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# Physicians' Work

Alice A. Oberfield and Pamela S. Tolbert

Medicine traditionally has been one of the preeminent professional occupations in American society. Mention the words profession, autonomy, status, and pay and most people think of doctors. Indeed, the power and privilege of the occupation have made it the target of considerable public and private criticism. Recent years, however, have witnessed dramatic organizational changes in the practice of medicine, changes that have fundamentally altered not only the nature and conditions of physicians' work but the primary form of health care services available to consumers as well.

There are a variety of indicators of the changing status of the medical profession. One is the growing numbers of physicians that practice within the confines of bureaucratic organizations. Over the last twenty years, the proportion of self-employed doctors has declined steadily while the number of doctors employed as salaried workers in large-scale health organizations has grown rapidly. Such organizations can offer doctors ready access to colleagues and costly medical technology, but this often occurs at the price of a marked loss of autonomy. Particularly in the last decade, increased efforts at cost control by government agencies and insurance companies have often led to the adoption of organizational policies that severely constrain doctors' autonomy.

Independent physicians have also felt the impact of forces that are bringing about changes in medicine. The specter of malpractice suits has significantly influenced physicians' decision making; in response to this threat, many doctors feel forced to limit their own discretion and to rely on standardized procedures.

In addition, a number of physicians in private practice have witnessed precipitous declines in income in recent years. For example, one group practice reported that between 1982 and 1985, the average income of its members declined by over 40 percent. In some metropolitan areas, the starting salaries of new physicians in group practices are lower in absolute dollars than they were five years ago. Such dramatic declines reflect a variety of forces: decreasing insurance

reimbursements, increased government regulation, increasing malpractice premiums, and the increasing cost of medical technology. In this context, young doctors confronted with the problem of paying off large loans for medical education face an unsettling future. Current medical school costs are as high as \$21,000 a year, while financial support for medical education has been cut back sharply in the last decade. Thus, declining salaries combined with enormous education costs may make it impossible for many aspiring doctors to enter the profession.

This possibility is consistent with yet another indicator of the problems facing medicine, the recent decline in applications to medical schools. Schools in the U.S. received 3200 fewer applications in 1987-88 than in the previous year. This decline may also reflect the growing disenchantment of practitioners with medical work. One medical school dean was astounded when he asked an entering class how many of them had been told by a doctor not to enter the profession and found that over 80 percent raised their hands.

In order to evaluate the full impact of such changes on physicians' work and the health care system, it is necessary to understand the forces bringing change about. Thus, we begin by providing a brief history of the contemporary medical care system, then turn to an assessment of current trends and their consequences for the practice of medicine.

## The Evolution of American Medicine

The Flexner Report (1910), a highly critical review of medical education in the U.S., is often identified as a turning point in the development of contemporary medicine. This report proposed standardizing and upgrading the requirements and curriculum for medical schools; and it suggested that the large number of medical schools that could not conform to the higher standards should be shut down. The physician-controlled medical system which was to dominate American health care for the next six decades became firmly institutionalized soon after the report's issuance, although the precise role of



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the report in the creation of this system is debated.

According to the ideological model on which the medical care system was now based, strong professional norms would guide doctors' work, preventing individuals from abusing their positions of trust and authority. The adherence of individual doctors to these norms was to be enforced by colleagues and by the American Medical Association (AMA). The AMA controlled entry into the profession largely through the accreditation of medical schools, with the purported aim of ensuring uniform, high-quality education of physicians. The education process was to involve intensive socialization regarding the norms and ethics of the profession, thus laying the foundation for effective self-regulation. The specialized body of knowledge on which medical practice rested presumably made self-regulation necessary; only members of the profession itself had the knowledge and skill to understand and evaluate medical decisions.

In this system, the autonomy of the individual practitioner was sacrosanct. The traditional fee-for-service payment method was important because it avoided the need for the administrative bureaucracy required by other systems of compensation, and so decreased the potential for bureaucratic control of medical practice. Doctors were responsible for protecting the interests of the public by controlling prices and quality of care; governmental intervention, it was argued, would only restrict the professional delivery of health care and cause more problems. This ideology still exerts a significant influence on the delivery of health services in the U.S. today.

The dramatic political shifts of the 1960s, however, laid the groundwork for major changes in medicine. Acceptance by the federal government of responsibility for defining and remedying general social problems led to the proliferation of social welfare programs. Federal involvement in medicine grew with increased public demand for social services.

A shortage of doctors in 1963 led to the creation of federally funded programs aimed at expanding medical education. The antipov-erty programs of the Johnson administration reflected the assumption that bad health was an integral part of the poverty cycle. Eventually, this led to the implementation of two major federal programs, Medicare and Medicaid. These programs did not lead to a large increase in government regulation; instead, the intensive lobbying efforts of the AMA insured that federal reimbursements for service were essentially unrestricted. Nonetheless, the AMA continued to object strongly to federal intervention, claiming that it threatened the doctor-patient relationship.

By the early 1970s, economic and administrative problems created by the health care efforts of the 1960s were widely apparent. The establishment of Medicare and Medicaid made the government a primary purchaser of medical services. As medical costs rose and continued to rise rapidly, both federal and state budgets were strained. In response, a variety of commissions and agencies were created and charged with examining ways to increase the cost effectiveness of the medical system.

At the same time, public concern with the power of the medical profession began to be voiced. The right-to-health-care movement made its debut, its proponents citing instances of abuse of patients and demanding more stringent regulation to assure patients' rights. The media also took up the crusade, spotlighting stories about families that were destroyed by huge medical bills. The passage of laws during this period, such as the "right to informed consent" and the right to look at one's own medical records, reflected the intensive lobbying efforts of health care activists. These laws, among others, were incorporated as the Patients' Bill of Rights, which was adopted in 1972 by the American Hospital Association.

One aspect of medical care that generated particular concern in these health care activists was the traditional fee-for-service payment system. Critics charged that this system discouraged preventive health care, thus ultimately raising health care costs. Moreover, it was viewed as rewarding doctors for the use of excessive tests and

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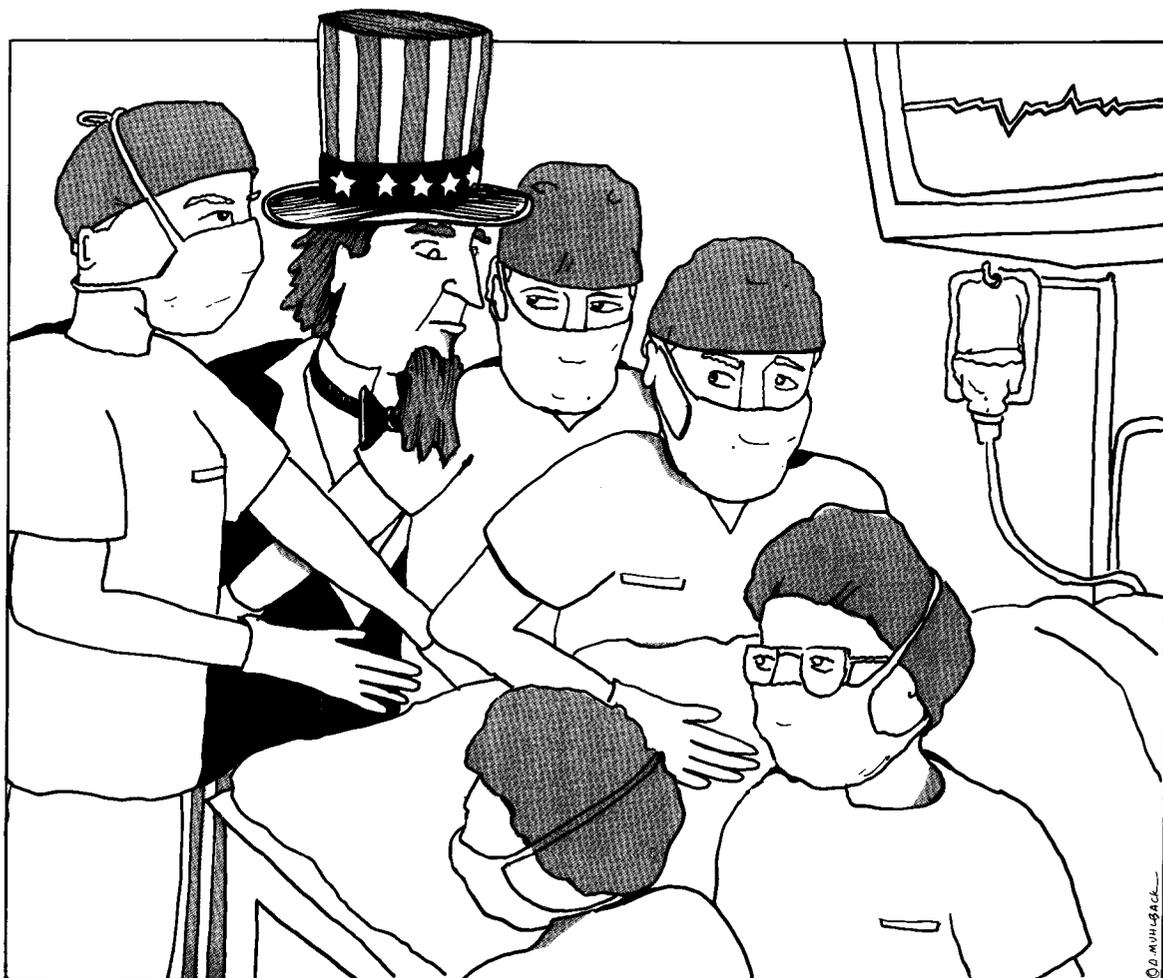
hospitalizations. For patients enrolled in Medicare and Medicaid programs, doctors knew that the government, not the patient, would be paying for extra services. In a number of well-publicized cases, some doctors were found to have routinely ordered unnecessary tests and overnight hospital stays in order to receive higher reimbursements.

Concern with the financial problems and abuses of the medical care system led to a growing interest in prepaid health insurance, and particularly in the development of health maintenance organizations (HMOs), organizations providing a full range of health care services for an annual flat fee. Prepaid plans were intended to encourage preventive care and to discourage doctors from seeking unnecessary tests and visits. HMOs were assumed to promote effective cost management since they received a fixed revenue from client members that had to be used to pay for all medical costs. Therefore, lower health

service costs meant larger profits for the doctors.

When initially proposed in the 1960s by liberal members of Congress in the context of a national plan, the prepayment system was considered radical and even subversive. It was the Nixon administration, however, that adopted HMOs as part of its health policies, calling it an efficient management strategy that would encourage doctors to be responsible for costs. As Paul Starr, writing in 1983, contended, "The socialized medicine of one era had become the corporate reform of the next." Support for HMOs in the Nixon administration was short-lived however. The attempts at regulation and government control of medicine were strongly rebuffed by both national and local medical associations through a string of lawsuits, which managed at least temporarily to slow down changes in the medical system.

It is important to note that professional associations were not the only barriers to



implementing reforms. The traditional medical system was and still is a venerated institution in the U.S., one that is based on mystical and idealized notions of medical practice. Its embodiment in the mythical image of the country physician, tirelessly making rounds of house calls, is cherished by the public. Thus, professional group resistance and public ambivalence led Congress, in the spring of 1972, to request that grants for HMO projects be halted.

While these forces helped to limit change in medicine at the beginning of the decade, by the mid-1970s pressures for change were mounting again. During the Carter administration, the HMO concept was revived, this time as a private system involving competition among independent health services organizations for subscribers. Although this was intended to be part of a national health insurance plan, political battling prevented the development and implementation of such a plan. However, private HMOs flourished, and became an important part of the trend toward the "corporatization" of medicine.

In sum, social changes of the 1960s set the stage for major changes in medical services delivery. The spread of third-party insurers (including the federal government), the increased agitation for reform by consumer health activists, and spiraling health care costs have all contributed to the erosion of the traditional system of health care delivery by independent practitioners. This system is being replaced by one of corporate-style medicine, a system in which health services are delivered by large, for-profit agencies that hire doctors as salaried employees.

## Medicine in the 1980s

Thirty percent of the nation's community hospital beds were part of multi-institutional corporations by 1980. During the 1970s, nonprofit hospitals increased their number of beds by just 28 percent, in sharp contrast to the 55 percent increase among for-profit hospitals. This growth in part reflects the rash of mergers among hospitals occurring in the late 1970s and early '80s. It was commonly predicted at one point that health care services would soon come to be dominated by four or five large hospital chains ("Super-meds"), which would be able to substantially lower costs through scale economies. (Current evidence shows, however, that the huge profits initially enjoyed by hospital chains are

decreasing; it now appears that the benefits of scale are much lower in medicine than expected.)

The trend toward corporate-style medicine has had a major impact on the distribution and delivery of health care. Because of recently imposed caps on reimbursement of services for Medicaid and Medicare patients, for-profit hospitals are generally reluctant to provide treatment for these patients. When beds are full, the chains take as few clients of these programs as possible. While hospitals are required by law to treat emergency patients, uninsured patients in for-profit hospitals are often transferred quickly to public institutions. Thus, stratification among hospitals by type of clientele is increasing: the poor and elderly are most likely to be found in overcrowded and underfinanced public institutions.

Serious questions have been raised about the quality of care in independent HMOs and in the new walk-in clinics that provide on-the-spot treatment for routine medical problems (sometimes described as "Doc in the Box"). Policies designed to minimize costs and to increase productivity not only limit physicians' autonomy but often have a very questionable effect on the appropriate delivery of medical services.

In some cases, these policies are reminiscent of speed-up practices on factory lines. One doctor reported quitting an HMO because she was required to see a patient every 12.5 minutes. In another case, a doctor in a walk-in clinic reported that the clinic routinely ranked doctors by the amount they had charged patients; doctors at the top of the list were favored while those whose charges were too low either quit or were fired. Still others have told stories about doctors in HMOs being given bonuses when they fail to refer patients elsewhere. As one doctor with experience in an HMO practice stated, "The physician is at the mercy of a corporate definition of productivity."

Other practices call into question corporate health care providers' commitment to lowering costs for patients. In the case of one walk-in clinic, administrators exerted strong pressures on doctors to keep the diagnostic machines busy (x rays and other tests are expensive and profitable). The fee for an examination was low (\$35-\$40), but an

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average of \$20 was added to the basic charge in test fees. A study by Lewin and Associates comparing for-profit and nonprofit hospitals in a matched sample from three states found that for-profit hospitals not only had higher costs but also much higher charges, particularly for subscribers to private health insurance.

In other cases, costs have been saved through the lack of administrative support and poor equipment. However, these cost-competitive pressures take their toll on patient well-being. Patients who are admitted to hospitals in highly regulated and competitive areas may actually have higher mortality rates. One recent study found that hospitals in states with the most stringent review procedures for certificates of need (which are the documents that allow hospitals to expand) had ratios of actual to predicted death rates 5 to 6 percent higher than those hospitals in states with less stringent procedures.

Despite these problems, there is little sign of contraction in the role of corporate enterprise in health care delivery. Indeed, continuation of the policies of the Reagan administration is likely to accelerate current trends.

### **Thoughts for the Future**

It is difficult at this point to assess the net costs and benefits to society of the striking bureaucratization of medical work that has occurred in the 1980s. However, the changes are having a number of clear consequences.

From the patients' viewpoint, the days of personalized care from a long-standing family physician are rapidly disappearing. There are both advantages and disadvantages to the depersonalization of health service delivery. In an emergency, individuals call or visit their health service organization and must deal with whoever is on call, who may or may not be a doctor they know and trust. On the other hand, routine appointments may be easier to schedule because there is a group of doctors available. Whatever patients' assessment of the net balance of costs and benefits of the new arrangements, they are unlikely to see a return to a more personalized system of doctor-patient relationships.

It is also clear that current trends entail a serious reshaping of doctors' work, imposing substantial limits on the traditional autonomy and prerogatives of individual practitioners. It has been argued that in some instances organizational control of doctors' work bears

a strong resemblance to the de-skilling that has taken place in craft occupations. At present, the reaction of practitioners to these losses is relatively weak and scattered, perhaps due in part to the recency of the corporate medicine phenomenon.

However, the lack of response is also due to the changes in the last several decades that have undercut the AMA's ability to control the environment of health services delivery. Some blame the association for the problems confronting doctors: if it had not so strenuously fought earlier attempts at change, it would have been better able to work with the government to produce a stronger health care system. In any case, its effectiveness as a representative of the interests of its members has been weakened in recent years.

One possible response to these problems is for the association to move toward a more union-like posture in the future. It has been suggested that some local medical societies, like the Mississippi State Medical Society, are already moving in this direction, operating their own IPAs (Independent Practice Associations). The members of these organizations collectively sell their medical services to organizations, such as insurance firms, HMOs, employers, and unions. The members negotiate contracts with the payer, and have been known to refuse to renew contracts because the payer would not meet their demands.

As with other professional workers, however, the unionization of doctors raises some difficult issues. While a number of doctors' unions do exist at present, their status is problematic because of the Yeshiva decision. Only salaried, nonsupervisory physicians can form a union. However, even in some salaried positions doctors exercise supervisory or managerial responsibilities. Hence, until a clear distinction is drawn between professionals and managerial or supervisory staff, doctors' unions will run the risk of being declared illegal.

Even without this problem, an effective doctors' union would have to be able to negotiate with state and federal governments, as the AMA has traditionally done, since these bodies are the primary source of new regulations. In addition, the traditional union



weapon is the strike: would doctors be able and willing to use this tactic in their negotiations? Unionized physicians in other countries, such as Israel, have used strikes as well as other creative bargaining tactics in their negotiations. But refusal to provide treatment is contrary to the physicians' code of ethics and professionals in this country have often been reluctant to use traditional negotiating approaches.

Thus, while changes in the structure of medical care presage increased dissatisfaction among physicians, the long-term implications of this are difficult to predict. It is clear, however, that the trend toward replacing practitioner control by corporate control may well create as many problems in health care delivery as it solves. There are obvious contradictions in the current situation that will require attention soon: simultaneous declines in physicians' salaries and increases in medical education costs; the growth of for-profit medical organizations and increasing restrictions on reimbursements by insurers; the increasing routinization of health service delivery and the fundamental ambiguities of medical practice.

These dilemmas need to be given close attention in future policy decisions. Incentives for cost-cutting must somehow be balanced against incentives for the provision of standard, quality health care. Perhaps a recent lesson from the automobile industry is applicable here: lowering costs is not the only criterion of success. Quality, achieved through the granting of autonomy and

responsibility to producers, is also critical. While some constraints on costs are necessary precautions against excesses that we have sometimes seen in the medical profession, that is not the whole solution. The short-run priorities of politics should not obscure long-run public interests in creating a medical system that satisfies both the providers and direct consumers of medical care services. □

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*ILR Report*, Vol. XXVI, No. 2 (Spring 1989). Published by the New York State School of Industrial and Labor Relations. Copyright by Cornell University. ISSN 0736-6396.

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