PHYSICIANS' DEFINITIONS OF A PREPAID GROUP PRACTICE

by

BEVERLY AMSEL

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May 22, 1975
date

Samuel W. Bloom
Chairman of Examining Committee

5/22/75
date

Benjamin B Rugg
Executive Officer

Lindsay Churchill

Emily Mumford

Rose L. Coser

The City University of New York

Abstract

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Beverly Amsel

Advisor: Professor Samuel W. Bloom

This is a case study of thirty-one physicians in one prepaid group practice of the Health Insurance Plan of Greater New York (HIP). The key question is: how can we explain the behavior of the physicians vis a vis patients and colleagues? The critical variables are the structure of the professional practice and physicians' professional perspectives.

We sought to discover the bases for physicians' role constructions in the medical group and how these roles effected the situation of medical practice. A case study approach employing participant observation and focused interviews was used.

The history of organized medicine's attitude toward prepaid group practice was described, and physicians' reputations and reference groups for professional identification were discussed in terms of the historically negative reputation of prepaid group practice among a large segment of the profession. The professional perspectives of physicians were explored as they effected perceptions of autonomy in the medical group; physicians' definitions of the prepaid group practice were analyzed.

In varying degrees, physicians were found to apply the perspective of fee-for-service private practice in their evaluation of the prepaid group. This led to definitions of the medical organization as a clinic.

Three distinct types of physician role constructions were analyzed:

1- "Patient-oriented" physicians defined the prepaid group as their group medical practice. They constructed physician roles in which they were committed to the group and caring for group patients with technical competence and personal interest.

2- "Private practitioners" defined the group as a clinic and constructed roles in which they saw themselves as "giving time" to the group and caring for the group's patients with technical competence but little or no personal interest.

3- "Isolated individualists" defined the group as a clinic and constructed roles in which they saw themselves as traditional

physicians working in a prepaid group practice. Although they treated patients with technical competence, "isolated individualists" were hostile to patients whom they saw as imputing the clinic doctor label to physicians.

These physician types were seen as varying adaptations to the strain in physicians' role identities created by conflict between organizational demands as defined by the physicians and physicians' professional perspectives.

We suggest that physicians' professional perspectives may predispose them to respond to a structure which they define as more constraining than the actual demands of the situation.

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Chapter 1

INTRODUCTION

This is a case study about doctors in a prepaid group practice, a form of health care delivery which is a distinct departure, structurally, from the solo fee-for-service practice that is traditional in the United States. These two systems differ most obviously in terms of method of payment (capitation vs. fee-for-service) and mode of delivery (group of physicians sharing patients and facilities vs. solo entrepreneur delivering care). There are also important differences in their respective situations which, for sociology, provide an opportune *in situ* setting for describing and interpreting the role behavior of physicians.

More specifically, in the study of physician behavior, the history of sociological inquiry reveals two critical facts. First, the basic work, particularly that of Parsons,[1] Hall,[2] and Merton,[3] is focused on the American medical profession and consequently is limited to the private practice, fee-for-service model. Second, and perhaps related to the first, the behavior of the physician was conceptualized according to theories of social role analysis, derived from Linton.[4] As a consequence, "culture" was interpreted to be the chief determinant of role, in the tradition of functionalist theories in social anthropology developed between the two World Wars.[5] This particular theoretical framework has exerted a powerful influence on the field of inquiry known as the sociology of medicine, just as it has in the field of sociology as a whole.[6]

With the appearance of *Boys in White*[7] the functional approach in the sociology of medicine was severely challenged. Appropriately, the challenge came from the view of symbolic interaction, and the

subject of inquiry was socialization for the physician's role. In essence, the difference is epitomized by the interpretation that it is in the "structure of the situation" more than in normative role expectations that the behaviors of physicians (and other professionals) are best explained.

But what exactly does the polemic between these two theoretical perspectives mean? The most complete explication has been made by Gouldner, working at the societal level dealing particularly with the phenomenon of bureaucracy.[8] In the sociology of medicine, similar critiques have appeared[9] but they have stopped short of a full view of the physician's role in the ongoing situation of practice. Freidson, for example, argues that in the functionalist view, values are the primary determinant of expectations, not performance. "Furthermore, those expectations are part of the broad institutional norms connected with professions as officially organized occupations.... They are quite distinct, analytically and empirically, from the actual norms of individual professionals."[10] In contrast, Freidson's own theoretical approach, which may be characterized as symbolic interaction, stresses the demands within the situation of work and the perspectives which arise from those demands. His key determinant is not norms or values, but the situational perspectives that influence medical work.

In this study we focus on the physician, the key professional of the health system. Our own conception underscores the importance of the distinction between ideational and behavioral components of social role. Our key question is: how can we explain the behavior of the physician <u>vis a vis</u> patients and colleagues? Initially our critical variable was the structure of professional practice. We emphasized structure because this case study specifically examines the relationship between the social

organization of a prepaid group practice and physicians' role behaviors. Our concern is not with society's expectations of the physician's role but with the actor's role construction and performance based on how he perceives and defines his situation.

Most research concerned with the physician's role has described the normative aspects of behavior. These expectations have been explained, for the most part, within the framework of the doctor-patient relationship. Henderson,[11] Parsons,[12] Szasz and Hollender,[13] Bloom,[14] and others have focused on the interaction between doctor and patient conceived as a functional social system. The normative expectations operating in their homeostatic systems emphasize the primary function of the doctor in his relationship to the patient.

Our point of departure was not what society expects of the physician (in order that the social system remain functional). We look for the actor's legitimations of his behavior. Why does he see that he should behave in one way rather than another? Says who?[15] Whose role definitions does he use to legitimate his conceptions of that role, i.e., what are his reference groups? Why this definition rather than another? Since we were interested in the physician within prepaid group practice and his relationship to that organization, the doctor-patient relationship as the arena for role behavior did not provide a broad enough framework for our approach. While most definitions of the physician's role are based on expectations of behavior in the doctor-patient relationship of fee-for-service solo practice, we sought to discover the physician's conception of his role based on <u>his</u> expectations of that role. As such, we examined not only the physician's conception of his role in the situation of prepaid group practice, but his definition of that situation as well.

Let us begin our inquiry, by examining what is meant by prepaid group practice.

PREPAID GROUP PRACTICE

This research views prepaid group practice as a system of health care delivery.[16] All prepaid groups share two essential features: (1) medical care provided by a group of physicians (2) to a population which prepays a yearly fee which entitles them to services. Within this framework, the organization of physicians for the delivery of care differs widely as do the rights and authority of the consumers. These differences are most notable in five major areas:

(1) The method by which physicians are paid (salary, pooling of income, points systems, merit systems, etc.)

(2) The relationship of physicians to the health plan and/or the medical group. (Physicians may be hired by a health plan which is a separate entity from the medical group. The health plan or the medical group may be responsible for contracting patients and/or physicians to provide care.)

   a. Physicians may or may not be partners or on contract (salaried) to the medical group.

   b. Physicians may or may not have policy making authority in the health plan and/or medical group.

   c. Physicians may work full- or part-time in the medical group.

(3) The relationship of the consumers to the health plan and/or medical group.

   a. Consumers may have varying amounts of authority in the medical group and/or health plan.

b. Consumers may own and/or operate the group and/or the health plan.

c. Consumers may receive services only as a member of an enrollment group or they may be permitted to enroll as individuals.

(4) The relationship of the medical group to the hospital. Some medical groups are hospital based, e.g., Kaiser-Permanente and the Group Health Cooperative. Others use Blue Cross or other hospital insurance for its subscribers and individual physicians hospitalize patients in hospitals with which they are affiliated, e.g., The Health Insurance Plan.

(5) The size of consumer populations served. Patient populations vary from as few as 7,000 served by one medical group, to just over 1,000,000 served by another group.[17]

Although actual plans differ greatly, the best-known conceptual model of prepaid group practice has been derived from the experiences of the Kaiser Foundation Plan. This model or "genetic code" asserts five basic principles or requirements for prepaid group practice:

(1) Prepayment of a comprehensive range of inpatient and out-patient benefits, so as to eliminate the financial barrier to medical services.

(2) Group practice of the common specialties utilizing full-time physicians who pool all their professional income. These physicians organize services so as to provide their continuous accessability.

(3) Integrated health care facilities to provide personalized care in a system providing continuity and efficiency of services.

(4) An emphasis on preventive medical care made economically feasible by reversal of the usual pattern of financing. In contrast to fee-for-service payment methods, capitation

payments produce the same revenue from members whether they are sick or well.

(5) Dual choice which secures to each individual the right to choose from among significantly different types of prepayment programs and preserves his freedom to select the system of medical care satisfactory to him.[18]

More recently, a sixth principle has been added:

(6) Physician responsibility for providing comprehensive care to the membership and as a partner, for administering the program.[19]

This model assumes a structure in which the medical groups are hospital based partnerships of full-time physicians who pool their incomes. Since many existant prepaid groups differ from the Kaiser model, we believe it is most valuable in directing our attention to the effect of the principles as they exist in an actual case chosen for study. The way we used this model in our research will be discussed in greater detail in another section.

The case selected for study here (henceforth called the Urban Medical Group)* is one of 30 medical groups of the Health Insurance Plan of Greater New York (HIP). With approximately 750,000 subscribers, HIP is the second largest prepaid health plan in the United States, exceeded only by the Kaiser Foundation Plan. In contrast to the Kaiser system, HIP has not been a hospital based plan, although it now owns one hospital. In addition, HIP physicians have primarily been part-time rather than full-time.

The choice of Urban as the case for study was influenced by the researcher's prior contact with the group for purposes of medical student education. When Urban's medical director and administrator indicated a

*This is a fictitious name, chosen to protect the confidentiality of our data.

willingness to allow entry into the organization for our research, we did not hesitate to accept. We were aware that the group was not representative of HIP because HIP groups differ so widely in their organization and size that no one group could be said to represent the Plan. For example, the mean number of enrollees for the 30 groups in 1970 was 24,753 with a range from 5,269 to 68,629.[20] We believe, however, the case chosen was appropriate because, compared to other HIP groups, it ranks high based on important criteria of group practice: partnership, full-time physicians, and services rendered in the medical center. Specifically, in the Urban Medical Group, the partners delivered 81.4 per cent of the services as compared to a mean for all HIP groups of 75.4 per cent. The per cent of services delivered by full-time physicians was 59.5 per cent in Urban compared to a mean for all groups of 32.5 per cent. Moreover, we believed that services rendered in the group centers as compared to physicians' private practice offices were a good index of the "group" aspect of prepaid practice. The mean per cent of services delivered in medical centers for all groups was 77.7 per cent; for Urban it was a higher 83.5 per cent. One important way Urban differed from others was in the number of physician encounters (per 100 enrollees) per year. Encounters for all groups were 412.7 and for Urban 219.7. This is particularly interesting in view of Urban physicians' perceptions, which we will explore later, that the group's patients tend to over-utilize services.

In the Urban Medical Group, a legal partnership of physicians, there are 26 partners and an additional six physicians who are contracted by the partners to provide services for the enrolled patients. Physicians include family doctors who act as general practitioners and a broad variety of medical and surgical specialists. Two of the physicians who

serve as family doctors are certified in internal medicine. No one is board certified in family practice.

The Urban Medical Group assumes responsibility for the health care of a population of some 28,000 residents in New York City who are voluntarily enrolled in the Health Insurance Plan. Consumers join through membership in union, employee or other groups who contract with the Plan for services. Each consumer who is offered membership in HIP must be given at least one other choice of health insurance. Through a system of capitation, HIP pays a yearly sum to Urban for each patient enrolled, Thus patients are entitled to unlimited services, with specified exceptions such as extended psychiatric services. Each partner then receives a percentage, agreed upon by the partnership, of Urban's profits. Full-time physicians are guaranteed a minimum amount of compensation regardless of profits but part-time physicians are reimbursed strictly on the basis of a predetermined percentage share.

Seven of the partners and one contract physician are full-time physicians. According to HIP guidelines, a full-time physician must work at least 20 hours per week in the medical group and have no outside private practice. He may, however, see private patients in his group office, returning 50 per cent of all such private patient fees to the group. (The per cent of fees returned to the group varies among HIP groups). Except for the prohibition of an outside private practice, full-time physicians may otherwise engage in paid medical activities (e.g., hospital clinic work).

Nineteen partners and five contract physicians work part-time in Urban and all but one of these (who is salaried by a hospital) are engaged in private practice. The amount of time that part-time physicians spend with group patients varies from 2 to 7 hours per week. Moreover, of the

19 part-time partners, five physicians see group patients primarily in their private practice offices.

The Urban Medical Group has facilities in two separate locations. The larger facility serves a largely lower-middle and middle-class population enrolled through employment groups while the smaller center's enrollees are mostly financed under Medicaid legislation. While the research was conducted at both medical centers, the greater part of the participant observation was carried out at the larger facility.

RESEARCH DESIGN AND METHODS

The methodology for this study evolved from our intent to study the effect of the structure of a medical practice on physician behavior and we viewed the research as an "exploration in unknown territory." This may seem extreme since most of us have come into contact with the physician, at the very least, as patients. It is, however, because the subject feels so familiar that we take for granted what the physician does. A few studies have been concerned with how the physician behaves with reference to specific standards of the requirements of quality care.[21] Otherwise, descriptions of what the doctor does in the situation of practice are either autobiographical or logical deductions.[22] On this basis, we concluded that the study of the physician in a particular practice situation is largely unmapped territory.

Because of our emphasis on structure, we believed a situational perspective would best meet the demands of this research. We concur with Freidson that

> ...it is at once attractively parsimonious and adequately true to assume that a significant amount of behavior is situational in character -- that people are constantly responding to the organized pressures of the situations they are in at any particular time, that what they are is not completely but more their present than their past,

> and that what they do is more an outcome of the pressures of the situation they are in than of what they have earlier internalized.[23]

At the outset, therefore, observations were focused, in the broadest sense, on the effect of the social organization of the prepaid group on the role of the physician. The rationale for our choice of participant observation as the basic method within a case study design is similar to that used by William Foote Whyte in Street Corner Society. Whyte's analysis of the social structure of a slum examines the social relationships between informal groups of "corner boys" and political organizations, police and rackets. The in-depth study of these relationships as they emerged in behavior required deep familiarity with people and situations and flexibility. As Whyte explains this method:

> This familiarity gave rise to the basic ideas in this book. I did not develop these ideas by any strictly logical process. They dawned on me out of what I was seeing, hearing, doing -- and feeling. They grew out of an effort to organize a confusing welter of experience...
>
> This explains why my research plans underwent such drastic changes in the course of study. I was on an exploration into unknown territory....It would have been impossible to map out at the beginning the sort of study I eventually found myself doing.[24]

The requirements of this study were similar. As such, participant observation, especially of physician behavior, was employed as the initial means to become informed about the Urban Medical Group. Although the research was to focus on the physician, it was decided that familiarity with the workings of Urban and with staff was essential. Thus the administrator told the supervisors of nursing, reception, lab and x-ray that they would be observed as part of a research study. At the same time, the medical director, in a letter to the physicians informed them of the research and asked that they cooperate; they were assured,

however, that cooperation was voluntary. It is noteworthy here, that staff were told to cooperate while physicians were asked.

The Process of Observations

Once everyone in the group was informed about the study, observations were begun. On the first day, for example, the researcher stationed herself in the reception area, a key spot in the medical center through which everyone entering or leaving had to pass. It was also the primary area in which patients, personnel and physicians congregated. From this vantage point, patients making and receiving appointments as well as interchanges among receptionists, patients, nurses and physicians could be observed. At the same time, the observable researcher could become a familiar figure in Urban.

Initially, the observer introduced herself to the staff and indicated she was trying to find out "how the group worked." A field journal was kept and notes were often taken as an activity or conversation occurred. No attempt at concealment was made. Although individuals being observed may initially have changed some of their behavior, over sustained periods, as Emily Mumford notes, behavior normalized.[25]

Over a period of eight months, nurses, technicians, secretaries, receptionists and doctor-patient interactions were observed. Within the first three months, formal and informal interviews with the non-medical staff were conducted. These dealt with each person's conception of his own role in the group as well as his perceptions of patients, doctors, other staff and the group in general. No one approached on the non-medical staff refused to be interviewed.

Observations of doctor-patient interactions were conducted with the consent of the physicians who were told the research was concerned

with "understanding how physicians work in prepaid group practice." While the physicians were somewhat hesitant about being observed initially, after a few sessions it was not unusual for them to ask the researcher "did she want to observe today?" Not one physician asked the patient if he objected to the researcher's presence and the researcher was rarely introduced to the patient. After two months of observations, the observer responded to the request of a nurse who noted, "patients would be more comfortable if you wore a white coat."

Problem Reformulation

From our observations a major theme began to emerge: physicians were constantly modifying their statements about their jobs, patients and staff in terms of "the way it was in private practice." It appeared that most of the group physicians perceived Urban as a situation of practice in which they were constrained while they saw private practice as a situation of total autonomy. We were aware of the popular assumption that the individual physician, without direct control over fees and by sharing responsibility for policy and patients, would have less authority over the terms of his work in Urban than in private practice. In Urban, however, we expected that a good deal of autonomy would be retained because the physicians are not so much working for an organization as they are themselves a partnership that is the organization: they make the policies and run the Urban Medical Group.

Physician perceptions and behavior, however, often contradicted our expectations based on the formal structure of the organization. For example, why was the structure as we saw it sociologically (a partnership) perceived and responded to by most physicians as "the organization" for which they worked? Why did they talk and act as if they had no control over the terms of their work even though they had formal

responsibility in the situation? Why did many physicians complain about having to work "the group's way" when it was apparent from our observations that each physician had a different manner of practice?

Our observations in fact revealed a significant absence of interaction among Urban physicians. It was typical for the physician to arrive at the Urban center, go directly to his office, see the patients on his schedule and leave the facility. Occasionally a physician would stop at the reception desk to ask for messages; often a physician would chat with the nurse assigned to him for the session; rarely would a physician go to another physician's office either to socialize or to discuss a case. (This was observed only once.) When consultations between physicians were required, this was accomplished either with a quick phone call, or more typically, the physican would fill out a report of his findings about the patient on a special form provided by the organization. This form obviated the need for face-to-face interaction among the physicians about medical cases.

We had expected group practice to produce greater face-to-face interaction than we assumed exists among physicians in private practice. But there were no case conferences; formal meetings of the partnership were for the purpose of discussing business not medical issues. Specifically, face-to-face contact between physicians in the Urban center was accidental: two physicians encountering one another on their way in or out of the facility might nod and say hello, shake hands and greet one another, but only for a moment. Given the amount of contact between physicians in Urban, they may as well have been scattered through the city, each in his own private office. Was the Urban Medical Group structured to maintain private practice behavior? Or, were physicians' professional perspectives producing private practice behavior?

Aware of the fundamental significance of autonomy to the medical profession which gives physicians the "special privilege of freedom from control by outsiders,"[26] we had to account for physicians' varying perceptions of their situation of membership in the Urban Medical Group and the consequences of those perceptions. It is noteworthy that when Freidson tried to account for the regulatory behavior of physicians through a purely structural analysis he found that focusing on the effect of the social structure on behavior had limitations. He was forced to turn his attention to "the norms or values of the individuals who are working in the organized settings."[27] So too were we forced to examine physicians' professional perspectives.

As Mechanic suggests, "the operation of...medical care in general is influenced largely by the physician's definition of his needs, his professional responsibility, his conceptions of autonomy, and his life style. Any serious attempt to understand the organization of medical care requires detailed attention to the doctor's perspective."[28] (Emphasis added.) Clearly, physicians were behaving according to their definitions of the situation of medical practice. If we were to understand the effect on behavior of the structure of the situation of medical practice, we would have to examine the situation as defined by the physicians. As Thomas noted long ago, "If men define situations as real, they are real in their consequences."[29]

With so little interaction among the Urban physicians, we soon realized the necessity of more than participant observation data. To obtain a full understanding of the Urban physician's definition of the situation of practice, focused interviews of the of physicians were required. Our change in method essentially mirrored our finding that physicians in Urban were isolated practitioners.

An interview schedule was developed* and administered to 31 physicians. (One partner refused to cooperate.) Although the questions were concerned to a great extent, with physicians' perspectives, questions were directly derived from observations of physician behavior. In addition, some objective data concerning the physicians' private practices was obtained through interviews and two-thirds of the private practices were visited.

THE WORK SETTING

Traditionally, the professional has been described as the free and autonomous practitioner. However, organizations are increasingly becoming the work settings of professionals. W. Richard Scott describes three types of organizational settings in which professionals work: The autonomous professional organization is one in which the members of the profession determine the structure. The heteronomous professional organization is one in which the professionals are subordinated to externally imposed regulations. A third type of setting is the professional department within an organization in which the professional is assumed to face the strongest conflicts between professional and bureaucratic norms and values.[30]

While it would seem that the Urban Medical Group fits the autonomous professional organization type, many of the Urban physicians perceived the organization as the heteronomous type, where rules are viewed as externally imposed. The Urban physicians were essentially calling attention to the conflict between the implicit autonomy of the profession and the bureaucratic demands for adherence to strict rules and regulations. Scott in fact, has outlined four areas of conflict for professionals in organizations:

* See Appendix for Interview Schedule

> (1) the professional's resistance to bureaucratic rules; (2) the professional's rejection of bureaucratic standards; (3) the professional's resistance to bureaucratic supervision; and (4) the professional's conditional loyalty to the bureaucracy.[31]

There is substantial evidence that conflict in the organizational work settings of professionals exert a powerful influence on the behavior of professionals. A number of studies have been conducted which suggest a variety of ways in which professionals adapt to this conflict.[32] For example, Reissman, in a study of the adaptation of middle level civil service workers to a bureaucracy, developed a typology which viewed the professional and bureaucrat on a continuum.[33] At one end was the "functional bureaucrat" who was oriented toward and sought recognition from an outside professional reference group. At the other end of the continuum, Reissman identified the "job bureaucrat" who was totally oriented to the organization. Between these extremes were the "service bureaucrat" who was identified with the bureaucracy but sought recognition from a group outside it and the "specialist bureaucrat" who was similar to the "functional bureaucrat" but had a greater identification with the bureaucracy than the "service bureaucrat."

Similarly, Gouldner found two types of adaptation among the faculty in a small college.[34] The "cosmopolitan" was oriented to an outside reference group on the basis of his specialty while the "local" was oriented to a reference group within the college. Wilensky, who studied professionals in labor unions identified four types of orientations to the organization. He concluded that professionals can adapt to bureaucratic organizations either by modifying their work role so that demands and expectations are more compatible with their outside professional orientation, or by shifting their orientation from the outside professional group to the organization.[35]

In his review of studies of professionals in bureaucracy, Pavalko concludes:

> Within the same profession there may be different orientations toward both the employing organization and the profession. While it is possible to be oriented toward both, it is difficult to maintain this state of marginality without some negative consequences for either the individual, the organization, or both. Although the degree of professionalism varies among persons in the same profession, the stronger this orientation is the greater will be the conflict between the professional and the organization.[36]

In this study, we will explore the ways in which the Urban physicians adapt to the potential conflict between their professional norms and the rules of the organization. We will examine the behavior of Urban physicians as it is influenced by both the organization of the Urban Medical Group and the physicians' professional perspectives.

THE PROFESSIONAL PERSPECTIVE

From our preliminary observations the question whether physicians' definitions of the situation had a greater influence on their behavior than the actual constraints in the situation emerged sharply. According to the concept of ideology or perspective, the holder of a perspective employs the beliefs and attitudes attached to that perspective as a rationale for his behavior. Examining the social structure of Urban, we found that the formal structure did allow for behaviors different from private practice, but there appeared to be a strain toward maintaining traditional behaviors of private practice. Thus we ask, does the perspective of fee-for-service private practice persist in the prepaid group practice situation and why?

In our usage, perspective is conceived as differing from attitudes. As defined by Rokeach, "an attitude is a relatively enduring organization of beliefs around an object or situation predisposing one to respond in some preferential manner."[37] We do not suggest that physicians merely prefer one mode of practice over another. Rather, the concept of

perspective refers to "an organization of beliefs and attitudes...that is more or less institutionalized or shared with others, deriving from external authority."[38] The group physicians' perspectives thus contain a variety of attitudes toward prepaid and private practice organization and patients as well as beliefs ("inferences made by an observer about underlying states of expectancy")[39] about private and prepaid group practice.

The power of ideological influences on occupational behavior may vary among and in occupations. Studying business and union workers, Glantz, for example, found that a general American ideology was more influential than any particular occupational ideology.[40] Form found varying values and attitudes among different segments of the occupational stucture, but he contends there is little evidence for a working class ideology.[41] In this study we ask to what extent physicians' perspectives direct their behavior.

The concept of perspective was applied by McElrath in his study of physicians in a prepaid group practice. In his view

> The perspective, thus, is considered as structuring the doctor's definition of a particular mode of practice. In addition, a perspective may be viewed as a 'professional ideology' in so far as this perspective is shared by others in the same position as the doctor and to the extent that it <u>legitimizes</u> this mode of practice in terms of a shared body of professional standards. In this sense ideology is considered as a linking of normative structure -- a set of ethical standards -- with a concrete pattern of professional activity.[42]

While we concur with McElrath that physician beliefs and attitudes effect their perceptions and behavior,[43] there are a number of critical questions that require attention: what is the process by which perspectives develop? Whom are the perspectives shared with? Do they develop in the situation of practice as a response to shared problems[44] or are

they brought to the situation? Where can we locate the "external authority" for these perspectives?

In this study we will examine the physician's reference group identifications as the source and legitimator of physicians' perspectives. Do physicians' reference group identifications influence their behavior in the prepaid group practice? If so, how? Can we describe a process which occurs in Urban that affects the perspectives attached to physicians' reference groups? What behaviors result?

Berger and Luckmann in The Social Construction of Reality[45] note that actors' role conceptions are determined by their social situation and at the same time determine that situation. In terms of this inquiry we tried to understand the process in which physicians' role conceptions determine and were determined by their membership in the Urban Medical Group. We asked how the special character of this form of care (the group and the mechanism of prepayment in particular) were viewed by the physician as effecting his role. How did his role conception effect his behavior? Moreover, how did his behavior effect the special nature of the group?

THE KAISER MODEL OF PREPAID GROUP PRACTICE

As an aid to help us focus on the special nature of Urban, we used the Kaiser model of prepaid group practice. As indicated in the previous section, this model asserts six principles or requirements for prepaid group practice: (1) prepayment, (2) group practice, (3) integrated health facilities, (4) preventive medical care, (5) dual choice, and (6) physician responsibility. These principles guided our effort to establish the effects of structure on physician behavior. Most critically, we sought to determine the effect of working in a group

situation (Principle 2) on the physicians. We looked at the relationships among the Urban physicians especially as they might effect consultation and peer review. Was the prepaid practice a group of peers who worked closely together and whose association provided impetus to quality control? Or, were these men sharing facilities and patients but working essentially as independent practitioners? Most significant in terms of the principle of "group practice" was our inquiry into the effect of working as a part-time vs. a full-time physician.

We also sought to discover the effect of prepayment (Principle 1) on the physicians' relationships with colleagues and patients in the group. With the absence of fee-for-service, does the physician, freed of financial concerns, turn his full attention to caring for his patients and consulting with colleagues? Or, as Mechanic suggests is the case for the British general practitioner,[46] does the absence of a money incentive result in less effort by the physician?

Principles 5 (dual choice which requires patient choice of HIP from at least two forms of health insurance) and 6 (physician responsibility) were of particular interest. Although the principle of dual choice suggests a basis for mutual consent between doctor and patient, many questions have been raised in the profession concerning the effect of a third party (HIP in this case) intervening in the doctor-patient relationship. Did the Urban physician believe patients accepted him as "my doctor"? Moreover, would the physician take responsibility for a clientele that was not attracted to him specifically?

In our application of the model's principles we did not consider the effect of integrated facilites on cost and quality of care (Principle 3). Although the Urban Medical Group is not hospital based, virtually all HIP enrolled patients have Blue Cross hospital coverage

and studies have been conducted which compare costs, utilization and quality of HIP and other systems of health care delivery.[47] Neither was any systematic effort made to determine the extent of preventive measures (Principle 4) in Urban. However, our impression is that there may be slightly more preventive efforts taken in Urban than in private practice but that physicians generally practice acute care medicine. The treatment of symptoms is not unusual since "it is safe to say that most Americans do not have adequate health care; they have crisis (episodic) care...."[48]

ORGANIZED MEDICINE AND PREPAID GROUP PRACTICE

Our interest in the effect of (1) prepayment, (2) group practice, (3) dual choice, and (4) physician responsibility is based not only on their inclusion in a model of prepaid group practice. More critically, they represent the focal points of antagonism, historically, for opponents of prepaid group practice. Indeed, the early history of prepaid group practice was one of intense opposition from the official representatives of medicine. At both the county and national level, the AMA opposed it with all the strength they could muster. Not until 1959 did the AMA change its official policy from opposition to a neutral stance.[49]

The stated grounds for this opposition can be tied to the four principles noted above. Organized medicine, as the official protector of private solo fee-for-service medicine viewed prepayment, on the one hand, as a financial threat to fee-for-service practitioners and, on the other, as a system lacking incentives for physicians to provide quality care. Furthermore, group practice, viewed as making the physician's work more visible, especially to non-physicians, was considered a threat to physician autonomy. The issue of free choice of

physician was also raised by the AMA: prepaid groups were considered systems which interfered with patients' abilities to choose their physicians. (The principle of dual choice was established by proponents of prepaid group practice so that patients could choose between at least two systems of health care delivery.) Choice of physician, the AMA argued, was necessary to establish mutual trust between patient and physician so that the physician could get his work accomplished. Moreover, organized medicine asserted that if patients did not freely choose their physicians, but were assigned to physicians through a third party, then the third party, not the physician, would have responsibility for the patient.

Because each organization's history affects the way that organization functions, in Chapter 2 we will trace more specifically the history of the relationship between organized medicine and prepaid group practice in general, and with HIP in particular.

NEW DIRECTIONS IN HEALTH CARE DELIVERY

Current legislation, we expect, will also influence the organization of health care delivery. The establishment of Health Maintenance Organizations (HMOs) which are prepaid group practices, have been legislated through Congressional passage of the Health Maintenance Act of 1973. According to the legislation, HMOs, through organized groups of physician, offer medical services to patients who prepay for care. The physicians, however, may either share a medical facility or work out of their individual offices. Both types of "group" arrangements are currently referred to as prepaid groups; however, only those sharing facilities fit the Kaiser model of prepaid group practice.

Although the rapidity of change in governmental policy in the

health area makes it impossible to accurately predict future policies,[50] the Health Insurance Institute reports "an estimated 85 operational HMOs throughout the country with some 8 million enrollees" and "an additional 135 HMOs are in various stages of development."[51] It must also be noted that while current legislation for National Health Insurance pending before Congress (The Kennedy-Mills and the Administration bills) does not suggest any reorganization of the delivery system, incentives for developing HMOs are included in those proposals.

In large measure, the development of HMOs, or prepaid groups, appears to be a response to analyses of health care delivery in the United States which attest to a crisis in health care.[52] These analyses underscore the need for a system which reduces the costs of care and efficiently uses resources and manpower. The Carnegie Commission on Higher Education, for example, suggests that the crisis in the delivery of health care "reflects the combined influence of five interrelated and overlapping factors:

(1) unmet needs for health care,
(2) rising expectations of the population for universal access to care,
(3) critical shortages in, and inefficient utilization of, health manpower,
(4) ineffective financing and
(5) rapidly rising costs."[53]

Although the Commission notes that the exact direction of change cannot be precisely foretold, "there is agreement that change is inevitable and imperative and there is some consensus about its general outlines."[54] Specifically, they assert "there will be a spread of prepaid plans."[55]

Echoing the Commission's analysis of the crisis, Mechanic states, "It is now widely appreciated that continued expansion of funds for

medical services -- without associated incentives for major changes in the organization and delivery of medical care -- will contribute to significant inflation in the health area and is unlikely to succeed in meeting population needs for health care."[56] "Inflation in the health area" has been increasing. The health industry is the third largest employer in the United States where health care expenditures in 1971 were $75 billion, an increase of $7 billion from 1970.[57] Projected national health expenditures for 1980 range between $155.7 and $189.2 billion.[58]

Oakes notes five major reasons for the health crisis which he relates to the rising costs of health care: (1) payment mechanisms provide no incentive for prevention; (2) insurance companies promote hospital care where ambulatory care would be satisfactory; (3) Medicare and Medicaid have increased demands for hospital services with no rewards for efficiency; (4) traditions of autonomy and independence discourage coordination of the "various elements responsible for medical care"; and (5) the impracticability in solo and small group practices of common use of diagnostic equipment.[59]

While most analyses of the crisis in health care underscore the increasing costs of care and point to evidence that suggests prepaid group practice as a solution to inflation in the health industry,[60] little evidence is available concerning the effects of prepaid group practice on the behavior of its participants. Because we can now expect an increase in the number of prepaid groups, it seems especially urgent that we begin to look at these systems, not only in terms of cost, but as they effect health behavior. It is only by understanding why participants in prepaid groups behave as they do in the provision of health care, that changes and innovations for improving these services

can occur. This case study, we believe, is a beginning toward that end.

CODA

In this research we discovered the power of physicians' perceptions, especially the perception of constraints, on their expressed satisfaction and on their behavior in Urban. Because we focus on these constraints, the negative aspects of the Urban Medical Group are stressed. We do not mean to suggest that this is all that is going on, that quality care is lacking or that patients are dissatisfied with the group's treatment of them. The research was not conducted by a physician and no attempt was made to determine the quality of care. It is, however, the impression of the researcher that technically competent care was provided and that patients in Urban found services easily available in the group. Moreover, without fee-for-service constraints, patients seemed able to take advantage of the services and return for follow-up appointments without concern for costs. In addition, we must emphasize that most of the doctors in the group are affiliated with better than average hospitals and some with excellent teaching centers. They are a fine, hard-working group of physicians.

Every organization is a product of its history and environment. This is particularly evident in the Urban Medical Group with reference to its relations with the County Medical Societies. Therefore in Chapter 2 we look at this history and at the development of HIP with specific reference to organized medicine's definition of the situation of prepaid group practice and HIP.

In Chapter 3 the relationship between physicians' reference group identifications and physicians' perspectives is explored.

The perception of autonomy in private practice and constraint in

group practice is analyzed in Chapter 4. We explore this perception in relation to physician perspectives and examine the behavior that results.

In Chapter 5 we see how the use of fee-for-service private practice norms in th group effect physicians' perceptions of group constraints on their time and money. We also observe and analyze the influence of these norms on definitions of the Urban Medical Group and patients.

These definitions are analyzed in Chapter 6 especially as they effect physicians' perceptions of and behavior toward patients.

We summarize and draw our conclusions in Chapter 7.

FOOTNOTES

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Chapter 2

THE DEVELOPMENT OF ORGANIZED MEDICINE's PERSPECTIVE TOWARD PREPAID GROUP PRACTICE

The Health Insurance Plan of Greater New York (HIP) became a possibility in 1943 when New York's Mayor Fiorello La Guardia proposed the establishment of a prepaid health insurance plan for "persons of average means."[1] The plan was expected to be a non-profit corporation providing medical and surgical care to employees of the City government and to workers whose employers agreed to pay half the premium. To work out the details, La Guardia called upon 16 representatives of City Government, medicine and labor and created the Committee to Provide Medical Services for People in Moderate Income Groups. A year later the Committee announced the preliminary details of a health insurance plan to operate on group principles and cover employees and their families earning up to $5000 a year for medical, surgical and hospital care.

Of the 16 members of the Mayor's Committee, only one of the eight physicians on the Committee voted against the plan. Dr. William B. Rawls, Chairman of the Coordinating Committee for the Medical Societies of the five Boroughs in New York City, as the official representative of "organized medicine," refused to accept the Committee's recommendations. Although this action publicly opened the conflict between the proposed prepaid group plan and "organized medicine" in New York, the entire medical community was not opposed to the plan. In fact, many of the strongest proponents of prepaid health insurance were physicians, notably Dr. George Baehr of the United States Public Health Service, a leading practitioner in New York City, and Dr. Willard E. Rappleye, Dean of the College of Physicians and Surgeons, Columbia University.

Opposition in the medical profession against the establishment of HIP was voiced through official policy statements of the AMA and New York's State and County Medical Societies. As the professional membership group of the majority of U. S. physicians, the AMA had strong lobbying capabilities for its policies and was a major source of professional identity of physicians. These factors helped make the Association a powerful organization. Moreover, as Freidson notes, much of the "power of the AMA over individual physicians lies in the fact that no other professional association of any significance in the United States provides the doctor with an alternative to membership in his local medical society and that his membership can be critical to his career."[2]

Whether or not physicians agreed with its official statements, the AMA has tried to present a united front to the public.[3] However, when response of the entire medical community is explored, we find diversity of professional opinion toward prepaid group practice as well as to other challenges to the status quo in medicine.

Although HIP had support and impetus from many prestigious physicians, the controversy with organized medicine was often bitter and hostile. In later chapters we will see that the angry criticisms leveled at HIP and its physicians molded the beliefs and expectations of many practitioners toward HIP and that many of those beliefs persist to the present. First, however, we will examine the conflict itself and the pressures which influenced a profession, characteristically hesitant to indict its own, to condemn the participants in the Plan. This struggle can best be understood in context of the development of organized medicine, specifically of the American Medical Association, from its founding in 1847.

THE AMERICAN MEDICAL ASSOCIATION

Organized medicine can be traced to the development, just before the Revolutionary War, of the earliest state medical societies. Each medical society attempted to control professional standards through its power over licensing. By 1830 almost every state had its own medical society but there was no central authority to establish unity or to coordinate professional standards nationally. Moreover, proliferation of proprietary medical schools in the first half of the nineteenth century jeopardized the societies because they claimed the right to set standards and license physicians. The medical profession could best be characterized by competition generally between medical societies and medical schools over legitimacy to control the profession:

> By the 1830s there was not only a mass of largely unenforceable licensing laws; there was also a network of medical societies concerned more with fighting quackery than with raising their own standards. Moreover, there was widespread public hostility to the medical profession's overriding concern with fee schedules and other methods of controlling competition. There were charges that those who proposed restrictions did so 'ostensibly for the protection of the sick, and the encouragement of medical science, but in truth, for the pecuniary benefit of a few aspiring physicians.'[4]

With the rise and fall of authority of local medical societies, the American Medical Association was founded in 1847 in an attempt to bring cohesion to the profession. At that time, the Association's constitution provided for representation from four types of organizations: (1) "county, district, and state medical societies"; (2) "faculties of 'regularly constituted' medical schools"; (3) "professional staffs of larger chartered and municipal hospitals," and (4) "some other 'permanently organized medical institutions' in good standing."[5] The organization of representatives from medical societies and medical schools into one Association, however, did not immediately

resolve their differences over professional standards or medical licensing.

Some unity within the AMA was achieved in 1874 when the voting strength of the medical schools was ended by eliminating representation from medical institutions. As a result, AMA delegates represented local and state medical societies almost exclusively. But the power of the Association as the profession's spokesman emerged only when its structure began to develop into a tightly woven network between the AMA and the county and state societies. The structure (which still exists today) whereby membership in the county society carries with it membership in the state society which appoints delegates to the AMA's House of Delegates was established in 1902.

With developments in technology, the emergence of specialization and the greater utilization of hospitals, differentiations among practitioners were increasing. General practice and a generalist oriented system of medical education were giving way to new alternatives for practitioners and educators. Prior to the Civil War specialization was associated with quackery. But by 1870, physicians were returning from specialty clinics in Germany and by the turn of the century, specialty associations began to emerge, originally to discuss recent developments in scientific research. However, they actually served to suggest special clinical capabilities of members. In addition, specialty oriented hospitals and general hospitals with specialty clinics and departments were developing. At the same time, the restructured AMA, still vying with the medical schools for responsibility for professional and educational reform, was directing its efforts toward creating a standard for a well educated physician. Moreover, "standardization went deeper than this. Above a defined

minimum all physicians were to be equal; once within the sheltered confines professional democracy was to reign."[6]

The state of the profession in 1900 was not generally distinguished. Less than 10 per cent of practicing physicians were graduates of genuine medical schools and about 20 per cent had never attended medical school lectures. The majority of physicians were products of apprenticeship and proprietary medical schools. Moreover, there was fear that the proportion of inadequately trained physicians was increasing.[7] By standardizing the profession, at least minimum standards for physician qualifications would be assured.

There was, however, an inherent conflict between standardization and the emergence of specialties. As a result of upgrading the curriculum in medical schools to standardize the profession, physicians with special expertise began to form an elite corps of teacher-clinicians. The gap between generalists and specialists began to widen. Special expertise implied superior knowledge viewed by the generalist as a financial threat and, perhaps more critically, as a threat to his self-image. He would no longer be <u>the</u> expert with full responsibility for his patient. He may well have foreseen the embarrassment of the local practitioner in front of his patient, reported by Kendall,[8] when the specialist acting the "expert" ignored the GP's attempts to describe the case. Most significant, however, may have been the generalist's fear of losing his autonomy in the doctor-patient relationship. The specialist would become a third party <u>with greater expertise</u> looking over the shoulder of the GP and sharing responsibility for the GP's patient.

As medicine changed, the AMA continued to fight against anything it saw as interfering with the traditional manner of medical practice.

Threats perceived as jeopardizing the generalist's position at the beginning of the century, i.e., threats to his autonomy, pocketbook and self-image, were again perceived with the emergence of new issues in the profession. In the struggle against National Health Insurance and prepaid group practice, for example, intervention in the doctor-patient relationship and retention of physician responsibility for his patients were viewed as threats in the same way as these features of medical practice were believed jeopardized with the emergence of specialties.

On face value, it would appear that the AMA's efforts have always been directed toward safeguarding the medical profession from all forms of external interference. However, an examination of the AMA's policies reveals a number of exceptions to this rule. The Association has, in a variety of instances, worked for external intervention in the profession. But when sought by the Association, outside intervention was perceived as protecting the profession. This may first be illustrated by the movement for government licensing of physicians.

In its attempts to standardize the profession, the AMA in 1902 established a committee "to take up with the U.S. Congress the question of national medical licensing."[9] It was believed that one national standard for physicians would eliminate practitioners with "bogus medical degrees and diplomas" and increase the "dwindling medical incomes" of the "struggling practitioner competing for his living in an already crowded profession."[10] A National Licensing Board was not established mostly because of states' refusals to give up that power. However, the fact is that the AMA saw National Licensing as a means to improve the situation of physicians in the United States.

Early in its development, the AMA appeared to support government intervention by means of compulsory health insurance. From 1913 to 1918 the possibilities for health insurance were discussed and in 1916 the AMA's Committee on Social Insurance reported to the American Association for Labor Legislation on health insurance abroad. They noted that the Health Insurance Act in England (1911) had "unquestionably improved the condition of the working classes."[11] Taking no official position toward health insurance, a major goal of the Committee was to "appear before legislative bodies to protect the legitimate economic interests of the profession in the laws coming up for discussion concerning social insurance."[12] The Committee, however, was clearly sympathetic to compulsory health insurance.

The AMA's interest in compulsory health insurance was largely influenced by a social milieu which was increasingly becoming concerned about the interests of the public, not just the privileged few. In the first two decades of the twentieth century, government intervention in the public's health was supported by the AMA. Legislation was passed regulating the food and drug industry (1906); a meat inspection law was passed (1906); the Children's Bureau was established (1912); and by 1915, thirty states had workmen's compensation laws. At that time, the AMA did not perceive policies favoring government intervention in health and compulsory insurance as taking control away from the profession. On the contrary, the government was viewed as a powerful ally in protecting the profession, especially from claims of "quasi-practitioners." In the case of compulsory health insurance, the AMA was the expert consultant helping determine the shape and form of health insurance legislation. And, by contributing to the Federal Government's effort to pass legislation, the AMA, concerned about the public's health,

incidentally gained credibility from the public by taking up their cause.

While the Progressive era was coming to an end by 1920, the movement for specialization was gaining momentum, and competition and disorder in the profession increased. The AMA apparently concluded that government intervention of any kind, but especially in compulsory health insurance, would be a threat to private practice and divide, even more, the quarreling factions of the profession. Moreover, when the United States entered World War I, the labeling of compulsory health insurance as German and un-American became additional ammunition in the AMA's assault. The compulsory health insurance concept was in fact viewed as German, having been initiated in Germany in 1883.

By 1922, the AMA went on record against all forms of "state medicine" noting "the ultimate harm that would come thereby to the public weal through such forms of state practice."[13] The AMA's definition of "state medicine" included:

> ...any form of medical treatment, provided, controlled, or subsidized by the federal or any state government, or municipality, excepting such service as is provided by the Army, Navy, and Public Health Service, and that which is necessary for the control of communicable diseases, the treatment of the indigent sick, and such other services as may be approved by and administered under the direction of or by a local county medical society, and are not disapproved by the state medical society of which it is a component part.[14]

Opposition to government intervention was in large part motivated by the generalists, still a majority in the profession, acting to preserve their power. During World War I, the differences between the old general practitioners and the newly trained specialists were underscored: The generalist was fast losing preeminence vis a vis his specialist colleagues. Moreover, he feared loss of public confidence in him:

> Seen from the point of view of the general practitioner who had been trained in a proprietary or university school at the end of the nineteenth century and who had begun practice at a time when there was little question of the profession's monopoly of the whole health field, the physician was indeed threatened. He was threatened by increased specialization. He was threatened by the hospital as a potential center for a medical elite. He was threatened by the public's growing interest in the standards of medical care. And all these threats were heightened whenever the government, particularly the federal government, hinted that it might lend them aid.[15]

Committed to the protection of the general practitioner who dominated organized medicine, the AMA became critical of all form of institutionalized medicine: hospitals, group practice, or any form of organization of primary care that differed from the solo fee-for-service practice of medicine was suspect. As specialty clinics continued to develop and hospital utilization increased, doctors claimed they were "being deprived of their legitimate fees by the use or 'abuse' of the free facilities (hospital out-patient departments) by middle-class patients."[16] The critical issue of care for the middle-class patient largely motivated opposition to new forms of medical practice. By attracting middle-class patients away from generalists, specialty clinics and hospitals and later prepaid group practice were perceived as financial threats. Although many physicians favored and participated in forms of medical care delivery other than solo fee-for-service practice, the AMA's official policy, to protect the generalist's middle-class practice, opposed these new forms of organization of health care.

While the AMA was struggling to maintain private general practice and confronting the problem of recognizing new specialties, it neglected the rising costs of medical care and problems involving the organization of health services. Thus in 1926, fifteen people from medicine, public health and social science met to evaluate the organization of

health services and their availability to the public. From this group, the Committee on the Costs of Medical Care was established (1927) consisting of 17 physicians and dentists in private practice, 6 representatives from social science, 6 from public health and 9 public representatives.

Established before the depression, the Committee focused on conditions in medicine which prevailed in the 1920s including those intensified by the depression. Its final report in 1932 concluded that medical care was a necessary service which should be available to the public. The organization of hospital affiliated group practices with a variety of medical and paramedical personnel was recommended with prepayment as the financing mechanism. Opinion divided, however, on whether financing should be public, private, voluntary, compulsory or some combination of these factors.

There was dissent from the majority point of view. The Committee's minority report, issued by nine persons including the AMA representatives, but notably not all the Committee's physicians, declared that "government competition in the practice of medicine" should be restricted and opposition to the "corporate practice of medicine" was recorded.[17] The minority report reflected the AMA's staunch policy against group practice as well as its opposition to any third party involvement in the delivery of medical care. It called the Committee's suggestions socialistic even though government sponsored compulsory health insurance had not been proposed and privately subsidized voluntary insurance was an equally possible recommendation.

In 1934 the AMA adopted ten principles in regard to insurance including "control of all features of medical service by the medical profession and their refusal to allow a third party to come between

physician and patient in any medical relationship."[18] The Association's effort to maintain control over the profession had essentially been its founding ethic evidenced in its early sense of responsibility for training and licensure. In its formative years, the AMA sought government intervention to protect the profession against non-medical practitioners and general abuses in medicine. Through Association efforts, the Federal and State Governments aided the medical profession to improve the quality of physicians but also to develop a monopoly over medical practice in the United States. As Freidson points out, "the state has ultimate authority in matters of licensing and prosecution of practitioners" and "much of its authority has either been given to the AMA or been based on the advice of the AMA."[19] The profession is granted autonomy by the state which "uniformly leaves in the hands of the profession control over the technological side of its work. What varies as relations with the state vary is control over the social and economic organization of work."[20]

The issue of maintaining the profession's autonomy had been critical in guiding the policies of the American Medical Association. It is noteworthy that in the AMA's view, little distinction is made between the profession's right to control "the social and economic organization of work" and its right to control the technology of medicine. However, as evidenced in the Report of the Committee on the Costs of Medical Care, there were segments of the profession which advocated change in the organization of health care delivery. Many of these physicians became involved, in the 1930s and 1940s, in the prepaid group practice movement. As attempts were made to establish prepaid groups in Elk City, Oklahoma; Los Angeles, California; Washington, D.C.; Seattle, Washington; and New York City, the AMA fought but lost in the courts to physicians who desired to work under financial and organizational arrangements different

from solo fee-for-service practice. The establishment of prepaid group practices was clearly perceived by the AMA as a double-barrelled threat: First, they believed that organized groups would promote specialization and force the general practitioner out of business. Second, they saw prepayment as a financial threat to both generalists and specialists in terms of competition for patients, especially middle-class patients.

The AMA and local and state societies, therefore, fought the groups with all available weapons. Group physicians were expelled from local medical societies and prevented from receiving hospital appointments. Prepaid care was said to be of poor quality. The AMA charged that with no incentive of a fee for each service, the physician would become lazy and less inclined to provide maximum care for the patient. Moreover, the Association argued that physicians would become pawns of the prepaid practice organization and compared the situation to socialism where physicians were controlled by an external non-medical source. Prepaid groups and their physicians were in fact labeled socialistic.[21]

What the AMA was fighting for was who was to serve the health needs of the middle class. We will see in the next section how the New York County Medical Societies were willing in 1947 to have HIP cover families earning up to $2500 a year but fought the Plan's coverage of families earning up to $5000 a year. In Chapter 6 we will explore how organized medicine's refusal to acknowledge that many of HIP's patients are middle-class has helped create and maintain physicians' definitions of prepaid group practice patients as poor.

The issue of providing medical care to the middle class underlay the rhetoric of the debates for National Health Insurance in the 1930s and 1940s. In 1938, President Roosevelt's committee released its Report on the Health Needs of the Nation, recommending expansion of public health

and maternal and child services under existing titles of the Social Security Act; a new interlocking system of Federal grants to states for hospital construction, state programs for general medical care and to subsidize state programs for the medically needy and compensation for wage loss from temporary or permanent disability.[22]

When these recommendations were endorsed by the National Health Conference called by Roosevelt in 1938, the AMA called a special session of its House of Delegates which reaffirmed opposition to compulsory health insurance. But the Association moved from its demands for complete control over the profession back to allowing government intervention in some situations. The Delegates approved a number of the Government's proposals: income loss insurance, hospital construction, increased public health services, care for the needy and voluntary hospital insurance. The Association, however, held tight to its autonomy in all areas involving services to the middle-class and possible competition to the private practice of medicine. The poor were beginning to be perceived as appropriate concerns of the Government.

President Roosevelt's message to Congress in January 1939 emphasizing the need to meet the nation's health problems clearly indicated pressure to legislate some form of compulsory health insurance. When New York's Senator Wagner proposed a bill to Congress supporting a state regulated medical system funded by Federal grants to the states, a vigilent AMA attacked the proposals declaring them dangerous to professional interests and the public's welfare. In an effort to publicize and gain support in the fight against compulsory health insurance, the "Platform of the American Medical Association" became a regular feature in the Journal, beginning in December, 1939:

1. The establishment of an agency of the federal government under which shall be coordinated and administered all medical and health functions of the federal government exclusive of those of the Army and Navy.

2. The allotment of such funds as the Congress may make available to any state in actual need, for the prevention of disease, the promotion of health and the care of the sick on proof of such need.

3. The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.

4. The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.

5. The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.

6. In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established.

7. The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical services and to increase their availability.

8. Expansion of public health and medical services consistent with the American system of democracy.[23]

The "platform" was totally irreconcilable with the proposed legislation. But a full-scale fight over what might have been the National Health Act of 1939 never materialized. With the increasing tension in Europe, the Roosevelt Administration turned its attention from domestic problems to issues of national security. Indeed, it appeared Roosevelt changed his mind about supporting the proposal and decided not to make it an issue in the campaign of 1940.

With the Federal Government's efforts to institute national health insurance slowed during the War, most of the demand for compulsory insurance came from the states. Between 1941 and 1944, promotors of

compulsory health insurance submitted 82 bills in 13 state legislatures. Only in Rhode Island was there some success when a wage-loss sickness compensation law was passed.

In 1943, the Wagner-Murray Dingell bill proposed to Congress an extension of Federal social security. Included in the proposal was a Federal system of compulsory medical and hospital insurance financed through payroll taxes to provide specific service benefits, not cash indemnity. The AMA responded vigorously to this latest of threats on their firmly held position. Not only did the bill advocate compulsory health insurance, but service, organized through a National insurance board was proposed.

> Less than a month after the introduction of the Wagner-Murray-Dingell bill the editor of the Journal charged 'it is doubtful if even Nazidom confers on its 'gaulieter' Conti the powers which the measure would confer on the Surgeon General of the U. S. Public Health Service.'[24]

Other officials of the American Medical Association also responded angrily:

> Louis Bauer warned the Association to offer no amendments to a measure that so fundamentally imperiled sound medical standards. At the same time Olin West charged that federal regimentation generally started with 'the mother and baby, or with the poor, downtrodden and underprivileged' and ended with the complete socialization of a nation's economic life. John J. Wittmer, a New York physician, used obstetrical imagery to describe the birth of 'the ghost which has haunted American medicine for so many years.' Maintaining that most of its body had appeared, he asked, 'How much longer will it take for the legs to appear and for the apparition to materialize into a living Frankenstein, able to walk among us and become the potent dominating factor in our work and in our lives?'[25]

According to the legislation, the Surgeon General would have the authority to decide which physicians would qualify as specialists. A referral system was also proposed requiring the patient to see a general

practitioner before he could use a specialist's services. Already under governmental auspices, licensing procedures maintained minimum standards for an M.D. degree. But should specialty certification become a government function, those generalists engaged in specialty practices would, in all probability, not be recognized. Moreover, the government's designation of specialists could be interpreted as a violation of the profession's autonomy in the technological sphere. Thus the determination of qualifications for specialty service was an area the AMA unequivocally considered the profession's domain.

Prolonged hearings marked the debate over the Wagner-Murray-Dingell legislation and slowed the passage of a series of revised bills. Repeated proposals were met by staunch AMA led opposition. While Truman's surprise re-election kindled some optimism that legislation would at last be enacted, the AMA was prepared; the public relations agency of Whitaker and Baxter was contracted at a cost over $2,250,000 to campaign against compulsory health insurance.

They attacked with a speaker's program, nationwide pamphlet distribution, use of communications media and an endorsement drive.

> No part of the campaign gave the AMA more encouragement than the favorable results of the endorsement drive. While making strong appeals for organizational support, the Whitaker and Baxter staff did not minimize the importance of individual assistance. By early June it had printed for use of physicians in reaching their patients some 10,000,000 envelopes and accompanying stickers that compressed the Association's case. These stickers, emphasizing that compulsory health insurance would offer 'inferior medical service at high cost,' encroach on medical privacy, and force patients and doctors alike under political control, urged convinced addressees to inform their congressional delegation of their opposition. Although individual response could not be measured, by December the staff's appeal for group assistance had brought 1,829 sympathetic local, state, and national organizations into the fight whose members had already flooded the national capital with thousands of letters.[26]

With intense pressure from the AMA and lack of support from Congress, by 1951 President Truman withdrew the administration's proposal.

Though most preoccupied with the threat of National Health Insurance during the 1940s and 1950s, organized medicine fought all legislation which it viewed as creating competition, explicitly or potentially, with private fee-for-service practice. Thus prepaid group practice, a form of medical care perceived as jeopardizing private practice was to be feared and fought. Indeed, the same arguments raised so successfully in the campaign against National Health Insurance were used to thwart the development of prepaid groups.

Organized medicine's insistence on maintaining private practice meant not only opposition to outside government control viewed as interfering with the free enterprise of the profession, but opposition to all external controls. The AMA insisted on the profession's right to self-regulation. Prepaid group practice, with third party intervention of a health plan and/or medical group organization between doctor and patient and lack of free choice of physician (through a closed panel) violated two critical values of the profession: autonomy and free enterprise. Organized medicine asserted that intervention of a third party would interfere with the physician's autonomy by making his work more visible and accountable to non-professional authorities. In addition, the physician's responsibility for his patient would be claimed by the organization especially when the patient did not freely choose his physician, but came to him through organizational auspices. Moreover, the patient's limited choice of physicians was seen as a threat to the physician's income and meant a closing of the open medical market, highly valued by the profession.

THE HEALTH INSURANCE PLAN vs. THE COUNTY MEDICAL SOCIETIES

In 1943, carrying the banner of prepaid group practice, New York City's Mayor Fiorello La Guardia marched into the war proclaiming:

> Here in New York, we have the best medical talent in the world. We have the very best voluntary hospitals. What I hope to see done within a very short time in this city is actually putting into practice a cooperative medical service plan: a plan whereby families of moderate income could be assured proper medical care for all the members of the family at all times.[27]

With that announcement, La Guardia formed the Committee to Provide Medical Services For People in Moderate Income Groups to plan the organization of care. From the outset, difficulties between the Medical Societies and the Committee emerged. Initially, the Plan was not totally renounced by the Medical Societies. Rather they wanted to work with La Guardia's Committee to ensure the Plan would not compete with private practitioners in New York City. They apparently favored the idea of medical care for workers in the city and were willing to see a prepaid group practice established. But their proposal of a $2500 eligibility ceiling was designed to make the Plan a service for the City's working poor. In fact, the remnants of this issue can be traced today to the Medical Group physician's view that the care of the poor patient in HIP is legitimate and to the physician's tendency to selectively perceive all Group patients as poor. The ways in which this selective perception results in definitions of the Medical Group as charity or clinic medicine will be examined in Chapter 6.

Almost a year after its formation, the Committee had reached no decision about the Plan. Responding to this delay, La Guardia noted the continuing debates over National Health Insurance and asserted the need to demonstrate that a similar scheme was possible:

> Everybody admits that it is necessary...except a few who have selfish interest. We are studying a plan which would afford an opportunity to residents of our city, including employees of the city, to cover themselves and their families against the expenses of normal and catastrophic illness....I must express at this time sad disappointment in the attitude of organized medicine. No one must be permitted for selfish reasons to hold it back.[28]

The Committee recommended a plan to provide services for workers and their families earning up to $5000 a year through physician groups providing medical and surgical care, including hospitalization. A non-profit corporation governed by a Board of outstanding community representatives would be established and a Medical Board of physicians would be responsible for the quality of care and all medical matters.

Attacking the proposal, organized medicine rallied against the Committee's recommended $5000 income maximum for family eligibility in the Plan. They wanted coverage extended only to families earning up to $2500 per year. If the $5000 limit was instituted, a large pool of private practice patients would become eligible for the Plan. Once again, organized medicine was fighting to retain control over delivering care to the middle classes.

Although organized medicine and the Committee had not reached agreement on the eligibility ceiling, in September, 1944, papers of incorporation were filed for the Health Insurance Plan of Greater New York (HIP) to operate a comprehensive plan for all persons living or working in New York City earning not more than $5000 a year. While the incorporation papers named many prominent physicians, no official representative of the five County Medical Societies was included. Organized medicine responded angrily. In a letter to the New York Times, Dr. J. S. Kenny, Chairman of the New York County Medical Society's Publication Committee specified the criticisms against the Plan published

in his Society's Journal:

1. The absence of rank and file practitioners as represented by their elected officials was the 'only important segment of the community' underrepresented among the incorporators.

2. The absence of the medical societies is based on the Mayor's failure to develop a working agreement on a plan that would be fair to all parties.

3. The medical societies had received no outline of the plan.

4. The doctors who will do the work and assume the risks of such a medical care program should be consulted through their elected representative in all stages of the development of the plan.[29]

The Medical Societies were responding not only to HIP as it might lessen the individual physician's control over practice, but, more significantly, to HIP's failure to acknowledge the Medical Societies as the representative of the medical community. Organized medicine, fighting to maintain its power over the profession, perceived HIP as a threat since a number of highly respected physicians publicly supported the Plan.

After the filing of incorporation papers, the dispute continued. The two major points of disagreement between organized medicine and the Plan were the ongoing quarrel over the $5000 eligibility ceiling and the issue of the open vs. the closed panel. The closed panel whereby the patient's choice was limited to physicians participating in the Plan was vehemently opposed by the Societies. Although they charged that HIP subscribers would suffer without "free choice of physician," the primary concern was to prevent economic competition between HIP and private practice and protect the profession's autonomy.

The open panel would permit participation of all qualified physicians interested in joining the Plan. As a result, the Plan's financial resources would be widely distributed among the City's physicians. Moreover,

the open panel system meant no changes in the organization of health care delivery. Patients would see private practitioners who would be reimbursed fee-for-service by the Plan. The closed panel, in comparison, would create new organizations to provide services. Furthermore, these organizations, perceived as situations of non-physician control over health care, elicited the profession's fear of losing autonomy.

In July, 1946, the City's new Mayor, William O'Dwyer, announced that HIP would begin to enroll city employees and their families. Still disputing with the Plan, the five County Medical Societies, in a telegram to the Mayor suggested:

> ...You and your committee studying health insurance for city employees and their families might broaden your study to include the United Medical Service sponsored by State and County Medical Societies and now providing medical insurance to more than 250,000 New Yorkers in collaboration with New York's Blue Cross hospitalization plan.[30]

By this time, the Societies realized the City could not be stopped from providing care to its employees. But they had prepared for this possibility. Spurred by Mayor La Guardia's announcement of a plan to provide a medical care program to city employees, the House of Delegates of the New York State Medical Society had approved and operationalized the United Medical Service which offered prepaid medical (cash indemnity) insurance to groups of employees in combination with Blue Cross (hospitalization insurance). The Societies were still seeking to gain control of the health care plan for the City. However, replying to the Societies' request, the Mayor's Committee reported that both United Medical Service and Group Health Insurance, Inc.,[31] had been considered but rejected in favor of HIP. Furthermore, the Committee noted it had studied the effect of the three plans on the maintenance of the doctor-patient relationship and concluded that all three would preserve the relationship.

The choice of HIP was made because it provided for preventive medicine and more comprehensive care. In addition, HIP's $5000 ceiling included more employees than the lower limits proposed by the other two plans. These findings were reported to the City's Board of Estimate and by October 1946, the City's participation in HIP was approved.

The contract between HIP and the city provided for the following medical services: general medical, specialty, surgical and obstetrical care; laboratory procedures; physical therapy; radiotherapy; services for the administration of blood and plasma; eye refractions; visiting nurse service; and ambulance service. These services were available to the employee, his wife and unmarried children, 24 hours a day in their home, the physician's office or the hospital. Each insured person had to select a personal physician from the HIP medical group of their choice. For these services, the City paid half the premium and the employee paid the other half. Membership in HIP was also open to groups of non-City workers, providing the employer paid half the premium.

On March 3, 1947, twenty-one medical groups were ready to provide services to HIP subscribers. The medical groups, contracted by HIP as twenty-one separate entities, did not yet share facilities or have group centers. Rather, each physician cared for HIP patients in his private practice office (where he also saw private patients) and referred them only to doctors within the group. All told, there were 562 general practitioners and specialists in Manhattan, Bronx, Brooklyn and Queens. By the end of 1947, HIP had 110,000 subscribers, mostly employees of the Board of Education and other City departments and members of the Painter's Union.

HIP was a year old when the New York County Medical Society, although never actually endorsing the Plan, voted to send a representative to its Board of Directors. HIP viewed this at least as an expression of the Society's willingness to cooperate. However, this apparent act of good will was abruptly ended when, a short two months later, the State Society's House of Delegates advised its members "not to become participating physicians in any voluntary health insurance plan unless it had been approved by the Medical Society of the State of New York."[32] HIP had not been approved.

Constantly harassing HIP around some issue, the Societies attacked the policy in which City employees, desiring medical insurance through their jobs (the City paid half the premium), were only offered HIP coverage. It further declared that the contract between HIP and the City in which the City pays half the premium was "monopolistic and discriminating." In the public airing of this dispute, Dr. George Baehr, the president of HIP, in a letter to the editor of the New York Times responded, in part:

> ...the term 'free choice' of insurance plan is used as a smokescreen because the proponents of the resolution dare not reveal the real issue. Their aim is to perpetuate the fee-for-service system of payment for medical services in all insurance plans.... Under prepaid group practice a group physician is paid a stated amount each year for each insured person whether he is ill or well. Because of its economics, greater efficiency and lower cost, prepaid group practice offers serious competition to the less efficient and more expensive solo practitioner of medicine on a fee-for-service basis.... This attitude (opposition) will not make sense to the public until it understands that the reason for the opposition to prepaid group practice is economics -- not concern for the public health and welfare.[33]

Later that same year, Dr. Arthur M. Master, retiring president of the New York County Medical Society gave his private opinion of HIP. While it was not an official statement of Society policy, it epitomized

medicine's enmity toward the prepayment Plan:

> One of the most insidious steps is its (HIP's) link with great hospitals so that the medical group can use the major facilities of the hospital with only a minimum and superficial cost and thus achieve a hidden subsidy with which to operate....I would remark that this combination of hospital and a voluntary medical care plan augments the pressing problem of the corporate practice of medicine. Again the private practitioner is squeezed. More and more of his patients if they live in a large low cost housing project, disappear into the group practice of medicine where they receive a glorified kind of out-patient care of the hospital....I think that the legalistic immunity which HIP enjoys in the matter of advertising and exploitation of its participating physicians turns our code of professional conduct into a mockery....I feel now that HIP is only a forerunner of medicine by subsidy; subsidy in part from private sources today, but subsidy by government tomorrow. I feel that HIP and plans like it are a long way down the road to a system of state medicine and socialized medicine like the government health service in England today.[34]

The peak of organized medicine's hostility toward HIP was reached when the Kings County Medical Society introduced a proposal to the State Society calling for the AMA to change its code of ethics. With AMA approval, the County Societies' attempts to compete with and perhaps even destroy HIP would be facilitated. The proposal, introduced to the State Society and subsequently approved by their House of Delegates called for the following:

1. Advertising should be understood to be unethical if it was aimed at getting patients for a panel of physicians of a medical care plan, company or other organization;

2. The practice of medicine by a physician on a salary should be restricted to institutions where patients are 'public charges';

3. Free choice of physician, one of the requirements of the present code of ethics should be understood to be vitiated if the patient was required to choose a physician from a panel or group of practitioners;

4. Proration of fees is not unethical, if both physician or surgeon actively participate in providing medical care and if the fee is paid by an insurance company.[35]

The proposal's first three items were aimed directly at the fundamental operating procedures of HIP. It is noteworthy that the second item underscores the Society's willingness to exclude services for the poor from their sphere of influence. This is reminiscent of the AMA House of Delegates' approval, in 1938, of government intervention in services for the poor. The fourth item attempted to strengthen claims of fee-for-service practitioners with voluntary cash indemnity insurance schemes. The AMA House of Delegates postponed consideration for a year by sending the proposal to its Judicial Committee. It was never approved.

By 1958, a turning point was apparently reached in the relationship between the Medical Societies and HIP. HIP had by that time over 500,000 subscribers. In eleven years of operation the anticipated 1,500,000 subscribers and a "series of little Rochesters" (referring to the Mayo Clinic) predicted by Mayor La Guardia were not realized. As the number of multi-specialty groups, clinics, and salaried hospital physicians increased, medical care delivery within an organizational framework became more acceptable. Moreover, with the improvement of medical technology and greater public use of the physician, there was more room for HIP in the medical marketplace. Under these circumstances, the Medical Societies could withdraw their opposition and call for a new working relationship with HIP. Indeed, many physicians opposed to HIP began to view it as an acceptable source of extra income. Dr. Phillip Allen, outgoing president of the New York State Medical Society in 1958, asked physicians to develop "a peaceable and working relationship" with insurance plans, union funds, industrial clinics, hospitals and schools in the health field.[36] And Dr. David Kershner,

president of the Kings County Society, stated that some kind of prepaid medical care was the "blueprint of the future....We as organized doctors, cannot be opposed to group practice or to health insurance."[37]

In 1959, the AMA withdrew its opposition to prepaid group plans. These official announcements eased the struggle but did not end it. As we have seen, the criticisms organized medicine raised against prepaid groups were fundamentally the same as those raised against most changes in medicine. For example, maintaining the autonomy of the physician, whether from government, hospitals or medical care insurance plans was always an issue. In the specific case of HIP, intervention from a third party in the doctor-patient relationship was viewed as diminishing the physician's responsibility for his patient. Indeed, we will see that the Urban Medical Group physician still raises the question of whom the patient belongs to -- HIP or the doctor. Moreover, his answer, in large part based on organized medicine's assertions in the 1940s and 1950s, molds his perceptions of patients and of his role in Urban.

In fact, many of organized medicine's early beliefs about prepaid group practice continue to color Urban physicians' perceptions. We will examine how the criticism that prepayment provided no incentives for the physician to deliver quality medicine finds expression in many Urban physicians' assertions that their full-time colleagues are lazy and don't deliver the best care. And we will see how free enterprise and individual independence, values believed by organized medicine to be jeopardized in prepaid group practice, are still highly valued by most of Urban's physicians. Furthermore, we will explore the consequences of this apparent contradiction as they

effect the physicians' definitions of their situation in prepaid group practice.

The issue of medical care for the middle-class which emerged with the competition between specialists and generalists and in the debates over National Health Insurance were again raised with the development of prepaid group practice. The medical societies' attacks on HIP were to a large degree motivated by the wish to protect practitioners from competition for middle-class patients. As we noted, we will examine the effects of this issue on physicians' perceptions of and behavior toward patients.

FOOTNOTES

1. The New York Times, April 5, 1943, 12:1

2. Freidson, Eliot, Profession of Medicine (New York: Dodd, Mead & Co., 1970), p. 28

3. While membership in the AMA is connected to local and state societies, Freidson's point may be somewhat overstated. It appears that physicians are becoming more involved with their specialty associations than with the AMA. According to Theodore and Haug (Theodore, C.N., and J.N.Haug, Selected Characteristics of the Physician Population, 1963 and 1967 (Chicago: American Medical Association, Department of Survey Research, 1968), p. 8, between 1963 and 1967 the number of diplomates increased by 16,791, a 21.1% increase between the two periods. At the same time, the AMA with its membership decreasing, may be losing power as well. As Oakes (Oakes, Charles G., The Walking Patient and the Health Crisis (Columbia, S.C.: University of South Carolina Press, 1971), p. 327, notes: "Despite the battles that ensued in the halls of Congress and despite the abundant testimony offered by representatives of the American Medical Association, first Medicare and then Medicaid were enacted. In what appeared almost as desperation response to declining membership in the AMA, student members of the association were granted unprecedented voting rights in December of 1971.

4. Stevens, Rosemary, American Medicine and the Public Interest (New Haven: Yale University Press, 1971), pp. 27-28

5. Burrow , James G., AMA: Voice of American Medicine (Baltimore: Johns Hopkins Press, 1963), p. 15

6. Stevens, p. 43

7. Ibid., p. 60

8. Kendall, Patricia L., The Relationship Between Medical Educators and Medical Practitioners: Sources of Strain and Occasions for Cooperation (Evanston, Ill.: Association of American Medical Colleges, 1965), pp. 41, 60

9. Stevens, p. 61

10. Ibid., pp. 61-62

11. Burrow, p. 143

12. Noted by Burrow, Op. Cit.: Journal of the American Medical Association, 66, June 17, 1916, p. 1951

13. Burrow, p. 157

14. Ibid.

15. Stevens, pp. 146-147

16. Ibid., p. 51

17. Ibid., p. 186

18. Ibid., p. 187

19. Freidson, p. 33

20. Ibid., p. 24

21. See Freidson, pp. 32-33, and MacColl, William A., Group Practice and Prepayment of Medical Care (Washington, D.C.: Public Affairs Press, 1966), p. 26

22. Stevens, pp. 192-193

23. Burrow, p. 225

24. Ibid., p. 295

25. Ibid., pp. 295-296

26. Ibid., pp. 363-364

27. The New York Times, Op. Cit.

28. The New York Times, 4/3/44, 15:5

29. The New York Times, 10/3/44, 22:7

30. The New York Times, 7/17/46, 15:3

31. Group Health Insurance, Inc., had been founded in 1938 by eight physicians to provide indemnity insurance to patient subscribers. Physician members of the plan agreed to charge subscribers the scheduled fees, on a fee-for-service basis.

32. The New York Times, 5/20/48, 31:1

33. The New York Times, 2/4/52, 16:6

34. The New York Times, 5/27/52, 29:4

35. The New York Times, 5/12/54, 33:8

36. The New York Times, 5/27/58, 23:3

37. The New York Times, 10/22/58, 70:4

Chapter 3

PHYSICIANS' REPUTATIONS AND REFERENCE GROUPS

In the previous chapter we saw that the AMA with its local societies was the official spokesman for the profession. Indeed, the criticism leveled at HIP physicians by New York's county medical societies put Urban physicians' professional reputations in jeopardy. As one founder explains:

> The reputation of the doctor or groups of doctors is like the reputation of a virgin. It is enough that they talk about it. Even when it's not proven, it's damaging.

Just as this physician's attitude toward virginity may be dated, so too may his conception of physicians' reputations be timeworn. Both virginity and professional performance have been considered private subjects -- inappropriate for public discussion. But the realities of sexual behavior and physician performance are not necessarily the same as the individual's reputation vis a vis these activities. Indeed, one may be good at attending to his reputation but not have the qualities implied or have the qualities and yet be maladapt at establishing the reputation.

In fact, physicians' reputations are not dependent on their medical performance. The nature of private practice in American medicine obscures the physician's medical activity from his peers. Lack of peer evaluation, however, is not simply a result of inadequate opportunity. Rather, the profession places high value on its "right" to privacy. Although many physicians, including most in Urban, remain protective of their own and their colleagues' "rights" to privacy, there is a growing movement within the profession toward peer review.

With the passage of legislation establishing Professional Standards Review Organizations, specific criteria for measuring the technical performance of physicians are being developed.[1] Physician performance -- at least the more visible or measureable aspects of it -- may eventually become a factor on which to base physician reputations.

At present, however, physicians' reputations are still largely based on their affiliations.[2] High status in the profession is associated with prestigious medical institutions or clienteles of high social class. Thus where the physician works and the type of patients who "belong to" him are a significant index of his status in the profession. Moreover, what separates the physician from the rest of the medical division of labor is his personal responsibility for the patient. For some physicians, unless the patient "belongs to" the physician, it is believed he cannot fully exercise his medical responsibility. Thus, if the HIP physician is seen as caring for an organization's clientele, he receives little esteem from the more elite segments and perhaps from even a majority of the profession.

The professional reputations of HIP physicians were severely affected when, in its assault on HIP, organized medicine raised serious questions about the quality of physicians belonging to the Plan. Even where this issue was not engaged directly, but only through innuendo, physicians found their reputations at risk.

In this chapter, therefore, we will explore the ways in which Urban physicians cope with their professional identities. According to Urban's physician founders, the early years of HIP's development were a constant struggle against harassment from non-HIP physicians. Given organized medicine's objection to HIP, the first half of this

chapter will focus on the decision by the Urban Group physicians to join the prepaid plan, who these physicians are and what motivated their membership. The second half of this chapter will examine the physicians' current sources of professional identification.[3]

Organized medicine, as represented by an official body like the AMA, is one segment of the profession from which a physician might seek his professional identification and reputation. Indeed, it was the intensely negative response of this powerful organization that physicians who joined HIP in the first ten years of its development had to confront directly. Although membership in the AMA and consequently in the State and County Societies was a membership requirement for HIP physicians, HIP physicians as one founder recalls, were not treated as members of organized medicine. "We were outcasts and we were absolutely ostracized." Referring to the "stormy meetings at the County Medical Society," the Urban physicians suggest it was not merely the leaders of organized medicine, but a large part of the rank and file who opposed HIP. While there was a greater risk of loss of professional reputation for physicians who joined the Urban Medical Group early, all Urban physicians may still in some way be touched by a residue of negative attitudes toward HIP.

Although we have no direct evidence of the extent of the physician's opposition to HIP, reports by the founders indicate a loss of referrals from community practitioners. Inferences about some practitioners' negative attitudes toward the Plan can be made, for example, from the applause of 400 doctors at a 1953 NYU College of Medicine Alumni Dinner when the termination of NYU's affiliation with HIP was announced.[4] In addition, as Urban's medical director pointed out, as late as 1972 discrimination by hospitals against

HIP doctors was widely experienced and HIP physicians were barred from appointments in Staten Island hospitals.

Not all physicians opposed HIP. Urban's founding physicians who are still in the Group describe their experience with the medical profession's opposition by referring to their difficulties with community practitioners. Many of the physicians who championed the Plan, however, had backgrounds in public health or were on the faculties of prestigious medical schools. These academic physicians, part of highly prestigious medical institutions and/or with membership in elite referral networks, were not a visible or felt source of support in the everyday practice of HIP physicians.

THE SIX FOUNDING PARTNERS

On the current roster of the Urban Medical Group are six physicians who have been partners since 1947 when they joined with ten other physicians to found Urban. On their own, the sixteen approached the Health Insurance Plan and were given a contract to care for patients whom the Plan was enrolling. At the same time, they were starting their first private practices or picking up the pieces of practices begun just prior to the War. Recalling vividly the harassment they and their colleagues faced as members of HIP, one founder, for example, describes how private practice colleagues stopped referring patients when they learned of his affiliation with HIP:

> I lost a lot of doctors, doctors who didn't approve and I had some very good private patients. But I think that my private practice suffered.

Loss of referrals was only one problem the partners report they encountered. The hospitals, largely under the control of the County Medical Society, began to withdraw privileges from HIP physicians.

One physician recalls:

> The war took the form of keeping HIP physicians out of certain hospitals, not giving them appointments, if they had appintments, not giving them promotions and so forth.

The County Medical Society was seen by Urban's founding physicians as the opponent in their struggle to become a viable Medical Group. At first the Society was merely cautious about HIP groups. Then it opposed the concept of prepaid group practice for all but lower class patients; rather than completely resist the Plan, the Society attempted to have some input into it. In fact, the Economic Committee of the Society acted to certify and approve the medical groups. As one of the partners who represented the Urban Medical Group before the Committee explained:

> I stressed very much that this was experimental, this was a pilot, something new. And they were all very interested and receptive to the idea. Except that one of the doctors became kind of disturbed. He said, 'you know, it's all right, this is a pilot and this is an experiment, but this experiment might put us out of business.'

As HIP continued to enroll subscribers, mostly from a captive population of city employees, the Society began to act as if the Plan indeed "might put us out of business." It withdrew its passive recognition of HIP and stepped up its campaign against the medical groups, returning to the hard line of the American Medical Association which branded prepaid group practice as socialistic. One of the founders recalls that the County Society churned out publicity about HIP "as a second-rate type of treatment, a clinic type of treatment, assembly line treatment."

The founders report that their private practices suffered from loss of referrals; that they were discriminated against by hospitals; and that their abilities as physicians and loyalties as citizens were publicly called into question by members of their own profession.

Since the profession, as a standard rule, does not publicly criticize its own members, this public chastisement by the profession of its own is even more significant. How could these men, under such apparently trying circumstances, join an organization which was harassed by many practitioners in the community and which was ostracized by the colleague networks of organized medicine?

According to the founders, when they joined HIP they found themselves in a tight market with many physicians returned from the War competing for patients. They saw HIP as a potential source of some financial help during those early lean years. As one physician noted:

> I came out of the Army, I was in another town and I needed money. So I did like many others. I saw a notice, 'sign your name if you're interested.' And I signed.

The founders also explain their decision to join HIP in terms of their need for patients. Without money they might have gone hungry to cover expenses, but as long as there were patients they could work. In fact, the practicing physician's definition of work necessarily includes patients and, for these physicians, HIP was a certain source of that fundamental need.

The founders' explanations for joining Urban reveal important criteria -- patients and money -- that most physicians would consider legitimate bases for choosing medical work. But their own explanations do not differentiate them from physicians who chose not to join HIP. We must consider, therefore, how these men differ from physicians who opposed HIP and would not join Urban.

Four of the six partners were born and received their medical training in Europe while two were trained in the United States in relatively low prestige medical institutions. All six had either just

returned from the Army and/or were beginning private practices. Thus when they joined the Urban Medical Group, they were essentially outsiders to the county medical societies and the hospital based medical community. Not only were they peripheral to organized medicine, but the six also had experiences either in Europe or in the Army which may have socialized them to accept prepaid group practice as a good way to practice medicine. As one American trained doctor indicates:

> In the Army I was really doing group practice because I was stationed in a large Army hospital, general hospital. And we practiced group practice and I liked it. When I came out I had to start scrounging around in private practice and I didn't have any. So financially it was very difficult. I missed the conferences and the group practice experience which I encountered in the general hospital. So when I heard about HIP I felt this is something I had become familiar with.

A European founder recalls his colleagues' support for this new enterprise:

> Some of us were school mates and met here after we emigrated. We kept more active social contact with each other. We were interested just for the fun of it -- not only financial profit. We wanted to see some progress, not exactly to try to come near government control, but we wanted to try what could be done for the benefit of all people who would be deprived of medical care. I think everyone was willing to give time at the beginning to let this thing succeed.

All six founders had been exposed to value systems in medicine at variance with or different from the free enterprise system of American medical practice. The European founders were socialized into their values abroad while the two Americans' first experiences as "full-fledged" physicians away from training institutions were in the Army whose medical system of salaried physicians and group work was, for these two physicians, particularly satisfying. Mannheim suggests the intense effect of what he calls the "moulding power of first impressions."[5]

For the two American physicians, with no prior commitment to a segment of the medical profession opposed to prepaid group practice, the Army, as their "first" significant medical experience was situationally and culturally compatible with prepaid group practice.

We suggest that the founders were able to join HIP because they were marginal to colleague groups attached to the value traditions of the AMA and perhaps, more significantly, they were peripheral socially to those physicians. When we look at the four founders born and trained in Europe we find they had been friends and colleagues prior to emigrating. In New York they resumed their friendships and formed a referral network within private medical practice. Even though organized medicine was opposed to HIP, these men had friends as professional colleagues who not only supported prepaid group practice, but participated in it. Criticism from organized medicine, therefore, did not stop these founders from pursuing medical careers within HIP. Indeed, their own and their friends' European training had not stressed the high valuation of free enterprise prevalent in American medicine. As Katz and Lazarsfeld's concept of the "two-step flow of communication"emphasizes, personal influence or <u>people</u> are crucial for forming and reinforcing ideas.[6] For the European founders, the influence of their friends reinforced ideologies compatible to prepaid group practice.

We have no direct evidence of the colleague-friendship groups of the two American trained founders in 1947. It is clear, however, that they were outsiders at least to the rhetoric of the private practice system. Each one had completed his residency in New York ten years before in a hospital with relatively low prestige and having no affiliation with a teaching center. Each had received his specialty

certification after the War. They were therefore not in a position of being dropped by many colleagues who opposed HIP: they had no developed professional group as a source for referral, status, or social support. At the time of membership in HIP, these two physicians were affiliated with their specialty organizations. (Membership in the AMA and County and State Societies was a requirement of HIP membership.) We can only conjecture, on the basis of the relatively low status of their training institutions, that they were probably not career oriented toward academic medicine, did not develop any strong anticipatory reference to university medicine or have any close friends in that segment of the profession. In addition, since the AMA was more oriented to general practitioners than specialists, it is not likely that they had strong ties to organized medicine. If they did have a particular professional reference group with which they identified and from which they expected to gain status, we suggest it was their specialty group. Thus, like their European trained colleagues, it would seem they had no particular investment in the prescriptions of organized medicine and, more critically, perhaps these European colleagues were the people who provided support and reinforcement for belief in prepaid group practice.

We have noted that one result of the conflict between HIP and organized medicine was the ostracizing of HIP physicians from the colleague networks and medical institutions controlled by organized medicine. But to label the founders deviant and ostracize them from a group in which they had no investment was of much less consequence than if these physicians' professional reference group was organized medicine. Although the Urban physician was made an outsider by the Medical Societies, he may not, as Becker suggests about the deviant,

> accept the rule by which he is being judged and may not regard those who judge him as either competent or legitimately entitled to do so. Hence....the rulebreaker may feel his judges are outsiders.[7]

Those who stipulated that prepaid group practice and its participants were deviant may well have been "outsiders" ideologically and personally to the Urban physicians.

PHYSICIAN AFFILIATION IN THE EARLY YEARS

Seven physicians currently in the group (in addition to the founders) joined prior to 1957 -- still a time of professional hostility toward HIP. Although they describe difficulties similar to the original partners', their experiences of joining the group were somewhate different. A number of years of organized medicine's damaging publicity against HIP made these seven partners sensitive to the negative image of HIP physicians. They, in fact, largely believed that

> These groups that started, many of them were not staffed by the very best physicians, because as you can see, the very best physicians were anti the whole concept. So they wouldn't join up with this idea. And so sometimes they had to be satisfied with lesser guys.

These men had become reluctant believers in organized medicine's propaganda. Why then did they join an organization whose doctors "weren't very good"?

In those early days before Urban had its own medical center, each physician (except one who worked for a hospital exclusively) had his own private practice where he saw Urban patients. Of these seven physicians, six were specialists and one was a family physician. Two of the physicians were trained in Europe, one in Canada and four in the United States. Like the founders, they were in the early stages of their careers and had weak or undeveloped allegiances to the official values of organized medicine. Their professional training and medical

experience provided no ready collegial network or reference group. These were physicians who were trained to be practitioners and their fundamental need was to work with patients. They exhibited what Veblen calls the "instinct of workmanship"[8] in their attitude toward their new careers. They appeared more concerned with "doing" than with the ideologies attached to the medical activity they thrived on.

We have noted the basic need for patients in the physician's work, but Urban provided more than just bodies. These new physicians found greater potential for clinical experiences and greater medical responsibility in the Urban Medical Group than in solo private practice:

> I happen to like to do surgery. And this was a wonderful opportunity to do surgery easily. I felt for the first ten years that I should be paying HIP; I was learning. I was doing things that I had done as a resident. I had seven years training in residency. In private medicine you don't get huge big cases and I was getting all the responsibility and all the surgery which I could do.

High valuation of medical responsibility and clinical experience were found by Becker and his associates in their study of medical education:

> Medical responsibility is responsibility for the patient's well-being, and the exercise of medical responsibility is seen as the basic and key action of the practicing physician. The physician is most a physician when he exercises this responsibility.[9]

> Clinical experience, in the view implied by this term, gives the doctor the knowledge he needs to treat patients successfully, even though that knowledge has not yet been systematized and scientifically verified. One does not acquire this knowledge through academic study but by seeing clinical phenomena and dealing with clinical problems at first hand.... it is believed that a person must learn much of what he needs to know by actual clinical experience.[10]

Able to see themselves as exceptions to the rule that "the very best physicians wouldn't join up," these seven physicians saw Urban as an opportunity to acquire new clinical experiences with personal responsibility

for the patient. This was a compelling influence in their decisions to join the Urban Medical Group.

THE LAST TEN YEARS: 1962-1972

Twelve of the current partners joined Urban between 1962 and 1972. They were less encumbered by the negative HIP label than those partners who had joined the group earlier but they still feel there is some stigma attached to being an HIP physician. They believe that while the medical profession no longer actively ostracizes HIP physicians, there is nonetheless a residue of belief that HIP physicians are second-rate. Consequently, they believe that the profession confers little or no esteem on HIP physicians.

But this group of partners was in a very different position vis a vis the attitudes of the profession toward HIP than the physicians who joined Urban earlier. In the intervening years of HIP's growth it had not become the threat anticipated by organized medicine. More and more opportunities opened in hospitals for HIP doctors and in the referral networks of their private practices. As a result, these physicians began to build reputations based on their private practice affiliations.

Moreover, by the mid 1960s, the profession had accepted HIP as a source of money and patients for physicians but not as the site for commitment to medical practice. The label "private practitioner working in HIP" is different from "HIP doctor." Thus, it appears that the physicians who joined Urban in the last ten years did not have as much difficulty making the choice to become members of HIP. They saw themselves primarily as private practitioners and therefore did not feel as vulnerable to the potential of the second rate "HIP" label as did their predecessors.

We have suggested that "HIP doctors" have low status in the organized medical profession. Indeed, Urban's physicians have reported the low esteem in which HIP physicians are held on the "outside":

> I do think there is a prevailing feeling on the outside which may be in part self protective and self righteous, that HIP physicians are second class physicians.

When Urban physicians are labeled "HIP doctors" they find they must defend themselves against the connotations of that identity. In the following sections we will examine Urban physicians' reference group identifications. Do physicians who refer primarily to the profession view their work differently compared with physicians who primarily identify with the Urban Medical Group?

THE PROFESSIONAL REFERENCE GROUP

We have noted that the profession consists of a variety of reputation systems. In a city like New York, the community of physicians contains, for example, both cosmopolitan and local groups. In the cosmopolitan reference group, the physician is oriented to the "top of the profession, far away."[11] This usually includes those physicians in the major prestigious teaching and research institutions in the country and the leaders of the formal organizations of the profession. In contrast, physicians oriented toward locals as a reference group look to their community -- at the practitioners who engage in the everyday work of medical practice. But even within these two groups we can find distinctions. Among the cosmopolitans we have academicians and practitioners and the locals form many networks of separate collegial reputation systems. These groups, existing side by side, represent different orientations and practices within the informal organization of American medicine.

Since all but one of the physicians in the study are essentially practitioners they are all involved in colleague networks of clinicians within the New York community. Thirteen of the 31 Urban physicians[12] have appointments at teaching institutions as well. The physicians, then, are involved in a variety of structures "through which information, influence and innovation flow."[13] The highest prestige colleague group has been referred to by Hall as the "inner fraternity" which he describes as

> a spatially segregated group, homogeneous with respect to ethnic and religious affiliations, involved in the lucrative specialized fields of medicine, occupying the dominant hospital posts, and having preferred claims on the good paying clienteles of the city. It maintains its existence and controls the practice of medicine, by sponsoring new members.[14]

Freidson has taken Hall's concept of "inner fraternity" and suggested that in large populations there are numerous informal networks of colleague groups "which are at least partly ordered by prestige."[15] And Solomon's study of physicians in Chicago indicates prestige differences among different hospitals' staff members.[16] There are thus a variety of professional networks which provide orientations for the physician's work and to which the physician's professional prestige is attached.

Within this informal structure of the American medical profession, each network tends to consist of physicians with similar clienteles, hospital appointments, ethnicity, religious affiliations,etc.; and these networks may be arrayed according to the prestige of these affiliations. But there is perhaps a more important difference among these networks: each has its own culture, with some values taking greater precedence in one than in another. Thus, while virtually all practitioners require a clientele and hospital affiliations, the value of high prestige

patients and institutional affiliations varies from network to network.

We have indicated the high valuation of medical responsibility and clinical experience in the profession, but how much responsibility and the amount and variety of clinical experience is differentially valued. Everyday practitioners emphasize practical work while more academically oriented clinicians find intellectual pursuits -- continuing education and research, most valuable. Autonomy, privacy and independence are highly valued in the profession, but again the weight placed on these values varies: Physicians involved in colleague networks closely tied to county medical societies, for example, prize autonomy to a greater degree than physicians working for medical institutions who value colleagueship and interdependence.

THE PART-TIME PHYSICIANS

If we examine the institutional affiliations of Urban's part-time physicians, we find they are involved in a variety of types of professional networks. There are six physicians who are members of academically oriented physician groups. They have affiliations with high prestige medical teaching centers and hospitals and generally treat an upper-middle class clientele. Two physicians belong to colleague networks which are essentially located in one medical institution. Fifteen practitioners are members of local colleague groups. Four of these have patients in the middle and lower classes and affiliations with good or average institutions. Eleven of the fifteen have clienteles of largely middle class patients and are affiliated with good, but not high prestige medical institutions. Of these eleven, two are founders of Urban. In the years since Urban was founded, they (along with the other founders who are part-timers) have become

increasingly involved in colleague networks in the community. These two founders, however, have retained their commitment to Urban. One is the medical director of the group. The second founder committed to Urban rents space in the Urban medical center for his private practice office.

With the exception of the two Urban founders who have stayed committed to Urban, part-time physicians have incorporated their professional reference group's evaluation of "HIP doctors" into their own attitudes. This has significant implications for the ways they identify their full-time colleagues. For example, an academically oriented physician with a busy, high prestige private practice evaluates full-time HIP doctors in the following way:

> The doctors are living and working from 9 to 5 where they know they'll be on call every sixth night or things like that. They sort of cut it down. I don't know one of the internists who is doing research or writing any papers or doing any work...I think it's bad personally, to become full-time and I'm thinking of full-time as a retirement phase. But for an active man, I think it cuts down on his medical intelligence and everything else.

Clearly, the highest value for this physician is in a type of medicine where there are intellectual demands and varied clinical responsibility. The HIP full-time routine is seen as a diversion from "real work," as something not for "an active man."

Another specialist who identifies with academic medicine implies that according to his high technical standards, Urban does not provide high enough quality care:

> If it were connected to a medical school and more directed to that kind of medicine -- academic quality, no commercial group could afford that quality and I wouldn't take this. I couldn't work with these people (the doctors) day in and day out.

When this physician was asked what he thought motivated the physicians to work full-time in Urban he replied, "they couldn't make it in private practice."

Physicians who are not committed to Urban tend to see "HIP doctors" as having limited clinical experience and lacking autonomy, privacy and independence. For example, one part-time specialist with a large middle class practice and good hospital affiliations was discussing a test he would recommend for a patient with a full-time family physician. When it became apparent that the full-time doctor had had no experience with the test and knew nothing about it, the specialist remarked, "You've been an HIP doctor too long." That statement was indicative of the specialist's belief that the family doctor's ignorance of a complex test was the inevitable outcome of full-time work in HIP.

The importance of autonomy and independence to clinicians is evident when they try to explain why they believe a physician would work full-time in Urban. They point to the lack of privacy and autonomy and assert that HIP doctors are not full-time "because they want to be." They suggest that the physicians become full-time because they "are insecure and can't face the challenge of private practice." Work in Urban is seen as easy. The family doctor can always pass patients on to the specialists. Indeed, the specialists believe that Urban's family doctors don't take full medical responsibility for patients and have given up being independent, autonomous practitioners. It is not unusual for the part-time practitioners with no commitment to Urban to characterize full-time family physicians as lazy and medically narrow.

The most salient feature in the negative evaluation of "HIP doctors" is the belief that for medical responsibility to be exercised, the

patient must "belong to" the physician. The full-time physicians are viewed as unable to attract a clientele, a fundamental component of medical practice. Instead, patients are seen as "belonging to" the organization. As a consequence, the uncomitted part-time clinicians ask, "How good could these full-time doctors be if they couldn't get their own patients?"

Essential to the physician's role is the relationship with his patients and nothing and no one is to intervene. It is interesting to note that in the United States the organization or the government is perceived as interfering with the physician's autonomy in this almost sacred relationship while in Russia, the relationship, just as sacred, is perceived as interfered with when money exchange intrudes between the doctor and patient.[17] The private practitioners with no commitment to Urban assume the doctor-patient relationship can be viable only if patients specifically choose them (even via referral from another colleague). As a result, most make little attempt at establishing relationships with the organization's patients. In contrast, most full-time Urban physicians and the two part-time founders committed to Urban who, as we will see later tend to be oriented toward Urban patients, are not as likely to see free choice of physician as prerequisite to a viable doctor-patient relationship.

Two part-time physicians who are in institutional colleague networks see less loss of autonomy in full-time HIP practice than the private practitioners. They value an organizational setting (they also value private practice) which they believe promotes high technical quality. But they believe the full-time Urban physicians are without sufficient supervision or peer review (in contrast to their own hospital

situations) and lack collegial interaction especially around case presentations. Because the Urban Medical Group does not fulfill their criteria of a high quality medical organization, they perceive Urban's full-time physicians as retaining the negative qualities associated with HIP medical groups.

The part-time physicians committed to colleague networks outside of Urban identify themselves with and gain their professional reputations from these professional reference groups. They see themselves as private practitioners (one physician sees himself as a hospital affiliated specialist) -- part of the profession's elite corps. Two Urban founders with colleague networks outside of Urban do not identify themselves only as private practitioners. They see themselves as belonging -- committed members -- to the Urban Medical Group. In fact, their perceptions of Urban most resemble the perspectives of Urban's patient-oriented full-time physicians. In our discussion of the lay reference group below, we will describe the part-time patient-oriented physician in greater detail.

THE FULL-TIME PHYSICIANS

The primary colleague network for the eight full-time group physicians is the Urban Medical Group. For these physicians, their group colleagues provide a referral network and are most familiar with their medical work. Although five of the eight physicians engage in some outside medical work (four spend an average of three hours a week in hospital clinics and one physician spends eleven hours doing physical examinations for a non-medical organization), the colleague relationships in Urban are more frequent and more stable than any outside medical activities.

Urban's full-time physicians find little sense of professional worth or acceptance from the profession's reputation system in general and from their part-time Urban colleagues in particular. As a consequence, the full-time Urban physicians may turn to the lay system as a source for their reputations as practitioners. But that system, too, is not a ready base for high esteem for "HIP doctors."

THE LAY REFERENCE GROUP

The lay reputation system in HIP consists of patients who are subscribers to HIP first and the doctor's patients second. We have stressed the importance of the patient belonging to the doctor in the professional reputation system. In the lay system, as well, the requirement that the patient be personally attracted to the physician is equally crucial.[18] Indeed, when a patient does not see the physician as "my doctor" he does not regard that physician with esteem. This fact proves most problematic for Urban physicians' reputations in the lay system.

In the Urban Medical Group, patients come to physicians through organizational auspices. This may be contrasted to the situation of private solo practice where patients tend to select physicians through lay or professional referral systems. In the traditional practice, the patient chooses a physician on the recommendation of a friend or through "his" physician. In the Urban Medical Group, doctors perceive their initial contact with patients as meetings between complete strangers.

In fact, through their place of work, patients have chosen (from at least two alternatives) this prepaid form of health insurance for themselves and their families. Individuals may also subscribe to HIP

for their health care if they are covered by Medicaid or Medicare. Individuals not offered HIP through their jobs, Medicaid or Medicare, are not eligible for HIP coverage.

Once HIP is selected, patients choose a medical group to provide their health care services. Up until 1973 (midway in this study) subscribers were required to choose a group geographically within their areas of residence. (This requirement has been changed so that a patient may choose membership in any HIP medical group.) Once a group was chosen, it became the patient's source of care; he could not, under ordinary circumstances, utilize the services of other HIP groups. (Exceptions are made for emergencies and consultations.)

When membership in a prepaid group is established, the patient chooses a family doctor from those on the group's panel. Patients do not tend to know the physicians in the group and thus either arbitrarily pick a doctor or have one suggested to them by the administrative office of the group. Thus there is no personal reputation which brings the patient to the physician. Rather, as Freidson noted in his study of HIP's Montefiore Medical Group, the patient

> will have no source of support for belief in the virtues of his Group physicians beyond his own experience and the formal designations of professional qualifications which the Medical Group may make available to him on request. The physician in the Medical Group is thus more likely than the physician in neighborhood practice to have no lay reputation of significance, practicing medicine solely on the basis of his professional reputation. The physicians are vouched for by the professional standards of the Medical Group and the Medical Control Board of HIP, not by fellow-patients.[19]

This statement suggests that reputation in the lay system is dependent upon a clientele's prior knowledge of the physician. The advance knowledge of the physician not only reassures the patient of the virtues of his physician; it also prompts the physician to believe that patients

expect him to be a capable practitioner. One part-time practitioner underscored the meaning for him of lay esteem:

> Patient referral is the soundest type of practice you can develop. That's where my stability comes from. So patients refer and talk. They know what kind of doctor you are.

In the physician's view, when the patient comes to him knowing "what kind of doctor you are," the stage is set for the doctor to perform: He does not have to negotiate for authority in the relationship, i.e., his technical competence is not called into question. The physician can assume the patient expects him to do his best and the patient expects the physician to make him well. The doctor-patient relationship can proceed with minimal strain for both parties.

Under organizational auspices, the patient sees himself as the doctor's patient when he comes to know and have confidence in the physician. As long as physician and patient remain strangers, both doctor and client hold the organization responsible for the provision of health care.

As is the case in the more typical medical care system, HIP is seen by Urban's physicians as tending to have a negative reputation in the lay reputation system. As a result, most individual physician members believe that patients attribute the negative qualities of the organization to them. Freidson's study of patients in another HIP group corroborates that patients do, in fact, identify the physicians negatively with the organization:

> There circulates among subscribers and potential subscribers a great deal of largely critical gossip about the Health Insurance Plan. Of the patients interviewed only four could recall hearing any enthusiasm of praise expressed for the Health Insurance Plan (though a considerable number of those interviewed themselves expressed enthusiasm). The Health Insurance Plan, as a fairly recent and contentious innovation

> in New York, is rather conspicuous and stands distinct from the loose organization of entrepreneurial practice. So while the unsatisfactory behavior of one solo practitioner rarely is taken by the outraged patient as a reflection on the system of 'private practice,' the patient frequently seems to regard the unsatisfactory behavior of one HIP physician as a reflection on HIP itself. Several patients told of people they knew who, believing that a HIP doctor had made a mistake or that they had been insulted by a HIP doctor, canceled their contracts with HIP. In this sense, then, patients of the Medical Group are unlikely to be acquainted with anyone who knows anything about particular doctors of their group but they are quite likely to have heard some highly negative gossip about HIP or HIP doctors in general.[20]

Although the part-time physicians committed to private practice define "HIP doctors" as only those who work full-time in HIP, in the lay reputation system all physicians, whether part-time or full-time, are defined as "HIP doctors." The Urban physicians, both full- and part-time, report experiences in which patients categorically evaluate HIP physicians as providers of poor quality care. One physician, for example, sighed:

> You still get HIP with some kind of an aura of being second class medicine. Because everybody has an experience with an HIP patient who has been manhandled by HIP. And you know if you can put a label on something it sticks more than if it were an individual doctor who did the same manhandling.

It is the patient's generalized hostilities toward HIP that the Urban physicians experience. Doctors believed patients to feel "I'm not quite as good as the man outside." As one physician recalls:

> I remember one (private) patient of mine I treated for years and years and I had to hospitalize her. She said, 'I have Blue Cross.' While she is fumbling around in her cards she pulls out an HIP card. I said, 'you belong to HIP?' She said, 'oh yes, I belong to that for years.' I asked, 'well don't you use it?' and she replied, 'are you kidding?'

PART-TIMERS: PRIVATE PRACTICE ORIENTED PHYSICIANS

Although most of the physicians at one time or another have encountered patients with negative attitudes toward HIP physicians, there are differences among the physicians in the way these attitudes are experienced. One group of physicians, those committed to their private practices, relate stories about some of their private patients who are members of other HIP groups. (They are not permitted to treat Urban's patients privately.) They delight in recalling how these private patients (who know nothing of their own affiliations with HIP) demean HIP physicians, while, at the same time, praise the individual practitioner, obviously perceiving him only as a private doctor. Since their patients view them favorably when they don't know about the HIP affiliation, what better proof that they are not really "HIP doctors"? With these stories, these physicians also imply (when they don't say it outright) that patients are not able to differentiate between a "good" and a "bad" doctor anyway. These physicians look to their private practice networks for professional esteem. They accept the validity of patients' devaluation of HIP physicians and dissociate themselves from the Urban Medical Group.

PART-TIMERS: PATIENT-ORIENTED PHYSICIANS

The two part-time physicians who are patient-oriented were founders of the Urban Medical Group. (Of the six founders currently in Urban, one is now a full-time Urban physician, positively oriented toward patients. The three additional part-time founders have become increasingly committed to their private practice networks which have developed over the last 26 years.) They have retained the strength of their original commitment to Urban even though they have become part of private practice networks

in the community. They continue to value prepaid group practice and have not taken on the negative attitudes held by some of their private practice colleagues.

The part-time Urban physicians committed to the Medical Group do not accept patients' or colleagues' devaluation of HIP physicians. Indeed, they describe the Urban Medical Group with pride:

> This is a group that has been in existence 26 years. This is a group that is financially stable. This is a group connected with outstanding hospitals. This is a group that has outstanding doctors.

Part-time Urban physicians who identify themselves with the Urban Medical Group and are patient-oriented share the attitudes and behaviors of the full-time patient-oriented physicians. These characteristics will be described below.

FULL-TIME URBAN PHYSICIANS

Full-time Urban physicians do not have the luxury of patients who know nothing of their affiliation with HIP. They take no delight in stories which differentiate between "my doctors" and "HIP doctors." With little reputational support in their Urban colleagues' networks, full-time physicians tentatively may turn to the lay system for their professional identities. But as we have seen, patients do not have high regard, at least categorically, for HIP physicians. If the physician seeks esteem in the lay system, the onus is on him to disprove the negative identity associated with HIP. He must convince the patient of his interest as well as his technical competence and establish his medical authority in the doctor-patient relationship. The patient must come to see the physician as "his doctor." Only then is he granted a positive professional identity.

FULL-TIMERS: PATIENT-ORIENTED PHYSICIANS

Of the eight full-time group physicians, five look to Urban and its patients as a source of professional identity. Their medical activities have consistently been observed as initially devoted to getting to know the patient and showing the patient their desire for an ongoing relationship. The message is, "I want to be your doctor and I want you for my patient. Trust me." One doctor, responding to a patient who said she would pay for vitamin B12 shots "if I had a private doctor," laughingly chastised, "I am your private doctor. What kind of doctor do you want? One that you can carry in your vest pocket?" This physician was aware that the patient was troubled and gently questioned her about her problems and gave assurance she would be fine. When the patient left, visibly more at ease, this physician remarked, "Maybe I'm too soft, but if patients leave with something sticking to them, they'll carry it with them to the next visit."

By showing personal interest in their patients, patient-oriented physicians begin to become persons to patients rather than representatives of an organization. As such the patient begins to see the physician as "my doctor" rather than as a "HIP doctor." In fact, through their efforts the patient-oriented physicians have built good solid reputations among their patients. One patient, for example, was overheard joking with a receptionist about the lottery. The receptionist asked the patient, "what would you do if your doctor (one of the 5 patient-oriented doctors) won the lottery and left?" The patient replied, "He'd never leave his patients. He likes them too much."

These physicians do like their patients. The get most of their satisfaction in their work from their patients and they tend to spend

more time treating patients than the required twenty hours in the group. They go out of their way to make it clear to personnel in charge of appointments that patients must have access to them.

Although patient oriented physicians receive little recognition from colleagues, they view their Urban practices as successful relative to their previous work situations. Coming to Urban from either salaried positions or failing private practices, these physicians saw their decisions to work in Urban as positive career moves. One patient oriented physican, for example, who "knew from the beginning I did not want private practice" states:

> From the way Urban was described to me it seemed they would be offering the things that I wanted. In other words, I wanted more or less regular working hours, availability of consultation, and a good chance to practice good medicine.

Patient oriented physicians generally see Urban as a situation of medical practice which can fulfill their professional needs. In particular, they find the system of capitation beneficial to their relationships with patients since it removes the economic barriers which prevent patients from seeking care and alleviates the problem of financial matters getting in the way of the doctor-patient relationship. One patient oriented physician, for example, was delighted with the prepayment system:

> It gives me several things. It gives me continuity of care and it gives me an involvement not only with that person but with the whole -- with his family and all the things that are involved to make it a lot easier to figure out what's going on. If you have fee-for-service, you will have people who will come back. But you don't have a particular type of involvement, as you have with a captive audience. Their captivity works to their advantage sometimes. Because there are many times that we can't figure out what's going on until we see the kid with the husband and all these other things that are going on there. On a fee-for-service basis I don't think you can do that. The patient comes in, sees you for this, pays you money and that's it.

The following statement by a group pediatrician also illustrates the attitude of a physician who is oriented toward patients:

> I treat my patients with the best I know. They get all the time they need: If they need a half an hour they get half an hour. If they need 15 minutes or for a follow-up, 10 minutes. And if I need more time I spend more time. I see that they get appointments for routine and they do not have to wait more than 2 or 3 days maximum. If they call today, 'my child has a fever, I want to see the doctor today,' I see them. All my nurses and the receptionists, they know. Anyone who calls and says my child is sick or has a fever or any reason a mother says I want to see the doctor today, the patient can see me the same day.

FULL-TIMERS: INDIVIDUALISTS

While 5 of the 8 full-time physicians are patient oriented, three doctors have negative attitudes and show little interest in their patients. Their orientations are best explained by the individual needs of each. For example, one finds that work in Urban gives him a good deal of leisure time which he desires for a variety of non-medical personal activities. He believes it would be impossible to maintain a group of patients in private practice with so few hours of work and he sees the Urban Medical Group as always available to his patients. He sees himself as a member of an occupational category: "doctor." What better situation for him to do his job of doctoring? He simply does his work and neither seeks nor receives esteem in the lay or professional reputation system. The second "individualist" has had a history of salaried positions in medicine. He very clearly relates to his work as a job. He would like recognition from the profession, but having been born and trained in another country, he has difficulty meeting the requirements of the medical profession in this country for specialty certification. In his frustration with the profession's withholding of esteem, he has begun to reject it as a source of status. Like his colleague above, he identifies himself as "doctor" and just does his job.

The third physician without support in the lay reputation system acts as if he does not want that support. He is extremely pragmatic

with patients and in contrast to the patient-oriented physician, shows little or no personal interest in patients. For example, he never introduces himself to new patients and places more emphasis on writing complete charts than on listening to patient complaints. The following excerpt from the field journal provides a picture of his habitual stance toward patients:

> The patient complained of a stiff neck and swollen glands and said she thought she had been smoking too much. She also said that in the past she had respiratory allergies, although she hadn't had them this year. She remarked that her lungs hurt and there was pain in her back and her ears. The doctor examined her and returned to the consulting room. He ordered a chest x-ray and silently wrote in the chart. When he did not tell the patient anything she asked, 'did you find...' He interrupted her and said, 'no, I did not find anything.' He gave her a prescription and looked at her with a dismissing stare. She asked him what the prescription was for and he said, 'it will help you breathe.' The interchange was very, very cold.

This physician seems uninterested in receiving status from patients and in fact orients to the professional system, but he is defensive about his inability to gain that recognition. He works hard at achieving a professional reputation:

> I am interested in high level medical practice and I'm interested to follow academic medical studies at a 'teaching center hospital'. I foresaw that this kind of set up (the group) would give me time to do both without having to worry about the practical point of view of practicing.

Working full-time in Urban, this physician has few contacts in the professional system other than the 2½ hours of hospital clinic work he is involved with. Moreover, the Urban physicians who are part of the professional reputation system in the community and a potential source of recognition for this physician, see him as a typical "HIP doctor." Nevertheless he continues to strive for professional identity and orients to a non-membership academic reference group. But he has been unsuccessful in his attempts for identity as an academic physician.

Having no commitment to Urban, his activities, like those of the other two individually oriented full-time physicians, are joblike.

The lack of commitment these three individually oriented full-time physicians exhibit toward Urban most resembles the orientation of the private practice oriented physicians who seek their reputation in, and are members of, non-HIP colleague networks. However, unlike the private practitioners, the individualists have no professional membership or reference group of people (they have an occupational category for reference) from whom they seek and receive professional esteem. Oriented either to the occupational category "doctor" or to the professional reputation system, these physicians' perspectives reflect the normative expectations attached to the traditional professional role of the physician.

With no recognition from either colleagues or clients, Urban provides little reward for the isolationist physicians. Although isolationists see Urban as a career move upward, in contrast to the patient oriented physicians, they find little satisfaction in Urban medical practice. For isolationists, the choice to join Urban was a negative one, not based on the type of practice available in Urban. As one isolationist notes:

> Urban was better than the place I was before....I don't know how it came about, but somebody phone me and they asked me whether I'd be interested to enroll in this group....But the main reason to move was that the group I was in before was very unsatisfactory to me.

A TYPOLOGY OF URBAN PHYSICIANS

We have described three sources of professional identification: the professional colleague network, the Urban Medical Group and patients,

and the occupational category "doctor". As Shibutani indicates, reference groups supply the perspective "used by an actor as a frame of reference in the organization of his perceptual field."[21] Urban physicians' varying references for professional identity become the bases for types of Urban physicians:

Type I - The private practitioner - These physicians are oriented to a professional reference group in the community. They are not committed to Urban and don't identify their primary functions as physicians with work for the Group. They display a job mentality toward and have little or no emotional or professional investment in the Urban Medical Group. They provide patients with technically competent care without personal interest. With their strong beliefs in the traditional values of the profession and their identities firmly rooted in their private practices and colleague networks, these physicians can deny their identity as HIP physicians (which they associate with negative qualities). They see themselves as physicians who "give" time to HIP.

Type II - The patient-oriented physician - These physicians are committed to their group patients and Urban which they see as a rewarding situation of medical practice. By working at establishing good doctor-patient relationships, they are responded to in positive ways by patients. Consequently, they view their identities as HIP physicians as positive self-conceptions.

Type III - <u>The isolated individualist</u> - These physicians are all full-time in Urban. They receive no support for their professional identity from the professional reference groups in the community (although they may seek that support). At the same time, they reject the Urban Medical Group as a source of professional identity. With no membership group of people as an accepting or acceptable source for professional identification, they may opt either to identify with the occupational category "doctor" or continue to seek acceptance from a professional reference group in the community. In either case, the "isolated individualist" identifies himself with the more traditional values of medical practice. These physicians show no personal interest in Urban patients and concentrate on performing the technical skills attached to their doctoring jobs.

We expect that physicians' differing professional identities and perspectives will differentially effect their definitions of the Urban Medical Group. Indeed, "people with dissimilar perspectives define identical situations differently, responding selectively to diverse aspects of their environment."[22] In the following chapters, therefore, we will explore physicians' definitions of the Urban Medical Group and the behavioral consequences of those definitions.

FOOTNOTES

1. See Welch, Claude E., "Professional Standards Review Organizations -- Problems and Prospects," New England Journal of Medicine, Vol. 289, No. 6, pp. 291-295; Stolfi, J. E., "Repeal Public Law 92-603?" New York State Journal of Medicine, Vol. 74, No. 2, pp. 321-322

2. Hall, Oswald, "The Informal Organization of Medical Practice," Canadian Journal of Economics and Political Science, Vol. 12, February, 1946

3. For a discussion of patients as a source of professional identification for medical students, see, Huntington, Mary Jean, "The Development of a Professional Self-Image," in Merton, Robert K., George G. Reader and Patricia L. Kendall, (eds.), The Student Physician (Cambridge: Harvard University Press, 1969), especially pp. 183-187. For a general discussion of identification with an occupation see Becker, Howard S., and James Carper, "The Elements of Identification with an Occupation," American Sociological Review, 21, June 1956, pp. 341-348

4. The New York Times, 6/5/53, 24:8

5. Mannheim, Karl, "The Problem of Generations," Essays on the Sociology of Knowledge (New York: Oxford University Press, 1952) pp. 296-299

6. Katz, Elihu and Paul F. Lazarsfeld, Personal Influence (New York: The Free Press, 1955), p. 31

7. Becker, Howard S., Outsiders (New York: The Free Press, 1963), p. 2

8. Veblen, Thorstein, The Instinct of Workmanship (New York: Macmillan, 1914)

9. Becker, Howard S., Blanche Geer, Everett C. Hughes, Anselm L. Straus, Boys in White (Chicago: University of Chicago Press, 1961), p. 224

10. Ibid., p. 231

11. Coleman, James S., Elihu Katz, Herbert Menzel, Medical Innovation: A Diffusion Study (Indianapolis: Bobbs Merrill Co., 1966), p. 185

12. The total number of physicians in the Urban Medical Group is 32. This study discusses only the 31 physicians who participated.

13. Coleman, Katz and Menzel, p. 69

14. Hall, p. 43

15. Freidson, Eliot, Profession of Medicine (New York: Dodd, Mead & Co., 1970), p. 199

16. Solomon, David N., "Ethnic and Class Differences Among Hospitals as Contingencies in Medical Careers," American Journal of Sociology, Vol. 66, 1961, pp. 463-471

17. Mumford, Emily, "Through the Cultural Looking Glass: Soviet Medicine in its Social Context," Report to the Milbank Foundation, 1969 (unpublished); Field, Mark G., "The Doctor-Patient Relationship in the Perspective of 'Fee-For-Service" and 'Third-Party' Medicine," Journal of Health and Human Behavior, Vol. II, No. 4, Winter 1961

18. See, Freidson, Eliot, Patients' Views of Medical Practice (New York: Russell Sage Foundation, 1961)

19. Ibid., p. 36

20. Ibid., pp. 161-162

21. Shibutani, Tamotsu, "Reference Groups and Social Control," in Rose, Arnold M. (ed.), Human Behavior and Social Processes (Boston: Houghton Mifflin Co., 1962), p. 132

22. Shibutani, in Rose, Op. Cit., p. 131

Chapter 4

PERCEPTIONS OF AUTONOMY IN THE URBAN MEDICAL GROUP

Since early in the twentieth century, the physician's autonomy was assumed, taken-for-granted as a natural fact of American medical practice. Indeed, autonomy is the essential feature which marks medicine as a profession. In this chapter, therefore, we will explore physicians' perceptions of autonomy in the Urban Medical Group.

Autonomy is granted to the medical profession through licensure by the state which permits the profession to control its work including who can do the work and how that work can be done. Such rights to control over work are based on medicine's claim to special expertise. The profession has convinced the state that only it has the knowledge to determine who the state can license. In effect, then, the medical profession has been given a monopoly over healing, a monopoly not simply over who may practice, but over the terms of practice as well. As Freidson states it:

> I would argue that autonomy of technique is at the core of what is unique about the profession, and that, in fact, when this core autonomy is gained, at least segments of autonomy in the other zones follow after....Granted autonomy in his technique, the professional has a number of advantages which give him a sturdy wedge into other zones of practice. There is, first of all, the authority granted and deference obtained by his conceded expertise.... Second, there is influence on non-technical zones of work that is contingent on assessments of the work itself: the professional can argue that he cannot perform his work adequately unless he is near a given group of colleagues or a given set of technical resources; he can argue that he cannot perform his work adequately if he must work alone or if he is subject to structured interference; or he can claim that his cases are too complex to handle safely or well on an average of five an hour. Arguing from his conceded expertise in diagnosis and treatment, he is well equipped to influence if not control many other areas of his work. Only a fellow professional may

> say no, for counter-argument can be justified only by reference to knowledge of the special characteristics of the work. Autonomy over the technical character of his work, then, gives him the wherewithal by which to be a 'free' profession, even though he is dependent upon the state for establishing and sustaining his autonomy.[1]

The idealized picture of the physician working within traditional solo fee-for-service private practice would show him in a good position to exercise his autonomy. As long as he could attract a clientele, he could maintain control over his everyday work. He made all decisions -- from diagnosis to when to see patients. He was not especially visible to other members of the profession except as he chose to refer patients to a select number of colleagues. Any ancillary help in his office owed their loyalties to the physician and took their orders directly from him.

When group practice began to emerge, the medical profession viewed it as a threat to the physician's autonomy. There were many reasons for the profession's objections to group practice and particularly to pre-paid group practice, but the AMA's strongest objection was on the grounds that the physician would no longer be a free professional but would become responsible to the organization. The physician's visibility and accountability to other workers in the organization were seen as destructive of his autonomy. It is precisely these beliefs that mold physicians' perceptions of constraints in the Urban Medical Group. In fact, the constraints they experience in the group are largely based on their beliefs in the mythology of freedom in the profession (as evoked in our picture of private practice) in contrast to the visibility of constraints in the group situation.

PERCEPTIONS OF PRIVATE PRACTICE

The physician's perception of private practice is more often based on the norms -- what should be -- than on the realities of the situation. Urban physicians tend to see private practice as totally autonomous -- a situation where physicians have complete responsibility for patients, personnel and choice of referral colleagues. What they fail to see is the informal operation of social controls on private practice behavior. Private patients, for example, exercise controls on the physician through their ability to leave the practice and through word of mouth in the lay reputation system which may praise or damn the doctor; and, as we have noted, the physician's esteem among his professional colleagues is related to his patients' social class status. Furthermore, all physicians who are affiliated with hospitals are subject to some constraints. For example, there are tissue committee reviews, decisions to admit the physician's patients to the hospital, decisions to give the physician hospital privileges, etc. Colleague affiliations too, are not completely under the control of the physician since referral patterns in private practice are largely a function of the physician's prior career patterns: where he was trained and what hospitals he has been affiliated with. We know that all physicians do not receive referrals from the most prominent physicians in the city. Even the control of the physician over his office personnel is not total. Many receptionists and nurses in private practice subtly manage the physicians routine as when they screen information and access to the physician. It is quite clear that the physicians' perceptions of private practice as totally autonomous fail to take note of the very real constraints on their behavior.

In contrast, the formal lack of total autonomy in Urban is easier to see than the informal constraints on autonomy in private practice. Furthermore, physicians, as others, perceive selectively in service of their beliefs. As a consequence of this selective perception and the more visible forms of supervision and social control in Urban (contrasted to belief in the myth of autonomy in private practice) Urban physicians define the situation of group practice as limiting their ability to exercise responsibility and independence. But the degree to which physicians subscribe to these beliefs varies among Urban's three types ("private practitioner," "patient-oriented," and "isolated individualist") of physicians. While some physicians may define a situation in Urban as constraining, others may view the same situation as lacking constraints or less constraining. In varying degrees, Urban physicians believe that individual autonomy over how work should be done is relinquished to the Urban Medical Group (other physicians, administrators and personnel). In addition, some physicians believe that the Urban Medical Group, through its intervention, affects physician autonomy with the Health Insurance Plan (which contracts Urban for services).

PERCEPTIONS OF THE HEALTH PLAN

The relationship between the Urban physicians and the health plan is mediated by the Urban Medical Group. Nevertheless, "private practitioner" and "isolated individualist" physicians complain that HIP is like "big brother standing over you." They argue that the Board of Directors of HIP is not familar with the everyday practice of medicine yet is in a position to judge and evaluate the physician's medical practice. As one "private practitioner" declared:

> You've got someone standing over you who basically is not medically minded. That's the big thing. They're not medically minded, the Board of Directors. The doctors are pretty much kept out of the Board of Directors of HIP. They are told when, what, and how. The violations of contract: we have to maintain what we sign, but they don't have to maintain what they sign.

And another is equally angry that the Board of Directors is not composed of practitioners:

> Because this Board of Directors, on these panels who are sitting are lay people, in every respect, including the doctors, they are lay people. Because they don't practice medicine, they don't know what actually takes place in a patient's mind. They have big charts, graphs, that's what they practice.

The assumption that only a physician can "know what actually takes place in a patient's mind" is at the very heart of the autonomy issue and part of the myth perpetuated by the medical profession. However, not in private practice or under any circumstances, can the physician ever really know "what's in the patient's mind." Nevertheless, physicians tend to believe that such knowledge is the ultimate consequence of the patient's 'belonging to" the physician. When these physicians observe the governance of HIP they see an outgroup -- men who, whether or not they have the M.D. degree, are not really physicians because they "don't practice medicine." And, regardless of the situation of practice, to "practice medicine" requires one doctor and one patient. Given this definition and the view of the Board as an outgroup, it is inevitable that the Board's legitimacy to control the group is judged inappropriate.

"Private practitioner" and "isolated individualist" physicians share a strong value commitment to autonomy with either their professional reference group or with the normative occupational role category "doctor." Thus their antipathy toward HIP is not surprising.

It is difficult enough for physicians to accept the concept of peer review (which they object to as a violation of their right to autonomy), but these two types of physicians don't even consider the Board members to be their peers.

The "private practice" and "isolated individualist" physicians point to the contract between the Health Plan and the Urban Medical Group as the source of constraint from HIP and note the provisions which stipulate the need for evaluation and review of their medical care activity:

> Monitoring of Standards. HIP will institute an on-going program of monitoring which will include maintenance of facilities, quality of care, subscribers' complaints, and subscribers' attitude surveys.
> Enforcement of Standards. The agreement will provide for the addition of penalties providing for the suspension of enrollment after due notice of lapse in adherence to standards or substantial continued subscriber dissatisfaction, followed by termination of the Group Agreement (if violation continues). The Group shall annually submit reports to HIP's Administrative and Medical Departments on adherence to standards and remedial steps taken to correct deviation from standards.
> Review of Quality Care. There shall be continuing review of quality care within each Medical Group including periodic medical audits under the direction of the Medical Department of HIP.[2]

The perception of these provisions as constraints on physician behavior is a specific instance of belief in the myth of freedom in private practice as compared to the constraints of supervision in Urban. All Urban physicians value autonomy. However, in contrast to their colleagues, "patient-oriented" physicians are willing to relinquish some independence because they strongly value working in a group situation. Thus "patient-oriented" physicians do not believe that the Health Plan intervenes with the physician's medical practice. Indeed, Urban's contractual agreement with HIP gives no authority to

the Health Plan for the disciplining or removal of a group physician. There are no stipulated sanctions against the individual physician in the contract. Rather, the Urban Medical Group as contractee is responsible to HIP for the quality of care. With this responsibility, it is the Urban Medical Group which must decide whether or not to act against a member physician. Therefore, the belief that a "big brother" Health Plan is watching them is true only to the extent that the Plan does monitor the quality of care through a yearly review of random charts. It is not true insofar as the "big brother" concept implies sanctions against individual physicians' lack of adherence to standards of quality medical care.

"Private practitioners" and "individual isolationists" tend to equate membership in a formal organization with autonomy loss -- regardless of whether or not specific rules function to limit their autonomy. In contrast, "patient-oriented" physicians do not react to the prepaid group practice as if it consistently constrained their behavior. They do not view the Health Plan as constraining their behavior because they perceive no social control mechanisms which directly effect their delivery of care. In fact, the Urban Medical Group as a partnership of physicians who believe in their right to autonomy is not likely to strongly sanction its members. As Freidson remarks, the values of the profession tend to limit evaluation among peers:

> The social background of the practitioner, the nature of consulting or clinical work itself, and the natural solidarity of the occupational class lead to a permissive state of mind which assigns primacy to the evidence of personal experience rather than to the knowledge of which the official expertise of the profession is composed. It also assigns primacy to a sense of responsibility for one's own actions evaluated by one's own

> personal experience rather than responsibility for those actions of colleagues which do not bear on one's own personal responsibilities. The benefit of the doubt is given to members of competing occupations, and deficiencies of performance are overlooked in favor of presumed good intentions. 'After all,' the argument goes, 'nobody wants to kill a patient.' But if one does kill a patient, perhaps good intentions are not enough.[3]

In the section on "The Partnership" we will explore how the physicians individually and as a group tend not to act when the quality of a physician's work is questioned.

PERCEPTIONS OF AUTONOMY IN THE URBAN MEDICAL GROUP

We have suggested that all Urban physicians have some value commitment to autonomy and that in varying degrees they view the Urban Medical Group as constraining. In what ways do physicians perceive the Urban Medical Group as constraining their behavior? How do these perceptions vary among the three types of Urban physicians?

Urban's medical director describes how the physician working in Urban is under some supervision:

> Of course there is supervision as to the hours spent in the group. I mean time spent, relationships with the patients, rapport with the patients, behavior with the patients. This is all the more subject to scrutiny if you're a full-time doctor than if you're a part-time doctor who comes and goes. Then, of course, and this is common to all, his medical performance is under some scrutiny, charts and so forth.

For physicians to be "subject to scrutiny" there must be some visibility of the physician's work. But, physicians' work in Urban in only minimally visible. In fact, physicians engage in little interaction around medical problems. They were asked, "in making medical judgements where you feel the need for consultation and help, what

doctors do you talk to?" Generalists responded to this question by saying, "whatever specialist is necessary." Specialists answered, "If I need a super specialist, I have to use one on the panel." When probed about interaction around medical cases, Urban physicians could not indicate specific physicians consulted. Moreover, when asked to specify "three physicians in the group, in order of preference, who you spend time with most often to just relax or joke," physicians consistently replied "no one."

Although patient charts are accessible to all Urban physicians, they rarely evaluate someone else's chart work, although they will look at a colleague's notation about the medical condition of a patient. The Urban Medical Group has a Patient Care Committee which periodically and randomly checks patient charts. However, the purpose of these reviews is to assess types of utilization more than to evaluate physician performance. What little supervision there is in Urban is essentially based on an attempt by the administration to keep the organization functioning smoothly rather than on any effort to keep watch over the physicians.

The medical director's statement above, asserts that full-time physicians are under more supervision than part-time physicians. But we will see that physicians' <u>perceptions</u> of constraints do not depend on the amount of time they spend in Urban so much as they relate to the physicians commitment to and identification with the Urban Medical Group. As we noted in our discussion of physician types, "patient-oriented" physicians (this type includes full-time and part-time doctors) identify with and are committed to the Urban Medical Group and its patients. "Private practitioners" (these are all part-time doctors) and "isolated individualists" (these are all full-time doctors) do not identify with Urban and have no specific commitment to the Group.

When physicians describe the effect of membership in Urban on their

behavior in general, they do not refer specifically to being under supervision. For example:

> When you're in a group you have to be dependent upon other people and procedures and how things are run. There are times when you may want to do things differently. Sometimes you can correct it, but very often you can't. You are also dependent upon a good number of people and the whole line of command from the time a patient first makes contact with the group right through the time when they see you and they have tests done, etc. There are many different other people that are taking part. Any person along the line can make things difficult as opposed to your own office where you have one or two staff and you train them the way you want.

In this statement, a "patient oriented" physician clearly is talking about his general loss of independence in the Urban Medical Group. "Private practitioners" and "isolated individualists" complain about loss of independence to a greater extent than "patient-oriented" physicians. Indeed, Urban's contract physicians (all five part-time contract physicians fit the "private practitioner" type and the one full-time contract physician is an "isolated individualist") have less autonomy than Urban's 26 partners. One contract physician states:

> I am essentially a practitioner and clinician and I'm an independent worker and I like to feel that I'm not beholden to somebody on a fixed contract and I would not care to be limited in the amount of income that I would like to make: I may limit myself but, I don't want to stick myself in any position. That's why I've never taken an academic full-time job.

While they can informally voice their positions on any issue, contract physicians have no vote in and do not participate on any of Urban's policy making committees. Moreover, they have no job security insofar as they can be dismissed at the end of any contract year. Even if their work is excellent, the group may decide, for example, if patient enrollment declines, that their services are no longer necessary. When a part-time contract physician was asked if he would work as a full-time contract physician, he replied:

> Of course we all have bosses, some are more remotely removed than others. And I hate like hell to be in a position where if

> I didn't please certain people I could actually lose out and start off the termination of my contract or whatever it was.

This physician holds the traditional attitude that the physician as sole entrepreneur is his own man. But such an attitude is not confined to contract physicians. Rather, it is a characteristic belief of "private practice" oriented and "isolated individualist" physicians. These physicians assert that in Urban they are no longer autonomous professionals. They feel they are wroking at jobs in which responsibility is not solely to themselves or the tenets of the profession of medicine. As members of the Urban Medical Group, their work is subject to rules and regulations agreed to by all partners in the group. Some of their work is visible to their colleagues and to ancillary employees of Urban who may have no special allegiance to a particular doctor. One "private practitioner" who is a partner voices what he feels are the consequences of this visibility:

> There is a tremendous loss of privacy for the physician in the center. My objections are directed strenously toward the nurses aides sitting across from you and watching everything you do.

The privacy of the physician is an important component of autonomy. The physician sees his work as visible to those around him and often assumes that the visibility of his medical performance makes him accountable for his activities. The implication of accountability is that autonomy is lost: someone or something can intervene in the physician's work. Such perceptions must be examined in view of the evidence. First, physician visibility to colleagues in Urban is minimal. With limited interaction between physicians around medical problems and the differing hours which physicians are in Urban's medical center, little opportunity is taken by physicians to view their colleagues at work. Moreover, given the strong tendency for all physicians to value autonomy, their own as well as their colleagues',

physicians simply do not make attempts to intrude on the practices of their peers. Illustrative is one "patient-oriented" physician's answer when asked how he would handle a situation where he found a group colleague incompetent. Looking incredulous, he replied, "Incompetent? A member of the group? A doctor? First of all, how can I decide who is competent and who isn't competent as far as another doctor?"

The expressed belief that the ancillary help, especially nurses, invade the privacy of Urban physicians, does have some basis in fact. As an employee of Urban, one of the official functions of the nurse is to report inappropriate physician behavior to Urban's administrator. While the nurses are not expected to report on the technical competence of the physician, they do report information about whether doctors are on time or whether they are nasty to patients. Moreover, the administrator's policy is to rotate the nurses among the physicians. Even if close ties should develop between a physician and a nurse, the system of rotation counteracts the possibility that a particular nurse might give preferential treatment or develop loyalty to a specific physician. In private practice, the nurse "belongs to" the physician and as such reinforces the physician's concept of himself as independent entrepreneur. The absence of "his" nurse in Urban may serve as evidence for the physician that he is not an entrepreneur but working for an organization.

However, the twenty-six partners are not employees of the Urban Medical Group. They are their own employers and hire the administrator. They, not the administrator, have the formal policy-making rights in Urban as well as the ability to dismiss the administrator if they don't approve of the way he is running the organization. In fact, the administrator is fully aware that his power is dependent on the physicians:

> The power of the administrator is like the power of anything else. As long as I bring in the money and they don't feel I'm exploiting them, basically I'm working for them. They're not my employees.

It would seem that while physicians do value their autonomy, they value money as well. By allowing the organization to have some control over them, the organization can function more efficiently, yielding greater financial return. In the next chapter we will explore the role of money as it relates to the autonomy of the physician.

As members of Urban, the physicians must accommodate themselves to the routines of the group. If they functioned as 31 separate individuals, the organization cound not exist. While the 26 physicians who work in one of the group centers* are subject to the established routines of Urban, many attempt in various ways to assert the authority in their physician roles to circumvent the rules. In the same way doctors use the concept of "emergency" in the hospital to circumvent the procedures of the hospital, the physicians in the Urban Medical Group also may subvert the everyday routines of the group. As a"patient-oriented" specialist explains:

> When a group is organized in a way, when people have to go on the waiting list and the person who feels sick doesn't want to wait so long, it is difficult unless the family physician makes out of the situation an emergency to get earlier the proper specialist. When I get a telephone call from any patient that I am in agony and pain, I don't wait, I say come right away. I squeeze the patient in.

In effect, the physician's labelling of an incident as an emergency evokes the technical competence institutionalized in his role. All Urban physicians retain this power implicit in the doctor's role.

*Five physicians, three specialists and two family doctors, see Urban patients only in their private practice offices. All five fit the "private practitioner" physician type.

"Patient-oriented" doctors are more likely to invoke their authority in situations where personal interest toward patients is at issue. In contrast, "private practitioners" and "isolated individualists" tend to invoke this authority in situations where determinations of procedures or referrals are involved. As a "private practitioner" stated:

> I have two people in the hospital now from Urban. It cost Urban money, but I passed by their medical men and got a specialist I wanted.

THE REFERRAL SYSTEM

Urban functions through a referral system in which the patient, after seeing a family doctor or pediatrician, is referred when necessary to an Urban specialist. Besides the nine family doctors and two pediatricians, Urban contains twelve different specialties. Seven of the twelve specialties have at least two physicians represented in Urban and all specialists are board certified or board eligible. The physicians must use only an Urban specialist unless a patient requests a consultation from a second specialist and Urban has only one physician in that specialty. In such cases a specialist from another HIP group is utilized; the physician may not choose any specialist from outside HIP as long as an HIP specialist is available. HIP also provides a list of super-specialists which physicians must choose from when a more involved procedure is required. Thus any consultation referral is available through the organization and there are definite limits imposed as to who shall give these services.

With these formal limits on the Urban physician's referral behavior, the physicians, regardless of type, see Urban's referral system as a constraint on their behavior. Family doctors who are full-time

in Urban and have no private practice nevertheless compare referral in Urban with private practice:

> You're in a group, and you usually join a group with certain personnel, others come in. You may or may not have chosen to work with that kind of doctor voluntarily where I suppose in a private practice you can choose who you are referred to and who you work with.

Another family physician notes:

> To the doctor, I guess its a disadvantage because you must utilize the things within your group. For example, I may feel that there is a cardiologist that I know who treats my patients better than the one I have here or a neurologist. And I would prefer my patients to go there but I must work within the framework of the group.

And another:

> In private practice if one wants to refer a patient to a specialist, one might have in mind a particular man or woman who you think would be the right person to treat this patient with this condition. Whereas in group practice one is limited as to whom one can refer to, although the specialists give competent service. (Emphasis added).

In these comparisons between Urban and private practice, these physicians do not acknowledge what Freidson suggests is a real control imposed through informal memberships in colleague networks of private practice.[4] At the same time they view Urban's formal and visible referral system as a case in point for their claims to loss of autonomy. When the family doctor or pediatrician decides a patient needs to see a specialist he may have some reservations about those physicians available to him in the group. It is not that he believes the specialists are not fully competent; rather, his reservations appear to result from the fact that he is limited in what should be an autonomous choice to use a specialist.

The specialists also feel that Urban's referral system imposes limits on them. But they are usually concerned with referrals to a super-specialist on HIP's consultation list:

> Take for example, that I want a special kind of x-ray taken. And I know a particular radiologist who is very good at a particular type of x-ray. I can send the patient, direct the patient to that radiologist. Whereas here, I'm limited to the panel. Likewise, if the referring physicians here, family doctors, have a case for me, they're forced to refer it to me. They have no choice. Now, I'm thinking that most of the men are preselected so that they are qualified and they can all render a good job in their specialty. But I'm talking about that extra special situation. For example, if I want something that our radiologist may not offer....Recently, I came across a patient and well, let me give you a hypothetical situation. If I had a patient who has a certain problem, now there are many so called super specialists on the HIP panel. If I wanted to refer the patient to one of the super specialists he could probably get reasonably good surgery performed. But in my mind I know there is one man in the city who does that operation particularly well and he's not on the HIP panel and I can't send the patient to him.

In their reactions to Urban's referral system, family doctors and pediatricians note that they are limited but believe that Urban's specialists are competent. The specialists, however, feel more constrained by Urban's referral system. Patients referred by specialists usually require the special expertise of a super specialist. In such cases, specialists prefer to use "the best man" (since all specialists are part-time, this usually means the one they use in their private practice) for the patient's particular problem. Moreover, with their high valuation of autonomy, the specialists believe that only they can judge who is most competent in what they define as a crucial situation.

The situation of referral in Urban places limits on physician choice. However, on rare occasions physicians do refer patients out of the HIP system. In fact, there are no official sanctions for

referring out of HIP but the physicians usually consider the cost to patients for non-group care and, perhaps more significant, the unofficial rule that HIP patients are expected to be cared for by professionals within the system.

All medical practices, those with formal organizations as well as private, have networks of referral. Networks in private practice, while informal, nonetheless impose restrictions on physicians' choices for consultations. Hall[5] and Freidson[6] have discussed those "inner fraternaties" or "colleague networks". As Hall indicates:

> ...the established members of the profession will in the course of time develop a sort of organization which functions to provide order, to ascribe and maintain status, to control the conduct of the members, and to minimize competition and conflict....the working constitution of any established profession is something that has to be discovered. Moreover, it is very likely to deviate significantly from the formal constitution. The latter is likely to present an idealized picture of what the members would like outsiders to believe, and should not be accepted uncritically as a description of the workings of the professional group.[7]

He also states:

> Hence the day to day workings of such organization may be effectively concealed both from those within and without the profession.[8]

The physicians in this study view private practice as an open system with unlimited choice of referral for physicians who engage in private practice. They fail to see the real similarities between the "formal constitution" or organization of group practice and the "working constitution" or organization of private practice. They selectively perceive according to the profession's "idealized picture" of autonomy in private practice and the equally exaggerated absence of autonomy in group practice. To be sure, there is loss of sutonomy in Urban -- and it is formal and visible. But for physicians to believe this is not

the case in private practice (where loss of autonomy is informal and hidden) is the consequence of a self-fulfilling prophecy.

THE DOCTOR-PATIENT RELATIONSHIP

Urban's physicians' beliefs about the organization affecting their behavior extend to the doctor-patient relationship;

> The patients over here (private practice) come to see me specifically. They were referred by someone else, either someone in the family, another physician, they want to see me in particular. Over at HIP, people by and large, unless they're old patients, don't know me from anyone else and they have to take whoever is there. I on the other hand, also have to take the patients in turn. I have no choice in the matter. (Emphasis added.)

The physicians point to the intervention of the organization which they see as setting the conditions for the doctor-patient relationship. But how valid is the physician's interpretation that in private practice referrals through patients or colleagues means the patient is coming to see him "in particular"? Attached to the belief that a patient is coming to see "him in particular" is the notion that the patient believes the particular physician is qualified. At the same time, the physician believes that referral through the organization may render him anonymous to the patient and therefore he will not automatically be seen as a qualified physician.

All things considered, it is the orientation of the physician toward the referring agent, i.e., the organization, that produces the belief that he is anonymous to patients. We have noted that "private practitioners" relate stories of patients they see in their private practices (who don't know of their affiliation with an HIP group) who say, "I went to an HIP doctor, but now I want to see a good doctor." If Urban physicians believe the label of "HIP doctor" implies a questioning of their ability, it is no wonder they believe that Urban

patients see them as less than qualified.

The Urban Medical Group, as part of HIP, has low prestige in the professional reputation system. Indeed, the fact of its low prestige contributes to "private practitioners'" and "isolated individualists'" lack of commitment to the Group. If a more prestigious organization like the Mayo or Leahy clinics were the referring agents, we believe physicians would adopt the perspective of the professional reputation system and "doctors", and would therefore accept referrals in those organizations on the same terms as referrals from the "family, another physician, etc." Thus it is not referral through any organization that produces the physician's feeling of lack of control over patients. Rather, it is referral through an organization with which the physician has no personal identification. Without a sense of "my medical group," "private practitioners" and "isolated individualists" cannot view Urban's patients as belonging to them.

As we previously noted, physicians place a high value on their right to be responsible for the patient and they believe that unless the patient belongs to the physician, they cannot exercise their medical responsibility. One "isolated individualist" who believes it is important for the physician to have control over selection of patients stated:

> To take away from the group all these group of people, neurotic people, people who are not really sick but who want to be sick for many reasons. Some of them, they come to see the doctor because they have nothing to do. They say, 'what am I going to do today? I'm going to see the doctor.' And then, let's talk about anything. You know, to select practice is to be in the situation to put away, very central, to put away these kinds of people that don't need medical attention. In fact, I think that they strain the manpower of medicine. But you can do that only when you are in a

> situation capable to do it. And in a prepaid group, that kind of goal is difficult to achieve.

Implicit in the physician's perception that he cannot control his clientele within the framework of prepaid group practice, is the belief that in private practice he can choose his patients. But Urban physicians have the option to refuse to see a patient and they do exercise this right. We believe, moreover, that when physicians see themselves as working for Urban and caring for Urban's clientele, they are more likely to perceive patients as irrevocably assigned to them.

Not all Urban physicians, however, see themselves as working for the organization and caring for its clients. The "patient oriented" physicians are committed to Urban and work to make the patients their own. Indeed, their patients do come to see them "in particular." The "private practitioners" and "isolated individualists" are not committed to Urban and they complain the most about lack of free choice of patients.

Another way in which Urban is perceived as intervening in the doctor-patient relationship is through its mediation of patients' complaints about doctors. One "private practitioner," for example, grumbled:

> I had a couple of complaints about me. On face, they were ridiculous. But if you looked into them, they were reasonable. But there was no reason, if I had known and they had known, they could take these things directly to me. (Emphasis added.)

These non-direct patient complaints effect physicians' views of their authority in the doctor-patient relationship. The physician can no longer take for granted the traditional expectation of his dominance over a passive patient. Indeed, Urban provides a legitimate channel through which the patient can express his differences with physicians: he can either go to HIP or to the Urban Medical Group to complain

about the physician. The "patient-oriented" Urban physician who sees the patient as belonging to him, more often perceives patient complaints as "patient complaints about him" -- signals of something wrong with the doctor-patient relationship. "Private practitioners" and "isolated individualists" tend to see patient complaints as "patient complaints to the organization" -- evidence for their lack of autonomy in Urban.

It is noteworthy that physicians in general are finding it increasingly difficult to take their dominance for granted in the doctor-patient relationship. Reeder, for example, points to three changes in the structure of medical care which are altering traditional patterns between physician and client: "(1) orientation of medical care away from 'treatment' to 'prevention'; (2) provision of medical services within bureaucratic structures, as distinct from the solo practice of medicine, and the growing sophistication with bureaucracy; and (3) the growth of consumerism as a social movement."[9] Bloom and Wilson[10] additionally note that in the treatment of chronic diseases the greater use of paraprofessionals on the medical team may diminish the physician's authority in the doctor-patient relationship. And Freidson underscores the increased education of the public which makes it "far more likely today than yesterday to participate intelligently in the active evaluation and pursuit of the solutions which professionals offer to their problems."[11]

In these terms, the doctor-patient relationship can no longer be explained by Parsons'[12] model of the patient as a helpless individual in the sick role who seeks help from the dominant physician. Rather, the possibility for the patient to become an agent of control by declaring the doctor deviant to an authority which can sanction the

physicians now exists. Neither can Szasz and Hollender's[13] paradigm of the doctor-patient relationship account for such active behavior on the part of the patient. While their construct provides more than Parsons' passive patient role by indicating the additional possibilities of patient cooperation or even mutual participation with the physician, no expectations of active initiating and contesting patient behavior are included in the paradigm. We believe that once the patient finds legitimate access to behave actively in terms of complaints about the doctor, patient initiated activity will become possible in all parts of the doctor-patient relationship.

The possibility of conflict between doctor and patient is raised by Freidson who suggests a "clash of perspectives" between physician and client. He notes:

> While both professional worker and client are theoretically in accord with the end of their relationship -- solving the client's problems -- the means by which this solution is to be accomplished and the definitions of the problem itself are sources of potential difference. The very nature of professional practice seems to stimulate the patient on occasion to be especially wary and questioning.[14]

When the patient's wariness and questioning develops into a complaint about the physician which is channelled through the organization, the traditional privacy, long the epitome of autonomy in the doctor-patient relationship, may be seen as violated. The physician perceives the organization's intervention as the profession's forbidden entry of a third party into the doctor-patient relationship.

In private practice, patient complaints are most often expressed by simply seeking another physician or by direct complaint to the physician. But when the organization mediates patient complaints, the physician finds them more a matter of concern than he would in private

practice. In the latter, a direct patient complaint can always be attributed to the ignorance or irrationality of the patient. But once a complaint becomes official, i.e., once it is acknowledged by the Urban Medical Group, the possibility that the organization will take it seriously arises. Most of all, it becomes public -- a violation of the physician's privacy. However, depending on a physician's identification with the medical practice situation, concepts of public and private vary. "Patient-oriented" physicians who see the Urban Medical Group as their own medical practice are less likely than "private practitioners" and "isolated individualists" to define acknowledgement of a patient complaint by their own medical group as a violation of their privacy.

What are the consequences for those physicians about whom patients complain? Can these complaints actually effect their tenure in Urban or is it simply a blow to their values of autonomy? Will the partners of the Urban Medical Group use patient complaints as justification to expel a physician from the group? In the next section we will explore these questions and contrast them to physicians' beliefs in their colleagues' rights to autonomy.

THE PARTNERSHIP

The twenty-six partners in the Urban Medical Group are bound together in a legal partnership. It is this agreement which sets forth the complicated procedure for the termination of a partner member of Urban. To terminate a partner is not simply a matter of some number of partners getting together and deciding a member must leave. Rather

> it's a legal procedure. It means hearings with attorneys and so forth. So it isn't something where you call a man and say you're fired, get out. It's nothing like that. It's a long difficult thing, it has to be well documented and so forth.

This is not a procedure the partnership is eager to instigate. Nor is the expulsion of a physician an act which is easy or pleasant to effect. As another physician indicates:

> It would have to be for reason, for cause. And the cause might be any cause. Incompetency, and that would be a very difficult thing. If I worked for the group for ten years, to say I'm incompetent for dereliction of duty -- you've decided you've got a panel of patients and you just go off. A failure to carry out what your normal duties are, to see the patients in the hospital and so on. But there would be cause and you have to document it. If it's medically, if we think you are medically unfit, and you say you're not, there is a mechanism where you pick a physician and we pick a physician and the two physicians then pick a third.

Even when the partnership, after hearings, decides a man must go, there is still legal recourse:

> If you terminate him and he doesn't like it, you can drop him and then he can sue you. We've never had anything like that in all the twenty-five years.

In the medical profession generally, as well as in Urban specifically, physicians tend to be reluctant to impugn or even criticize their fellows. Added to this implicit tenet of the medical profession not to judge one's fellow professionals is an added constraint: the reputation of Urban is believed in jeopardy (and thus the reputations of all Urban physicians) if an Urban physician is thought incompetent. As the physician above stated, in twenty-five years there has been no legal case brought against an Urban physician to remove him from the partnership. But what happens when a partner is thought to be performing under par? As the medical director indicates:

> You sit down with the man and say Joe, you're not doing something the way it should be done and this is why I say that and you discuss it with him. There are letters that come in, complaint letters from patients, and you begin to, it's like where there is smoke there is fire. So if you have a doctor who doesn't have any complaint letters, well something must be good. If you have a doctor who

> gets a complaint letter every day in the week, or every week, then you say something is wrong. Then you sit down with him, and you talk about it.

When a physician who receives a number of complaint letters is sanctioned by having the medical director talk with him about it, we must question the physician's perceptions of limitations from the organization. Even though the physician may view talk as intervention by a third party and as a violation of his autonomy, laymen find it difficult to see this as a strong form of social control. In order to understand the physician's feeling about intervention from the Urban Medical Group, we must look to the values of the medical profession.

When Urban physicians were asked what they would do if they discovered incompetence in another group physician, they conceded there was little, other than talking to the man, that could be done. Some believed that no action could be taken and voiced a feeling of helplessness that this was the situation in Urban:

> It is impossible to do anything. There are several men, in my opinion, who are incompetent and nothing can be done.

Looking at the history of solo fee-for-service practice, one can't help recognizing the medical profession's pattern of non-action toward incompetent colleagues. In Urban, moreover, physicians view the required legal procedure for removal of a partner as complex and almost impossible to effect. Such a view increases the likelihood of inaction.

The Urban physicians do acknowledge that some pressure can be brought to bear on a physician through effecting the amount of money he can earn from the group. Speaking of one of the Group's physicians, a member states:

> He's been spoken to many a time...individual things that he has done has been attempted to be corrected, and maybe he's improving. You know, I'm not up with it currently,

> but there are mechanisms available to force better work out of him because it's possible to take away that economic protection that he has. You see, he's a full-time physician which means by the terms of our contract, he's absolutely guaranteed a certain minimum amount which goes up each year according to the scale. So that he's got economic protection and if we wanted to use that lever we would have to do something about it. We would have to, for instance take him off the full-time program so that his monthly income would be based more or less on his panel size. Now, if his panel decreases because people don't want to use him his income would fall. So, I mean, that would be a possible weapon that could be used in that kind of situation.

But the work of the physician mentioned above has not changed appreciably in over two years and the group has not taken any action other than "talking to" in all that time. Indeed, physicians believe they cannot be the judges of other men's work:

> Well, I haven't found it (incompetence) because I don't go around evaluating other physicians. And this is not up to me to decide if another physician is incompetent because I don't think someone who specializes in a field is in a position to judge a man who specializes in another field.

In general, then, both attitudes and actions taken in Urban tend to follow the traditionally self-protective behavior of the profession. Although the structure of the Urban Medical Group is such that possibilities for quality control exist through, for example, the unit chart system and the potential visibility of physicians, Urban physicians do not take advantage of the structure to keep check on their colleagues. Rather they follow the principle of autonomy -- the physicians remain <u>private</u>, separate practitioners <u>by choice</u> in the Urban Medical Group. They act according to the professional belief that "nothing can be done."

Freidson in <u>Profession of Medicine</u>[15] explains physician's unwillingness to regulate themselves, given the existing structural

possibilities, in terms of the "clinical mentality." Accordingly, the physician bases his actions on the learned norms of personal responsibility and clinical experience. As Becker and his associates[16] found in their study of medical students, these values produce a tendency toward independence and self-reliance. The physician learns to believe in his own actions and take the responsibility for them. As a result:

> The clinician feels that his work is unique and concrete, not really assessable by some set of stable rules or by anyone who does not share with him the same first hand experience. And he emphasizes his own personal responsibility. On both grounds he asserts his autonomy. In addition, perhaps reacting to the extended period of supervised practice he went through in the course of his professional training, he stresses his maturity: 'I'm a big boy now.' he is wont to say. Being supervised is synonymous with being a student. It implies not being trusted with one's responsibility. Indeed, to be granted freedom from supervision is a mark of being trusted, of being autonomous; in short, of being a professional. Being visible when the work itself requires it or where one himself so requests is acceptable, but anything more is uncomfortable, if not demeaning. A professional does not lower himself by snooping into the affairs of colleagues and expects his colleagues to respect the privacy of his affairs.[17]

This statement reflects the views of the physicians we studied. As we have seen, in varying degrees they indicate their high valuation of autonomy through their assertions about the group's usurpation of that taken-for-granted right. But we have also seen that assertions about the group's infringement upon their autonomy were based largely on selective perceptions. "Private practitioners" and "isolated individualists" perceived a greater loss of autonomy in Urban than did the "patient-oriented" physicians. We saw too that controls by a formal organization as the Urban Medical Group are much more visible than controls by informal organization, as in solo fee-for-service practice. Although it is not as often true for "patient-oriented"

physicians, the values inherent in solo private practice are brought to and changed little by work in the prepaid group practice. As a result, physicians consistenly make invidious comparisons between the two forms of health care delivery. These comparisons are based more on the mythology spawned by the profession than on meaningful differences between the two systems.

In the next chapter we will continue to explore how these assumptions effect physicians' attitudes and behaviors. We will examine the physician's perception of his control over two of his fundamental resources, time and money, and we will compare these perceptions to the realities of the situation.

FOOTNOTES

1. Freidson, Eliot, Profession of Medicine (New York: Dodd, Mead & Co., 1970), pp. 45-46

2. Health Insurance Plan of Greater New York, "Contract Between HIP and the Medical Groups," August, 1971, pp. 2-3; p. 8

3. Freidson, p. 366

4. Ibid., pp. 91-93

5. Hall, Oswald, "The Informal Organization of the Medical Profession," Canadian Journal of Economics and Political Science, 12, February 1946, pp. 30-44

6. Freidson, Op. Cit.

7. Hall, p. 32

8. Ibid., pp. 31-32

9. Reeder, Leo G., "The Patient as Consumer: Some Observations on the Changing Professional-Client Relationship," Journal of Health and Social Behavior, 13, 4, December 1972, p. 407

10. Wilson, Robert N. and Samuel W. Bloom, "Patient-Practitioner Relations," in Freeman, Howard E., Sol Levine, Leo G. Reeder, (eds.), The Handbook of Medical Sociology (Englewood Cliffs, New Jersey: Prentice-Hall, 1972), pp. 328-329

11. Freidson, p. 354

12. Parsons, Talcott, The Social System (New York: The Free Press of Glencoe, 1951), Chapter 10

13. Szasz, Thomas S. and Marc H. Hollender, "A Contribution to the Philosophy of Medicine: The Basic Models of the Doctor-Patient Relationship," A.M.A. Archives of Internal Medicine, Vol. 97, May 1956

14. Freidson, Eliot, Patients' Views of Medical Practice (New York: The Russell Sage Foundation, 1961), pp. 175-176

15. Freidson, Profession of Medicine, pp. 158-184

16. Becker, Howard S., Blanche Geer, Everett C. Hughes and Anselm L. Strauss, Boys in White (Chicago: The University of Chicago Press, 1961)

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1. Freidson, Eliot, Profession of Medicine (New York: Dodd, Mead & Co., 1970), pp. 45-46

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17. Freidson, Profession of Medicine, p. 180

Chapter 5

PERCEPTIONS OF TIME AND MONEY

This chapter continues our exploration of physicians' autonomy by focusing on two important resources, time and money. First we ask: How does the Urban Medical Group effect physician time and money. Second, how do our findings compare with physicians' perceptions of the situation?

The Urban physician has a large range of alternatives, limited by organizational requirements, in deciding how he wants to use his time. The full-time physician, for example, is required to spend at least 20 office hours in Urban. All Urban physicians must meet patient demand for services according to informal guidelines. Specifically, patients must be able to receive non-emergency care from a family physician or pediatrician within two days; appointments for Ob-Gyn must be available within three weeks; all other specialties must have time available within one week. As long as these criteria are met, each physician decides how many office hours per week are necessary to fulfill the organization's needs. In addition, Urban physicians are required to put in office hours on specific days or times so that the space in the medical center can be most efficiently utilized and to assure that certain specialties have sessions at convenient times for patients. But these requirements are informal and subject to change within reason at the request of the physician.

Urban physicians may choose to schedule patients as they wish. Thus some physicians schedule patients every ten minutes, while others schedule patients two every five minutes or 20 minutes for each patient. (This does not necessarily reflect the actual time spent with patients.) If a physician wants to spend half an hour with each patient, the organization

might require that he add office hours to satisfy patient demand. Or, if he gives too little time to patients, the organization might intervene.

A similar process is at work in private practice where physicians are constrained by patient demands for service and their own definitions of how much income they need. In private practice, physicians employ, but take-for-granted, informal guidelines which determine how many hours they must work to meet these demands; they are largely unaware, as are people in general, of the social constraints on their everyday behavior.

In Urban's prepaid system, physicians are reimbursed through a capitation method. The Urban physicians as a partnership are contracted by HIP to care for a specified number of patients enrolled by the Plan. The Medical Group is reimbursed per capita for each patient and agrees to provide as many or as few services as the patients require on a yearly basis for the per capita payment. Thus the patient does not pay each time he receives a service from the Urban Medical Group. Rather, one yearly fee is paid assuring the patient all procedures whether he makes use of the services frequently or not at all. Within such a system, each patient visit or each procedure cannot be equated with a specified amount of money. In Urban, therefore, the traditional fee and service equivalent does not apply.

Each partner is paid a percentage, or share of Urban's yearly profit. (Contract physicians are paid either hourly or by the session if they are part-time and on a salary basis if they work full-time.) How much share of the profits each physician receives depends, in general, on his value to the Urban Medical Group based on supply and demand of his specialty in the market place and on the amount of time he will be needed to accommodate patient demand for his services.

Specialist partners enter the partnership with an agreed upon share of the profits. Full-time partners' shares are based on 1000 patients which is a guaranteed minimum. If a full-timer has more than 1000 patients, he gets an additional fee for each patient over 1000. All full-time physicians have more than 1000 patients on their panels. In addition, they can increase their income by seeing private patients in the Urban medical center for which they are reimbursed 50% of the fee (50% goes to the Medical Group for overhead). Most of the full-time physicians see private patients in the office hours set aside for Urban patients.

All physicians' shares are open to negotiation at yearly share reviews. If, for example, patient demand increases and a physician must spend more hours in the medical center, he can ask for an increased share. There is a finance committee which reviews physician claims and decides if a change in shares is warranted. But there is a six to ten month lag between increased hours and greater money. Thus the physician first risks putting in the extra time and gambles that the partnership will increase his share. Moreover, there is some constraint from colleagues to limit time since time costs Urban money and could result in a decrease in overall group profits. This would then devalue each physician's share. In some way then, less time (consequently less expense to Urban) can mean a larger profit to share.

At the time of this study, there were financial difficulties in HIP which made money scarce. As a result, Urban has made cut-backs on ancillary personnel and physicians have incorporated what they perceive as non-physician functions into their activities. (They do this rather than spending the money for personnel and cutting the

profits which they share.) In addition, physicians who leave Urban are not being replaced. This results in greater time requirements for the physicians who do remain. Physicians complain "we have to do more for ourselves" and that "they changed the hours the medical center is open and we had to adjust our schedules."

As a consequence of these cutbacks, physicians are taking on increased responsibilities so that Urban's financial resources will accrue to them, not ancillary staff. In addition, HIP has insisted that groups remain open later in the day to accommodate patients. Thus physician schedules are changing (although time spent is not necessarily increasing). Physicians perceive these changes as placing greater demand on them but they see no concommitant change in their incomes.

Physicians who complain about the inadequacy of their Urban income point to this situation to underscore their claims. It is a visible example of the idea of income in a partnership as dependent on the group's profits. However, separate from the notion of income dependent on profits are the strong assertions by some physicians that work in the prepaid group does not reward them adequately. Before we discuss differences in perceptions of income among physician types, we will examine physicians' actual incomes.

How do Urban physicians' incomes compare with other physicians' incomes? Because income figures for physicians in New York are unavailable, our comparison using the AMA's income data on physicians in metropolitan areas,[1] presents a number of difficulties. First, since AMA figures are based on reported incomes they might be underreported. Second, the available income data refers to metropolitan areas in 1968 but our Urban data refers to New York City in 1972 when

the standard of living was higher. Third, the AMA specialist categories include non-Board eligible or certified practitioners while Urban specialists are all at least Board eligible. Finally, there is a good deal of hidden income in private practice although Urban physicians also have hidden income in benefits such as retirement funds, investment plans, insurance, etc.

The income reported in the AMA figures are based on physicians' net income, i.e., earnings minus professional expenses but before income taxes. AMA statistics on physicians' working hours refer to hours of direct patient care, including office, hospital and home visits.

When we examine the incomes of full-time (average of 21 office hours per week) Urban family physicians, we find a range from $32,000 to $45,000 with a mean of $39,500. The mean income of general practitioners working in metropolitan areas in the U.S. in 1968 was $31,740.[2] This lower figure for general practitioners represents more than twice the number of hours per week that the Urban family physicians spend with patients.[3] The mean $39,500 income of Urban family doctors is also greater than the reported income of practitioners in internal medicine. We find the latter, in metropolitan areas (1968) average $34,286.[4] Urban's pediatricians average $34,000 for 20 hours compared with pediatricians in metropolitan areas (1968) who average $30,267.[5] This too, for more than twice the number of direct patient care hours than the Urban pediatricians.[6] When we examine the income the specialists receive from Urban, we find for an average 15 hours per week for the two surgeons combined, that their combined income is over $44,000. Both the time estimate and the income include 112 operations done in

1972 as well as somewhat over 1000 patient visits in hospitals. For surgeons in metropolitan areas (1968) the income for a greater amount of time was $41,122.[7] In obstetrics-gynecology, we find the income of $38,427 for practitioners in metropolitan areas in 1968.[8] In Urban, one obstetrician-gynecologist who earns more than $23,000 averages four hours a week office hours. During 1973 he had 13 deliveries, 31 operations and made over 300 hospital visits.

Although we cannot draw any definitive conclusions based on these comparisons, we believe there is little income difference between Urban physicians and physicians generally in the same specialty. However, when the physicians state their Urban incomes are inadequate, they do not make comparisons with average incomes of all physicians in the same specialty. Rather, comparing themselves to their specific reference groups, they feel deprived. Relative to their own private practices, for instance, the time "private practitioners" spend with Urban patients appears, in some cases, to be worth less. While we have no specific data on the private practice incomes of the physicians, we did ask some of them about the per cent of their income derived from Urban and for an estimate of how they distribute their time.in all their paid medical activities. On the basis of these reports, we find, for example, one physician estimates that 30% of his income is derived from Urban while he spends one-third of his time with Urban patients. Another physician who estimates that 10% of his income is from Urban spends 25% of his time with Urban patients and a third physician who estimates his Urban time at 10% states that the group provides 15% of his income.

Although there are some differences between the value of time between same specialty physicians in metropolitan areas and the Urban physicians, these differences are minor. Furthermore, the intensity of physician complaints of inadequate remuneration do not seem warranted by the discrepancies. To understand why some physicians believe their remuneration is inadequate, a more detailed analysis of physicians' perceptions of Urban's effect on time and money is required.

TIME AND MONEY: PHYSICIAN PERCEPTIONS

Urban physicians perceive the Urban Medical Group as controlling their time and money. They assert, "they can tell you exactly how much time you can devote," and state that "there are certain clear-cut decisions that are made that a doctor puts in more or less time" and conclude this "obviously effects the way he works." As one "patient-oriented" physician remarked, "I often feel I would like to spend a little more time and often I will, but a lot of times, why I just have to take care of everybody that has to be seen." "Patient-oriented" doctors, in contrast to all others, tend to spend more than the required time with Urban patients: Full-time "patient-oriented" physicians spend more than 20 office hours in the Medical Group and part-time "patient-oriented" physicians (they have their private offices in the Urban medical center) see Urban patients during their private practice hours. These physicians do report, however, that they are very busy and often feel rushed in the medical center.

"Isolated individualists," all of whom are full-time in Urban, spend only the required amount of time in the medical center. They have less patients on their panels than the "patient-oriented" full-time physicians and do not often complain about being rushed.

"Private practitioners" more than indicate control of their time by the Medical Group. They state not only that there is someone watching to see if they arrive and leave on time, but that it is on the Group's authority that they are forced to spend less time with patients than they desire. When a physician has to see "15 or 16 patients... in one hour or two hours ... you are not going to see them well." These physicians contrast Urban to solo fee-for-service practice which they see as a situation of independence. "I can do more or less as I choose." "I don't have to justify myself to anyone but the patient." As one "private practitioner" suggested, group practice is "like being married, it's give and take. You can't always do what you want to do; you have to consider the partners." In private practice, the physician can "spend as much or as little time as I want to" and can "come and go as I please."

While "private practitioners" point to the highly visible constraints on their time in Urban, they fail to take cognizance of the external constraints in private practice which effect their fee structures and the amount of time they spend with patients. For example, physicians who charge very wealthy patients high prices may feel constrained to spend more time with them to please them and justify the fee. Physicians with busy practices may be constrained to spend less time with patients than physicians with smaller caseloads. Moreover, if a physician's patients tend to be poor, he may be forced to see a greater number of patients to earn what he considers an adequate income. Although the physician can determine what income is satisfactory, he does not have complete control over whether or not patients will seek his services and he has little control over

his clientele's ability to pay. Furthermore, if he wishes to attract and keep patients, his fee structure must take external economic conditions into account.

The external constraint of patient demand on physician time is common to all forms of medical practice. David Mechanic, for example, notes in his study of British general practitioners:

> As patient demand grows, the doctor must practice in a more hurried way to get through the daily queue. The doctor, of course, can cope by increasing his surgery hours substantially; but a capitation system of payment provides no incentive for him doing so.[9]

The "private practitioners" in the Urban Medical Group respond to the capitation system in ways similar to the general practitioners Mechanic studied. That is, as patient demand increases they tend to see more patients in the same amount of time. But they blame the organization for the assembly-line treatment rather than acknowledging, that they choose this treatment, and, if they wished, could spend more hours in the group. They rationalize the fact that they don't spend adequate time with patients into the belief that Urban constrains them and they are too busy.

In private practice, the same pressures from patients force physicians to alter either the time they spend with each patient or the hours they spend in their offices. In all cases, the physician makes the choice. But the absence of a fee for each service frequently inhibits the physician from adding more office hours in the Urban Medical Group. He sees the time he spends in the Group as fixed by requirement, not by his own choice.

The "private practitioner" and "patient-oriented" physicians assert that it is difficult to interact with their colleagues in the

Urban medical center. They point to a center staffed with part-time physicians and with physicians required to put in only 20 hours a week. They claim that this creates few occasions when more than a handful of physicians are in the center at any one time. However, "patient-oriented" physicians report that they attempt to contact physicians in person about medical problems. Their complaints about collegial relations reflect their desire for more interaction.

"Private practitioners" feel most constrained to stay on their patient care schedules. If they wish to discuss a case with another Urban physician they most often do so by phone or in writing, not in person. "Private practitioners" state that they must leave on time to vacate their offices for the next physician scheduled for its use and that they have private office hours and hospital commitments which they must meet. As one physician, when asked about spending time with other physicians in Urban to chat or joke, reported:

> Once in a while. I don't have time. I'll tolerate a man for five, ten minutes, but that's all. If I had a few patients I wouldn't mind. But I have to do my work and get out on time.

There is some basis in fact to these physician claims: they are busy when they are in the center and Urban does constrain them to vacate their offices on time. However, the most pressing constraints on "private practitioner" time with patients and colleagues in Urban originates, not from the organization of the Medical Group, but from the physician's greater commitment to private than Urban practice. The "private practitioner" does feel hurried, but that feeling results from his need to get the Urban work done so he can leave and get back to his private practice activity.

"Isolated individualists" do not complain that Urban constrains their collegial relations. Indeed, they rarely interact with Urban colleagues. If a medical matter requires a consultation, they rarely communicate in person with other Urban physicians. Without a private practice, the "isolated individualist" is not constrained to rush out of the medical center. Moreover, with no commitment to Urban, he is less concerned about the lack of collegial consultations than the committed "patient-oriented" physician.

Let us examine this situation more carefully. Focusing on the 26 partners, we must remember that they run the Group. They make the policy and have the power to institute change. These men work in a medical center well furnished with technical equipment, with help from nurses, technicians, a social worker, a nutritionist, receptionists and secretaries. Patients who are members of HIP utilize their services. When physicians define this situation as a busy one, with inadequate time to accomplish everything that should be done (they point out that the quality of care is not effected) and act on this defintion, a culture develops which reflects the hurriedness they perceive. And the culture, through the authority of the physician, becomes institutionalized into a structure which reinforces and supports the norms which develop. What the physicians fail to see is that they form the structure and support the behavior which they label "the organization" and then claim it constrains their behavior.

By defining the structure of the situation as hurried, the tone is set for the organization. Although the "patient-oriented" physicians attempt to spend more time with patients, they often respond to the culture of Urban, created by the "private practitioners" who constitute

the majority of physicians in the medical center. When the "patient-oriented" physicians fall behind their patient schedules, as is often the case, although attentive to patients, they often appear rushed.

"Isolated individualists" share the group norm of keeping on time. They leave the medical center precisely at the time their session ends. Even though they have free time on their patient schedules, "isolated individuals" spend less time with individual patients than the "patient-oriented" physicians. While they treat patients perfunctorily, "isolated individualists" do not act hurried or rushed. We believe that in addition to the fact of their lighter patient loads, "isolated individualists" detach themselves from the Urban Medical Group and do not internalize the group's shared perception of busyness and act on it. For example, when a number of "patient-oriented" physicians were on vacation, "isolated individualists" covering for their colleagues had very full patient schedules. However, no change in their behavior toward patients resulted: They spent the same amount of time with patients and did not act or complain about being rushed.

Keeping on time becomes a norm which is also shared by Urban's ancillary staff. More than simply valuing keeping within physician schedules, ancillary personnel act to assure that the physicians stay on time. One new physician was unhappy with the pressure from the nurses to work quickly:

> I took time to see the patients. I could see they were happy. But the personnel wasn't. The nurses....thought I took too much time with the patient, that I should try to work faster....talk to the people who have been with HIP and they tell you that's the name of the game. You have to do it this way.

When we examine the role of the nurse in Urban we get further insight into how the emphasis on time directs the operation of the organization. The Urban nurse functions as she would in a hospital, as an intermediary between physicians, patients and administration. In relation to the physician, she feels pressure to keep on schedule. She observes the physician rushing into the center and she is the focus of demand to quickly call the next patient. She knows the doctor wants to get out on time:

> Sometimes we have too many patients scheduled with one doctor and it's not their fault but they can't give them all the attention that they want because otherwise you'd have the waiting room packed with people who would want to see the doctor. So sometimes we have that problem and the doctors have to work real fast because <u>they want to catch up</u>. (Emphasis added.)

The hurried tone of Urban is so pervasive that when a physician wants to take more time with patients, nurses continue to maintain a rapid pace. In the case of one "patient-oriented" doctor who tends to spend a great deal of time with patients, one nurse reports, "all the nurses turn his clock ahead so that he thinks he is even later." The nurse who reported this information was observed turning that physician's clock ahead twenty minutes!

Why do nurses continue to function to keep things on schedule even when a particular physician indicates wishes to the contrary? In the previous chapter we underscored the system of nurse rotation which operates to assure nurse allegiance to the group not to the individual physician. In terms of the nurse's relationship with the administration she sees her role as acting to keep the schedule of the organization on time. She is responsible for the physician's vacating his office so there is ample time to set up for the next physician to use the office. But physicians' schedules are such that if they

should finish their sessions an hour late, there is always time to prepare the office for the next physician. In addition, by making nurses responsible for official reports of physician's time of arrival and conclusion of his session (the head nurse, in fact, has primary responsibility for keeping track of the physicians), the nurse's role obligation to the organization is stressed.

In their relationship with patients, nurses believe that patients consider them responsible for long waits to see the physicians. Moreover, and more significantly, when patients are forced to wait for the physician, the nurses are the ones most often complained to by the patients about waiting. Thus the nurses perceive patients as an additional source of pressure to assure that activities are on schedule.

Although the nurse's role set may create conflicting constraints as when she sympathizes with patients or when she resents having to inform the administration about the lateness of a physician she likes, she remains primarily a functionary of the organization. As such, she acts on the organizational value (set by the definitions of physicians) to keep on time. In her relationships with the administration, patients and physicians, she essentially acts as a facilitator. In fact, behavior in each of the three different role relationships is based on the value of keeping on time. So long as she acts to implement this value, her visible behavior to her role partners will indicate she is doing her job of keeping the organization running smoothly.

Other personnel in Urban also recognize the importance of staying on time and incorporate this value into their own activities. Receptionists, whose main function is the scheduling of patients most obviously act to ensure proper scheduling. They see their function in

relation to the time regulated workings of the group: "If you get the appointment wrong, you mess up everybody else. It's like a chain reaction." Another receptionist notes the importance placed by a technician on maintaining the schedule properly: "Like the lab technician, she's very petty with her schedule. If something doesn't go exactly according to it she's gonna get on it." Other personnel similarly observe the value of keeping on time in Urban: They point out, "it's a well oiled machine" and "it runs like a clock." Moreover, "if that clock is turned back a little bit, then you're in trouble."

This description of Urban reflects a strain toward efficiency in the functioning of the organization. It is reminiscent of the automobile assembly line worker in Walker and Guest's study who remarked, "the bad thing about the assembly line is that the line keeps moving. If you have a little trouble with the job, you can't take the time to do it right."[10] Urban physicians similarly feel that their work is controlled by their overburdened schedule. But Urban is not an automobile plant and Urban physicians are not assembly line workers. Since the physicians, in contrast to the auto workers, have authority over organizational rules, they essentially choose to exascerbate the conflict between organizational and professional requirements. We believe this conflict functions to legitimate the detachment of the "private practitioners" and "isolated individualists" from the Urban Medical Group.

In Urban, the relationship between physician time and money reimbursed is complex. Nevertheless, "private practitioners'" perceptions of the time/money relationship are simply that they are not being adequately rewarded based on the amount of time they spend. This is a result of their tendency to use the standard fee-for-service

model to evaluate their compensation for medical services. Although we have noted that the fee-for-service system does constrain physician time and money, the visibility of controls in Urban's capitation system is more vivid. When the physician receives a share of the group's income, the one-to-one relationship which the "private practitioner" expects between financial rewards and time spent with patients is absent.

While the "private practitioner" may increase his income from Urban through negotiation for a greater percentage of the profits, he doesn't see the added amount of money as equal to the extra hours. If he wants to increase his income, he is more likely to add time to his private practice where he believes he gets greater rewards for his time. Indeed, "private practitioners" believe that time spent with Urban patients produces less money than time with their fee-for service patients. As a result, "in HIP there is a tendency to treat patients a little more matter of fact. Not that it's bad medical treatment."

When "private practitioners" apply the fee-for-service model to Urban patients who need hospitalization and/or operative procedures, they especially believe they are not receiving adequate financial rewards.

> It feels like slave labor. You get the same fee whether you operate on 20 patients each month or whether you don't operate at all. And I think that's unfair. Because if you spend that much time separating your practice from HIP, your private practice will suffer. And recognition should be given to doctors who spend maybe 2/3 or 3/4 of his whole professional time working on HIP patients in the hospital.

This physician's belief produces a negative attitude toward Urban. Moreover, as we shall see in the next chapter, physician beliefs of inadequate compensation for treatment of patients often produce

negative attitudes toward patients.

Fee-for-service as a norm of medical practice is the traditional payment mechanism in American medicine. All but one of the "private practitioners" are engaged in private fee-for-service practice which takes up, on the average 75 per cent of their professional time. (One "private practitioner" works in a hospital.) Moreover, over 75 per cent of their incomes are derived from private practice. These physicians joined Urban either early in their careers for extra income when their private practices were getting under way or as a source of new "material" or for the potential for interesting patients. Not one revealed a commitment to prepaid group practice in general as a form of health care delivery or to the Urban Medical Group, specifically. Rather for these physicians, a job mentality perspective is most evident in the way they relate to the organization. There is, however, real interest in Urban as a source of stable income, insurance and retirement pension benefits. Although the researcher was not admitted to physician meetings, physicians report these meetings generally concern business affairs -- primarily involving the financial status of the Urban Medical Group and individual partners.

When so much of the physician's time and money is a result of his private practice activity, most of his concerns are directed to that situation. With greater commitment to his private practice, the physician wants to see himself in full control -- as autonomous in that situation. Then, with his identity as autonomous physician secure in his private practice, the physician can take the position of just doing the job of taking care of HIP patients (not <u>his</u> patients) in the Urban Medical Group.

In contrast to "private practitioners," "isolated individualists" have no private practices and are full-time in Urban. Moreover, "isolated individualists" do not judge their Urban incomes to be inadequate. They came to the Urban Medical Group either from salaried positions or from unsuccessful private practices. Indeed, their current incomes are greater than their compensation before membership in Urban. Nevertheless, "isolated individualists" apply the fee-for-service model in the Urban Medical Group. They, more than any other type of physician, assert that patients abuse their medical services. They emphasize that without fee-for-service, patients

> have the idea that it's their right. (Patients display) a very demanding attitude sometimes, sometimes a quite overt hostility toward the doctor.

Application of the fee-for-service model effects the doctor-patient relationship by forcing comparisons between Urban and private practice patients. "Isolated individualists" imply that Urban patients are more demanding, and unreasonably so, than private practice patients. Furthermore, they interpret this patient behavior as evidence for their own loss of autonomy in Urban.

Full-time "patient-oriented" physicians make comparisons between the income they receive in Urban and fee-for-service incomes. As one full-timer states:

> There are doctors outside who make much more than I do but there are doctors who make as much as I do and probably those who make less. So I cannot say exactly if (Urban) is a financial convenience or not. But again, as I say everything is relative. For me, what I make is enough. And I am satisfied.

Although full-time "patient-oriented" physicians are aware that greater rewards might be possible on the "outside," they suggest that

> You've got to give up something in order to get something else. So here I know we have relatively regular hours; we are not on all day and all night and we have a very good back-up service.

Part-time "patient-oriented" physicians are also generally satisfied with their Urban incomes. As committed members of Urban, they accept their share of the group's profits without "bickering about how to divide the money that comes in." They explain

> You cannot really be fair. The doctor who is not willing to close his eyes and not look at what the other man is getting will always find situations where he will be unhappy.

Although "patient-oriented" physicians compare their incomes to the fee-for-service system, they are the least likely of the three physician types to apply the fee-for-service model to the doctor-patient relationship.

What happens when physicians do apply the fee-for-service model to the doctor-patient relationship in the Urban Medical Group? Do physicians believe that patients expect care as a right in Urban? How does this effect their definitions of Urban? In the next chapter we will explore physicians' definitions of the Urban Medical Group and examine the consequences of these definitions for physician relationships with patients.

FOOTNOTES

1. Reference Data on the Profile of Medical Practice, 1971, Center for Health Services Research and Development, The American Medical Association

2. Ibid., p. 67

3. Ibid., p. 53

4. Ibid., p. 67

5. Ibid.

6. Ibid., p. 53

7. Ibid., pp. 53, 67

8. Ibid., p. 67

9. Mechanic, David, "Patient Behavior and the Organization of Medical Care." Center for Medical Sociology and Health Services Research, University of Wisconsin, No. 1-73

10. Walker, Charles R. and Robert H. Guest, "The Man on the Assembly Line," in Bell, Gerald D., (ed.), Organizations and Human Behavior (Englewood Cliffs, New Jersey: Prentice-Hall, 1967), p. 237

Chapter 6

DEFINING THE URBAN MEDICAL GROUP

We have seen that physicians' perceptions of autonomy vary among the three types of Urban physicians. In this chapter, therefore, we will analyze physicians' varying perceptions as they effect the definition of Urban as a situation of medical practice. First we explore physicians' responses to the physical space and everyday functioning of the Urban Medical Group. Second, physicians' perceptions of Urban patients are examined.

How do Urban physicians view Urban's medical center? One private practitioner suggests:

> The group has a clinic kind of concept. Clinics in New York City are a dirty word. Clinics away from New York City are very acceptable. It's a dirty word because it brings to mind dirty waiting rooms, sitting on benches, bawling kids, people running around being mistreated and maltreated.

Although Urban physicians don't believe HIP patients are mistreated and maltreated, they tend to see the group center as having the physical appearance of a clinic, "a sort of clinic atmosphere." And indeed, the medical center could be viewed as physically resembling a clinic. There is a central reception desk where all appointments are made for all physicians and where patients must check in when they enter the building. There is one large waiting area for laboratory and x-ray tests and four smaller waiting areas, each shared by a number of physicians. All "private practitioners" share their offices while "isolated individualists" and "patient-oriented" physicians have their own offices. The atmosphere is generally cold -- the center is clean but shabby and although there are no "benches," the long line of chairs are worn. But apart from the

large size and number of facilities under one roof, the austerity is not unlike the atmosphere in the private practice offices of some of the Urban physicians. One private office, for example, was large and new but with inadequate seating for patients waiting. Most chairs were straight-backed and uncomfortable and there were few pictures or decorative touches. Another office,old and with a small waiting area was shabby and dark. Neither office had a warm or relaxing atmosphere.

The perception of physical space as clinic-like may be reinforced through the way Urban functions. In fact, the everyday routines in the group resemble a clinic model. Complaining that HIP's concept of the way to practice medicine was formulated by non-practitioners into a clinic plan, one "private practitioner" states:

> The clinic plan -- HIP was dearly pushing no part-time. Doctors shouldn't be in their own (private) offices, they should be here (the group center). That son of a bitch who found that the ideal practice is that the doctor is there, in that thing (the group), the son of a bitch never practiced medicine.

This doctor implies that the solo practice model is the one most valued by practitioners. For him a group center becomes equated with a "clinic plan." Moreover, he suggests that only a non-practitioner would advocate that model of practice. Another "private practitioner" expresses anger toward the HIP plan:

> They don't know how to count, they don't know how to put two and two together. It's 15 minutes for the patient, four patients in an hour. They're absolute imbeciles. This is not piecework: this is not a button sewed on. Sometimes you have to talk to the patient for a very small special matter that you can settle with a prescription. But if you want to help the patient you have to talk to him for half an hour. Half an hour for a patient. What do you do with the next half an hour if instead of two you have three patients? So you can't do this exactly, the idea of this. There is no machine business here.

The image evoked by this physician's statement is of a clinic. Not only are patients hurried in and out as in the clinic concept, but the physician sees the routine as a constraint on his ability to "help the patient." Under these circumstances, the physician feels there is interference in exercising his medical responsibility since decisions about the patient are being made by the organization. However, the allocation of 15 minutes for each patient is not a rule set by HIP. It is a guideline which suggests the minimum amount of time that should be spent with the patient. Physicians are, in fact, not prevented from spending more time with patients. But when a physician expects constraints, he defines the guidelines as a rule imposed upon his behavior. Moreover, by transforming this guideline into a rule, the physician legitimates spending less time with patients.

Urban physicians believe patients view Urban as a clinic:

> So many of my patients feel they are in a clinic, they sit in a line, they have a secretary who really doesn't care. Give them the name; give them an appointment for a week or two weeks or three weeks.

"A secretary who really doesn't care" is not limited to prepaid group practice. Private practice has its share of non-medical staff that do not treat the patient well. But in private practice the physician assumes responsibility for the division of labor: he assumes his secretary cares. In constrast, when the physician sees himself without responsibility and control over the division of labor, he expects that non-medical staff in a "clinic" won't care. These expectations, however, are based on the definition of the situation and are not always founded in reality.

Indeed, perceptions that patients receive poor treatment from receptionists are not altogether accurate. Observations of receptionists'

behavior over a period of months revealed their genuine attempts to be polite and courteous to patients. In fact, many patients appeared to be quite fond of the receptionists and went out of their way to chat with them. There were, however, a number of patients who abused the receptionists and blamed them for the organizational difficulties of waiting for appointments. In this respect, the physicians too see the receptionists as a visible symbol of patient complaints about Urban. When physicians believe they have little or no control over the organization, any negative behavior of non-medical staff is seen as evidence of physicians' lack of autonomy. As such, physician response to that behavior is inclined to be exaggerated.

Physicians also blame "bureaucracy" for problems patients encounter in Urban. One "private practitioner" who sees HIP patients in his private office and will not work in the group center states:

> I don't like the way patients have to make appointments and the treatment they receive relative to nurses and the aides. There is an indifference to the paramedical personnel. There is too much paramedical personnel. They become entrenched in the system which I don't care for or like. I'll give you an example: For the first time last Friday, a patient came in and I had to refer her to a specialist in the group center. She exploded. She said, 'I'll have a hassle with the girl getting an appointment on the telephone.' This shouldn't be called the 'Health Insurance Plan' it should be called the 'Hassle Insurance Plan.'

The more physicians compare Urban to private practice, the more likely they are to underscore the differences for patients. We must underscore, however, the significant finding that when the (17 of the 22) private offices of these physicians were contacted either on the phone or with a personal visit, <u>little or no difference</u> was found with the Urban practice in regard to either the wait to get an appointment or the amount of time the patient with an appointment must wait

in the office to see the physician. On the average, it takes two to four weeks to get an appointment in the private practices of the Urban physicians. In the Urban Medical Group, the average wait for an appointment is two to three weeks. Waiting time in the private offices of these physicians average three-quarters to one hour. In Urban, the patient waits an average of one hour to see the doctor. The real differences are in perception and related to the greater number of people visible in Urban who are waiting for many doctors in one area, as well as the impersonality of dealing with an organization (in which the physician sees himself without complete control) rather than a solo practice (where it is believed that physicians are autonomous and responsible). One "patient-oriented" physician explains what he sees as the patient's point of view:

> The whole matter of making appointments or getting referred to a specialist. You know, all these various details. Or what happens when an appointment is not kept, how do you get back again? I think it may be a little more difficult in this kind of situation than in a small private office where one person receptionist has all the reins in her hand and can smooth things out. Here you have to deal either with the nurse or receptionist or the doctor or the laboratory technician. So I think a lot of patients get the feeling that it's a heck of a hassle dealing with a medical group.

The hassles patients encounter are to some extent real. There are, for example, more people for the patient to deal with in Urban than in physicians' private practices. Nevertheless, physicians tend to exaggerate the complexity of the system. "Private practitioners" and "isolated individualists" perceive a screen of red tape blocking the patient's access and preventing the patient from "belonging to" the physician. When the patient does make contact with the physician, "private practitioners" and "isolated individualists" still see Urban

intervening in the amount of time they can spend with patients. Thus they define Urban as a situation of practice which prevents the establishment of a good doctor-patient relationship. Moreover, they act according to this definition and do not attempt to show personal interest toward patients.

"Patient-oriented" physicians, in contrast, don't like the system because of the problems patients encounter which make it more difficult for the physician to establish a good doctor-patient relationship. These physicians perceive Urban as a situation of medical practice which limits the possibilities for a good doctor-patient relationship. But "patient-oriented" physicians not only believe that such a relationship is possible, they also work hard to achieve it. Thus through their behavior they deny the definition of Urban as a clinic and create a situation which they define as their medical group practice.

The "private practitioner's" and "isolated individualist's" belief that they have no control over the time they can spend with patients is reinforced by the definition of the situation as a clinic where care is expected to be perfunctory. As one "private practitioner" describes it:

> Well of course there is this clinic business. The doctor looked at me in a minute and he got me out and he says I need something and he sent me. One of the big problems is that so many doctors are like paramedical people. 'Oh, you have something wrong with your skin, I'll send you to a skin doctor; you have a pain in your belly, I'll send you to the surgeon; you have an itch, I'll send you to the gynecologist; you have a backache, oh, that's the orthopedist.' So many of the HIP doctors do that and so many of the patients complain 'he never looked at me. He just asked me what's wrong and he said I know where you should go.'

This description by a "private practitioner" specialist is illustrative of the general feeling among "private practitioner" specialists

that Urban family doctors ("patient-oriented" and "isolated individualists") are lazy and inappropriately refer patients. Indeed, the family doctor in Urban has nothing to lose by referring to specialists while in private practice, the general practitioner is always in danger of losing patients to specialists. In Urban, "private practitioner" specialists attribute the "ownership" of patients not only to the organization, but to a possible large number of physicians, none of whom take full responsibility for the patient. But neither under- or over-referrals are desirable physician behaviors. In any case, "private practitioner" specialists' perceptions of family physicians are not solely a function of actual referral behavior in the group. In private practice, specialists often feel superior to general practitioners; but the Urban specialists attribute the family physician's behavior to the nature of the system, not to the fact they are general practitioners. Clute[1] found in his study of general practitioners, a definite antipathy between specialists and GPs:

> In addition to the physicians who suggested that the superior quality of the specialists' work was a reason for the general practitioners' lack of prestige with them, another 18 per cent of the Ontario sample said that the specialists thought that they knew more than the general practitioners. Some men felt that it was 'just human nature' for a specialist to feel superior, especially in view of the greater length of his training. One physician said that the specialists thought general practitioners too lazy or too stupid to specialize and added, 'Maybe they're right.'[2]

When "private practitioner" specialists identify specific family doctors as lazy they never identify the two part-time ("private practitioner") family doctors in Urban. Rather, only the full-time family doctors are mentioned. Moreover, these specialists make no distinctions between the full-time "patient-oriented" family doctors

who treat patients thoroughly before referring to specialists and the full-time "isolated individualist" family doctors whose referral behavior does fit specialists' descriptions. Indeed, "private practitioner" specialists attribute laziness to family physicians not because of their lack of specialty or their actual referral behavior, but because of the family doctor's choice to be full-time in Urban. Full-time to these specialists implies the willingness of the physician to work at a job ("private practitioners" in fact see their own work in Urban as a job!) and relinquish autonomy to the group. They do not attribute negative qualities to the personalities of the full-time men so much as they view their behavior as a consequence of full-time Urban membership, implying that family physicians in private practice behave otherwise. But, as Clute suggests, this may not be the case. The two "patient-oriented" specialists do not categorize all full-time family doctors as lazy or assert that they over refer patients. "Patient-oriented" specialists point specifically to the "isolated individualists", the only full-time physicians whose referral behavior, in fact, could be characterized as lazy.

Although the "private practitioners" do not view their own behavior as exhibiting a job mentality - a detachment from their work in Urban - they do in fact exhibit that attitude toward their work. They note minor differences in their treatment of Urban and private patients but regard the quality of care they give in the group as high (often implying some doubt to the quality of care rendered by family physicians). They suggest that Urban patients receive better care in the group -- "technically good care" -- than they've ever gotten before. While they admit that there is not enough time to

show personal interest in patients, they defend the care they provide and state that "these patients" never had such good care:

> This kind of care is good care without personal attention. You can't possibly see all these people in the period of time allowed. For most, however, it's the best care they've ever had.

One "private practitioner" states his view of work in Urban:

> I think there is a need for this type of care, just like there is a need for people who work in city hospitals to give private care with dignity to people who cannot afford to come and pay standard fees. There is a need to give this. It's an obligation I think we have as physicians to give.

For "private practitioners," work in Urban is seen as most acceptable as an expression of the value of the profession's service orientation. Significantly, the definition of the situation of practice in terms of the value of service is one basis for perceptions of Urban as a clinic and of patients as recipients of free medical care. By invoking the service value, work in Urban becomes defined as the physician's obligation to give service to the community. In contrast, service, as it is conceived in reference to private practice, refers to the physician's dedication to help his individual patients get well. Moreover, service in the prepaid group is viewed as a duty -- an obligation to provide care for patients who can't afford care from the fee-for-service system. The use of this definition of service in the group serves to legitimate the physician's membership by emphasizing an acceptable professional value of medical activity. As we will see, many of the patients can afford fee-for-service care, but "private practitioners'" perceptions of patients are selective and mesh with the rationale for their own membership (obligation) in Urban rather than with the realities of the situation. So too does the emphasis on

"obligation" as a rationale for Urban membership effect "private practitioner" definitions of the group as clinic like. Moreover, these definitions are taken-for-granted. One physician, commenting about his work in the group states:

> I like clinic work, I really do. I've always worked in clinics, and I worked in them for years in which I never got paid. And it wasn't the fact that I learned anything.

In this statement the "private practitioner" was not talking only about a clinic, he was describing Urban which, in fact, is not a clinic. He made it clear that he wasn't paid for clinic work nor was he there for clinical experience: he didn't "learn anything." For "private practitioners," clinic work is engaged in as a way of fulfilling the service obligation. Urban is seen in the same context:

> I felt that when I do charity work in the hospital and I don't get anything for it, in money, only the reward of my professional activity, I can afford to do for a little money, the same thing for other people.

The attitude of the "private practitioner" toward Urban may be described as "noblesse oblige." His medical activity is based on his sense of charity since he does not get a fee for each service and considers his financial rewards inadequate. In Urban, a situation perceived as lacking autonomy, "private practitioners" say they perform with technical competence but without showing personal interest in the patient. Thus they acknowledge that their role performance in Urban is incomplete. Indeed, it may be that they consequently expect their reward to be incomplete or inadequate. Moreover, they define this incomplete medical performance in Urban in contrast to their private practice role as delivering clinic-like medical care. Definitions of Urban as clinic-like reinforce expectations of inadequate payment.

Physicians, in fact, still believe that clinics in hospitals are places where doctors "give" time. (Most clinics today reimburse physicians on a fee-for-service basis through Medicaid. Thus in clinics physicians are now seeing rewards for each service they perform. This makes the lack of fee-for-service in Urban seem more inadequate.)

Without fee-for-service, Urban resembles, at least on the surface, the old clinic model. But as we noted in our discussion of Urban physicians' incomes in Chapter 5, compared to same specialty physicians generally and to their own private practice incomes, Urban physician compensation is not different (and in some cases may be greater than in private practice). The "private practitioners'" inaccurate perceptions of their financial rewards from Urban as being well below what they would receive in fee-for-service medicine, may be based on their rationale that work in Urban is an obligation and consequently must be poorly rewarded. The fact is that "private practitioners" do define the Urban Medical Group as clinic or charity medicine although it is actually a partnership of physicians, part of the private sector of medicine in which patients pay for receiving care and physicians are reimbursed for providing care.

PATIENTS AS RECIPIENTS OF FREE MEDICAL CARE

"Private practitioners" and "isolated individualists" see Urban as providing free medical care to patients. They point to unions and city government as the sources of their (the physicians') capitation payments or salaries (when they acknowledge outside sources) and maintain that patients sacrifice nothing to receive care. But is this perception accurate? While patients who subscribe through the city government do not pay out of pocket expenses for basic coverage, the amount of the

premium is part of their benefit package, and in effect, they get these benefits in lieu of additional salary. Moreover, for more than basic coverage and/or to cover family members, city employees must pay out of pocket expenses to subscribe. But not all employers provide full coverage for their employees who choose HIP. Some HIP subscribers pay over $325 per year for family coverage. Except for Medicaid and Medicare patients, there is always cost, either direct or indirect, to all patient members of the health plan. (While prepaid medical care can cost less on a yearly basis than using fee-for-service medicine, this is not the case for all prepaid patients. Fees for prepaid medical care are higher than costs for fee-for-service insurance. Thus depending on the amount of utilization, the cost of prepaid premiums may be more per year for any given patient than the cost of fee-for-service insurance plus fees.)

Nevertheless, "private practitioners" and "isolated individualists" believe that patients are receiving free care and that services not paid for are not valued. And these physicians are angry:

> In my estimation, the very idea that you go to a free doctor, you know because the patient doesn't pay for it; in many cases the union pays for it, the city pays, and this pays and that pays. So if the patient wants to get good service then he goes to a real doctor. It is so, this attitude in the HIP patient. It's free, therefore it's worth nothing. If I really need a doctor I'll go to a real doctor, not to a HIP doctor. HIP doctors are just HIP doctors, they are not doctors. They're just HIP doctors, you understand?

When physicians believe patients don't value their services they feel personally undervalued. They see the fee-for-service system as promoting the physician's worth since the fee is considered an acknowledgement of the physician's good service. But the capitation system promotes, as far as they are concerned, a lack of patient appreciation

for care rendered:

> You know, like something that's given out to you, that's handed out to you; you don't appreciate it that much. Eventually you might even scoff at the giver; you might even have some kind of contemptuous attitude.

Seeing no direct exchange of fee-for-service, "private practitioners" and "isolated individualists" tend to view the provision of care to patients as a requirement which they must meet because patients have a contractual right to that care. Consequently they often describe patients as demanding and "acting as if they were entitled to service." (sic) This grates on the physician's attitude of "noblesse oblige":

> When I can assure the patient there is no emergency and he can be seen the following day and in the meantime he can get the treatment, the patient will still suspect the physician is not doing the most. For the doctor, it's a strain. It's more time spent for the physician to explain to the patient that he is giving full attention. The patient thinks that the physician is not doing the most for him....So this is a problem we have to deal with. Because it's a fact that in prepaid medicine patients expect more and at a faster rate. They can't wait because it's something they paid for. So they make their own decision and they don't want to wait when it's not an emergency.

PATIENT DEMANDS

The physicians who see patients as so demanding are essentially complaining that they are being seen as "HIP doctors." In this respect, we find that physicians who are oriented to patients for their sense of professional identity do not view patients as unreasonably demanding. But "private practitioners" and "isolated individualists" do see patients as demanding and suggest that these demands are independent of and sometimes contradictory to what the physician believes the patient needs. Moreover, they compare Urban patients to private patients, (whether or not they have private practices) and assert that HIP patients

use services more often and for minor complaints:

> When a person is freed of the fee-for-service constraint you will find the visits tend to be less, I don't know exactly, I don't want to use the word important or trivial, but I found it very definite that HIP patients tend to come in more often with minor respiratory and minor aches and pains.

Similarly, Ann Cartwright, in her study of British general practitioners suggests, that "some general practitioners -- and some patients -- feel the formal definition of patients' rights under the National Health Service has detracted from their prestige in the community. The impression that patients 'demand their rights' was strongly associated with the idea that a high proportion of consultations were trivial."[3]

Although we have no substantial evidence, we believe physicians respond differentially to similar behaviors of prepaid and private patients. "Private practitioners" and "isolated individualists" believe, for example, that prepaid patients present trivial complaints and over-utilize services. In fact, patient utilization rates in the group (4.1 in 1972) are lower than for any other HIP group and the national average of 5 visits per year. Physicians attribute over-utilization and trivial complaints to the capitation system in which patients "are not paying for each service so they're going to use it."

The belief that such patient behavior is inevitable in the prepaid system creates frustration which increases the physician's detachment from his medical work. That trivial complaints are inevitable in this system may be the case, not as a direct consequence of patients' taking advantage of "free" visits but as a result of the way physicians are constrained by the organization to define those complaints. That is, time, which is needed by physicians to treat properly what might appear

to be trivial, is a scarce resource in the Medical Group. David Mechanic, in his study of British general practitioners finds a similar relationship between time and the physician's perception of complaints as trivial. He suggests "that British general practitioners define patients as trivial because the nature of their practice induced them to treat patient complaints as if they are trivial."[4] Specifically, he adds, "We suspect that attributions of triviality reflect the reactions of a technically inclined physician burdened by a heavy patient load and with few incentives to be responsive to the psychological and social concerns that are associated with many patient consultations."[5]

While Mechanic finds the British general practitioners are frustrated, he makes no mention of any outright physician hostility toward patients. In Urban, the less physicians are committed to the group, the more likely they are to see patients as abusing their services and to become hostile as a result. One reason these physicians think that patients present trivial complaints is because they believe that patients don't think they are good physicians and won't use their services when they have more serious complaints:

> Some will go and say, 'yes, I went to my HIP doctor and he says I need an operation. So I better go to somebody Mrs. Jones knows who only charges $1000.'

"Private practitioners" and "isolated individualists" also become hostile when they feel patients take advantage of their time. Moreover, they feel abused because they have to give in to the patient's "rights". As an "isolated indivdualist" remarks:

> The patient in private practice goes to the doctor when he really feels he must go to the doctor. And that's another reason why you find more pathology in a private practice than in an HIP practice. Because any patient that needs to pay $10 to go to see a private doctor,

> they think I must go to see the doctor because there is something that bothers me and I want to know what's wrong with me. And an HIP patient, just by the fact that they have a beautiful kind of puppet, they can go in to ask anything and they're not going to pay anything.

This physician's feeling that he is a puppet is a result of his seeing the patient as having the right to "ask anything" and that he, the physician, is obligated to the organization to meet the patient's demands. He doesn't even have a fee as leverage for control in the doctor-patient relationship. But what does the patient ask to make the physician feel he is a puppet?

This physician sees patients acting, not only as if they were entitled to services in general, but as if they knew what kind of services were required. This is seen as a direct encroachment on the physician's monopoly over technical competence: the patient is instructing the physician about what procedures are necessary. A Medical Group physician who feels his time is constrained so he cannot give personal interest to patients, needs to feel that his technical competence is recognized and appreciated. This is crucial for his identity as a physician. When he feels this competence is questioned by patients who tell him what to do in a situation where he believes the patient, through contractual agreement, has the right to make such demands, he is left feeling totally without autonomy. Another "isolated individualist" angrily notes:

> When you are dealing with group patients, you will see that patients come to the group if they have any complaints whatsoever. And they would want you to request many examinations that you don't feel are necessary. They feel like you owe all the things to them. If you don't do it they don't seem to be very happy. Each time you see a patient you have to explain to them, your child is in good condition, good shape, it's not necessary to have an x-ray. But they would insist. They know they are not going to pay for it.

This physician is caught in the bind of trying to exert his technical competence and at the same time accede to patient demands. In private practice, to be sure, not all patients are pleased with care received and those may go elsewhere or complain. No matter how the physician behaves in terms of patient demands, those demands exist in all forms of health care delivery. However, in most cases, patient demands are not seen as a function of a contractual agreement. There are many physicians who are committed to input from patients and see the doctor-patient relationship as a joint negotiation in the struggle toward health. Some physicians choose to give in to patient wishes completely, thus the vitamin B-12 shots and the amphetamine abuse, while others almost never lend credence to the patient's point of view.

The "private practitioner's" and "isolated individualist's" refusal to take part in negotiating demands with the patient by assuming he is obligated to meet those demands because of a contract, is a continuation of behavior in a pattern based on his perception of the group as constraining. When the physician expects he must give his authority to the Urban Medical Group and does, he diminishes his authority in the doctor-patient relationship. But the Medical Group's contract to provide medical services does not stipulate that patients may decide what they need. Rather, it is stated that medical services

> shall be made available and shall be provided at such times and at such places as deemed necessary and practicable by the GROUP, and shall be in accordance with accepted medical and surgical practices and standards prevailing at the time of treatment in the area of the HIP service coverage and in conformity with the professional and scientific standards adapted by the HIP Medical Control Board.[6]

The contract upholds the physician's right as technically competent professional to determine necessary services. It is a group responsibility and therefore the physician's -- not the patient's or the organization's decision. For a physician to accede to patient demands when he personally doesn't believe he is doing the right thing technically is to continue to give his medical responsibility to Urban and fail to see himself as autonomous. Indeed, physicians who maintain their autonomy as members of the Medical Group behave quite differently toward demanding patients:

> I've had HIP patients walk in to me and say, 'I need some vitamins, doctor.' I say, 'You don't need any vitamins.' 'Well, what do you mean, I'm paying.' 'Find somebody else.' Oh yes, because they're prepaid they think they can walk in here and get notes to stay out of work for two weeks and all kinds of other nonsense. I don't practice that kind of medicine. As I said, nobody tells me what to do....And I must say that prepaid patients do have a tendency to make a phone call, 'make a house call on me.' For what? 101^{o} temperature is no big emergency. I'm not going out for that....They say, 'well, you're being paid.' I say you're paying nothing man.... I have a list in my mind of 5, 6 medical emergencies for which I make house calls. I ain't going home to see somebody with 103^{o} temperature, that's no big deal to me.

This "private practitioner" sees himself, regardless of the situation of practice, as the sole arbitor of what the patient needs. Although he does not give in to patient demands, he nevertheless feels angry at patients who make them. Indeed, whether or not Urban "private practitioners" and "isolated individualists" accept the patient's demands they see these demands as aggressive and tend to be outraged at such patient behavior. These physicians see demands in the Urban Medical Group as a function of patient rights (whether or not they give in to those rights). At the same time, they attribute patient

demands in private practice to the personality of the individual patient. Indeed, the quality and quantity of Urban patients' demands are exaggerated. Moreover, "private practitioners" and "isolated individualists" are angry because they see patient demands as evidence for their being devalued: patients don't believe they know what should be done.

These physicians become equally hostile toward patient complaints they see as minor. Although in this case the physician doesn't feel the patient is taking over his technical competence, instead, he feels frustrated in his attempts to use that expertise. As a result minor complaints are often defined as false:

> I wouldn't say I've been too happy with HIP employment. Fifty to sixty per cent of the patients come just for notes so they can get time off their jobs. The system is clogged too much with false complaints. One man who works for the Post Office comes here every year with a complaint I can't validate, like diarrhea or a backache. In private practice, the really sick come. (Emphasis added)

The belief that prepaid group practice attracts patients who aren't really sick -- "crocks" -- while in private practice "the really sick come," is not substantiated in the literature. A number of studies suggest that private patients are often seen as "crocks". Paul Barabee, for example, found that physicians in one hospital responded negatively to patients they believed were not sick. He suggested that these patients endanger the physician's self-concept.[7] Renee Fox points out that fourth year medical students working in a Comprehensive Care Program "frequently apply the epithet 'crock' to 'patients who don't have any organic lesion' or whose behavior appears to be 'psychoneurotic.'" As one student in her study pointed out, "The central feature in all these patients we call 'crocks' is that they threaten our ability as doctors.'"[8]

Becker et al also found that medical students reacted negatively to patients they labeled as "crocks." Becker explains this response in terms of the value of medical responsibility in the culture of medicine. When the physician is frustrated in using his skills to cure a patient "the physician lacks some of the essence of physicianhood."[9] Becker adds that physicians believe that "those patients who can be cured are better than those who cannot. Furthermore, those patients who cannot be cured because they are not sick in the first place are worst of all."[10]

The experiences in these hospital settings with patients who physicians see as "not sick" suggest that prepaid group practice may not be responsible for attracting "crocks" and that physicians find them in all forms of health care delivery. Indeed, Mumford, in a study of a University Hospital notes that "House-staff members at University Hospital throughout the year tended to express annoyance over seeing 'too many' patients who were 'hypochondriac,' 'paranoid,' with 'psychogenic symptoms.'"[11]

In all practice situations, physicians' perceptions of patients as "crocks" seem to create frustrations and raise questions about the abilities of physicans. But in the prepaid group, the "private practitioner" and "isolated individualist" may become angrier and may be more frustrated with the "crock" because they see the system as attracting these patients. And these physicians are already frustrated with the system which they see as constraining their use of medical responsibility. The "crock" is an explicit instance where the physician finds it difficult to exercise that responsibility. In general uncertain about the patient's acceptance of his abilities, these Urban physicians are further threatened in their sense of physicianhood

by the non-sick patient who exacerbates his feeling of insecurity and endangers his self-esteem. Thus to perceive the "crock" as a function of the organization allows the physician to retain his self-confidence: It is not that he can't make the patient well, but that the system attracts patients who aren't sick.

Patient demands are common in all forms of health care delivery. But the "private practitioners" and "isolated individualists" tend to exaggerate demands because they see them as a function of a system which they define as giving free care to patients who have the right to determine what they want. But we have shown that the utilization rate in Urban is not higher than the average rate in the country and that minor complaints and "crocks" are common in all forms of practice. It is the definition of the Medical Group as constraining their time and their medical responsibility through which these physicians filter their perceptions of patient presenting complaints and respond with hostility to symptoms they see as trivial or patients they define as not sick. But "patient-oriented" physicians who take responsibility for patients and develop good relationships with them are less likely to see patients as "crocks" or to blame the organization for these patients. For example, one "patient-oriented" physician discussed how patients expected him to behave:

> The first thing they expect from me is to try to be a friend of theirs, and to understand them. And I think they expect you to give them some relief of their problems; they expect me to be accessible and available, either to see them or talk to them on the phone. This becomes obvious when they come back in or call you that they want to see you, sometimes just to chat to say 'I'm all right.' They expect a person that they can go to to tell their troubles, and a lot of them know that some of the things they have are, they're going to have to learn to live with. They want some ease and some comfort but mostly they want somebody who is going to

> listen to them and try the best they can. And I think this is really all that they expect of me, that they think that I try to do the best that I can.

This physician, referring to the psycho-social nature of patients' complaints, views such problems as legitimate and does not label patients as "crocks." He takes responsibility for his patients and does "the best that I can." As has been observed, this physician and his patient oriented colleagues, establish doctor-patient relationships where they negotiate jointly with patients to reach the goal of health.

PATIENT COMPLIANCE

Even though non-compliance with physicians' orders is common to all forms of practice, "private practitioners" and "isolated individualists" who see the "system" as responsible for patient demands also blame the system for patients' non-compliance:

> I think private patients, they're paying so I think they want to get more out of it. I think HIP patients tend to figure, well it doesn't cost anything, although it obviously does cost. If it doesn't cost anything they take it more lightly. We have a big problem with missed appointments and people not showing and not doing what you tell them to and not coming when they're supposed to and so on.

These physicians largely believe that patients won't take them seriously when they "don't pay for services." Thus they assume the capitation system explains non-compliance with physicians' orders. Another explanation for patients' non-compliance assumes a particular type of patient is attracted to prepaid group practice. As a "private practitioner" notes:

> If you're a poor paying patient you may have to sit and wait but it's the poor paying patient that tends to get into this comprehensive system.

Even though "private practitioners" and "isolated individualists" generally speak about their Urban clientele as poor, in the same breath

they note that school teachers are the most demanding patients. In fact, the patient population of the Medical Group appears to be largely a mix of lower-middle and middle class patients. Unfortunately, the data available does not provide any precise indication of patients' social class backgrounds. However, in a ten per cent sample of the Urban's patients in June 1973, it was found that 64.1% were enrolled through group contracts. Of these, 42.1% were employed by New York City, 4.4% by the Federal and State governments, 11% through trade unions and 6.6% "all others." In addition, 3.5% were no longer affiliated with contract groups and paid the entire premium themselves. The remaining 32.4% of patients in the sample were enrolled through Medicaid.[12] While it might appear that this one-third of Urban's population would skew the physicians' perceptions toward seeing patients as poor, it must be noted that the great majority of Medicaid patients are seen in Urban's subcenter where the majority of physicians do not work. Moreover, there are few differences between physicians who work in the two centers as far as their perceptions of patients as poor, and two "patient-oriented" physicians who work in the subcenter do not generalize about the social class of their patients. The ten per cent sample seems to indicate, at least, that the majority of patients seen in Urban's primary center are employed.

Moreover, observations of patients in the primary center did not suggest a poverty group. Patients were black, white and Puerto Rican and tended to be well or presentably dressed and knowledgeable about their medical problems. Patients in the subcenter were mostly black and Puerto Rican, less well dressed and less articulate. In no way, however, did observations suggest that the poverty label fit the

majority of Urban's patient population. Perceiving patients as poor, however, is consistent with the view of "private practitioners" and "isolated individualists" that Urban provides free or inexpensive medical care. The patient is seen not only as poor but as uneducated and without intelligence to follow doctor's orders. As one "isolated individualist" who works in the primary medical center remarks:

> In this particular population they don't seem to have too much understanding of what the doctor is able to do for the patient in terms of health care. Secondly, there seems to be quite a number of them who don't do what the doctor advises them to do. They seem to be rather casual about their health problems, they tend to neglect their health. They don't take advice from the doctor. The doctor prescribes medicine and they don't take it. Or they take it irregularly. The patient runs out of his anti-diabetic or anti-hypertension medication when it's been explained to them that this is something that they have to take indefinitely. They let three or four weeks elapse before they think of coming back for more medicine.

To attribute non-compliance with physician's orders to the "poor" and "uneducated" patients that get into the system, denies the very real problem of non-compliance which is frequent in all forms of health care delivery. Davis, for example, reports "A review of the literature demonstrates a range of from 15 to 93 per cent of patients reportedly non-compliant."[13] Davis in fact found in one study of complaint behavior:

> no significant relationship between compliance and any of the demographic characteristics investigated. This finding is, nevertheless, noteworthy. No variations in patient compliance can be attributed to demographic characteristics peculiar to the patient, i.e., age, sex, marital status, religion, education, or occupation. This supports the contention that dimensions in the doctor-patient relationship are more fruitful avenues for explaining variations in patient compliance.[14]

As in the Davis study, we believe the source of non-compliant patient behavior in Urban is to be found in the doctor-patient relationship. Indeed, when we asked the physician who made the above statement about non-compliant patients if there was anything he could do about this situation, he replied in the negative. When physicians see non-compliance as a result of patient characteristics or a function of organizational constraints, they are denying their own role in the problem and the prevalence of non-compliant patients in all forms of health care delivery. Thus they do not act to remedy the difficulties. Here we get to the crux of the situation: communication. The "private practitioners" and "isolated individualists" describe their patients as non-communicative. At the same time they bemoan the lack of time they have to show personal interest in the patient, thus seeing their own failure to communicate as a function of time. But communication is not necessarily related to time. In a study of 800 clinic visits of mothers with children Korsch and Negrete found

> no significant correlation between the length of the session and (1) the patient's satisfaction or (2) the clarity of the diagnosis of the child's illness. Indeed, on examining some of the longest sessions we noted that the time was consumed largely by failures in communication; the doctor and patient were spending the time trying to get on the same wave length![15]

Korsch and Negrete also discovered that patients complied with physician advice when they were satisfied with the doctor-patient interaction. At the core of patient satisfaction, then, was the <u>quality</u> of the communication. Thus "a demonstration of warm concern and individualization of his advice achieved satisfying results."[16]

"Private practitioners" and "isolated individualists" do not describe their communications with patients as satisfactory and they

believe patients feel likewise. As we noted, they point to their harried schedules as the cause of their inability to give the patient personal interest. Peterson et al in their study of North Carolina general practitioners state, however, that

> Press of time is a complaint frequently voiced by the general practitioner. Time alone is not the sole determinant of the quality of care rendered in a practice. Some of the very best doctors had hurried practices, while others had smaller practices which could be conducted in a much more leisurely fashion. The same applies to some of the less adept physicians; so that size of practice and press of time do not correlate well with the quality of care rendered.[17]

And Clute in his study of general practitioners noted:

> One doctor was proud of his ability to appear relaxed before patients and said that he acted as though he had 'all the time in the world' with the result, he said, that very few of them noticed that he spent only about two minutes with them on the average.[18]

"Private practitioners" and "isolated individualists," in contrast, define the situation as hurried and their behavior toward patients becomes curt and abrupt. They tend to assume that such superficial involvement with the patient is inevitable in this situation of practice, but justified as long as the medical care is technically competent (as they define technical competence):

> I think they feel as if they're a number or a statistic here. That they don't get the personalized attention that they would get in the fee-for-service situation. Not that this is necessarily, that it impinges in any way or effects the medical care from a strictly scientific point of view. But I think patients in this country want the luxury of getting a physician's personal interest. It may in no way effect whether a man can do a good appendectomy, whether he's personally interested in the patient, though I think patients want that.

What this physician fails to see is that personal interest is a quality of the interaction between doctor and patient, not time spent with him. But "private practitioners" and "isolated individualists" believe that performing technically well is all they can do given the time constraints. But we have seen in Chapter 5 that these constraints are largely of the physician's making and could be otherwise. We have also shown how most physicians have a job mentality and relate to Urban and consequently to patients in a detached manner. Unlike "patient-oriented" physicians who relate well with patients, "private practitioners" and "isolated individualists" do not look to the Urban Medical Group for their professional rewards. As a result, they act to service -- technically -- "Urban's patients." We have seen how they define the situation as charity medicine and consequently patients as demanding and not valuing their services. As a result, these physicians related with hostility to patients and this hostility is no doubt communicated. Moreover, these physicians believe that Urban patients characteristically don't comply because of the "kind of people they are." Thus "private practitioners" and "isolated individualists" not only have negative attitudes toward patients but they do not intervene as long as they believe that the physician has no role in patient compliance.

The physical space, the everyday routines and patients' characteristics do not make the Urban Medical Group <u>essentially</u> like a clinic. Rather, when physicians perceive Urban as a clinic, it is a result of <u>the meanings they attach to the situation</u>. There are three fundamental beliefs which foster physicians' perceptions of Urban as clinic-like and produce clinic-like behaviors.

I. <u>The Urban Medical Group constrains physician behavior and diminishes the physician's autonomy in relationship to</u>

patients and staff. Thus the organization has responsibility and control in the situation.

II. The service value is defined as "obligation to the community" and emphasizes the notion of "duty" to care for an organization's patients. This highlights the difference between the physician's private practice where he sees himself as a committed responsible professional caring for his patients who can pay, and the Urban Medical Group where he sees his work as a "duty" because he defines Urban's patients as unable to pay.

III. The capitation method of payment in contrast to fee-for-service perpetuates the myth of either free or minimum payment and receipt of inadequate rewards: free or "cheap" medicine becomes charity medicine.

The first belief, that Urban constrains physician behavior is, as we have discussed, subscribed to in varying degrees by all three types of Urban physicians. But only the "private practitioner" defines his Urban work as a "duty." With a private practice, the "private practitioner" is able to see his work in Urban as extra work -- fulfillment of his service obligation. "Isolated individualists" do not define Urban work as their duty because it is their only situation of medical practice. Nevertheless, both "isolated individualists" and "private practitioners" define Urban as a situation of charity medicine.

"Patient-oriented" physicians do not define Urban as charity medicine or see their care of patients as an obligation. However, we were surprised to discover that they seemed only slightly more socially conscious than their "private practitioner" and "isolated individualist"

colleagues. In fact, for the "patient-oriented" Urban physicians, the value of service in Urban is, as it is for the "private practitioner" in his private practice, to care for their individual patients. These physicians are professionally committed to Urban and perceive far fewer constraints in the situation. They act with greater autonomy and tend to take responsibility for their patients. As a site of their professional commitment, Urban becomes their group practice where they are invested for professional satisfaction and reputation. For the full-time "patient-oriented" physician to conceive of the organization as a clinic would be to promote a self-image of low esteem since, with no private practice, it is in Urban that his professional status is at risk. As Joseph Axelrod noted in his study, the full-time prepaid group practice physician's "entire economic and professional stake is in the group's success."[19] While there may be little economic risk for the part-time "patient-oriented" physicians, because of their identification with Urban, they too have a "professional stake in the group's success." For all "patient-oriented" physicians, then, Urban is not defined as a charity practice; rather, it is their professional work situation in which they are independent practitioners with responsibility for their own patients; they are not "clinic doctors." Thus when "patient-oriented" physicians complain that the physical space and routinization are clinic-like and describe many of the "private practitioners" and "isolated individualists" as delivering perfunctory care, they note these observations with dismay. For "patient-oriented" physicians, observations of clinic-like behaviors are elements of Urban that should be otherwise because, as they define it, Urban is not a clinic; it is their medical practice where they treat their own patients.

In contrast, "private practitioners'" and "isolated individualists'" perceptions are based on their definitions of work in Urban as a clinic-like job. They are estranged not only from the Medical Group where they feel and act as captives to organizational forces rather than as participants in a group of medical care providers, but from the patients who they see as hostile and in league with the organization. By reciprocating these attitudes, and failing to communicate with patients, "private practitioners" and "isolated individualists" don't get to know the real patient. Rather, they remain captives of their own false perceptions. Indeed, they not only meet patients as strangers, but most often part as strangers.

FOOTNOTES

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Chapter 7

ADAPTATIONS TO STRAIN IN THE URBAN MEDICAL GROUP

The role behavior of physicians can be discussed from a number of perspectives. For example, one can talk about the normative role, the typical role or the actual role performance of physicians. It has been our objective to underscore how the Urban physician's own role conception and thus his behavior is not solely a function of his professional perspective but is also effected by the situation of medical practice. Indeed, it is our belief that Urban physicians' role conceptions and consequent performance in the Urban Medical Group are effected by

1- The physician's professional perspective

2- The structured strain in the Urban Medical Group

3- The structured strain in the occupation of the physician.

As a prepaid group practice, Urban is a situation of medical practice which has a history of conflict with the traditional medical care system in the United States. Historically, the traditional system has highly valued fee-for-service private practice, and the traditional role of the physician has been ideally conceptualized as the autonomous solo entrepreneur. While there has been increasing movement in the medical profession toward new forms of medical practice, there remains an insistence on the physician's need for autonomy, long associated with fee-for-service private practice.

Prepaid group practice, according to the traditional professional perspective, is a situation in which the physician's autonomy may be jeopardized. In fact, Urban physicians are concerned about loss of autonomy and the necessity to be responsible for patients in Urban.

Although all Urban physicians value autonomy, they disagree on how much and in what ways the prepaid group limits their independence. We have suggested that physicians' selective perceptions depend on physicians' reference groups for professional identification. Attached to these reference groups are conceptions of typical physician roles.

The definition of the Urban Medical Group which is most prevalent among Urban practitioners is "clinic." It is this definition of practice which creates a situation of structured strain for all Urban physicians. Thus, "private practitioners" define Urban work as clinic work but identify their professional roles as private practitioners. In Urban they are strained to disavow the identity of clinic doctor to maintain their identity as full professionals (as they define it). "Isolated individualists" also define Urban doctors as clinic doctors. At the same time, they value the traditional physician role. But "isolated individualists" have no collegial support for traditional professional identities. Moreover, the "private practitioners" from whom they seek recognition identify them as clinic doctors. Thus in Urban, "isolated individualists'" professional self-conceptions as "doctors" are jeopardized. While "patient-oriented" physicians do not define Urban as a clinic, they are consistently confronted with that definition from their colleagues and initially, from patients. Because "patient-oriented" physicians define Urban as their group medical practice where they can be full professionals, they must continuously deny their clinic doctor labels by evoking positive identifications from patients.

In effect, Urban is a situation where the general expectation is that clinic medicine will be practiced and where doctors are clinic doctors. This situation produces threats to the professional self-identities of all Urban physicians. Indeed, given each physician's professional self-identity, he will have expectations about his role performance in general and his role performance in relationship to others which are contradictory to expectations for clinic medicine. Most significantly, he will expect others to respond to him in terms of who he asserts he is. As Foote suggests, "the establishment of one's own identity to oneself is as important in interaction as to establish it for the other."[1] In interaction, to be sure, identities are negotiated between participants and are altered in that process. However, there is a strain toward maintaining consistency in self-identifications:

> On entering an ongoing social situation, one responds to that situation by defining it. This definition includes the assignment of position to others, and thus the setting up of expectations concerning their behavior. It further, includes an assessment of self, that is, the assignment of positional identities to one-self. Others in the situation are, of course, engaged in the same kind of activity. The behavior that ensues is a function of such definitions. A crucial question thus becomes one of the congruence of definitions, situations, role and self, of the interacting persons. Congruence permits efficient, organized behavior. Expanding this, again noting the individual moves through a variety of interpersonal situations, the congruence of definitions, and so the behavioral expectations these imply, is fundamental to continuity of behavior. Personal organization is thus seen as a function, not simply of that which the individual carries around with him, but of the relationship between that which he carries with him -- in the form of self-concepts -- and the situations in which he interacts with others as these are mediated symbolically.[2]

The physician's professional identity, then, impinges on every situation in which he is involved. It is the basic unit for his interpretation of situations and is the filter through which each role performance must pass to maintain consistent personal organization.

The physician's role has been described in the sociological literature in terms of the norms attached to an idealized conception of the role.[3] But there is more than one physician role. In fact, the occupational role structure of the physician includes such diverse physician roles as the research physician, the Army doctor, the private practitioner, the industrial doctor, the academic physician, the clinic doctor. Attached to the typifications of these roles are a variety of role requirements. Moreover, the obligations attached to one physician role may conflict with the requirements of another role. Thus the academic physician may see his primary role requirement as teaching his house staff while the primary role obligation of the practitioner may be to make his patient well quickly and with as much comfort as possible. Indeed, Kendall has documented the strains between the town and gown physicians.[4] Mumford has described how the role of the community hospital physician differs from the role of physician in the teaching hospital.[5] Fox has analyzed the conflict in the research physician's role.[6]

In both Kendall's and Mumford's studies, physicians assumed one role or another, depending on the location of their medical practice. But Fox describes a situation in which the physician is simultaneously researcher and clinician. In consequence, Fox's research physicians experienced a great deal of stress and used such coping mechanisms as humor, "personal and privileged treatment" of patients, and the "game of chance"-- betting on the accuracy of their diagnoses.[7]

Urban physicians also experience stress in their physician role. This stress, however, is different from that experienced by Fox's research physicians who are faced with conflicting role obligations within the research physician's role. Essentially, the role strain for the Urban physician is a consequence of attempts to fulfill professional role obligations consistent with the physician's professional identity in a situation which is perceived as requiring an alternate occupational role: clinic doctor.

In order to understand the strain confronted by Urban physicians, it is critical to think of the physician's role not as given but as problematic. Indeed, these physicians do not take a role appropriate to the situation so much as each physician, through his activity, makes his role as Urban physician.[8] In fact, physicians construct their Urban physician roles and role performances so as to reduce the inconsistencies between their professional self-identifications and the identity of clinic doctor. That there are three types of Urban physician roles is illustrative of the fact that the role of Urban physician is not given or typical, but varies according to the way the physician adapts to the conflict between his professional perspective and the organization of the Urban Medical Group.

How then, can the behavior of Urban physicians be shown as strain reducing?

THE "PATIENT-ORIENTED" PHYSICIANS

The "patient-oriented" physicians find themselves in a situation of medical practice in which the prevailing definition is one of a clinic. But the "patient-oriented" physician does not see himself as a clinic doctor. In fact he shares many traditional professional values with his colleagues and defines his role obligations similarly.

There was consensus among all Urban physicians, for example, that patients should belong to the physician, seek help from the physician when ill, and comply with physicians' orders. Urban physicians also valued responsibility for patients, clinical experience, autonomy, esteem from colleagues and adequate compensation for their services. Although a large number of professional values were shared by Urban physicians, there was a major difference. "Private practitioners" and "isolated individualists" highly valued fee-for-service private practice and believed that work in prepaid group practice created difficulties for the physician to fulfill his professional values and perform his professional role. "Private practitioners", in fact, saw fee-for-service private practice as a necessary condition for the physician to meet his role obligations. In contrast, "patient-oriented" physicians highly valued prepaid group practice and perceived Urban as a situation where, ideally, their role obligations could be met.

Because the Urban Medical Group has both full-time and part-time doctors and because many of the behaviors and routines in Urban are clinic-like, the "patient-oriented" doctor most often is responded to as a clinic doctor. But this response to the "patient-oriented" physician is inconsistent with his own role identity as medical group doctor. As long as the "patient-oriented" physician is responded to with a negative identity label, he encounters strain in the Urban Medical Group. He must act, therefore, to maximize inconsistency between his professional self-identification and the identity imputed to him by others.

For the full-time "patient-oriented" physician, the Urban Medical Group is the major or only situation of medical practice. Thus if he

is to fulfill his role obligations, as he defines them, he must do so in Urban. The part-time "patient-oriented" physician has a private practice where he can perform his professional role and be identified in terms of his role identity. But the part-time "patient-oriented" physician values prepaid group practice and sees his role obligations in Urban as no different from the role requirements of private practice. Indeed, as founders of Urban, the part-time "patient-oriented" physicians have retained a strong commitment to the group. However, their identities as physicians are strongly attached to Urban. To accept the Urban physician role as clinic doctor would mean acceptance of their own role identities as clinic doctors.

Full-time "patient-oriented" physicians have only the Urban Medical Group in which to fulfill their role identities; part-time "patient-oriented" physicians' strong identifications with Urban make it a situation of practice in which they feel obliged to fully meet their role requirements. Furthermore, these physicians have no strong attachments to professional reference groups which constrain them from identifying with Urban. Thus, "patient-oriented" physicians, in order to maintain consistent role identities, are constrained to deny the clinic physician role and create an Urban physician role which, through performance, will elicit responses consistent with physicians' self-identifications.

THE "PRIVATE PRACTITIONERS"

All "private practitioners" are part-time in Urban and define Urban as a clinic. Their private practices are situations in which their professional identities are based on the perspectives of these private practice colleague networks. As we have seen, "private practitioners"

role identities -- who they are as physicians and how they should behave -- depend on the values of their professional reference groups. We have also seen that "private practitioners'" reference groups do not value prepaid group practice as a situation of medical practice. As long as the "private practitioner" subscribes to the values in his colleague network and believes that physicians wholly committed to prepaid group practice are disapproved in that network, he may not act as a committed physician in Urban. To do so would promote strain in his professional role and would create inconsistency in his own self-identification. According to the perspective of his reference group, he is an esteemed physician in private practice but is held in low esteem as an Urban doctor.

In Urban physicians' private practice networks, the prepaid group practice physician's role is defined as clinic doctor. As conceived in these networks the physicians in Urban are expected to lack autonomy and responsibility and to take care of an organization's poor patients. The clinic doctor role is viewed as requiring adherence to organizational requirements; thus it conflicts with the"private practitioner's" conception of his professional role and threatens the maintenance of a consistent professional identity. If he is to minimize strain in his professional role, the "private practitioner" cannot accept the identity of the Urban physician. Thus he withdraws his identity from Urban and acts with detachment toward his medical activities in the group. This is best illustrated in the "private practitioners'" stance toward patients who are treated with technical competence but with little or no personal interest. The "private practitioner" constructs the Urban physician role on the basis of what he believes is an adequate performance for a private

practitioner giving time to a clinic. Applying "norms of adequacy"[9] to his role, the physician determines what obligations are required for performance.

Becker, in his study of dance musicians notes how roles may be redefined according to norms of adequacy:

> One way of adjusting to the realities of the job without sacrificing self-respect is to adopt the orientation of the craftsman. The musician who does this no longer concerns himself with the kind of music he plays. Instead, he is interested only in whether it is played correctly, in whether he has the skills necessary to do the job the way it ought to be done. He finds his pride and self-respect in being able to 'cut' any kind of music, in always giving an adequate performance.[10]

In the same way the dance musician redefines his job of playing for "straights," to maximize self-respect, the "private practitioner" redefines his physician role in Urban in a way to maximize his self-esteem. The "private practitioner" also acts as the "craftsman." He is no longer concerned with showing personal interest to patients, instead he is interested only in performing a technically competent job. He maintains his pride and role identity by giving patients "better care than they've ever had," by always performing his physician role adequately.

Not only does the "private practitioner" construct his Urban role in terms of norms of adequacy, he also defines the prepaid group in terms of elements of adequacy. In the same way he views his Urban role performance as incomplete -- only adequate -- so too is the Urban practice situation defined as incomplete. As such, Urban is defined as lacking autonomy. Moreover, Urban is not perceived as a situation where the physician can make his own patients well. Instead, the Medical Group is perceived as a situation where the physician's service

obligation can be fulfilled with the group's patients.

By defining the Urban Medical Group as only an adequate situation of medical practice, the "private practitioner" can continue to perform his Urban role according to norms of adequacy. His definition of Urban as a clinic and his construction of the Urban physician role based on that definition, allows him to perform "as a private practitioner should in a clinic." Indeed, through his detachment, he underscores for himself and his colleagues that he is still the skilled private practitioner, not to be identified with the Urban Medical Group.

THE "ISOLATED INDIVIDUALISTS"

"Isolated individualists" have a great deal of difficulty in establishing their professional role identities. They want to be identified as traditional physicians who happen to work in a prepaid group practice. For one "isolated individualist" this is less problematic. In contrast to his colleagues, this physician does not see his physician role as his "central life interest."[11] He is content to be a "physician" and do his job of doctoring. The other two "isolated individualists," however, wish to be identified with the traditional physician role but are not accepted as members of a reference group of people who support traditional professional values. While they do not view fee-for-service private practice as essential to the traditional physician role, neither do they highly value prepaid group practice. In order to maintain a role identity consistent with the traditional values they hold, "isolated individualists" identify with the occupational category "doctor." At the same time, they continue to seek acceptance from the "private practitioners" in Urban. As such, they accept the "private practitioners'" role conceptions of the Urban physician as a clinic doctor.

Unlike the "private practitioners," however, "isolated individualists" are full-time in Urban and have no alternate medical practice situation where they may perform their professional role. Moreover, as long as they continue to seek acceptance from the "private practitioners," and conform to the "private practitioner" role conception of Urban physicians, they cannot identify themselves with the Urban Medical Group. To be viewed as committed to Urban is to run the risk of being labelled a clinic doctor. Essentially, the "isolated individualist" sees himself as damned by the "private practitioners" if he acts committed to Urban; but in fact he is damned when he doesn't act committed. Only through commitment, as is the case for "patient-oriented" physicians, can he get reinforcement of his professional identity through his relationship with patients.

Caught in this bind, "isolated individualists" choose to act with detachment in the Urban Medical Group. But with Urban as the only situation for commitment to medical practice, their detached behavior is better characterized as <u>negative attachment</u>. In his study of the strain in the role of the chiropractor, Wardwell notes that "strain in a social role produces tension, anxiety or frustration."[12] He adds that one type of "psychological reaction to tension and frustration" is aggression.[13] Indeed, "isolated individualists" display more anger toward Urban and patients than any other physician type. This anger is the result of the frustration they experience in attempting to maintain a consistent role identity. Moreover, "isolated individualists" are angered at Urban because they see their rejection by "private practitioners" as a consequence of their affiliation with the Urban Group and they blame Urban for this rejection.

"Private practitioners" are detached from Urban and show no personal interest in patients; but they are not often actively aggressive toward patients. In contrast, "isolated individualists" are hostile toward patients and constantly blame them for attributing the clinic doctor label to the physician. Moreover, these physicians attribute negative qualities to patients. Thus patients are described as "neurotic," "paranoid," "taking advantage,""treating physicians as puppets," "crocks," etc. "Isolated individualists'" attitudes and perceptions of patients are a consequence of the physicians' efforts to reduce the strain of their own role identities.

Hewitt and Stokes have described how verbal disclaimers are used when identities are problematic in interaction.[14] They state that

> Having failed to disclaim an identity implied in his actions and utterances, the user may attempt to salvage his identity by more or less forcibly working on the identity of the others, seeking to portray the other in a light that makes his own discredit less serious or even makes it disappear.[15]

By "working on the identity" of patients, "isolated individualists" are attempting to disclaim their own negative identities. Indeed, these physicians are constrained to disclaim their negative identities in Urban because the Urban practice situation is the only opportunity they have to fulfill their professional role.

THE URBAN PHYSICIAN ROLE AS ADAPTATION TO ROLE STRAIN

The key question in this research was: how can we explain the behavior of Urban physicians vis a vis patients and colleagues? In our analysis of the Urban physicians we found three types of Urban physician behaviors. Each physician type was associated with an Urban physician role constructed on the basis of the physician's professional

perspective. In fact, these perspectives, attached to physicians' varying sources of professional identification, provided physicians with a conception of the appropriate role for an Urban physician. These role conceptions, however, should be viewed as implying boundaries on expectations for role behavior in Urban, not as supplying the physician with a specific role to take as Urban physician.

Definitions of Urban and physicians' consequent behaviors were further influenced by the inherent conflict in the occupational role structure of the physician, a role structure which includes a variety of alternative and often conflicting physician roles. Because physicians' self-identifications (role identity) often conflicted with the prevailing definition of the Urban physician role, physicians experienced role strain in the Urban Medical Group. This strain was largely a result of the conflict between the requirements of the situation as defined by the physicians and the requirements of the physicians' own role identities.

The behavior of Urban physicians must be viewed as the consequence of the way each physician constructs his role to adapt to the conflict between his professional perspective and the demands <u>as defined by the physician</u> of the organization. As noted in our introduction, studies have shown that professionals in organizations must come to terms with the basic conflict between professional norms and values and the rules of the organization.[16] What is most surprising in Urban is that the physicians exacerbate the conflict between their own professional perspectives and the demands of the organization by defining the organization and thus making a situation which is more constraining than the actual formal organization. Thus the structure of the organization which Urban

physicians respond to is a product of physicians' definitions of the situation. This is especially significant in view of the assertions of studies of professionals in organizations that actual demands in the organization conflict with professional perspectives. The perspectives of professionals with strong value commitments to the tenets of their professions (in which autonomy is inherently antithetical to organizational work) may predispose physicians to define and respond to organizational requirements which are more demanding than the actual situational constraints.

Since Urban physicians define the Medical Group largely on the basis of their professional perspectives, it would appear that these perspectives have greater influence on their behavior than the actual demands of the organization. But the behavior of Urban physicians also varies according to the availability of alternate structures for the fulfillment of professional values. Specifically, "private practitioners" were able to detach their identities from Urban because, in private practice, an alternate situational audience offered identities which didn't require major negotiations. Moreover, private practice provided rewards of professional colleagueship and prestige. The "private practitioner" detached from Urban "frees himself from one group, not to be free, but because there is another hold on him."[17] At the same time, however, full-time membership in Urban was not necessarily predictive of commitment to the Medical Group or of definitions of Urban as a situation where professional goals could be realized: Physicians with only Urban as a situation of practice could construct the "isolated individualist" role. The critical question is, will the physician's need for positive identification from patients and colleagues influence physicians who have no alternate practice situations to define the

situation as professionally rewarding?

This is not an easy question to answer. There is little doubt of the physician's need for patients. Moreover, within the profession, perhaps the most crucial reward is recognition from colleagues. Even though a physician works in an organization, he is, at least theoretically, part of a larger professional community. As Goode notes, "this community exerts continuous professional judgements of high or low achievement."[18] Furthermore,

> To the extent that any community exists, it evaluates the behavior of its members. Professional life is so fundamentally based on achievement, that such judgements of rank are made constantly. Indeed, rankings within the profession are a mode of social control.[19]

As members of the medical profession, Urban physicians are judged on achievement. But we have noted that this does not necessarily mean medical performance. Rather, physicians are judged according to the prestige of the medical institutions with which they are affiliated. According to Oswald Hall, the most crucial institution for the physician is the hospital. It provides the link for the physician to acquire and improve his clientele and to develop colleague relationships.[20] Essentially, the hospital is the key to the physician's career mobility:

> The successful practice of medicine involves participation in the hospital system. This system is integrated with a series of other institutions. These constitute a sifting device which functions to establish the status of the various doctors in the community. In this sense they influence markedly the careers of medical men.[21]

The Urban Medical Group, with low professional prestige and a clientele of low status provides little means of career mobility for the physician. For the Urban physician, then, the primary means of career mobility is external to the Group. However, the limitations of mobility within Urban are not essentially a product of prepaid group

practice. Instead, we believe mobility limitations are a consequence of the low prestige of the Urban practice. Indeed, low status private solo fee-for-service practitioners with client-dependent practices confront similar mobility restrictions. Richard Hall, discussing generalists in law studied by Carlin[22] states that

> these lawyers also feel insignificant in the overall legal structure and are frustrated because their high ambitions have not been realized, even though they are professionals. Carlin suggests that these individual practitioners, like general practitioners in medicine, are 'most likely to be found at the margin of (their) profession, enjoying little freedom in choice of clients, type of work, or conditions of practice....' They only get the business that comes their way or that they can bring in. Their cases usually are in one type of taxation, and they are generally geographically limited to their immediate neighborhoods.[23]

Limitations on career mobility for professionals exist in all types of professional practice organization. Moreover, those professionals who do not move to the top of their profession, as most do not, seek alternate rewards. The "patient-oriented" Urban physicians, for example view their partnership in the Medical Grop as a measure of success. As clinicians they derive satisfaction from the work itself. "Private practitioners" see their extra clinical "material" as rewarding while "isolated individualists" find rewards in the security of Urban practice.

One reward we assumed group practice would provide was colleagueship. But there was little interaction among physicians in Urban. In fact, the performance of physicians at work is as isolated in Urban as it is in private practice. Although we found three types of Urban physicians, their perspectives were similar in so far as they retained (in varying degrees) the traditional values of private medical practice. Thus, even though Urban physicians are reimbursed through capitation, we believe they structured the organization as a "mock private practice."

While physicians' perspectives seem to have a major influence on their behavior, we do not believe these perspectives can easily be changed. Consequently, for Urban to become a situation of practice where physicians are of the "patient-oriented" type, or at the very least not detached from the practice, we believe two critical structural changes are required. These changes are the requirements of the Kaiser model of prepaid group practice. First, all Urban physicians should be full-time. Second, Urban should be a hospital based prepaid group practice. We would argue that these two major structural changes would produce cohesiveness and colleagueship among Urban physicians. Most crucially, a hospital based practice would make the external professional reward system internal to the prepaid group practice.

Once the rewards are internal to Urban, the problem of the status of the organization within the profession remains. It has been suggested that the low prestige of the HIP prepaid group practices relative to Kaiser prepaid groups is a function of the civil service type organization of HIP compared to Kaiser's industrial type organization.[24] We do not yet know if this is the case or if it is what the specific consequences of these two models are for physicians. It does seem likely that if any change in the prestige of HIP is to occur, it will be a result of structural change. However, such change will necessitate a large input of resources into the HIP system. Much of the potential for change, therefore, may rest with the Federal government. Clearly, the passage of National Health Insurance with financial incentives for health maintenance organizations may be the only source of financial resources for a major restructuring of HIP. Whether such legislation will be passed or when is difficult to predict. As the costs of health care in the United States continue to increase, federally funded HMOs

may become the least expensive means of health care delivery.

If health maintenance organizations or prepaid groups are to become a major form for the organization of health care delivery in the United States, further studies of prepaid group practice, especially of hospital based groups of full-time physicians are needed. Such studies would both test our findings and uncover additional influences on physicians' role behavior. We believe the Urban Medical Group is a seed of some hybrid form of health care delivery organization which may bloom in the future. As Hughes envsions it

> The people in organizations will be -- although in some sense bureaucrats -- the innovators, the people who push back the frontiers of theoretical and practical knowledge related to their professions, who will invent new ways of bringing professional services to everyone, not merely to the solvent or sophisticated few. Indeed, I think it likely that the professional conscience, the superego of many professions will be lodged in that segment of the professionals who work in complicated settings, for they must, <u>in order to survive</u>, be sensitive to more problems and to a greater variety of points of view.[25]

FOOTNOTES

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APPENDIX

Physician Interview Schedule

Prepaid group practice as a form of health care delivery is becoming popular as a new means of providing care. HIP, as one of the first prepaid group practices, however, is not new.

1. Could you tell me something about how and why the organization was founded. Probe for reactions by AMA, physicians generally, the public; ideology and goals. What's your feeling about that?

2. What is HIP like now? Probe for reactions as above; changing clientele, changing physicians, ideology and goals.

3. How would you characterize HIP generally -- not this group -- in terms of the advantages and disadvantages for patients and physicians?

4. What are HIP patients like? Doctors?

5. Does this group differ from your general characterization of HIP? If yes, how? Probe for differences in physicians.

6. What do you see as the motivation for most physicians to work in HIP? Distinguish between full- and part-time doctors, partners and others.

7. What differences do you see between HIP doctors and those with private patients only?

8. What criteria did you use that led you to the decision to become a doctor here? Differentiate between full-time and part-time, specialists, family doctors and pediatricians.

9. In terms of opinions about health care delivery, do you see any difference between yourself and other doctors here? Differentiate between full-time and part-time, specialists, family doctors and pediatricians.

10. HIP is described as a prepaid group practice. What in your view does this mean?

11. Advocates of prepaid group practice usually discuss the advantages of this type of organization in terms of the patients. What advantages and disadvantages do you see for the physicians? Patients?

12. Do you think working in a group situation effects what you do or do not do? Specify basic function of group. How do your peers in the group influence your practice of medicine? Probe for autonomy.

13. Do you think prepayment effects what you do or do not do? Probe.

14. Would you prefer working in a group that is fee-for-service or prepaid? Probe.

15. Are their occasions when you would prefer to refer patients to a non-group specialist? Explain.

16. If you had to choose one category to identify yourself, which of the following do you tink is most appropriate? a physician, your specialty, an Urban physician, an Urban specialist, an HIP physician, an HIP specialist.

Now I would like to ask you some questions about patients:

1. What do you think motivates patients to join HIP?

2. How do you think most patients characterize HIP doctors?

3. How would you describe the behavior of an ideal patient? How would you respond to this?

4. If that is an example of ideal patient behavior, how do your HIP patients generally behave? Your response? Differentiate for private patients.

5. What do you think most of your HIP patients' expectations are concerning your treatment of them? Probe for patient attitudes and goals. Differentiate for private patients.

6. What do you expect from your HIP patients? Your goals in the encounter? Differentiate for private patients.

7. When your HIP patients don't behave according to your expectations, i.e., when you think they are acting inappropriately, what do you do? Get specific example. Differentiate for private patients.

8. All patients are not the same. What kinds of categories do you use to differentiate among your patients? What are your criteria for placing patients in one category rather than another? Probe for HIP, private.

9. Do you think patients categorize doctors in some way? Probe.

10. What kinds of criteria do patients use to determine if you are a good doctor? What do you think about that? What do you do to influence the patient's perception? Probe for keeping communication fluid.

11. In what ways do you think patients are satisfied and dissatisfied with services they receive here?

12. What is your view of how society thinks of doctors? Probe for status component.

13. Why does society confer high status on the physician?

I would now like to ask some questions about how decisions are made here.

1. How are decisions which effect the policy of the group made?

2. Do you participate on any of the committees in the group? If yes, describe the purpose of the committee and what you do. If no, why not?

3. Do you see the committee system as a decison-making vehicle for the physician? Probe.

4. What role does the group administrator play in decision-making?

5. What role does the medical director play in decision-making?

6. I understand a consumer council was recently formed here. What role do they play in decision-making? Do you think this is appropriate?

7. Do you think there is any role the consumer council should play?

8. Do you think that you as an individual can influence the policies of the group? How or why not?

9. Do you think policy influences you directly? That is, does it influence your practice of medicine? Probe.

10. If a doctor was deciding between joining this group or setting up a private practice, what could you tell him to persuade him to join this group? To discourage him?

11. How are disagreements between physicians managed? Probe for feelings.

12. How are disagreements between physicians and patients managed? Probe for feelings.

13. As far as you know, has the consumer council been involved in any of these disagreements?

14. Do you think the consumer council should play a role in resolving such disagreements?

15. How are disagreements between physicians and staff managed? Probe for feelings.

16. If there were a colleague who you believed to be incompetent, would you take any steps to exert some control over him? What would you do? Should others do anything? Who? What?

17. In making medical judgements in areas where you feel the need for

consultation or help, what doctors do you talk to?

18. Would you specify three physicians in the group, in order of preference, who you spend time with most often to just relax or joke.

The following questions are important to give me some idea of who the physicians in this group are:

1. Age 2. Marital status 3. Number of children 4. Religion

5. Ethnicity 6. Place of Birth 7. Years at this group

8. Years in current private practice 9. Type of private practice

10. Occupation of father, mother 11. Education of father, mother

12. Undergraduate college 13. Medical school

14. Internship and Type 15. Residency and Type

16. Board Certification

17. All positions held since residency (include type of practice and location

18. Member of the AMA 19. Member of other medical organizations (specify)

20. Specify medical journals and magazines preferred

21. Volunteer work currently: where and time spent

22. Other paid medical work currently: where and time spent

23. Proportion of income from HIP (medical care income only)

24. Proportion of income from private practice

25. Hospital Privileges and Appointments

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