA) responded that time can be an obstacle to collective organizing:

I understand that it's [collectively organizing] probably something that's gonna happen. I don't think the time is right yet. I was interested in hearing about it, but I was frequently overwhelmed with work so I didn't make time to pursue it more.

Opposition to unionizing also dealt with issues of class lines and image. While some group NA subjects indicate they are leery that the public would perceive physicians who unionize as greedy, others are concerned that they would be perceived as behaving like blue-collar workers rather than as professionals. Dr. Underwood (group NA), who fears that a physicians' union would be viewed as any other union if they became a "totally self-interested group," suggested that any physicians' union should distinguish themselves as a professional union that "is different than blue-collar unions." Dr. Zimmerman (group NA) expressed similar concerns.

[Professionalism has] always been the sticking point for most physicians who think about organizing, because it puts you into the same category in your own mind, and perhaps the mind of other people, as, you know, marching to a baser drummer than high ethical principle...I had the opportunity [to unionize]; I frankly was very turned off [by the presentation]...It seemed to me that we were all gonna get cement boots and everybody was gonna be in the bottom of the lake somewhere.

As were a few group A subjects, some group NA subjects were concerned about the unethical nature of strikes. Without regard to alternative actions such as pinch-hitter strikes like that described in the above section, Dr. Linman (group NA) stated he would not join a union because he would never strike nor refuse to see patients. Dr. Simpson (group NA) stated that he would not belong to a union associated with other unions because he would not be willing to respect another union’s picket line.

Dr. Simpson and Dr. Zimmerman (group NA), who are leery of strike actions,
were still supportive of forming a "uniform voice." Dr. Zimmerman stated, "I think we should pursue every possible way that we can for collective bargaining; we need to come together and present a unified front."

Slightly less than half the group NA subjects reported they were not in favor of unionizing. Most of those stated such unionizing was simply not necessary. Dr. Peabody (group NA) responded, "not only do I feel I can take care of my own needs, but I would really be reticent to turn over, to give anybody else the authority or the responsibility of, taking care of my needs." Dr. Vaughn (group NA) also explained that she is actively involved in effecting change through methods such as quality circles and focus groups. Others indicated that there are no issues at hand in need of resolution. Dr. Nabors (group NA) stated that he has a "fair amount of autonomy," and "it feels like what the patient needs the patient gets." Dr. Simpson (group NA) stated that the organization by which he is employed is currently experiencing a "good relationship" with the parent organization, unlike a few years ago prior to exploring unionization.

The following table shows subjects that could envision conditions under which unionizing would be appropriate, and also whether these subjects would be likely to vote “yes” or “no” for a union under current conditions.

Table 8: Subjects’ Position on Unions

<table>
<thead>
<tr>
<th></th>
<th>GROUP A</th>
<th>GROUP NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Favorable to Unions in General</td>
<td>15 of 16 (93.8%)</td>
<td>12 of 17 (70.6%)</td>
</tr>
<tr>
<td>Unfavorable to Unions in General</td>
<td>1 of 16 (6.2%)</td>
<td>5 of 17 (29.4%)</td>
</tr>
<tr>
<td>Would Vote Yes Current Conditions</td>
<td>12 of 16 (75%)</td>
<td>4 of 17 (23.5%)</td>
</tr>
</tbody>
</table>
POLITICAL PERSPECTIVE OF COLLECTIVE ACTION

Only group A subjects were also asked if they considered the process of organizing and/or union activity to be a social or political movement. This question was asked to ascertain whether there was shared ideology regarding joining in a political struggle. Three (23%) group A physicians responded that they did not feel it was a social or political movement. Eight (62%) group A subjects responded that it was a movement. Two (15%) group A subjects that could not decide either way both had responses that would fall within social/political movement ideology. One group A physician stated that "physicians need to find a way to sort of commune – community." Dr. Peters (group A) advised:

I would like to reemphasize that if physicians are considering joining a union for collective bargaining purposes, they have to be realistic that joining the union is the first part of the process. It's just the beginning and not the end. And they have to have the strength and conviction that the blue collar workers had in the 1920s and 1930s when they were unionizing.

CLASS CONSCIOUSNESS - SUMMARY

The first question addressed was, Do you feel you have things in common, such as work experiences or personal experiences with other doctors? The group A subjects (94%), with the exception of one, all responded affirmatively to the first question. However, six group A subjects also pointed to significant differences between doctors, some including differences between specialists. Fourteen (82%) of the group NA subjects indicated some degree of commonality with other physicians. Two of the group NA subjects responded negatively. Group NA doctors, however, were more apt to qualify reports of commonalities by also citing differences, including differences in financial orientation between HMO doctors and private-practice physicians, and differences
between specialists. In addition, several of the group NA subjects who responded "yes" to commonality with other physicians referred to commonalities outside of the workplace.

There was less variability between subject groups in response to the next question of whether they have things in common with other professionals. Of all subjects, only three expressed commonality without reference to experiences outside of the workplace. Several group A physicians referred to differences in ethics and responsibilities. Many group A subjects referred to differences in financial orientation and autonomy. Group NA physicians similarly pointed to ethics and responsibilities; however, only one mentioned financial orientation.

Whether or not the subjects believed they shared commonality with general workers is a more convoluted factor. Subjects from both groups suggested that although they shared the experience of being a worker, and only get paid when they work, differences were attributed to "punching the clock" - being able to leave work at work. There were incidents of expressed complete affinity with workers in general. Again, however, affinity with another occupation was a more rare occurrence with group A; only six (37.5%) group A subjects expressed commonality with general workers; nine (52.9%) group NA subjects expressed some degree of commonality. Two group NA subjects cited class and cultural differences. However, several of the group A physicians who did express commonality with the worker did so adamantly based on power imbalances in their relations with management/insurance companies.

Group A doctors (60%) who expressed commonality with management related business objectives in general to their own entrepreneurial objectives, whereas group NA subjects (40%) pointed to organizational success concerns or just the fact that
management is comprised of physicians. Reasons for reporting differences varied significantly for group $A$ subjects, though group $NA$ tended to focus on whether or not management took physician concerns seriously.

When asked if worker satisfaction affected other areas of their lives, all but one group $A$ subject indicated that it did to some degree. Four group $NA$ subjects stated work does not affect their self-esteem. Similarly, two group $NA$ doctors stated they were able to "separate" work from the rest of their lives.

Subjects were asked questions to evaluate unions, and management responses to unions. All but one group $A$ subject indicated that unions are useful; however, whether the Alliance is powerful yielded mixed results. Twelve group $NA$ doctors cited at least some situations where a union would be useful. Many of the group $NA$ subjects believed that threats of unionizing had brought about some change by management. Overall, the group $A$ subjects (75%) continue to support Alliance activity, whereas only a few (25%) of the group $NA$ subjects currently would support unionization efforts.
CHAPTER 3: ANALYSIS and CONCLUSION

In recent years some physicians have sought unionization or similar collective organizing. This study explored the reasons behind organizing efforts, the goals of unionization, and class consciousness among physicians. This final chapter addresses the findings on their own merits and in relation to previous research and existing theory.

REASONS FOR ORGANIZING

Traditionally the physician has been afforded the benefits of being a professional. These have included authority (Haber 1991, Starr 1982), autonomy (Collins 1979, Haber 1991, Hoffman 1989, Larson 1977, Starr 1982), and having domain over esoteric knowledge (Hoffman 1989, Starr 1982). Changes implemented by health-care management have altered the physician’s role as a professional. Some theorists (such as Haug and Oppenheimer in Freidson 1984, Ritzer and Walczak 1988) have characterized these changes as “deprofessionalization” or “proletarianization.” These theories argue that administration is striving to make the professional more accountable to fiscal goals and customer service demands. These theorists suggest that administrators within professions attempt to implement these changes by imposing formalized methods upon their members, and in so doing erode the professionals’ individuality (Freidson 1984). I suggest that in the case of the changing medical industry, these formalizations are imposed not only by physician-managers, but also by non-physician managers. Nonetheless, in both contexts the erosion of individual power translates into the erosion of the primary elements of professionalism - authority, autonomy, and domain over
Subjects in group A indicated that such changes prompted their involvement with the Alliance. Most of the group A physicians explained that their autonomy and authority over how they treat their patients has decreased. Though they report that the requirements by insurance companies for prior authorizations have lessened, some physicians claim prior authorization remains a burden for them. Others, who also say prior authorization has decreased, report that insurance companies simply limit the types of procedures for which they may be paid. In addition, all group A physicians reported they are underpaid for the services they do provide. Overall, group A physicians stated that this reduces their income, either in staffing costs for prior authorizations processing, or by limiting the type of care they perform, and by underpayment for services. Group A physicians indicated they have experienced a decrease in power over controlling their income, their autonomy over practice logistics, and their authority over patient care.

Group NA physicians indicated that similar problems were occurring during the time that efforts to unionize were underway. They reported that changes in management had caused friction between administration and the physicians. Upper management was taking control away from the individual departments. Management threatened budget cuts that would affect staffing and pay. They also began talk of imposing employment criteria upon physicians that are more characteristic of those criteria relegated to non-professionals, such as drug testing. The physicians viewed these criteria as blows to their status as professionals.

The similarities between the two groups are apparent. Both group A and group NA physicians were responding to income instability and decreasing autonomy over the
logistics of how a practice is run. However, group A physicians experienced affronts to their authority over patient care, whereas, group NA physicians did not report problems with prior authorizations or limitations to patient care. At first glance there appears to be another difference as well between the two groups, in that the group NA physicians reported degradation of status resulting from being treated as non-professional employees, whereas group A physicians are not in an employee position and, therefore, could not experience such a phenomenon. However, group A physicians did report that they were treated as “peons” by insurance personnel. I extrapolate from these reports by group A subjects a similar perception of status degradation. With the exception of differences in control over patient care, the two groups shared the main points of contention with insurance companies or management. Throughout this analysis I will often refer to both insurance company management (in the case of group A data) and management (in the case on group NA data) simply as management for both groups.

Whereas previously the professional associations legitimated physicians’ authority over esoteric knowledge, thereby allowing autonomy from direct task control and market control (see Starr 1982, Larson 1977), the managed care system has appropriated control (Reagan 1999) over these areas. As Freidson (1994) indicated, more and more physicians are now working for large corporations or organizations. It is therefore easy to perceive the HMOs expanding control over employed physicians like the group NA doctors. Overlooked, however, is the similar relationship between the insurance companies and the private-practice physician in that insurance companies assert the same types of bureaucratic control over these physicians (Budrys 1997), such as group A subjects. It appears that both groups responded in like ways to the loss of
control by turning to an alternative form of association - the labor union or similar organization (i.e. the Alliance).

GOALS AND EFFECTS OF ORGANIZING

As described above, both groups expressed concerns with extrinsic and intrinsic rewards. The extrinsic rewards are pay, job security, and benefits, whereas the intrinsic rewards are related to autonomy and authority (Fenwick and Olson 1986, Gruenberg 1980). Group A members claimed that they wanted better pay, more power, better quality of healthcare, less red tape, and more autonomy. They reported that appropriate tasks for a union are attaining more political power, collective bargaining with the insurance companies, lobbying for legislation seeking the right to collectively bargain, and improving the quality of health care.

Group NA physicians said that both extrinsic (pay) and intrinsic (autonomy and authority) concerns drove the effort to unionize. However, they mentioned only intrinsic matters among their current concerns. Many of these subjects reported they would like changes in staffing and organizational matters. Other issues were that they would like addressed are less red tape, more autonomy, and one subject claimed she would like to see her specialty more highly recognized professionally. However, similarly to group A subjects, group NA subjects stated that both intrinsic and extrinsic matters are appropriate union issues. In order of the most frequently reported, they referred to staffing and organizational logistics, collective bargaining with the employer, autonomy, and red tape. The most apparent difference is that group NA subjects did not overtly refer to politics
and power as much as group A subjects. Group NA subjects tended to focus on immediate issues rather than long-term objectives.

Very few of the group A subjects stated that the insurance companies had made efforts to appease the physicians. Several claimed that instead insurance companies were focusing on stopping Alliance efforts to change anti-trust legislation - changes that would allow non-employee physicians to collectively bargain. In addition, several group A subjects indicated that the insurance companies did not have to respond to Alliance pressure as long as they continued to have access to non-unionized physician resources that by default accommodate insurance companies’ objectives.

Group NA doctors indicated that management had responded to their efforts to unionize. They reported that an administrator who was disliked by the physicians had been replaced by a more acceptable manager, control had been given back to local management, quality circles and physician feedback opportunities had been developed, plans of implementing non-professional employee criteria such as drug testing were dropped, and salary bonus systems were developed. Although a few of the group NA physicians stated that the bonus system is only a token reward in that it is dependent on too many factors unfairly applied, most of them reported that the intrinsic rewards are significant; they stated that their concerns were addressed and that management valued their input. Similarly, most of these physicians reported that management treated them like professionals. This is far different than the reports of group A physicians who indicated management did not treat them as professionals.

Barry Gruenberg (1980) found that workers show preference for either extrinsic or intrinsic rewards depending on which type are available. He also found that when
possible, workers value intrinsic rewards over extrinsic. His latter finding circumvents, though it does not contradict, Maslow’s (1957) theory that workers must first have basic subsistence, or extrinsic, needs met thereby freeing them to seek the most valued rewards, i.e. the intrinsic rewards. Instead, however, Gruenberg argues that workers naturally gain satisfaction from intrinsic rewards, but must learn to value extrinsic rewards as sources of satisfaction. This provides a useful paradigm in which to distinguish between group A and group NA concerns.

Group A subjects were more apt to point to difficulties with pay, whereas group NA subjects were more likely to express concern over intrinsic issues such as control over staffing and other logistical issues. If the group A subjects’ salaries were much lower than the group NA subjects’ were, it could be argued that group A subjects are primarily seeking subsistence needs. Using this same analysis it could be argued that the group NA subjects have had their income issues resolved through the bonus system. However, it does seem highly unlikely that group A physicians are having difficulty meeting their subsistence needs6. Indeed, several of the group A subjects mentioned that they are well paid compared to other workers. An income differential does not seem applicable.

Gruenberg’s (1980) theory allows for other explanations for these differences. The availability of the different forms of rewards differs between the two subject groups. Group A and group NA subjects’ relationship to management differs. Because group A physicians are not officially employees of the insurance companies, established methods of employee participation, and therefore intrinsic rewards, are not utilized. Conversely,

---

6 Income results may be limited in that the coding scheme did not allow for measuring income variation over $120,000.
group NA physicians, as employees, are more easily accessible for management to reward intrinsically through such avenues as quality circles and physician feedback. Assuming the subjects’ incomes are comparable, I argue that the availability of intrinsic rewards drives the group NA subjects to value those rewards more highly than do the group A physicians. This finding corroborates Gruenberg’s (1980) and Fenwick and Olson’s (1986) findings that workplace participation directs employees from extrinsic concerns to intrinsic concerns.

Group NA subjects frequently stated that they felt current employer-employee relations were adequate to mediate any conflicts that arise. These findings seem related to Elden’s (1981) work that looks at workplace participation and sentiments of political efficacy. Similarly, the lack of structural access for group A subjects to participate in workplace operations involving the insurance companies and the physicians’ apparent disbelief in effective mediation with the companies under current relations also supports the logical opposite of Elden’s findings – workers feel less content in the absence of worker participation.

However, the question still remains - why is pay a prominent concern of group A subjects although they have high incomes? Group A’s focus on pay is not only due to the inaccessibility of intrinsic rewards to appease their job dissatisfaction, but also may be because their extrinsic reward of pay, albeit adequate pay, is unstable. Group A members indicated that they were worried about financial difficulties and keeping their practices in the black. Group A members experience more instability because of their vulnerability to market changes without the buffer of employers mediating those market effects on the physician - as in the case of group NA physicians. This impact of relative
stability augments previous findings on the effects of stability offered by employer organizations and the freedom for professionals to then focus on intrinsic rather than extrinsic issues (see Engel and Hall 1973; Burris 1993).

Leo Wolman’s (1936) analysis of unionization and unemployment provides a useful framework for analyzing the diverging paths of group A versus group NA unionizing efforts. Wolman reports that unionization increases under conditions of full employment and decreases during economic downturns. His perspective is based on opportunity and power. During periods of full employment the employer has fewer employee resources outside of existing ones; therefore employers have less relative power and are less likely to utilize union-busting strategies. If, as Wolman posits, management’s power is based on the amount of resources separate from current employees, in the case of the group A, then private-practice physicians who are not unionized are steady resources for insurance companies. In this situation the insurance companies are not dependent upon group A physicians and are, therefore, not inclined to appease them using extrinsic nor intrinsic rewards. Therefore, it is not surprising that insurance companies have not responded well to group A demands. However, continuing group A efforts seem to contradict Wolman’s theory. Why is this so?

Under Wolman’s paradigm, the group A has no hope of power in that the insurance companies have outside resources - much more than a simple majority of the physicians nationwide. However, in this relationship between insurance companies and physicians, there are not a finite number of physician slots to be filled. Instead the insurance industry seeks to expand its market - its physician resources. The group A
subjects are depending on growing physician support to reduce the power of the insurance industry over the physician labor market.

Conversely, the group NA physicians, employed by an insurance company in a staff-model HMO format, would seem to have more market power than the employer does in that there is a shortage of physicians nationwide. Under Wolman’s analysis we would expect the group NA physicians to have followed through with the unionization process. However, it seems the threat of unionizing was sufficient to gain the attention and responses of management. Group NA physicians appear to be satisfied with management’s financial and worker participation concessions, whether significant or not. They also appear to appreciate the stability of employment as opposed to the instability experienced by private-practice group A physicians. In addition, contrary to Fenwick and Tausig’s (1994) findings that a large organization is able to provide employment stability because of high bureaucratic control that consequently has negative and controlling effects on the employee, the group NA subjects positively report employment stability but do not indicate much difficulty with bureaucratic controls. It appears that the group NA physicians’ option to unionize will be deferred as long as there is a physician shortage, and management continues to appease these doctors with intrinsic rewards. These physicians’ moderate requests are more readily acceptable by management than those demands by group A subjects. Group NA physicians will continue to be satisfied with adequate pay and a fair amount of worker participation as long as the insurance companies continue to make private-practice work unappealing, and as long as they continue to at least appear to be making concessions to the employee physicians. The
fact that only four of seventeen (24%) group NA physicians indicated that they would currently support unionization supports this conclusion.

Conversely, twelve of sixteen (75%) group A members indicated that they would support unionization again. Why are group NA subjects, though disadvantaged by market-place power structures and disillusioned with the lack of Alliance impact, continuing to support the Alliance? The Alliance appears to be maintaining support due to fear caused by income instability. A possible way for private-practice physicians to regain stability would be to find employment at an HMO. However, because a significant amount of time and energy has been invested in opposing the insurance industry, the group A subjects appear committed to continuing the fight as long as they practice medicine.

**CLASS CONSCIOUSNESS**

Given that the group A and group NA subjects have taken divergent paths in efforts to unionize, do they also differ according to class consciousness? According to Paul LeBlanc (1996:109) there are four elements to class consciousness: recognition that one belongs to the working class, that the interests of the working class are "counterposed" to those of the capitalists, that one should "identify and have solidarity with all members of our class," and "that the working class should struggle for political power in order to bring about the socialist transformation of society."

All but one group A physician stated that they shared things in common with other physicians. All but three group NA subjects reported that they had things in common
with other physicians as well. However, the group NA subjects were much more likely to express differences with other physicians in addition to common points. One of LeBlanc’s (1996) criticisms of American culture’s effect on class consciousness is that workers often do not express common interests with other workers outside of their specific occupation. We can then assume that expressed common interests with fellow workers within the same occupation are expected at minimum. Group NA physicians’ responses contradicted LeBlanc’s underlying assumption. However, the group A subjects’ responses much more clearly represented solidarity with other physicians. Group A physicians were cognizant that physicians in general are individualistic rather than a collective type of people; yet, they viewed this predisposition as a shared characteristic. Could the difference be attributed to group A involvement - an awareness or education of shared difficulties disseminated through Alliance communications and literature? The difference was so distinct between the two groups it seems difficult to believe their adamantly expressed perspectives could have developed within only a few years time. Another possible explanation is that group NA physicians work in close proximity or are co-employees at minimum with a few hundred other physicians of varied specialization. This explanation of proximity yielding differentiation rather than commonality might seem at first thought to be counterintuitive. It may be, however, that frequent interaction allows physicians to witness differences as well as commonalities. The group A subjects, however, may only interact with other physicians outside of their practices in limited frequency and only in situations where physicians with like interests are drawn. I suggest that in this case, frequent exposure to great numbers of persons of the same profession with different specialties may impede solidarity. This differentiation
seeming to arise from the proximity of specialists, yet specialists within the same profession, is contrary to the Marxist conceptualization that proximity yields class consciousness.

Subjects from both groups did not indicate that they had much in common with other professionals outside of medicine. Differences were often attributed to ethics, similar to the characteristics of professionalism identified by several theorists (Abbott 1983, Fitzgerald 1946, Pavalko 1971). Group A subjects were more apt to point to different remuneration structures for other professionals, specifically regarding attorneys, and to express jealousy, if not animosity, for these other professionals. This supports Haber’s (1991) and Collins’ (1979) positions on the value of professionals’ livelihood standing outside market dynamics. Group A members were also more likely to point out that other professions are not as closely regulated as are doctors; this illustrates their appreciation, yet elusive, desire for autonomy - a benefit of professionalism described by many (Abbott 1983, Collins 1979, Haber 1991, Larson 1977, Starr 1982, among others). Subjects from both groups explained that the stress from life and death consequences were unique for doctors and set them apart from other professionals. Very few subjects from either group described commonality with other professionals without also stating differences. The most significant differences between the two groups are that the group A physicians were more likely to point to remuneration differences and that other professionals enjoy more autonomy; the former is another manifestation of their overall concern with financial matters in general, and the latter demonstrates the perceived difference between group A and group NA subjects regarding their roles in management’s decision making.
Group NA physicians were more likely to state that they had things in common with workers in general than were group A members. The group NA subjects stated that they were employees or that they shared similar interests outside the workplace. Group A doctors that found commonality with workers in general had a power-based perspective; they specifically referred to getting paid for work as well as made specific reference to blue-collar workers. Though the group NA subjects were more likely to report commonality of some type, the group A members who did so appeared to identify with general workers more from a power perspective.

Compared to LeBlanc’s (1996) outline of class consciousness, my findings show that both groups reported mixed degrees of commonality with others who may or may not be members of a similar class (i.e. physicians, professionals, and general workers). Group A subjects identified more strongly with other physicians than did group NA doctors. Both groups did not identify strongly with other professionals. Although group NA doctors identified more frequently with workers, group A doctors were more likely to identify with them as workers who similarly have diminished power. Overall, group A doctors demonstrated more class conscious identity with others than did the group NA physicians. The differences between the two groups regarding identity with others are apparent in that the group A physicians demonstrate more class identity. Their responses to management were more complex. LeBlanc’s (1996) paradigm states that class consciousness involves the recognition that one’s position is opposed to that of the capitalist, or in this study to that of the organization in power. While the group A doctors recognized that management’s goals of pure profit making are counterposed to theirs, they also acknowledged that they shared commonality in running a business. Group NA
doctors also provided mixed perspectives. For the most part, group NA doctors reported they shared management’s interest in the success of the organization, yet most reported that management was more preoccupied with success than with medical care. Although on the surface, the numbers make it appear that the group A doctors were more likely to identify with management, they were adamant about the differences and were clearly disapproving of management’s goals. Similarly group NA subjects saw commonality as well as opposing goals; however, the marked difference is that group NA subjects were not as negatively adamant. I suggest this is because the group NA doctors are more likely to believe their concerns are well received and addressed by management, and therefore, adequate negotiation of opposing goals is likely. This analysis demonstrates that management’s implementation of intrinsic rewards prohibits this element of class consciousness, strict employee/employer conflict, within the group NA subjects. The reduced conflict at work also allows some workers to leave work at work. This is demonstrated in that only 65% of group NA doctors said that work affects the rest of their lives, compared to 94% of group A physicians.

The degree to which subjects believe that work affects the rest of their life corresponds to their level of commitment to change through solidarity and unionization, as LeBlanc (1996) asserts is part of class consciousness. Group A members pointed out that a high degree of unhappiness is a pre-requisite to solidarity and seeking change. Not surprisingly, group A subjects expressed more dissatisfaction, a greater degree of work affecting life in general, and 75% indicated that they currently support continuing Alliance efforts. Group NA subjects as mentioned above expressed less dissatisfaction by means of more worker participation, a lesser degree of work affecting life in general, and
only 24% indicated they would currently support unionization efforts. In summary, it appears that the group A subjects demonstrate a higher degree of class consciousness as compared to group NA subjects.

**CONCLUSION**

This pilot study compared two groups of physicians that took different paths in unionization. Research questions included the reasons for organizing, the goals and effects of organizing, and the class consciousness of the subjects. Although the findings are not generalizable to all physicians, organized or not, these results are useful for theory building and designing future studies.

I found that both groups of physicians began organization efforts in response to bureaucratic impositions negatively affecting income and autonomy. It has been argued that these changes have deprofessionalized or poletarianized the physician (Haug and Oppenheimer; in Freidson 1984 and Burris 1993, Ritzer and Walczak 1988). The group A physicians sought remedies to the loss of income stability, declining authority over medical care, and decreasing autonomy over practice logistics. The group NA subjects had begun unionization efforts to remedy the threat of these impositions from management changes.

Group A’s efforts have been hampered in that insurance companies have alternative physician resources as the majority of private-practice physicians are not organized. With the exception of fighting anti-trust reform efforts, the insurance companies have not responded to pressure from group A. Conversely, management met
group NA subjects’ demands during the unionization drive. Management fired one administrator who physicians strongly objected to, returned the majority of organizational control to local administration, implemented bonus programs, and instituted worker participation programs. Group A efforts to gain power in relation to the insurance industry continue, whereas group NA subjects have been appeased and organization efforts have ceased.

Findings reveal that group A members exhibit higher degrees of class consciousness. Although the group A subjects are somewhat discouraged, the majority of them support continued organizing efforts. The vast majority of group NA physicians do not currently support unionization. The differences between these two subject groups are apparently related to differences in income stability, or extrinsic conditions, and differences in the accessibility to intrinsic reward systems (see Chart 3).

However, the class consciousness, whether in the past as in the case of group NA subjects or in the present as in the case of group A subjects, is a complex issue to understand. Are the group A doctors collective by self-selection, or are they collectively oriented due to difficult structural environments in that they are private-practice physicians dealing with external administrative organizations? It also may be that group A subjects are class conscious due to the process of organizing itself and having membership in a group such as the Alliance.7

What do these findings indicate for physicians in an ever-growing corporate environment? If organizations such as the Alliance do not successfully regain control of the medical profession, it seems likely the insurance industry will continue to develop

7  Though differing structural causes are possible, it may be that these class conscious groups of physicians
HMOs and reduce the appeal of private practice. If such a scenario takes place, what does that mean for employed physicians? These findings indicate that, although not consistently class conscious in the traditional sense, employed physicians may actually be better able, compared to private-practice physicians, to find both extrinsic and intrinsic satisfaction in their work. This will only be possible, however, as long as the physician labor pool does not grow to the point that the insurance industry has the advantage of available alternative employee resources.

This field of study could significantly benefit from additional research investigating the relationships of power between professionals and corporations. As more professionals become employees, will their income, autonomy, and authority continue to decline? If so, what are the mechanisms for them to remedy declining professionalism? Can labor unions serve as an effective tool for these purposes without compromising professional ethics? In a corporate structure, are there methods other than labor unions that can protect professionalism?

have been exposed to other consciousness-raising mechanisms such as charismatic leadership.
Chart 3: Managed Care’s Maintenance of Resources

Continued Resource of Physician Labor Power =

Managed Care Changes

<table>
<thead>
<tr>
<th>Intrinsic</th>
<th>Extrinsic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Autonomy Decrease</td>
<td>Physician Pay</td>
</tr>
<tr>
<td>Physician Control over Care Decrease</td>
<td></td>
</tr>
</tbody>
</table>

Insurance Company Resource

Private-Practice Physicians Dissatisfied

Resource

Physicians That Do Not Organize

Resource

Physicians That Organize

Resource – No Threat to Insurance Company

Conflicts Continues

Physicians Continue Organizing

Group Solidarity Necessary

HMO Resource

Employed Physicians Dissatisfied

Resource

Physicians Begin to Organize

Resource - Threat to HMO

HMO Appeases Conflict

<table>
<thead>
<tr>
<th>Intrinsic</th>
<th>Extrinsic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change Management</td>
<td>Implement Bonus’</td>
</tr>
<tr>
<td>Quality Circles</td>
<td>Department Input</td>
</tr>
</tbody>
</table>

Physicians Stop Organizing

Group Solidarity Unnecessary
LIST OF APPENDICES

Appendix A. Interview Questions ........................................................................................................ 107
Appendix B. Alliance Subjects’ Demographics ................................................................................... 110
Appendix C. Non-Alliance Subjects’ Demographics ........................................................................... 111
Appendix D. Alliance Subjects’ Opinion – Union & Profession ........................................................... 112
Appendix E. Non-Alliance Subjects’ Opinion – Union & Profession .................................................... 113
References .............................................................................................................................................. 114
APPENDIX A  
Interview Questions

Alliance and Non-Alliance:

1) What is your specialty?

2) Where did you go to Medical School? Is this a prestigious school?

3) How long have you been practicing medicine - post residency?

4) How do you identify your ethnicity?

5) How old are you?

6) Last year was your gross income:
   Less than 60k
   61k to 90k
   91k to 120k
   120k ->

7) While you were growing up, was your father’s occupation:
   Working class
   Middle Class
   Upper Class

8) Do you supervise other physicians? How many?

Alliance Only:

9) How long have you belonged to the Alliance?

Non-Alliance Only:

9) How long have you worked for the Corporation?

Alliance and Non-Alliance:

10) Is being a doctor what you thought it would be when you were in medical school?
APPENDIX A – Continued

11) Have you always worked for or contracted with an HMO? Do HMOs change the practice of medicine?

Do you see any problems with HMOs?

12) Do you feel like you are treated like a professional by your patients? By the HMOs or payer organizations?

13) On a scale of 1-5, with five being the most, how much do you feel you are reviewed by non-physicians compare to physicians?

What effect has this had on your work?

Can you give examples?

14) What would you like to see changed about how you do your job?

What would make your job easier?

What would improve quality of care?

What would improve patient relations?

15) How often do you talk with colleagues about medical issues other than in consultations or meetings? Is there enough time for this type of communication?

16) How often do you socialize with doctors outside of the workplace?

17) Do you feel you have things in common with other doctors? Other professionals? Workers in general? Management?

18) Do you feel your degree of satisfaction with your work affects other areas of your life, such as family relationship or satisfaction with yourself?

Alliance Only:

19) Why did you join the Alliance?
APPENDIX A – Continued

20) Did a specific event precipitate organizing?
21) Has your pattern of socializing with your colleagues changed since you organized?
22) What do you want the Alliance to do for you? What types of things do you want them to bargain for?
23) Do you feel you are part of some sort of movement?
24) How have insurance companies responded to the efforts of the Alliance and the whole process?

Non-Alliance Only:

19) In recent years, there have been efforts to unionize physicians; how do you feel about that? Have specific events influenced your perspective?
20) Do you see any purpose in unionizing? If so, what types of things would you want a union to do? If not, do you feel there are any alternative ways to change the aspects of your work you dislike?

Alliance and Non-Alliance:

25) What do you believe is important about the way that medicine is practiced that I have not asked about?
# APPENDIX B

Alliance Subjects’ Demographics

<table>
<thead>
<tr>
<th>ALLIANCE DOCTORS</th>
<th>GENDER</th>
<th>AGE</th>
<th>SPECIALTY LEVEL</th>
<th>ETHNICITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allen</td>
<td>M</td>
<td>50</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Brown</td>
<td>M</td>
<td>50</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Cage</td>
<td>F</td>
<td>41</td>
<td>1</td>
<td>NW</td>
</tr>
<tr>
<td>Dillon</td>
<td>F</td>
<td>40</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Edmonds</td>
<td>M</td>
<td>39</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Fitz</td>
<td>M</td>
<td>65</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Gallagher</td>
<td>F</td>
<td>45</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Hatch</td>
<td>M</td>
<td>42</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Irving</td>
<td>M</td>
<td>37</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Jackson</td>
<td>F</td>
<td>39</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Kepler</td>
<td>M</td>
<td>37</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Lutz</td>
<td>M</td>
<td>60</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Miller</td>
<td>M</td>
<td>52</td>
<td>1</td>
<td>NW</td>
</tr>
<tr>
<td>Nelson</td>
<td>M</td>
<td>36</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Ottman</td>
<td>M</td>
<td>43</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Peters</td>
<td>M</td>
<td>40s</td>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>
## APPENDIX C
Non-Alliance Subjects’ Demographics

<table>
<thead>
<tr>
<th>NON-ALLIANCE DOCTORS</th>
<th>GENDER</th>
<th>AGE</th>
<th>SPECIALTY LEVEL</th>
<th>ETHNICITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hunter M</td>
<td>43</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ives M</td>
<td>52</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Johnson M</td>
<td>37</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kelley M</td>
<td>36</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Linman M</td>
<td>54</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moody M</td>
<td>42</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nabors F</td>
<td>39</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Osborne F</td>
<td>45</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peabody M</td>
<td>50</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rivers M</td>
<td>48</td>
<td>1</td>
<td>NW</td>
<td></td>
</tr>
<tr>
<td>Simpson M</td>
<td>51</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thatcher M</td>
<td>56</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Underwood M</td>
<td>52</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vaughn F</td>
<td>47</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yaeger M</td>
<td>Early 40s</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Walker F</td>
<td>49</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Zimmerman F</td>
<td>49</td>
<td>4</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX D

Alliance Subjects’ Opinion – Union & Profession

<table>
<thead>
<tr>
<th>ALLIANCE DOCTORS</th>
<th>WOULD VOTE FOR UNION</th>
<th>LIKE BEING DOCTOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allen</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Brown</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Cage</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Dillon</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Edmonds</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>Fitz</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>Gallagher</td>
<td>N</td>
<td>Y</td>
</tr>
<tr>
<td>Hatch</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>Irving</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>Jackson</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>Kepler</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>Lutz</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Miller</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Nelson</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>Ottman</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>Peters</td>
<td>N</td>
<td></td>
</tr>
</tbody>
</table>
# APPENDIX E

Non-Alliance Subjects’ Opinion – Union & Profession

<table>
<thead>
<tr>
<th>NON-ALLIANCE DOCTORS</th>
<th>WOULD VOTE FOR UNION</th>
<th>LIKE BEING DOCTOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hunter</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>Ives</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Johnson</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Kelley</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Linman</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Moody</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Nabors</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Osborne</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>Peabody</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Rivers</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>Simpson</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Thatcher</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>Underwood</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Vaughn</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Yaeger</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Walker</td>
<td>N</td>
<td>Y</td>
</tr>
<tr>
<td>Zimmerman</td>
<td>N</td>
<td></td>
</tr>
</tbody>
</table>
References


