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PHYSICIAN AUTONOMY: SOCIOLOGICAL THEORY OF THE PROFESSIONS EXAMINED THROUGH PHYSICIAN PARTICIPATION AND ASSIGNMENT DECISIONS UNDER MEDICARE

by

Richard Allen Culbertson

DISSERTATION

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San Francisco

PHYSICIAN AUTONOMY:
SOCIOLOGICAL THEORY OF THE PROFESSIONS
EXAMINED THROUGH PHYSICIAN PARTICIPATION
AND ASSIGNMENT DECISIONS UNDER MEDICARE

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By

Richard Allen Culbertson

To Susan and the
memory of our
friend Goldie

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PHYSICIAN AUTONOMY: SOCIOLOGICAL THEORY OF THE PROFESSIONS EXAMINED THROUGH PHYSICIAN PARTICIPATION AND ASSIGNMENT DECISIONS UNDER MEDICARE

Richard Allen Culbertson

Professional autonomy has been identified as the pivotal concept in the sociological theory of professions. This study addresses the theoretical problem of the shifting nature of professional autonomy through four major historical phases coinciding with changes in the medical profession and American society. A divergence of autonomy theory from a unified concept to separate elements of clinical and economic autonomy is identified.

The research problem of the study is based on the premise that autonomy theory can be defined and measured through the actions of physicians at a given historical point. This opportunity was provided in the creation of the Medicare Participating Physician program in 1984, and the creation of an option to accept Medicare payment as payment in full or to refuse and "balance bill" the patient for full charges.

Data were obtained through a stratified sample of 1,988 physicians from the 1988 National Survey of Physicians. Three hypothesized models were developed to test a general theory of physician participation and balance billing,

based on the premise that physicians pursuing economic autonomy would elect Medicare payment which would maximize economic return. These physicians were hypothesized to be predictable from identified physician and practice characteristics used as independent variables for analysis.

Employing regression analysis, a limited association was found between eleven independent variables and the participation decision. Seven of the variables were found to be of significance in the model. In contrast, a moderate association was found in the decision of nonparticipating physicians to balance bill. Six of the eleven independent variables attained significance in this model. Chi square analysis of a residual group of ten percent of the sample physicians revealed unexpected concern for economic rather than clinical autonomy. However, the limited predictive power of the models suggests social forces not explained by economic factors identified in the models.

Health policy implications of the elimination of an economically viable election of balance billing are considered, and its implications for a future health policy based on clinical autonomy and the needs of beneficiaries for protection from economic hardship is identified. It concludes that opportunities for better measurement of autonomy exist, and that autonomy must be considered in establishment of future physician payment systems.

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CHAPTER I

INTRODUCTION

In his critique of the development of sociological thought, The Sociological Imagination, C. Wright Mills identified the key problems of a gulf between "grand theory" on the one hand and narrow empiricism on the other. The first, he argued, pursued high levels of generalization which took into account only superficially the "social facts" which Durkheim identified as the basis of sociological theory. In the second instance, he argued that methodological pursuits dominated the development of sociological thought and the result was a fixation on data and its analysis which lends itself only to creation of very narrow theoretical structures (Mills, 1959, 74).

A more contemporary critique in this direction was provided by Collins in his work on sociological theory Conflict Sociology. He argued that development of a "meso-theory" was critical to the progress of future sociological thought. It was his contention that sociology had languished in an historical conflict during the later half of the 20th century between macro-theory, that had sought to achieve broad explanations of social phenomena akin to Mills' "grand theory", and micro-analysis, which had lost its sociological and explanatory power through concentration on methodological detail. Neither of these was sufficient to revitalize what Collins regarded as the stagnation of contemporary sociological scholarship (Collins, 1975, 5).

Following on these ideas from a somewhat different perspective was the contemporary French sociologist Bourdieu. His argument in support of the development of the school of "reflexive sociology" was that sociology and history have been erroneously and inappropriately severed. He wrote that "the separation of sociology and history is a disastrous division" (Bourdieu and Wacquant, 1992, 90). Without grounding in historical development, social forces, no matter how well analyzed empirically they might be, are plucked out of context and appear as sterile abstractions.

This study is an effort to bridge these profound theoretical objections by incorporating the key concepts of the sociology of professions, professional autonomy, through its historical development and change as the profession of medicine has evolved and changed to a specific historical picture which provides the basis in "social fact" for an empirical test of that theory. The specific case for empirical investigation is provided by the medical/economic practice of physicians in "balance" or "extra" billing of patients for the services provided in the aftermath of a major change in physician payment policy undertaken by the federal government in 1984.

To complete the intellectual development of this work, it is critical to provide an outlet for the sociological work

in what Marx referred to as "praxis", that is, the application of sociological theory and its findings to the development of social policy and practice. The outlet for this work is in the development of health policy, with specific reference to policies of the state toward physicians which reflect the clinical conditions of practice and the economic terms under which they take place.

In this regard, the relationship of the state to physicians is uniformly critical across all industrial societies. Physicians are regarded as the dominant professional power group in the health arena of these societies, and their decisions have profound influence on the nature and scope of health care in a given nation, as well as on its rate of health expenditures.

In the relationship between the medical profession and the state, balance billing or extra billing is at this historical juncture the single most critical question in the determination of the nature of that relationship, William Glaser, whose cross-national work on physician payment policies has been widely recognized since his seminal work Paying the Doctor (1970), has boldly asserted that the decision to balance or extra bill the patient beyond insured levels is "in every country...the most explosive issue between public authorities and medical

profession" (Glaser, 1989, 129).

By an organic metaphor, we may liken the development proposed in this work to form distinct levels of analysis, proceeding from the most general to the specific, and then to the policy application. The development of this statement is as follows:

Level of Analysis	Conceptual Reference	Organic Metaphor
Theoretical	Professional autonomy	Population
Historical	Development of clinical and economic conditions of the medical profession (1950 to 1990)	Individual
Empirical	Physician decisions to participate or not after the passage of the Participating Physician Program (1984)	"Thin-section" examination
Policy Application	Future change in physician payment policy	Prescription

There are two distinct aspects to the problem statement in this effort: The theoretical problem and the research problem statement. The first of these is the theoretical problem, which involves the diminution of professional autonomy as the defining characteristic of the medical profession under conditions of social and historical stress. It will be developed initially, with discussion of the research problem to follow.

THEORETICAL PROBLEM: PROFESSIONAL AUTONOMY

In undertaking this analysis, the key concept on which discussion focuses is autononmy of the profession. Wolinsky stated that autonomy is the keystone of a theory of professional dominance, stating that "All other characteristics of a profession flow from it. Thus, autonomy is the acid test of professional status" (Wolinsky, 1988, 44).

Medicine has been the archetypal representative of a profession in sociological literature in the second half of the twentieth century. Hughes has referred to the development of a profession as a "professionalizing movement", implying a dynamic process which an occupational group undertakes to advance its perceived interests (Hughes, 1984, 379). Presumably, this process might prove to be reversible as well. An occupational group might attain dominance within an occupational hierarchy under specific social and historical conditions, only to see this disappear as change occurs. In this regard, the classic example cited is the compromise of the professional standing of the clergy under conditions of secularization in Western nations. As the temporal influence and power of the church faded, so too did that of the clergy.

In earlier studies of professions, theorists tended to

array sets of characteristics or traits attained at the completion of a professionalization process by which one might identify a mature profession. Goode described these traits as part of an ideal type best exemplified by medicine and the clergy. Included in his list were items gleaned from a variety of professional theorists, including professional autonomy and "high income, prestige, and influence" (Goode, 1969, 276). Autonomy for Goode can be defined as having one's behavior judged by colleagues within rather than outside the profession. He argues that these facets, however, are derived from two central qualities of professions; namely, a basic body of abstract knowledge and the ideal of service (Goode, 1969, 277). Autonomy is considered a lesser feature of a profession in Goode's analysis as it will result from possession of the two key qualities.

It was left to Eliot Freidson to make autonomy the key distinguishing characteristic of a profession's development, rather than a derivative concept as Goode had argued. Freidson was sympathetic to Hughes' notion that a profession evolved and negotiated autonomy in relationship with its host society. Thus, he speaks of a "strategic" distinction that a profession acquires that separates it from other occupations. Simply stated, autonomy in Freidson's early work is the key factor in identifying successful strategy on the part of the occupation. It is

nothing more or less than the right of the profession to control its own work (Freidson, 1970a, 71).

This "clinical" dimension of Freidson's definition is based upon the profession's domination of the medical division of labor and its occupational hierarchy, and will be described throughout this work as "clinical autonomy." Basically, this concept provides for the independent exercise of professional judgment within parameters defined by the profession itself and scrutinized only by one's professional peers, if at all. This element of occupational hegemony within the health care division of labor is a pervasive thread through the work of all theorists examined here, although later theorists argue that it is weakening.

In keeping with Freidson's statements on autonomy, one can observe that at the macro level of the profession as a group that "clinical" autonomy exists as a delegation of authority from society, usually the state, to act in a self-regulating manner. How this legitimation is achieved is a point of controversy throughout the work, and clearly varies across nations and over time. This theme is also consistent throughout the work of the theorists discussed in this study with the exception of Parsons and his functionalist colleagues.

At the micro level of the patient-physician interaction, autonomy is derived from the perceived necessity of trust between the two parties in order to obtain beneficial therapeutic results. It is presumed that the physician acts in a fiduciary relationship on behalf of the patient who is unable to make appropriate choices in these matters as she/he lacks the professional and technical expertise of the physician. So that the fiduciary relationship is not violated, the physician must be granted autonomy to make the optimal choice on behalf of the patient. This construction of the relationship between the two parties has been challenged as "asymmetric", with undue assumption of power by the physician over the patient.

The second element of a discussion of autonomy follows directly on the profession's dominance of clinical work. This is economic autonomy, or the ability of the profession to control unilaterally the economic terms of its work. One might argue that this is most developed in the United States at the macro level, where organized representatives of the medical profession have argued over time for economic self control in the form of the fee for service model of medicine (Gray, 1991, 179). Freidson has written that this model creates the opportunity for abuse of the fiduciary relationship with the patient. Citing the credentialing process for physicians and its control by the profession, he refers to "an occupational cartel which

gains and preserves monopolistic control over the supply of a good or service in order to enhance the income of its members by protecting them from competition by others" (Freidson, 1986, 24).

The above summary based on Freidson's work refers to the ability of the profession to control supply of services in the instance of medicine through control of education and licensure programs. These privileges were obtained as a delegation from the state, as has been noted in the case of elements of clinical autonomy. This authority would lead to the ability to control price for services in a classical economic model of monopoly behavior (Feldstein, 1988, 171). So far, this is a relatively conventional economic situation, and one which might lend itself to restructure through increase in the supply of providers or controls on price. Neither of these, of course, would be popular with the profession's organizational representatives. Yet the first could be attained through greater public involvement in the educational process to train more physicians or the change of licensure laws to allow more ready importation of physicians. The second could be altered by the exercise of economic power by a significant purchaser of service, as has now occured in the United States with physician payment reform under Medicare.

The unique aspect of economic autonomy which sets this

discussion apart from other examples of economic behavior is derived directly from the fiduciary ethic which undergirds clinical autonomy. This is the ability of the physician to create demand through the ordering of services on behalf of his or her patient. These services, of course, in a fee for service model benefit the physician and create the unique role blend of purchasing agent for the patient as well as seller.

Gray has observed that "The dual role of the physician as entrepreneur and medical professional causes tensions and contradictions for the individual and the profession" (Gray, 1991, 178). This leads in turn to a conflict between a perceived business ethic and the professional ethic in instances when patients are rejected on the basis of inability to pay for services. This conflict, Gray notes, has been aided and abetted by several traditional components of the physician's business autonomy. He writes that "The physician's autonomy was maximized by several basic elements, most notably self-employment, fee-for-service payment, and a passive orientation on the part of third-party payers regarding whom the patient chose as a physician and what services were provided" (Gray, 1991, 204).

The exercise of this autonomy becomes problematic for society in a period of perceived shortages or misallocation

of resources for physician services. Autonomy may be derived from its clinical origins in the physician/patient relationship, but its major public policy ramifications are observed in the economic arena of health care expenditures. This development has significant implications for the state as a major payer for care and for Medicare recipients with potential personal obligations to pay for care. This study seeks to test this problem through specific physician choices which reflect exercise of economic autonomy.

RESEARCH PROBLEM STATEMENT

The research problem statement attempts to give a problem focus to the conflict Gray cites between the clinical and economic imperatives expressed by the medical profession. Specifically, this study examines the extent and nature of physician participation in balance billing practices as legislatively prescribed under the Medicare program. Balance or extra billing constitutes a significant problem in national health policy because it constitutes a critical convergence of the interests of the state, the elderly, and the autonomy of the medical profession. This study examines a specific historical point at which the exercise of physician autonomy is tested through the imposition of new payment policies of the state which directly challenge the basic ability of the physician to control his or her fee.

The fee has historically provided the basis for the economic autonomy of the medical profession in that the physician has been free to establish a valuation or price for his or her efforts (Starr, 1982, 63). Defense of fee for service practice has been a consistent principle for development of political strategies on the part of the medical profession in the latter half of the twentieth century (Starr, 1982, 272). Even a notable a figure in recent intellectual history as Freud felt obliged to

address the importance of physician control of the fee as part of the therapeutic process. He argues that the analyst should adopt the same unwavering attitude toward the extraction of the fee from the patient as the "surgeon, who is frank and expensive because he has at his disposal methods of treatment which can be of use" (Freud, 1958, 131). In other words, the fee is a source of validation of the worthwhile nature of treatment, and to be rewarded as a scarce and valuable service.

The enactment of the Participating Physician Program in 1984 created a unique opportunity to examine the choices of physicians with respect to billing of patients beyond established Medicare fees. At that time, physicians were required to choose through the signing of a formal participation agreement whether they wished to become a participating provider and forgo the opportunity to extra bill patients for balances in excess of Medicare allowable rates. Prior to the passage of DEFRA 1984, physicians had been allowed to determine assignment practice on a case by case basis.

For the convenience of the reader and for reference throughout the study, a description of Medicare Physician payment policies prior to and following the enactment of DEFRA 1984 is described in Tables 1.1 and 1.2. These Tables are designed to show the interrelationship of

TABLE 1.1

MEDICARE PHYSICIAN PAYMENT POLICIES
PRE-DEFRA 1984
APPLICABLE TO ALL MEDICARE PROVIDERS

	Medicare's Policy	Definition
Assignment of Claims	Case by case basis: Selection made by physician based on individual patient or procedure at time claims assigned; Medicare allowable rate.	Beneficiary's directive to Medicare to pay benefits directly to the physician. Medicare will only do this if the physician accepts Medicare's allowed rate as payment in full (Guarantees not to balance bill). (PPRC, 1992, 363)
Balance (Extra) Billing	Allowed in all cases up to level of full fee if claim is not assigned; patient billed directly and pays balance as well as Medicare portion (with exception of Medicaid)	A physician's charge exceeding the Medicare-allowed charge. (PPRC, 1992, 363)
Economic Consequences	Physicians lack incentive to assign claims; incentive balance billing as Medicare fee freezes of 1970's cause charges and Medicare allowable payments to diverge.	Behavioral implications for physician choice-making based on the economic conditions of the program; physician characteristics; and patient characteristics. (Rice and McCall, 1983)

TABLE 1.2

MEDICARE PHYSICIAN CHOICE ALTERNATIVES
POST-DEFRA
1984

	Participating Physician	OR	Non-Participating Physician
Assignment of Claims	Yes - Mandated by by contract		No - Subject to choice of physician on case-by-case basis as was true pre-DEFRA.
Balance Billing	No - Forbidden by contract		Optional - allowed to to extent of full charges if physician chooses to balance bill.
Economic Consequences	Physician assured: 1) 7-day payment 2) Exemption from fee freeze (4% advantage over non-participants) 3) Electronic billing 4) Directory inclusion		Physician can balance bill to extent of full fee; but is at risk for balance on non-assigned cases. Receives payment at lower non-participating level on those assigned cases.
Definition	A physician who signs a participation agreement to accept assignment on all Medicare claims for one year. (PPRC, 1992, 371)		A physician who does sign a participation agreement and, therefore, is not obligated to accept assignment on all Medicare claims. (PPRC, 1992, 370)

payment policy, assignment of claims and consequent balance billing behavior by physicians.

Advantages to particpating providers were both economic and qualitative in nature. Physicians signing an agreement were exempted from an imposed Medicare fee freeze which was applied to non-participants. The net effect of this freeze was to alter the profile of the individual physician in favor of participation by allowing fee increases while those of non-participants remained stable. Physicians were included in a directory, however accurate or inaccurate it might be, of participating providers as a marketing incentive, and beneficiaries were informed of the availability of such directories (Holahan, 1986, 105). In order to assist participants in the billing process, dedicated phone lines were established for submission of electronic claims. Payment time was also shortened to seven days less than that for non-participants (Mitchell, Rosenbach, and Cromwell, 1988, 17).

By creating a decision to participate with enhanced incentives, one might presume that physicians who decide not to participate would pursue a strategy of economic maximization in which patients would routinely be billed at full charges in excess of the Medicare allowed amount. Feldstein (1988) has shown the balance billing decision as one in which the physician trades off certainty of payment

under assignment of claims against the higher level of total payment which he or she might receive through non-assignment. Physicians serve private market patients up to the point where marginal costs equal the Medicare assigned price. This assumes that the physician is unable to fill his or her panel exclusively with private patients. If the physician becomes a "price taker" and accepts the assigned value paid by Medicare, he or she does so to offset lack of more lucrative business. The physician would enter the Medicaid market only in the absence of private or Medicare patients. Should either the supply of available private patients to the physician increase or marginal costs increase beyond Medicare allowed payments, the physician might reverse his or her election to accept assignment and revert to balance billing as the market will sustain it (Feldstein, 1988, 192-193).

The economic model of Medicare assignment presents the physician as rational actor pursuing a strategy of economic maximization. Prior to DEFRA 1984, the choice to assign a claim could be made on a case by case basis with no disadvantage to the physician. The introduction of the participating physician program created incentives to commit to take all patients on assignment rather than case by case. A key element which has been criticized as lacking in the early work on the economic basis of electing case by case assignment is the factor of risk of

non-payment of the charge by the patient. Proponents of this position argue that a physician may well decide in a rational economic sense to accept payment on assigment if substantial risk of failing to collect the balance bill amount exists. Examples of such instances are patients in financial distress, those lacking in supplementary coverage for physician fees, or those receiving large bills such as those of surgeons (Rodgers and Musacchio, 1983, 60).

The enactment of the Participating Physician Program created what would initially appear to be a division of physicians into two groups. The participating physician agreed to accept assignment in all cases, and received specified incentives to encourage this choice. In this instance, the Medicare program pays the provider directly and in full the "reasonable" charge, minus the patient's mandatory twenty per cent coinsurance required by law and any deductible amount. The clear public policy intent of this legislation was to increase assignment rates for claims and charges, which had hovered around the fifty per cent level throughout the 1970s, with an actual decline in each rate in the mid-1970s and a slow increase thereafter (McMillan, Lubitz, and Newton, 1985, 62). The physician selecting participation could be said to opt for a position in which risk is avoided and administrative costs are minimized while foregoing the opportunity for income maximization. In Feldstein's terms, she or he becomes a

price taker rather than a price setter operating in a public market rather than a private one.

Conversely, if the physician chooses to refuse to participate, he or she retains the ability to set price and to depend upon the patient for payment of the total bill beyond the amount allowed by Medicare. As noted in the theoretical discussion, control of price setting within the profession is a key characteristic of professional autonomy. Historically, the patient bore full direct liability in situations in which he or she saw a non-participating provider. The patient was billed for the full amount by non-participants and asked to pay the physician directly while being reimbursed by Medicare for the allowed amount. This practice was modified by the passage of OBRA 1990 to require that the non-participating physician must bill Medicare for the allowed amount rather than imposing this burden on the patient.

To this point, the choices seem straightforward and explainable within the context of conventional economic theory. The Physician Payment Review Commission, however, observed in its 1988 Annual Report to Congress that "carrier representatives indicate that they serve significant numbers of physicians who accept assignment nearly all of the time but who do not participate" (PPRC, 1988, 145). This stance seems economically paradoxical

given that these physicians will neither receive the higher allowable payment level provided by participation; nor the benefit of eventual higher payment as a non-participant who balance bills.

The PPRC suggested that these decisions may result from ideological stances on the part of the individual physician. In its 1988 Report, the Commission stated that "philosophical attitudes appear to be the single most influential factor affecting participation rates" (PPRC, 1988, 145). The Commission report continued that physicians who accept assignment as a matter of routine yet do not sign participation agreements appear to be well informed concerning the program and the consequences of their choices, yet refuse on the basis of their belief in the freedom of physicians to set fees (PPRC, 1988, 145). The Commission concluded that "Given the financial incentives to participate for physicians who generally accept assignment, noneconomic factors must primarily explain such discrepancies. Apparently, since PAR [participating] physicians are locked in--albeit voluntarily--to Medicare's fees for an entire year, some physicians view the PAR program as government fee setting" (PPRC, 1988, 145-146).

FACTORS INFLUENCING THE ASSIGNMENT DECISION

A significant body of literature developed in the late 1970s and early 1980s surrounding the decision of physicians to accept assignment on a case-by-case basis which resulted from federally funded inquiries into the problem. Many of these studies predated the Participating Physician Program, and were instrumental in creating the argument for its adoption as public policy in 1984. The results of these studies to date are such, however, that one might conclude that significantly greater insights into physician behavior might well be possible. McMillan, Lubitz, and Newman have written that "Our understanding of physician decision making about acceptance of assignment is limited. We know raising charge levels will raise assignment rates, but we have few other policy-relevant findings" (McMillan, Lubitz, and Newman, 1985, 74).

Perhaps the most direct response to the above statement is furnished by the work of Rice and McCall (1983). In their paper entitled "Factors Influencing Physician Assignment Decisions under Medicare", they employed multiple regression analysis to examine physician decisions in 6,500 claims filed in 1979 through the Medicare program by Colorado physicians. They determined the relative influence of physician characteristics, beneficiary characteristics, or characteristics of the particular service performed by type or dollar amount on the assignment decision (Rice and McCall, 1983, 46). This study, of course, predated the

passage of DEFRA 1984, so the assignment decision at the time of the study was still solely made at the time of consideration of individual claims.

The most significant conclusion reached by Rice and McCall (1983, 54) is that "characteristics of physicians themselves proved to be the most important determinants of assignment rates." Their study indicated that physicians charging higher fees were less likely to accept patients on assignment, as evidenced by lower rates among board certified physicians and medical specialists versus generalists (Rice and McCall, 1983, 54). Moreover, the conservative explanation of the medical profession that patients are balance billed on the basis of their ability to pay or physical condition, in a sort of individual means test, was not supported. Such factors were of lesser importance, although of some significance, in determining assignment behavior than were the characteristics of the physicians and the opportunities for balance billing that possession of special attributes might furnish to a physician (Rice and McCall, 1983, 54).

STRUCTURE OF THE STUDY

The purpose of this study is to review the development of the theory of professional autonomy as an historical evolving phenomenon. It is then the objective to test this theory at a specific point in time using survey data gained from a nationwide survey of physicians to "ground" discussion of their attitudes toward a specific problem, the Medicare participation and assignment decision, which is reflective of a general theory of professional autonomy.

Chapter II traces the development of the key concept of professional autonomy through four distinct professional eras. This is demonstrated through a review of the literature of the complex reactions of physicians to a changing professional environment.

Chapter III provides the theory and develops the models for hypothesized relationships explored in this research. Specifically, the empirical portion of the study elaborates on the assertion of Rice and McCall that physician characteristics are the most important determinant of assignment choice; surpassing those considerations of patient characteristics or economic and service characteristics. These questions will be tested through the use of multiple regression techniques involving selected physician characteristics chosen on the basis of

prior identification in the literature of physician assignment behavior. For those physicians choosing not to balance bill, chi square analysis will be conducted of the expressed practical or ideological reasons for not balance billing.

Chapter IV presents a review of salient findings and tests three theoretical models. Chapter V presents a summary of the study and integrates the policy recommendations with refinement and expansion of several generations of theory related to professional autonomy. The prospects for replication and future research and theory development are also explored.

The critical application of the work presented in this study concerns the future of physician payment in the evolving Medicare program and the broader health system of the United States. The historical review and discussion of the alteration over time of the concept of professional autonomy are meant to demonstrate that the concept is not static and is subject to redefinition under changing historical circumstances. If a strategy for physician payment is accepted as a key element of any successful health care reform program, then the lessons drawn from the evolution of autonomy and its influence on the clinical and economic decisions of physicians as tested in this study will be of major import. Such a policy cannot rely simply

on economic analysis and strategy, but must also encompass the social forces encountered in this study.

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CHAPTER II

REVIEW OF THE LITERATURE: PROFESSIONAL AUTONOMY

INTRODUCTION

This paper traces the development of the key concept of professional autonomy through four distinct interpretive eras, reflecting a study in the sociology of knowledge. The first of these is the functionalist, commencing with the work of Parsons and continuing through 1970. In this period, autonomy for the profession is seen as functional to the conduct of society. Clinical and economic autonomy are seen as in balance.

In the second period, professional dominance, theory is derived primarily from Freidson and is oriented toward the physician's dominance of the occupational hierarchy and clinical activity. The "flaw" of professional autonomy appears, but in the context of lack of professional self regulation. This phase extends roughly through the 1970s.

The third period, the 1980s, is one of revisionism, in which focus shifts to economic concerns in an era of increased awareness of physician costs and income. Business autonomy is seen by revisionist commentators as a prime motivator which is camouflaged by clinical autonomy. International comparisons to the United States demonstrate that autonomy is relative across different systems, and that varying levels of both clinical and business freedom exist in Europe and Canada. Cost containment efforts and

the creation of the Physician Payment Review Commission push economic interests to the fore of the policy agenda. At the same time, sociological theorists are also examining the relationship of medicine to other occupational sectors and forces outside health care which are seen as directly affecting medicine's autonomy.

The fourth period, and the one which leads to the empirical analysis in this study, is that of decline and redefinition, starting in the late 1980s to the present. Clinical autonomy is reasserted as a concern, while leadership of organized medicine begins to support economic reform. This latter sentiment is not shared in all sectors of the profession, as the ideology of entrepreneurism remains strong even in the face of changing forms of payment and practice organization.

PERIOD ONE

FUNCTIONALIST ORIGINS OF THE CONCEPT OF PROFESSIONAL AUTONOMY

PARSONS AND THE PROFESSION: MEDICINE VERSUS BUSINESS

In reviewing the development of the concept of professional autonomy, one must first consider the pioneering work of Parsons in his writings on the professions. His major theoretical effort in this area may be identified in his 1951 work The Social System. Gerhardt has suggested that Parsons' theoretical treatment of the relationship between the professional and client established medical sociology as a legitimate branch of sociological inquiry (Gerhardt, 1979, 229).

The problem which led to Parsons' interest in the professions had appeared in earlier phases of his work, and has been depicted as a response to the classic Hobbesian problem of "How is society possible?" Such a characterization is consistent with Parsons' general interest in the nature of social order within the broader social framework of a capitalist economic system. This problem had provided the basis for his doctoral dissertation at Heidelberg, and was carried forward into his first major theoretical statement, *The Structure of Social Action* (1937). In this work, he approaches the question of why a simple economic utilitarianism is an incomplete answer to this question-- even in a capitalist social order which espouses the benefits of pursuit of calculated, rational action oriented towards maximization of one's economic gain. In this respect, he is readdressing

the problem identified earlier in the century by Max Weber in The Protestant Ethic and the Spirit of Capitalism.

Interestingly, Parsons' writings on this subject have given rise to two alternative readings of his position. The most frequently cited is that identified by Light in which Parsons contrasts the pursuit of self interest on the part of the businessman as archetypal contemporary capitalist versus the more altruistic orientation of the professional. Light suggests that in Parsons' early work professions were viewed as taking a collective stance toward clients, while business assumed a competitive one (Light, 1989, 465).

This observation is derived from Parsons' early writings on the relationship of the professions to capitalism. In his essay on "The Professions and Social Structure", Parsons depicts contemporary capitalism as an economic system dominated by the "high degree of free play it gives to the pursuit of self-interest" (Parsons, 1954, 35). In this popular view, the profit system is the predominate feature of business and commerce, while the professions are seen to be distinguished by their "disinterestedness", presumably in the material benefits held out as a reward in the capitalist order for rational pursuit of one's economic advantage. He does comment, however, that some contemporary observers view the professional "spheres as

becoming progressively commercialized, so that as distinctive structures they will probably disappear" (Parsons, 1954, 35).

In a later work Parsons sheds some "semi-autobiographical" light on his interest in this problem and its broader implications for the discipline of sociology. In his review of his sociological career, Parsons suggests that at the time of his initial writing in medical sociology that the "principal link between medicine and the social sciences was by way of 'medical economics,' not medical sociology" (Parsons, 1964, 325). The particular catalyst for this observation was the report of the Committee on the Cost of Medical Care which appeared in 1932 (Anderson, 1985, 94). Parsons notes that this enterprise was undertaken in the early stages of the New Deal to bring together the insights of academic economic analysis and public policy-- an effort which has enjoyed renewed popularity in the health cost "crisis" atmosphere of the 1980s. While the report of the commission did succeed in bringing the issue of medical costs to public consciousness and the recommendation that better management of hospitals through application of business principles take place, the bulk of the report was rejected as a result of violent opposition of the American Medical Association which had denounced the report as socialistic. Parsons acknowledges that his initial line of inquiry was framed in economic

terms as well (Parsons, 1964, 326).

Parsons suggests that theorists of capitalism, especially those in the Marxist tradition, had treated the business firm as the building block organizational form of society beyond the family. Yet the existence of the professions seemed to defy this conceptualization of society in that self-interest appeared to be repudiated by and for the rising professional groups. At the same time, the professions existed within the private sector, and were not to be identified with the "socialistic" interests of government (Parsons, 1964, 327).

Other commentators, Parsons observed, had seen the relationship of the professions to business roles as a dichotomy found in the classic social thought of Toennies and the differentiation between Gemeinschaft and Gesellschaft. In this schema, the self interested action of the businessman is seen in the modern form of gesellschaft which Toennies deplored as undercutting the traditional communal social fabric. This controversy was observed in the work of Durkheim, who took exception to the glorification of the past he observed in Toennies, identifying instead the superiority of organic solidarity in modern society (Durkheim, 1984, 101). Rather, Durkheim views the communal ethos of Toennies' Gemeinschaft as a less developed and inferior conceptualization which he

identifies with mechanical solidarity evidenced in socities in which the division of labor is less developed. Parsons too suggests that the differentiation of social orders in the Toennies formulation was simplistic and in any event did not serve to explain the relationship of business or economic development of society in contrast to the professional order. He poses the question, "Could these dichotomies suppress consideration of the independent components which were not inexorably tied to each other?" (Parsons, 1964, 328).

Departing from consideration of the economic versus altruistic features of the professional role, Parsonsa suggests that greater attention be paid to the "functional specificity" of the professional role, which demonstrates the particular place of the professional in the division of labor in the broader society (Parsons, 1954, 40). Here his theory coincides with that of Durkheim in attempting to demonstrate the place of the professional in a general division of labor under capitalism and its functional importance. Parsons suggests that in fulfilling these functions that there is "little basis for maintaining that there is any important broad difference of typical motivation between business and the professions, or at least any of sufficient importance to account for the broad differences of socially expected behavior. On the other hand there is a clear-cut and definite difference on the

institutional level (Parsons, 1954, 46).

AUTONOMY'S FUNCTIONAL BASIS: THE PATIENT AND PHYSICIAN

One must instead look at the universal elements manifested in the patient-physician interaction, for the patient is also a producer of his/her health in Parsons' typology as well as a consumer (Parsons, 1964, 338). This relationship is identified, of course, in Parsons' now classic formulation of the "sick role" in which specific obligations of social control are created for the physician and in which an asymmetric power relationship between the two parties is a given.

In his most succinct discussion of the subject of the sick role, Parsons describes illness as a social role which attracts individual actors to a deviant status which must be controlled (Parsons, 1956, 613). The characteristics of the role of the sick person which he identified included (1) the exemption of the sick person from normal obligations of daily life; (2) exemption from responsibility for his/her condition; (3) the partial legitimation of the claim to the role in that the person must concede that the role is an undesirable one; and (4) the obligation to seek help, "of persons specially qualified to care for illness, above all, of physicians" (Parsons, 1956, 613). It is informative that Parsons characterizes the role of the sick person as one in which

he/she is "exempted" from other social obligations, thereby emphasizing the deviant aspect of the role from what is otherwise required for the "functioning" of society.

The role of the professional in society, and the particular requirement of professional autonomy which is most fully developed in the case of medicine is in Parsons' scheme an outgrowth of this interaction of the patient and the practitioner. In Parsons' system as developed in *The Social System*, the physician is an agent of social control to ensure the "reintegration" of the person with illness into society (Parsons, 1951, 477). The autonomy associated with the role of the practitioner is an affirmation of the "professional authority [of the physician] and justification of the 'privileges' he must be accorded (Parsons, 1951, 475). Without the acceptance in trust of the role of the physician on the part of the patient, therapy will fail and society sui generis will not be served.

As in the case of the patient occupying the sick role, specific obligations accrue to the physician as well. The first of these is the technical specificity of the physician's role. It is necessary that this be achieved through rigorous training, and that continuation in the *role be on* the basis of satisfaction of performance criteria for technical competence (Parsons, 1951, 434). A

second element and corollary of technical competence is the delimitation of the expertise of the physician to the functionally specific area of health. Much as Weber identified the possession of technical competence as the requisite crieria for advancement within the bureaucratic model of society, Parsons makes similar claims for the profession of medicine (Weber, 1946, 197). Parsons writes that "There is an intrinsic connection between achieved statuses and the requirements of high technical competence....." (Parsons, 1951, 434). In effect, the high status of the physician is "deserved" in this system, and stratification is justified as a reflection of the "complexity and subtlety of knowledge and skill required and the consequent length and intensity of training" which the physician possesses in contrast to a mother with a sick child in Parsons' own example (Parsons, 1951, 434).

A third element of the practitioner role is that of the affective neutrality of the physician toward the problem of the patient. Parsons argued that without such distancing on the part of the physician that the need for painful or difficult courses of treatment might be rejected which would otherwise be in the best long term interest of the patient. It is obligatory that the physician act to treat "objective" problems in "objective, scientifically justifiable terms" (Parsons, 1951, 435).

The final element in the physician's role is that of universalism, or the obligation to treat all patients alike regardless of attributes other than objective medical conditions and demonstrated need of assistance. It is in this regard that Parsons draws the distinction against which he is arguing in a narrow sense; that of the differentiation of medicine and business. He suggests that the ideology of the profession demands that the "'profit motive' is supposed to be drastically excluded from the medical world" (Parsons, 1951, 435).

He suggests that it is necessary to look beyond the limits imposed by viewing the patient and the physician as a transaction between two actors, and instead "To treat even this dyad as a total social system, above all as a collectivity with common norms and values" (Parsons, 1967, 357). In this manner the asymmetrical power relationship between the physician and the patient is justified as fundamental to the functioning of society in returning the person to health rather than as a reflection of passivity on the part of the patient (Parsons, 1975, 257). In this notion, Parsons again stresses the orientation of the physician to the "collectivity", and the special obligations to the broader society which this entails (Parsons, 1951, 475).

TRUST AS THE BASIS OF POWER

The superiority which Parsons ascribes to the role of the physician is based upon "special responsibilities" which the physician holds on behalf of the broader society in relation to the patient. The basis for autonomy of the profession in his scheme is confirmed not merely on the basis of technical competence, but rather the fiduciary obligations granted to the physician for the health of society (Parsons, 1975, 268). Trust must be present in the relationship of the patient to the physician in order for recovery to take place in Parsons' microanalysis of the specifics of the patient-practitioner relationship. In this conclusion he borrows from the psychoanalytic model of overcoming ambivalence in the mind of the patient through the dynamics of the mechanism of transference to the therapist (Parsons, 1954, 611). On a macroanalytic level, the social role of the physician is described by Parsons as the exercise of fiduciary responsibility for the health of patients "and to act within the limits of his prerogatives as a genuine trustee of the health interests of the patient population relative to whom he assumes responsibility" (Parsons, 1975, 268).

Role symmetry is an impossibility for Parsons if these ends are to be achieved, and autonomy for the professional is a result. In a review of his work in 1975, he argues in response to critics that "with respect to the inherent

functions of effective care and amelioration of conditions of illness, there must be a built-in institutionalized superiority of the professional roles, grounded in responsibility, competence, and occupational concern" (Parsons, 1975, 271). The status differential of the practitioner from the patient and of the physician in relation to the remainder of society exist because they serve the interests of society-- they are, in a word, functional.

The asymmetry of roles of professional and patient is critical to Parsons' notion of autonomy of the professional. In a different context, discussing the sociological derivation of power, Parsons suggests that in democratic societies "the limit to the equating of universalism and equality lies in the concept of competence" (Parsons, 1983, 123). It is on this basis that autonomy for the professional is crucial, for the unique technical competencies which she/he possesses in Parsons' view makes critical external review an impossibility. Furthermore, it is likely to be undesirable as well for the interests of actors within the social order, given the functional requirement of trust in the patient/practitioner relationship.

CRITICISM OF THE SICK ROLE THEORY

Parsons' depiction of the relationship and its asymmetry

has been a point of disagreement with his critics, who see the Parsonian depiction as a debatable ideological construction. Barber has neatly summarized the problem by noting that the autonomy garnered by the professional in his/her role "is often at the expense of the autonomy of others, both their subordinates and their patients" (Barber, 1985, 219).

Criticisms of the sick role paradigm are widely discussed in the medical sociology literature, and have been identified by Light as including: (1) Too narrow a theoretical domain; (2) Applicable to only a limited range of illness, specifically neglecting chronic diseases; (3) Its formulation suffered from a management bias, giving excessive weight to professional definitions; and (4) although the model might be a reasonable description for society in total, it revealed little about known variations witin societies (Light, 1989, 466). For the purposes of this study, the most significant objections are those surrounding point three, that of the "management bias." However, it must be stated that in a broader context of the Parsonian social system that the other objections are of equal significance in that the autonomy of the profession is justified in a variety of ways which support the system in toto.

Gallagher has argued that the problem of asymmetry has been

focused too narrowly. While it is true that within the immediate doctor-patient relationship that a greater amount of influence resides with the physician, "the patient has the prior option of deciding whether to consult him at all; and the continuing option to terminate the relationship lies much more with the patient than with the doctor" (Gallagher, 1976, 216). Fox, perhaps the most prominent of Parsons' students in the specific area of medical sociology, has noted that the patient is in a greater power position as "client" or "consumer" vis-a-vis the physician (Fox, 1986, 392). She also points to a second area in which the preeminence of the physician may be said to have diminished; that of the emergence of new practitioners who have appropriated certain of the tasks and responsibilities formerly reserved in the division of labor for physicians. Fox writes that "The emergence of nurse-practitioners and physician's assistants on the American scene is perhaps the most significant sign that some blurring of the physician's supremacy vis-a-vis other medical professionals may also be taking place" (Fox, 1986, 392).

The "management bias" cited earlier is a reflection of a particular model of physician/patient interaction, that of a one to one encounter of the two participants. As Freidson would later demonstrate, the advancing trend toward practice in multi-provider settings has altered this interaction significantly (Freidson, 1989, 86). Within

the context of group practice, the patient is offered the option of selecting from a number of providers without leaving the group itself. The result is in theory a decrease of the patient's dependence on any single provider.

On a broader scale, Starr has observed that the widely discussed physician surplus projected in the GMENAC study of 1980 will further erode the traditional dyad of the "loyal" patient and physician (Starr, 1982, 422). Corporate decisions concerning the inclusion or exclusion of various providers from their plans have introduced a variable beyond simple patient/physician preference in which the relationship with a specific provider may be prevented, if not necessarily mandated, by a third party payor. A significant caveat to these objections concerns current debate regarding the access of the patient to primary care providers on which one might argue that Parsons' model is primarily based given the relatively limited degree of specialization which had taken place at the time of its publication in 1951. Colwill has observed that the ratio of primary care physicians to specialists has reversed in the ensuing 40 years from a 70% primary group in 1950 to 70% specialist today (Colwill, 1992).

CONSUMER CHOICE AS A CHALLENGE TO PARSONS

The shortage of primary care providers alters the assumption in Parsons' scheme of a continuous relationship of patient and provider. Instead, patients increasingly access the physician through groups or organizations. This creates a new asymmetry in which the patient lacks power in relation to an organization rather than an individual and which now becomes the agent of social control.

Objections to the classic Parsonian model are grounded in interactions which lend themselves to analysis on a specific case basis. Empirical studies have been particularly significant in challenging the general applicability of the model as too culturally and historically specific; ignoring issues of cultural diversity in the patient population and supporting middle class virtues traditionally associated with American individualism. An excellent example of such an alternative approach is the work of Zola. In his classic study of cultural differences in response to illness among Irish and Italian Americans, he observed a difference in symptoms which would be reported to the physician, the severity of the distress experienced, and even the decision to enlist the help of the physician in the first instance (Zola, 1966, 615).

An alternative challenge to the Parsonian model is the

categorization developed by Hayes-Bautista Drawing upon grounded theory and the concept of negotiated order, he argued that the patient was indeed able to exercise autonomy in influencing the physician in the direction of an outcome perceived as desirable by the patient. These strategies are referred to as convincing and countering tactics (Hayes-Bautista, 1976, 234). This approach seems to reflect greater symmetry in the patient/provider relationship than was conceptualized by Parsons. Indeed, the technical competence which Parsons promotes as the functional basis for the superior relational standing of the physician is reduced to a set of tactics on the part of the practitioner to sustain the imbalance in the relationship. Hayes-Bautista refers to these tactics as the "overwhelming knowledge" approach and the "medical threat", both of which seem geared to keep the patient in "their place" (Hayes-Bautista, 1976, 234).

The notion of patient autonomy is further developed by Gallagher in his paper concerning the Parsonian paradigm of illness and resultant behavior. In addressing the problem of chronic illness, Gallagher observes that the concept of social control in Parsons' scheme requires that the patient actively seek to get well in the sense of cooperation or compliance with the advice of the physician. However, he notes that while the patient may accede to the technical expertise of the physician in the sick role, the patient

"does not delegate moral authority" (Gallagher, 1976, 210). He continues that the patient will cooperate "not because his independent control is already pre-empted by the professional's conduct as a legitimate representative of a moral order but rather because it 'makes sense' for him to do so-- in the sense of an autonomous ego. He is not simply compliant" (Gallagher, 1976, 210).

The autonomy of the patient as a moral actor threatens in Gallagher's analysis the trust which Parsons deems essential to the complete interaction of the patient/physician dyad. The Parsonian model is presented as physician dominated in its emphasis, with the physician unleashing the powers of the institutional apparatus of the hospital and technology. The shortcoming of the theory, Gallagher argues, is that "it overestimates the therapeutic impact of the physician and medical institutions. It correspondingly underestimates the potential therapeutic impact of the family and other lay supportive systems" (Gallagher, 1976, 213). Rather than continue the Parsonian tendency to overly stress the autonomy of the physician in relation to the patient as a result of the functional requirements of society put forth in his model, Gallagher concludes that it is necessary to make a "more specific theoretical delineation of the social structure of the medical profession" (Gallagher, 1976, 218).

Another less supportive analysis than that of Gallagher to the general Parsonian model is advanced by Idler. She advances the Gallagher argument of medico centrism by asserting that Parsons, and his detractors for that matter, have failed to analyze illness or health states independent of the medical profession . She states that the limitation of this view is one in which Parsons adopts a medical definition of the situation and then follows "its social consequences" (Idler, 1979, 724). Her criticism centers on the supposition that medical sociology is shaped by the Parsonian insistence that the ill person seek "technically competent" help of medical professionals. In this respect, the autonomy of the patient is immediately subordinated to that of the physician. Idler suggests that all of this is necessary in the functionalist framework to stem the deviance implicit in the sick role and attendant desocialization (Idler, 1979, 724).

PARSONS' RESPONSE: RELATIVE AUTONOMY

These criticisms have in part been confronted by Parsons in his later writings. Noting the criticisms which had been made of the sick role and its perceived emphasis on deviance, Parsons responds by suggesting an interrelatedness of integration of the person back into society on the one hand and adaptation on the other which neatly set forth the functionalist position. He chastises his sociological colleagues by stating that they do not

commonly take into account "the underlying relativity as between the concepts and functions of integration on the one hand, adaptation on the other. Certain concrete problems and phenomena may belong in one of [sic] the other category according to the system reference in terms of which they are treated" (Parsons, 1975, 261).

This illustration is significant to the development of the concept of autonomy within Parsons' thought, for it shows in a very specific case his ability to assimilate within his system a variety of critical positions. He argues that the interpretation which emphasizes integration as of greatest importance in drawing upon the resources of the person as actor is really an unduly "micro" orientation. In fact, therapy is "predominantly a reintegrative process" in which social solidarity with the family and other elements of society is restored (Parsons, 1975, 260). In the "macro" world of the social system, it makes little difference which perspective is taken on individual episodes. So long as the system, the "social environment" which Parsons quotes as constituting the organism as a whole in Durkheim's terms, is served individual cases matter relatively little (Parsons, 1975, 261). As noted earlier, the concept of asymmetry in the patient/physician relationship is challenged in the work of Zola and Hayes-Bautista among others. Yet as Parsons notes in the same paper, asymmetry is still to be regarded as functional

and supportive of the social order in the same manner in which by analogy asymmetry exists in the relationship between instructor and student in higher education (Parsons, 1975, 275). In both instances, society is served by the technical competence the instructor and physician bring to bear on the interaction, and power is legitimated in the Weberian usage of the word by their respective competences in relation to those whom they ostensibly serve (Parsons, 1983, 123).

This seeming tautology in Parsons' general theory is one in which the evidence gleaned from studies of discrete interactions may always be subsumed in the more general theory of action. But before leaving Parsons on this concluding note to explore his students and his critics, it is significant that Parsons actually attempted an explanation of the social organization of medicine from a political/economic perspective which would be considered in Collins' scheme to be a "meso-level" theoretical analysis (Collins, 1988, 247).

In earlier discussion, it has been noted that a critical point in the physician/patient interaction, one which legitimates the asymmetric power relationship between the two parties, is the principle of trust. Without the establishment of the "fiduciary" relationship, therapy cannot succeed in either a physical or psychological sense,

and society's interests sui generis will not be served. As Gerhardt argues, "A common element of value orientation is the commitment towards effectiveness for the doctor who treats and for the patient who restores his capacity" (Gerhardt, 1987, 126). This value orientation, she contends, is at the base of the current dominance in industrial society of medicine over other professions such as the law, clergy, and social work in that medicine represents a role of "instrumental activism" on society's behalf in curtailing deviance, and is thus most congruent with industrial society. Parsons articulates this point by writing that "the pattern of this value-complex has not changed in the relevant time period, but the *content* has become more inclusive and more generalized, so; that those committed to the value-pattern, and so situated in the social system that they must take and important share of responsibility for its implementation, must consider a wider range of conditions to fall within their sphere than before, and must be open to the relevance of a wider range and higher level of facilities, notably knowledge and skill, than before" (Parsons, 1964, 354).

PARSONS AND THE POLITICS OF MEDICINE

As Gerhardt has astutely observed, in one of Parsons' less widely known writings several important observations are made regarding medical politics and its influence on the shaping of public policy in the health care arena.

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Gerhardt writes that Parsons interprets the AMA, speaking on behalf of its constituent physicians, as only partly reflecting the values of contemporary industrial society and increasingly powerful "scientific" (or rational, technically proficient) medicine (Gerhardt, 1987, 126).

The AMA, in his view, represents "the interests of the traditionally single-handed small-entrepreneur practitioners," and ignores the fact that even in the 1960's the majority of medical services were insurance financed through government or private third parties (Gerhardt, 1987, 129). Parsons makes this point directly when he writes that "Personally I do not think for a moment that the critical institutional difference between business and the profession with respect to the profit motive has been eliminated. What I do argue is that insistence by the official spokesmen of 'organized medicine' that the individual fee-for-service mode of organization is the morally ideal one lays the profession wide open to the charge that they have abandoned their ancient and honorable devotion to the welfare of the patient" (Parsons, 1963, 29). This observation results in a difficult problem for Parsons within the overall functionalist system. As Colombotos and Kirchner have accurately observed in commenting on the same Parsons essay, "for Parsons, it is a paradox why a profession which is 'organized about the institutionalization of applied science' and thus is

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expected in general 'to be in the forefront of the general process of progressive change in industrial society should politically align itself with the eelements which have been resisting these very patterns of change'" (Colombotos and Kirchner, 1985, 25).

Gerhardt suggests that the above statement demonstrates a greater awareness on Parsons' part of the social and economic milieu in which medical practice operates, and demonstrates an anticipation of later criticisms which view physician autonomy as "an ideological offshoot of the control exerted by the medical profession over the populace (Gerhardt, 1987, 128). The significance of this observation for sociological theory is the understanding that Parsons is creating in his model of the physician/patient interaction an "ideal type" in the truest Weberian meaning. As Weber noted in his writings, the ideal type is "prepared with a rational consistency which is rarely found in reality" (Weber, 1946, 323). In this case Parsons notes the tension between an economic institution, namely fee-for-service medicine, and the greater coherence with functional values of the broader society which is contained within the physician-patient relationship regardless of economic structure. One might even suggest here that Parsons is forseeing the emergence of later elite theories in which a minority dominates policy formation and pursues narrow economic interests.

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Parsons' observations regarding the AMA also call into some question his early theoretical reliance on voluntarism. In this instance, the leadership structure within medicine is seen at odds with the general direction of society as manifested in its norms of patient/physician interaction. If autonomy is demanded for the practitioner in the realm of direct interaction with the patient, can this not be compromised by the admittedly misguided acts of a leadership elite which he has identified? In a real sense, the development which Parsons observes is reminiscent of Michels' observations regarding the development of oligarchy within democratic organizations and his famous maxim that "Who says organization, says oligarchy" (Michels, 1981, 49). In this instance, that oligarchy is the dominance of the few big city practitioners with a dominant say in professional politics (Gerhardt, 1987, 128).

COLLEGIALITY AS PROFESSIONAL CONTROL

If Parsons can be said to have anticipated his detractors to be considered later in this paper at the macro or societal level, the same is not so clear at the meso or organizational level. Barber has argued that Parsons' view of medicine as a profession focused on collegiality as the dominant pattern of authority and control within the profession. In contrasting the development of medicine

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with bureaucratization in ther industrial sector, Parsons writes that "medical organization must take a form which is closer to that of the university faculty than it is to the classical paradigm of bureaucracy" (Parsons, 1964, 345).

He sees collegiality as possessing great significance for professional autonomy. One area is its impact on the financial operations of medicine, with a growing tendency for taking financial decisions to higher levels as professional groups form, even though the method of payment might remain fee-for-service. Parsons notes that the making of common decisions in larger groups of practitioners, coupled with decisions concerning the flow of patients through referrals and scheduling constitute "the abdication of one of the most cherished aspects of the 'sovereignty' of the traditional practitioner, but one which could be scarcely avoided unless the advantages of large-scale organization are to be abandoned altogether" (Parsons, 1964, 347).

Another area in which this "sovereignty" which Parsons cites is the "fiduciary" function of the profession. Parsons writes that even "the storied private practitioner" has "always been a member of a profession which collectively has been conceived to be responsible for the welfare of the patient population" (Parsons, 1964, 347). He sees the institutional basis for the maintenance of

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professional standards and scientific advancement in the university medical school. A second check, he suggests, is that of trusteeship of the institutions in which medicine is practiced. He suggests that through these devices the "risks" inherent in medical practice are shared with a broader set of institutions than simply resting with an "aristocracy" from within the medical profession which could assume complete responsibility for and control of the standards of practice. These concepts were to be further developed by his student Fox and her student Bosk.

PARSONS' VIEW OF AUTONOMY AND ITS LIMITATIONS

In summarizing Parsons' contribution to the development of the concept of physician autonomy, Parsons attempted to move beyond a superficial differentiation between the self-interested practice of business as a dominant orientation in contemporary capitalism and altruistic practice of medicine. Rather, he saw medicine in a specific functional role in society through the involvement of the physician in the specific relationship with the patient/occupant of the sick role. This innately asymmetric relationship, founded on the technical skill and unique fiduciary responsibilities of the physician in the broader functional order of society, created a special privileged place for medicine exempt from the marketplace controls of capitalist competition. Challenges to this view from the perspective of research into the

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patient/physician interaction on a micro level have been noted.

Yet even in Parsons' own thought problems exist which manifest themselves at the level of the broader social order. Conservative medical leadership in the public arena contradicted Parsons' view of the proper development of medicine within the framework of advancing scientific discovery. His reliance on collegiality failed to see the potential application of self-interest and cartel-like behavior on the part of physicians which were described by later critics. The source of the dominance of professionals over clients went unexplored as simply an accepted feature of a functional society. Similarly, the limitations of collegiality and its limitations in serving the patient were also given limited examination in his thought.

Despite the above criticisms, it was Parsons' contribution to frame the issue of professional autonomy and the ensuing debate surrounding the concept. It has been Parsons' contribution to the development of the concept of professional autonomy to bring two key approaches to the study of professions, one of which asserts the primacy of values and norms while the other asserts the primacy of calculation and rationality, into focus and debate. In turn, these are developed in the work of his students.

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FOX: UNCERTAINTY AS THE BASIS OF AUTONOMY

Turning from the work of Parsons to that of his students, it is the writings of Renee Fox which have most clearly carried the Parsonian system and method forward into medical sociology. Fox directly acknowledges her debt to her mentor in a pivotal article which appeared in 1980, "The Evolution of Medical Uncertainty". In her introduction to the paper, she points to the importance of the concept of uncertainty as "central to my work in the sociology of medicine since its inception." She continues that "The importance of uncertainty in modern medical practice as a theoretical concept, an empirical phenomenon, and a human experience was first impressed on me by my teacher, Talcott Parsons" (Fox, 1988, 533).

The theoretical implications of Fox's development of the concept of uncertainty are quite direct for professional autonomy. Parsons justified as functional to the social system the granting of autonomy to physicians as a direct consequence of the uncertainties with which they were seen to deal in the practice of clinical medicine. This theme was developed and amplified by Fox through extensive field research as well as through theoretical development.

Fox's early work developed the topic of professional socialization, which was of great interest to Parsons, Hughes, Bucher, Becker and a wide range of medical

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sociologists of the 1950s. Fox adopted the Parsonian theme, which in turn represented an elaboration on earlier theoretical work of Weber, of the physician as technical expert of the highest order. A critical problem arises, however, from the reality that the knowledge of any given physician is in some way necessarily limited. In her early work, Fox divided this limitation into two types of uncertainty. The first was identified as resulting from "incomplete or imperfect mastery of available knowledge, while the second "depends upon limitations in current medical knowledge" (Fox, 1989, 451). As a consequence, Fox regards the preclinical portion of medical education as an opportunity to directly confront this dilemma through exposure to an impossible volume of material. The result is "to make the student aware of how vast medicine is", and that her/his knowledge of the discipline will never be total (Fox, 1989, 453). A third form of uncertainty is a hybrid of these two; namely, the difficulty the individual experiences in distinguishing between one's own limitations or those of the profession.

In a curious way, the experience of uncertainty justifies greater rather than lesser autonomy on the part of professionals in functionalist theory. In assessing the social ramifications of the early course of development of organ transplantation, Fox ties this development to the socialization process of medical education. She writes

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that "Students and young physicians are more than witnesses to the attitudes and behaviors toward death that predominate in the profession. In the early stages of their training they are sharply aware of the complexity and mystery of death and dying, and of the painful moral dilemmas the physician faces. But the latent socialization process to which they are subject-- especially the attitudes-in-action of their teachers-- is likely to move them toward a more unilateral determination to combat death and win out over it than either they or their teachers intended" (Fox and Swazey, 1974, 323).

The attribution of these actions to the consequences of socialization in the service of society rather than in the interest of one's personal interest and reputation has been criticized by Barber and others. Barber argues that Fox, as well as Parsons before her, placed too great an emphasis on value elements in the work of medical clinicians and researchers (Barber, 1985, 213). This has occured at the expense of other facets of Parsonian theory which might have been developed to account in a multidimensional way for the actions of physicians.

The public policy implications of the problem of uncertainty have opened a dispute which has challenged earlier functionalist views of risk as justifying the need for professional autonomy as only the expertise of the

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professional could answer such questions. In her more recent writings Fox acknowledges this development. She notes that "Both collective awareness of problems of medical uncertainty and uneasiness about them seem to have grown significantly since the 1950s when I wrote the 'Training for Uncertainty' essay. At that time, it was primarily through the professional education and socialization process they underwent that medical students came to recognize these problems, formulate them as such, and attach to them considerable importance" (Fox, 1988, 546). She continues that students now arrive at medical school with heightened awareness of limitations reflected in uncertain outcomes of clinical and research applications, and that this awareness is no longer the sole province of the educator as might be construed from Parsons' earlier writings.

Furthermore, multiple professional and public groups have evidenced interest in involvement in such decisions. This trend, of course, poses a challenge to functionalist concepts of unfettered professional autonomy. Fox identifies public and professional awareness of and in medical uncertainty as resulting, at least in part, "from the organized way in which uncertainty, error, and risk and their implications for health have been continually highllighted by the mass media" and a variety of interest groups and public agencies (Fox, 1988, 547). This

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contentiousness has significant negative consequences for the medical profession, for it introduces the potential of "lay" evaluation and even determination of matters heretofore considered within the realm of the profession. Fox writes that "The need for reducing uncertainty and regulating risk is affirmed and reaffirmed, accompanied by a cacophony of opinions about who should do it, and how" (Fox, 1988, 546).

In her more recent work she is especially concerned about the implications of such intrusions on basic and clinical research. This is not a complete surprise given that Fox's field studies from *The Courage to Fail*, published in 1974 and dealing with organ transplantation, through more recent studies dealing with genetic engineering have focused heavily on avant garde basic and clinical research and its practitioners. Organ transplant surgeons, for example, are depicted in earlier work as "specialists in uncertainty" (Fox and Swazey, 1974, 58).

The limits of professional expertise are most evident in recent cases which have been placed before courts for decision. Fox reviews several instances of such litigation in her discussion of recent developments in the concept of medical uncertainty. She is doubtful of the judiciary's, or other groups for that matter, ability to address such monumental questions. She writes that "The McFall, Jaffee,

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Becker-Park, and Green cases described are characteristic of the uncertainty- and risk-associated scientific and technological cases that are increasingly coming before the courts and legislatures, although many of the questions they raise surpass a judge's, lawyer's, or legislator's domain of professional competence" (Fox, 1988, 565). Paradoxically, the net result of the very complexity of these questions and the "professional and public preoccupation with medical uncertainty" may be to place the issues directly back with the medical profession, the "specialists in uncertainty" (Fox, 1988, 567). She concludes that "In the end, what generally happens is that the questions are recast in more narrowly disciplinary and practically manageable ways. The issues are operationalized and reduced so they can be analyzed and decided upon within the framework of existing scientific, technological, legal, and ethical theory, knowledge, and procedures" (Fox, 1988, 566).

FOX'S VIEW OF THE CONSUMER CHALLENGE TO AUTONOMY

If institutions such as the legal system and other professions provide no answer to the dilemmas of medical uncertainty, neither does the public as "consumers" of medical care. Fox directly addresses the issue of professional autonomy in two ways in her paper on "The Medicalization and Demedicalization of American Society". In both instances she concludes that the autonomy of the

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profession should be retained. In the first instance, she comments on the emergence of nurse-practitioners and physician's assistants by characterizing them as occupying "essentially marginal roles" (Fox, 1981, 530). Similarly, she dismisses the challenge of organized consumer groups and those advocating self-care as an alternative to contemporary medicine by suggesting that "This point of view is based on the moral supposition that greater autonomy from the medical profession coupled with greater responsibility for self and others in the realm of health and illness is an ethically and societally superior state" (Fox, 1981, 530).

The contrast of autonomy "from" the profession which Fox demeans in the above paragraph versus autonomy "for" the professional is significant. Fox suggests later in this paper that "There is reason to believe that, as a consequence of pressure from both outside and inside the medical profession, the doctor will become less 'dominant' and 'autonomous,' and will be subject to more controls" (Fox, 1981, 533).

While Fox may argue that demedicalization of American society is in fact occuring, it is not clear how this interpretation fits within a broader functionalist framework. It appears from previous discussion that no other social group is capable of making decisions in the

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realm of uncertainty beyond the medical profession. While noting the historical trend toward greater societal involvement, she implies that this ought not to occur from a normative perspective. This reflects the questions posed which challenge the functionalist viewpoint.

BARBER'S CRITIQUE OF FUNCTIONALIST ASSUMPTIONS

Barber has been critical of this inconsistency by suggesting that Fox has tended in recent writings to expand the Parsonian framework of expertise in response to uncertainty without grounding her theory in "specific empirical situations" (Barber, 1985, 219). Barber might agree with Fox regarding the influence of uncertainty on the preparation of medical students as a special situation demonstrated in her initial field research. This research was consistent with overall Parsonian theory that found the major assurance of the profession of medicine's functional social role through the education and attendant socialization process for its new initiates.

Though uncertainty might be an issue for new students of the profession or for researchers at the frontiers of the biosciences, much of medical practice is relatively mundane and lacking in uncertainty. Barber is quite critical on this point, viewing uncertainty as an ideological weapon to justify unlimited autonomy for physicians. He writes that "the concept of uncertainty has become not just a

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scientific account of specific medical situations but an ideological justification of a variety of medical practices. For example, doctors can justify their authoritarian patterns on the grounds of an alleged intense and endless uncertainty that they do not actually face in many situations" (Barber, 1985, 219).

As observed in the discussion of Parsons and his view of the profession of medicine in relation to the broader society, power relationships with patients or other professional groups cannot be overlooked. The demand for autonomy in practice inevitably results in asymmetric power situations with the physician holding a commanding position. Barber is quick to observe that "If, as Fox says, doctors are 'specialists in uncertainty,' then they need practically unlimited autonomy to face this hazardous situation. But their autonomy is often at the expense of others, both their subordinates and their patients" (Barber, 1985, 219).

Barber's criticism suggests that Fox, though basing her initial work and subsequent writings which touch upon physician autonomy on observations carried on in the field, fails to "ground" her theoretical development on the data at hand. The irony in this criticism is apparent on several levels. First of all, Parsons has been accused by other sociological theorists of ignoring empirical research

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and chose instead to confine his work to abstract theorizing. C. Wright Mills is highly critical of Parsons on this point, attacking *The Social System* as a particular case in point. Mills states that "What is 'systematic' about this particular grand theory is the way it outruns any specific and empirical problem" (Mills, 1959, 48). Fox attempts in her studies first of medical education and subsequently of transplant researchers to apply Parsonian theory in specific circumstances. Barber's criticism suggests that uncertainty, while possibly demonstrable and of explanatory value in these two specific instances, cannot be applied further in support of a broader theory of the profession of medicine and its function in the broader social order.

BOSK AND AUTONOMY IN THE FIELD: EDUCATING PHYSICIANS

The methodological irony of this observation is taken a step further in the "third generation" work of Fox's student Charles Bosk. In his highly regarded study of graduate medical education in surgery, Bosk attempts to understand through extensive on site observation of a major surgical training program the professional development of surgeons through the study of episodes of "medical failure" (Bosk, 1979, 16). In describing the methodology he employed, Bosk makes direct reference to the grounded theory of Glaser and Strauss, and the necessity of grounding his theory through saturation of his

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observational categories (Bosk, 1979, 14).

His theoretical purpose in conducting this study is consistent with Parsonian thought on the pivotal importance of professional socialization as the key ingredient in social control of the profession's members. In this respect he is in accord with Fox, and directly critical of "structural" analyses of medicine by Freidson and others which will be discussed in the following section of this study (Bosk, 1979, 21). Like his teacher Fox, Bosk stresses the importance of uncertainty in the career of the surgeon and the necessity of training to confront it (Bosk, 1979, 23). He argues that a "negotiated order of social control -- exists within the surgical specialties which enables surgeons to deal effectively with uncertainty and the inevitable resultant errors which follow even the best training and best intentions (Bosk, 1979, 24).

Bosk makes his most impassioned defense of the Parsonian normative approach to professional control and consequent autonomy based on unique expertise when he confronts those who advocate formal regulatory controls on medical practice. His attack is one which is ultimately conservative in defending the prerogatives of the profession from outside intrusion as existing values instilled in the socialization process of education are sufficient to protect the public as the broader social good

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is served. He writes that those who advocate regulatory controls outside the profession, or at least formally structured within it, base their arguments on "the decidedly asociological proposition that the only effective social control is coercive or formal control. Totally dismissed is the notion that individual control or group pressure effectively constrains behavior. It seems to me possible to argue for a more formal system of controls while acknowledging the substantial amount of control that is built into the system through socialization, work routines, and normal relations with colleagues. It is precisely this that a professional dominance perspective fails to do" (Bosk, 1979, 21).

By joining this debate, Bosk paves the way to the foremost alternative to Parsonian functionalism in medical sociology-- that of the structuralists, as exemplified by Freidson. Their retort is put forth by Barber, who interprets Bosk's theory of surgical training as supporting the position "that the professors need complete autonomy to cope with the perennial uncertainty of their practice" (Barber, 1985, 220). The "no surprises" and "no excuses" norm of the surgeons toward their trainees "tells the resident to protect the surgeons and his or her absolute autonomy" in Barber's view (Barber, 1985, 220). Barber points to a basic asymmetry in this position of Bosk as well as Parsons and Fox before him-- that of greater regard

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for the uncertainty of the physician than that of the patient. This imbalance is a justification for the autonomy of the professional based upon her or his special technical expertise, but which ignores fundamental power relationships with respect to other professionals as well as the patient.

In an exploration of contemporary bioethics, Fox notes that concerns have begun to appear in the literature regarding a too great emphasis on individual autonomy at the expense of societal good. Her point is that with the accelerating development of existing and new medical technologies that the social order will be threatened if controls are not exerted on the proliferation of technologies (Fox, 1986, 28). At the conclusion of her article she poses the question of whether such issues will be decided by the broader society or otherwise be defined as technical problems for expert solution simply for clarity of definition. One might argue, based on this reading of Parsons and his descendents, that professional autonomy in the solution of such problems will be maintained because this is in fact the only way in which society can approach such issues. Professional autonomy will override individual autonomy because it is functional and in the interests of society to achieve such a resolution.

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PERIOD TWO

FREIDSON'S FORMULATION OF AUTONOMY: PROFESSIONAL DOMINANCE

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FREIDSON AND AUTONOMY: DEPARTURE FROM PARSONS

The most coherent and extensive development of the concept of physician autonomy is that of Eliot Freidson. He has been regarded as a structuralist in his approach, emphasizing the importance of institutions and groups in exerting political and economic power which seized autonomy as a desired political end for the group, rather than as a benign grant from society in general. Under Freidson's scrutiny professional autonomy takes on a more menacing character as a culmination of social forces which threaten the very delivery of health care Parsons and his colleagues believed necessitated the granting of autonomy to medicine. In Freidson's analysis, the granting becomes instead a taking, a critical differentiation which points the way for future students of the profession to analyze the profession's leadership and its members as acting primarily in the pursuit of self interest.

Gerhardt has argued that Freidson's point of departure into medical sociology is clearly from Parsonian functionalism, referring as she does to Freidson's "laborious" reworking of the Parsonian sick role into six categories of differential occupancy (Gerhardt, 1987, 113). She argues that Freidson attacks Parsons on the issue of personal responsibility in illness as opposed to the more generic formulation of the sick role by Parsons.

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If it may be argued that Freidson can be considered in dialogue with Parsons in attempting to qualify and redefine the sick role, it is equally valid in his assessment of the profession. It is of course in this sphere of medical sociology that Freidson has gained greatest recognition, and in which he has exerted the greatest influence on subsequent research. Yet, Gerhardt's assertion that the development of medical sociology after Parsons is an attempt to answer the question of "How much Parsons?" one should expect in an adequate sociology of medicine is a question which clearly engaged Freidson as well (Gerhardt, 1979, 229).

As has been observed in the case of Parsons, Freidson acknowledges a debt to his sociological predecessors Durkheim and Weber. In his theoretical writing Freidson confronts both around the issue of professional "expertise," which has been observed to be critical in Parsons' work in securing the unparalleled position of power in society which the profession enjoys. He turns his attention to this problem in writing about Weber, whose own work had seen technical expertise as a critical characteristic of the ideal type of bureaucracy (Weber, 1946, 234). Weber notes that even the "absolute monarch is powerless opposite the superior knowledge of the bureaucratic expert", a principle which may be carried forward to other hierarchical organizational forms. An

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alternative structuring which Weber identifies is found in the application of the "collegiate principle", in which an attempt is made to create "a synthesis of *specialized experts* into a collective unit" (Weber, 1946, 237). This development finds a clear parallel in the efforts of hospitals and other organized health care entities to fashion such a collegium through the organized medical staff.

Freidson addresses this problem directly by noting an distinct inconsistency in Weber between the notion of hierarchical authority with technical expertise and its distinct authority. This problem was also identified by Parsons, who exempted the professional from the control of a "monocratic model of rational-legal bureaucracy" of the type posed by Weber since professional skill is "of such complexity and refinement that autonomy of judgment is necessary" (Freidson, 1970b, 24).

Freidson finds fault with Parsons' critique of Weber when Parsons argues that "Weber overlooked the logical (or 'pure') distinction between the authority of office and the 'authority' of knowledge or technical competence" (Freidson, 1970b, 108). Parsons, he argues, reasons that professions in general and "the medical profession in particular exemplify the authority of technical competence" (Freidson, 1970b, 109). Yet the apparent contradiction

which Parsons had identified in Weber's ideal type is not easily resolved, Freidson suggests. Rather than persuading the client to accept the opinion of the physician solely on the basis of expert knowledge, Freidson argues that a variety of social factors intervene which create a more complex sick role for the patient and professional role for the physician than Parsons had allowed. Instead, Freidson contends that Parsons has overlooked elements in Weber's model which allow the physician to function as a "gatekeeper" exercising control over access to resources or privileged status much in the same manner as a bureaucratic official in Weber's model (Freidson, 1970b, 117).

AUTHORITY IN THE DIVISION OF LABOR

The issue is therefore more complex than Parsons in his interpretation of Weber would allow. Freidson's alternative is to suggest "that professional 'authority' is a logically mixed or impure case, containing some of the elements of the authority of technical competence and some of the elements of the authority of legal or bureaucratic office" (Freidson, 1970b, 108). Whereas the scientist, to cite a contrasting example in which "expert" authority is invoked, might rely on a common set of rules and procedures-- a common paradigm, the example of the professional is different (Freidson, 1970b, 109). Instead, the asymmetry of the professional- patient roles observed earlier results in a quite different relationship.

Freidson summarizes this point when he states "*What distinguishes the professional from all other consulting experts is his capacity to solve some of these problems of authority by formal, institutional means. His solution minimizes the role of persuasive evidence in his interaction with his clientele*" (Freidson, 1970b, 110).

Freidson's discussion of classical theories moves from Weber to Durkheim through the pivotal concept of the division of labor. Continuing with the observations made in the prior paragraph, Freidson writes that Weber has suggested the rationalization of work through planned methods of a rational- legal bureaucracy. He comments that the division of labor will be hierarchical and formal, and the career of the worker an orderly and continuous one (Freidson, 1976, 309). By contrast, Durkheim argued through development of the concept of organic solidarity that the division of labor was an essential feature of society replacing the earlier contractual basis of society based on mechanical solidarity (Durkheim, 1984, 149). Freidson writes that "Durkheim insisted that the division of labor was socially regulated, and was not a mere aggregate of individually contracted exchanges" (Freidson 1976, 305). In this observation Freidson reflects Durkheim's development of the notion of society as an entity sui generis rather than simply the sum of individual interactions.

Freidson is critical of Durkheim's failure to develop a systematic definition of the division of labor, seeing his efforts in this area as primarily a polemic against Spencer and the utilitarians (Freidson, 1976, 305). He refers to the divsion of labor in such terms as "the apportionment of functions", which Freidson considers of little help in establishing an external point of reference for the concept. In this regard, Durkheim differs little from Adam Smith's classic formulation of specialization as the basis of industrial activity. Perhaps the closest that Durkheim comes to identifying a specific place in his concept of organic society for occupational and professional specialization is in the essential role he ascribes to such developments in supporting the state. Durkheim writes that "A nation cannot be maintained unless, between the state and individuals, a whole range of secondary groups are interposed. These must be close enough to the individual to attract him strongly to their activities and, in so doing, to absorb him into the mainstream of social life. We have just demonstrated how professional groupings are fitted to perform this role, and indeed how everything marks them out for it" (Durkheim, 1984, liv).

In assessing this observation, Freidson writes that "specialization cannot be defined empirically without reference to a concrete, historical process, bounded in

time and space, by which a task performed by one person or class of persons becomes replaced by more than one task performed by more than one worker or class of workers" (Freidson, 1976, 306). He concludes by stating that "The reality is a *prior* task, not a logically whole or complete task" (Freidson, 1976, 306). It is this insistence on grounding the concept of division of labor in the historical and social action of the medical profession in relation to society and other professions which most clearly characterize Freidson's view of professional roles and ultimately professional autonomy. In making this assessment, Freidson appears to reject what might be regarded as the functionalist implications of Durkheim's organic concept of society in bringing about the transformation from a mechanistic social order. Rather, the political action of the profession as a group is perceived as critical in creating social change.

Instead, Freidson attempts to ground the division of labor in a negotiated order. In adopting this approach, he specifically refutes three other approaches to understanding the division of labor that have been invoked as more specific types of the concept which Durkheim failed to develop completely. The first is Adam Smith's theory of organizing labor through a free market without the intervention of any alternative kind of social organization. The second is the rational-legal bureaucracy

depicted by Max Weber in which work is assigned based upon a hierarchical and formal basis through a central authority.

GUILD INTERESTS OF THE PROFESSION

The final example, not identified by a classical figure but closely associated with Parsons' view of the division of labor, is that of guilds or their successor, professional organizations in which the worker sets the organization of the division of labor and directly controls work (Freidson, 1976, 309). In Parsons' writing, this division is founded on the basis of professional expertise, an element of Weber's bureaucratic model as well in which attainment of position and advancement occur solely on the basis of technical competence (Weber, 1946, 216). Freidson correctly notes that Parsons identified this attempt at differentiation of the bureaucratic basis of the division of labor as an inconsistent one in Weber's own work. It is probably not fair to suggest, as Freidson does, that Weber "overlooked" the distinction between these two bases of authority; as both are contained within his ideal type of bureaucracy (Freidson, 1970b, 108). Rather, Weber developed the distinction in a different way by commenting on the inability of the politically empowered head of the state to function effectively without the benefit of the specialized expertise of the technically based worker (Weber, 1946, 234).

Freidson develops this last type further by noting that a negotiated, political dimension exists in defining the division of labor. Noting the development of guilds and professions, he writes that, "Committed to both their security and their work, they have stabilized their work for their lifetime by negotiating power from the state to set comparatively stable boundaries between occupational roles, and to control recruitment, training, and access to jobs" (Freidson, 1976, 309). A hierarchy may result as a consequence of this process, but it is a hierarchy of occupational groups arrayed as a result of claims to superior skill and responsibilty on the part of some occupations, which thereby gain the right to order and coordinate others (Freidson, 1970a, 127).

THE DIVISION OF LABOR AS NEGOTIATIVE INTERACTION

Freidson's own conclusion is to identify strengths in each of the aforementioned perspectives, but to conclude that the division of labor is basically an interactive process. In addressing the work of organizational theorists in identifying the concept of informal organization, Freidson recasts their work to an interactionist framework (Scott, 1989, 143). He writes that "The concept of informal organization is the analyst's abstraction of what is a process of negotiative interaction" (Freidson, 1976, 310). He then applies this observation specifically to the

political arena and the activities of professionals in this area to use the process to their particular advantage. He states that "The formal boundaries of jurisdictions are often established by legislation [as opposed to technical expertise], produced and reproduced in the course of a process of political struggle and negotiation during which the occupational spokesmen work to sustain or improve their relative position in the interoccupational organization we call the division of labor (Freidson, 1976, 311). The division of labor is grounded in the everyday world in "a process of social interaction in the course of which the participants are continuously engaged in attempting to define, establish, maintain, and renew the tasks they perform and the relationships with others their tasks presuppose" (Freidson, 1976, 311).

It would be a mistake, however, to assume that these negotiations occur in a market or society emphasizing the free transactions of individual actors. Groups such as professional bodies intervene in this process, and render Smith's classical economic model naive. Freidson concludes his discussion of the division of labor by noting that hierarchy and managerial task differentiation are considered to be functional characteristics of contemporary industrial societies and are justified on the basis of superior efficiency. Others, he notes, argue that the more critical issue is that of control of work by the worker or

by capitalist or state management (Freidson, 1976, 312). He concludes his essay by stating that the test of these theories and ideologies of the division of labor can best be found "in the social interaction of participants in everyday work settings" (Freidson, 1976, 312).

SOCIAL CONSTRUCTIONISM IN FREIDSON'S THOUGHT

An alternative perspective on Freidson's theoretical base may be found in his earlier work which attracted his greatest popular acclaim, *Profession of Medicine.* In this 1970 publication, Freidson cites approvingly the work of Berger and Luckmann, *The Social Construction of Reality* (Freidson, 1970a, 379). It is significant that Berger and Luckmann are known for their contributions to the sociology of knowledge, a theme Freidson appropriates in subtitling *Profession of Medicine* "A Study of the Sociology of Applied Knowledge". Berger and Luckmann attack functionalist explanations of social actions a "theoretical legerdemain" (Berger and Luckmann, 1966, 186). At the same time, they are equally critical of structuralist explanations, and sound a theme which closely resembles Freidson's approach, writing that "we hope that we have shown cause for our conviction that a purely structural sociology is endemically in danger of reifying social phenomena" (Berger and Luckmann, 1966, 186).

Freidson adopts the theory of Berger and Luckmann, which he

describes as "recently expounded", as a basis for his development of a major section of his work entitled "The Social Construction of Illness" (Freidson, 1970a, 206). In his conclusion to *Profession of Medicine* Freidson describes his work as having been "stimulated by Berger and Luckmann, who declare that reality is socially defined. But the definitions are always *embodied,* that is, concrete individuals and groups of individuals serve as definers of reality" (Freidson, 1970a, 379). In other words, he is inclined toward a view of social action which is based on a compatibility with microanalysis of the actions of individuals who ultimately form society.

In embracing Berger and Luckmann, he rejects Parsons and his theory of individuals and institutions operating within broader social norms. Even this generalization is somewhat flawed, however, as Parsons critically described and blamed the American Medical Association as intervening and thwarting the development of a more rational medical-economic system (Parsons, 1964, 341). It is probable, based on Freidson's study of the medical profession and later of the specific instance of group practice that he would be comfortable dealing with institutional structures as well as individual interactions (Freidson, 1975, 1).

As will be shown in the discussion of Freidson's

development of professional autonomy which follows, his theoretical framework is an eclectic one which borrows from the interactionist, social constructionist, organizational theory, and even conflict traditions. It is ironic and simplistic to dismiss his work, as does Bosk, as that of a structuralist. To be sure, Freidson discusses professional autonomy as a structural problem or "flaw" to which there are institutional solutions (Freidson, 1970a, 368). To some extent, Freidson does encourage this view when he describes the assumptions of a structuralist sociology as including the assertions that individual motives are dominant only if reinforced by society; the environment can lead individuals to forego one set of values for another; and that group behavior can be predicted more accurately with reference to the environment than to values of individuals within the group (Freidson, 1970b, 66) Bosk adopts this particular one of Freidson's multiple points of emphasis, and writes that a "recent spate of prescriptive treatises in the sociology of medicine [including Freidson 1975] all make a similar argument; namely, since the profession does not have a well-articulated system of formal controls then regulatory responsibility must be removed from the profession or at least structurally formalized" (Bosk, 1979, 21). He then continues that this is to ignore the influence of the informal organization. Through analysis of professional autonomy we shall see that this is clearly unfair to the breadth of Freidson's work.

STAKING THE CLAIM: THE SOCIAL CONSTRUCTION OF AUTONOMY

For Freidson, the characteristic of the profession which differentiates it from all health professions and all but the law and clergy outside of health care is autonomy. In his definition of autonomy he has included a theory of struggle which appeals to economists and to an extent to sociological theorists in the conflict tradition. Defining this orientation, Freidson writes that "Insofar as this value [autonomy] refers to social and economic independence, it reflects the entrepreneurial and individualistic ideology of the bourgeoisie...." (Freidson, 1970b, 97-98). From this vantage point, it is a relatively simple extension to suggest that professional autonomy reflects the consumate attainment of a class striving for itself as theorists of a post-Marxian "new class" have contended (Ehrenreich, 1990, 146). These writers argue that a class of managerial and professional individuals has emerged in society which differs from traditional Marxist notions of class limited to capitalists and proletarians. A hallmark of this theory is the sriving for independence of new class members in the expression of ideas and their popularization to the rest of society. It is probably fair to say that this former orientation is the ones which have dominated more recent discussions of the professions which will form the basis for the remainder of this chapter.

Yet it is critical to bear in mind that this turning point

in the analysis of the profession, correctly credited to Freidson, grew from the sociological foundation discussed previously. This is, of course, the process of the division of labor. Freidson summarizes this perspective when he writes that "Insofar as the value refers to technical or professional independence-- that is, the freedom to practice one's craft without interference, advice, or regulation by others-- it seems more closely related to a state of mind encouraged by the character of professional work" (Freidson, 1970b, 98). This is basically the orientation of Parsons and the other functionalists discussed earlier.

MICRO AND MACRO BASES OF AUTONOMY

It is Freidson's unique strength to be able to articulate and bridge both of these perspectives. It is also this duality which has allowed subsequent commentators to be able to appropriate from Freidson as they choose or to reject him in similar fashion. As an exercise in the sociology of knowledge, this is a reflection of two major intellectual tasks which Freidson undertook. The first of these, at a level of microanalysis, was to break away from the limitations he perceived in the sick role formulated by Parsons. Specifically, Freidson saw the necessity of breaking from the asymmetric dyad of the individual practitioner and patient to recognize broader social groupings which impinge on the interaction of the two.

Specific examples are the family structure of the patient, and alternative forms of medical organization such as groups as an alternative to the classic solo practice model which Parsons modeled.

Secondly, he saw the necessity of extending consideration to the influence of larger organizations at which Parsons had only hinted. These might include the regulatory apparatus of the state as well as the institutions of organized medicine, such as the American Medical Association, local societies, and specialty organizations. He also noted the rise in influence of the third party insuror, an institutional occurance further distorting the earlier Parsonian paradigm. Each of these will be discussed in detail with a view of placing Freidson in the sociology of knowledge as a theorist of professional autonomy but also as an empirical observer witnessing historical evolution and alterations in the concept throughout his intellectual career.

On a micro level, Freidson demonstrates the influence of Berger and Luckmann in that illness is a social creation, as he entitles the third section of *Profession of Medicine.* It is his argument that medicine defines the social reality of illness, and "*creates the social possibilities for acting sick*" (Freidson, 1970a, 206). He defines this authority as a bureaucratic role, stating that "medicine's

monopoly includes the right to create illness as an *official social role*" (Freidson, 1970a, 206).

This authority is not one of a mere functionary bestowing legitimacy on the illness state as Parsons might be read to suggest. Rather, in describing the professional construction of illness, he suggests that medicine acts as a "moral entrepreneur" in Becker's terms (Freidson, 1970a, 252). Moral entrepreneurship fosters a bias to identify illness in that the "health professional typically assumes that it is better to impute disease than to deny it and risk overlooking or missing it (Freidson, 1970a, 255). As illness is a socially constructed state arising from the interaction of the professional and the patient, a variety of states of legitimacy may be attributed to illness based on its seriousness and extent of deviance (Freidson, 1970a, 247).

Freidson concludes that minor deviations are dealt with in the context of a lay referral system, while more serious ones find their way into the professional network of expertise and authority. Freidson ties this observation back to the socially constructed nature of the physician-patient interaction when he writes that "Human, and therefore social, *evaluation of what is normal, proper, or desirable is as inherent in the notion of illness as it is in morality*" (Freidson, 1970a, 208). He then adds that

medicine is like the law and the clergy (the two other ideal type professions in his and other commentators' typologies of professional autonomy), in that it attempts to define and control within its system those things "it considers undesirable" (Freidson, 1970a, 208). The primary distinction in the case of the professions is that "medicine is kept apart from religion and law because, unlike them, it is believed to rest on an objective scientific foundation that eschews moral evaluation" (Freidson, 1970a, 208).

TRUST IN MEDICINE AS AN EXERCISE IN SOCIAL PERSUASION

It is his disavowal of the scientifically objective basis of medicine as a profession that creates the climate for his larger view of the profession as a socially constructed enterprise which aspires to and protects claims to autonomy. It is not, as Parsons would claim, a benign agent of society carrying out a socially useful function in the micro-encounter of patient and physician.

Rather, autonomy is subject to the strength of assertion in the unique nature of one's expertise and the need for recognition of this claim by others. This may in turn engender conflict with other occupational groups to enforce such claims. Freidson emphasizes the socially constructed nature of this claim at the macro level as well. He writes that "*Belief* in the extraordinary character of the work and

of the performer sustains the worker's claim that he must be able to exercise his own complex, individual judgment independently of others, that is, he must be independent and autonomous" (Freidson, 1970b, 154). He then relates this observation to that of the claim of professional expertise by noting that "While members of *most* occupations seek to be free to control the level and direction of their work efforts, it is distinct to professionalism to assert that such freedom is a necessary condition for the proper performance of work (Freidson, 1970b, 154).

The audiences of this persuasion are two fold, consisting initially of societal elites and then subsequently the state with its formal authority. Both of these recognitions appear essential to achieve the fully developed autonomous state Freidson identifies, that of "legitimate, organized autonomy"-- a state characterized by the right to control one's own work (Freidson, 1970a, 71). He suggests that "A profession attains and maintains its position by virtue of the protection and patronage of some elite segment of society which has been persuaded that there is some special value in its work. Its position is thus secured by the political and economic influence of the elite which sponsors it...." (Freidson, 1970a, 72). He continues that once granted autonomy the profession may diverge from the value set of its sponsoring elite, and that this in turn may lead to the eventual withdrawal of

autonomy (Freidson, 1970a, 73).

The critical embodiment of autonomy in Freidson's scheme is state recognition and legitimation in a Weberian sense. He writes that "Clearly, professional autonomy is not absolute: the state has ultimate sovereignty over all and grants conditional autonomy to some" (Freidson, 1970a, 24). He continues this theme by noting that autonomy results from *interaction* betwen political and economic power and the profession's representatives, assisted by universities and possibly other institutions to "persuade the state that the occupation's work is reliable and valuable." He harkens back to the division of labor and the establishment of a hierarchy of occupations when he suggests that the process establishing this hierarchy is "essentially political and social rather than technical in character-- a process in which power and persuasive rhetoric are of greater importance than the objective character of knowledge, training, and work" (Freidson, 1970a, 79).

Freidson displays some ambivalence on two points in his discussion. The first of these concerns the conditional nature of autonomy and what would be required to revoke it once gained. He cites the clergy in the United States in absence of a state religion as a possible example. However, more of his discussion centers on professions which have not attained dominant status. Secondly, the

issue remains of how one passes from the state of elite sponsorship to formal state recognition. It is this discussion which is borne out in his later historical discussions on the state of contemporary medicine and the deprofessionalization debate.

The critical element which becomes controversial in Freidson's discussion is that of the service orientation of the profession. Here he is engaged in debate with William Goode and his analysis of core characteristics of the professions. Goode had suggested that the service orientation of the profession is critical to the willingness of the society to bestow autonomy. Freidson argues against Goode's point that society must trust the commitment of the profession to the collective good and that it must have autonomy to accomplish its work properly (Goode, 1969, 292).

It is Freidson's contention, in keeping with the social constructionist outlook, that this aura of service to society is socially negotiated and is often to the detriment of other professional groups making claims to autonomy in the division of labor. Freidson suggests that "...all that may be distinct to professions about a service orientation is *general acceptance of their claim*, acceptance that is the fruit of their earlier success at persuasion" (Freidson, 1970a, 82). He concludes that the

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creation of the aura of autonomy is a social and political one, arising from the winning of the favor of elites and later society in general. He writes that *"The profession's service orientation is a public imputation it has won in a process by which its leaders have persuaded society to grant and support its autonomy"* (Freidson, 1970a, 82). He is quick to add that this not subject to objective verification on the basis of a series of attributes, as earlier professional trait theorists had contended.

Rather, this acceptance of the prescribed attributes of autonomy is subsequent to the persuasive interaction which results in granting autonomy in the first place. This would encompass the derived characteristics of autonomy which Goode identified; including professionally determined standards of training; legal recognition through licensure; licensure boards drawn primarily from the profession itself; professional dominance of legislation which pertains to its practice; and freedom from lay evaluation and control (Goode, 1969, 276). Directly attacking this perspective, Freidson writes that "It may be true that the public and/or a strategic elite always come to believe that the training, ethics, and work of the occupation they favor have some exclusive qualities, but this is a consequence of the process of persuasion rather than of the attributes themselves...." (Freidson, 1970a, 83).

RISKS TO SOCIETY OF BESTOWING AUTONOMY

The public relations element of professional autonomy makes a practical attack upon the profession of medicine a viable one for Freidson. In his introduction to *Professional Dominance,* his position is made clear even in this early work. He states that "I shall argue that professional dominance is the analytical key to the present inadequacy of the health services" (Freidson, 1970b, xi). Once the profession has gained autonomy, it bears an implied responsibility for the health of society as granted to it in a social contract. However, Freidson argues that accountability to society is sacrificed in this contract by the paradox of professional autonomy. This paradox is sustained by the unchallenged dominance of the occupational hierarchy by the profession, and its insistence that only its members are competent judges of performance of themselves or their colleagues due to the specialized nature of work performed and the unique expertise required (Freidson, 1970b, 136).

He argues that the occupational hierarchical structuring carries the same hazards to society as that of bureaucracy, in contrast to Parsons' efforts to differentiate the two. Freidson suggests that instead "Expertise institutionalized into a profession is not, as much writing seems to assume, an automatically self-correcting, purely task oriented substitute for 'arbitrary' bureaucracy. Expertise

establishes office and hierarchy analogous to that of bureaucracy" (Freidson, 1970b, 157). This observation is particularly important in establishing control for the profession over the political and economic conditions of its practice. As Weber observed, "Every bureaucracy seeks to increase the superiority of the professionally informed by keeping their knowledge and intentions secret" (Weber, 1946, 233). He notes that both the parliament and the absolute monarch, to whom the bureaucracy is in theory accountable in their respective forms of government, are equally powerless in the face of the bureaucrat's use of expert knowledge (Weber, 1946, 234).The modus operandi of professional groups appears to differ little from this approach.

THE "FLAW" OF AUTONOMY: UNCONDITIONAL TRUST AND POWER

Freidson developed the notion of the "flaw" of professional autonomy as a result of lack of accountability to the public good most fully in *Profession of Medicine.* He traces this problem back to the place of medicine in the hierarchy of health occupations as the "dominant profession". He writes that "...by their very nature, professions in general and medicine in particular cannot live up to their professional ideals as long as they possess thoroughgoing autonomy to control the terms and content of their work and as long as they are dominant in the division of labor" (Freidson, 1970b, 234).

He argues elsewhere that the profession has suffered the development of a professional narcissism which results in the tragic flaw of inability to self-regulate as demanded by the public interest. He states that "This is the critical flaw in professional autonomy: by allowing and encouraging the development of self-sufficient institutions, it develops and maintains in the profession a self-deceiving view of the objectivity and reliability of its knowledge and of the virtues of its members" (Freidson, 1970a, 370). In a similar vein, he suggests that "Protecting the profession from the demands of interaction on a free and equal basis with those in the world outside, its autonomy leads the profession to so distinguish its own virtues from those outside as to be unable to even perceive the need for, let alone undertake, the self-regulation it promises" (Freidson, 1970a, 370).

The directly adverse consequence of professional autonomy has been, in Freidson's judgment, the corruption of the delivery of health care to society's members. In an italicized statement, he argues that "*While the profession's autonomy seems to have facilitated the improvement of scientific knowledge about disease and its treatment, it seems to have impeded the improvement of the social modes of applying that knowledge*" (Freidson, 1970a, 371). Freidson suggests that this is a result of the

profession's insistence on self-regulation, a sentiment carried successfully to the strategic level by its own professional advocacy groups-- most notably, the American Medical Association (Freidson, 1970a, 363).

A direct consequence of unfettered autonomy has been the ability of the professsion to act as an economic cartel. Freidson states directly that medical decision making which emphasizes the detection of disease rather than promotion of health is analyzable as "a function of economic self-interest" (Freidson, 1970a, 359). In this regard, he poses the influence of economics to that of ideologies of the profession promoted through its process of professional socialization. This latter approach had formed the basis of the majority of sociological analyses to that point, certainly those of the functionalists. As this question is crucial to the development of the thesis of economic versus ideological motivations in the case of the practitioner, it will be examined here in detail.

ECONOMIC CONSEQUENCES OF AUTONOMY

Freidson makes autonomy and its preservation the foundation of the economic and consequent political strategies of the profession. He notes the resistance of medicine to involvement of external entities in its affairs as defined by the profession itself. He then notes the established monopoly position of the profession over the use of select scarce resources and services. He suggests that "freedom to set the terms of compensation is, without some form of professional self-regulation in the public interest, obviously subject to abuse" (Freidson, 1970a, 363).

Yet it is also clear to Freidson that the exercise of autonomy in practice with respect to the definition of terms of practice has also occured in the economic arena as well to the advantage of the profession. He hypothesises a connection between autonomy of practice and economic interests when he writes "Perhaps fearful of infringing on the individual practitioner's freedom, it has failed to institute any systematic method of review to determine whether or not economic freedom, in conjunction with monopoly over services, has been used by practitioners to charge all that the helpless traffic will bear rather than only the decent income to which the practitioner is entitled" (Freidson, 1970a. 363).

This statement displays a distinct sentiment of indignation

on Freidson's part toward the economic activities of the profession. He argues that the profession has made no effort at self-regulation of fee practices on the part of its members. Rather, it has left any attempt to redress grievances on the part of patients to the courts. He suggests that in the United States that the profession has made little effort "to insure that its members do not asbuse their privileged economic position by seeking more than a 'just price'"(Freidson, 1970a, 363). He states that society in the United States has had a difficult time establishing a concept of a "just price", but he is certain that a free market model of competition will not achieve this since physicians enjoy a regulated advantage in the division of labor as a result of preferential licensing acts.

It is at this point that autonomy of the profession becomes a malevolent force in society as it is joined with economic power. As noted earlier, Freidson has delineated the two bases of autonomy as existing on the one hand in the division of labor of the occupations and on the other in the ability of the profession to control its social and economic environment. This is a costly combination for society, as the profession controls both the clinical requirements for its services, including to a great extent the ability to create demand, as well as price for those very services. Freidson summarizes this point in the

following manner, when he writes that "...the profession cannot insist on freedom and autonomy in the marketplace at the same time as it insists on having the protection of a monopoly: within the limits of a monopoly, a free market merely means license to the profession without the economic benefits of competition to the consumer" (Freidson, 1970a, 364).

Freidson suggests that the concentration of economic power in the hands of the profession is a reflection of the solo practitioner ideology romanticized by the profession (Freidson, 1970a, 365). This ethos, although later eroded by forces of social and economic change, is partly behind the lack of critical review of work of one physician by his or her peers. Given the acceptance of the ideology of uncertainty in the profession's work and the idiosyncratic nature of applied knowledge, the profession left to its own devices does not fulfill the trust placed upon it by the public in its delegation of professional autonomy (Freidson, 1970a, 365).

In summary to this point, the development of professional autonomy may be seen in Freidson's major work as an ideal type in the Weberian sense. Its characteristics are most succinctly summarized in *Professional Dominance*, in which Freidson points to the characteristic of organized autonomy as a requisite characteristic of the autonomous profession

(Freidson, 1970b, 133). Here the emphasis is on "organized", and it is this characteristic that has attracted the attention of critics from Parsons foreward who have attacked the role of the American Medical Association in furthering the economic interests of the profession. Ironically, it has been the role of the AMA and other bodies at state and local levels to protect the diffuse practice of medicine under the private practice model. Thus, the organizational framework is one of association for the protection and continuation of this decentralized mode of practice, which Freidson finds detrimental to the public interest through lack of economic discipline and true quality control through effective peer review (Freidson, 1970a, 365).

The greatest methodological concern at this point is the possibility that the remaining characteristics of autonomy may be tautological in nature. As previously noted, Freidson defines autonomy as "the quality or state of being independent, free, and self-directing" (Freidson, 1970b, 134). The other characteristics of autonomy may be seen as dependent on this definition, and as consequences of autonomy rather than as explanatory elements to account for its existence. The ability of an organized professional grouping to gain autonomy may lead to its ability to structure those elements which are seen as added dimensions of autonomy to its advantage. These include the

profession's ability to control its own educational processes (invariably in conjunction with university sanction); domination of others in the occupational hierarchy through ordering of the division of labor; and the ability of the profession to regulate its clients through imposition of controls on conditions of provision of service and the economic bases on which these services are rendered (Freidson, 1970b, 133-135).

REMEDIES FOR THE "FLAW" OF AUTONOMY

Freidson ultimately moves beyond the basis of observation and description of autonomy and its manifestations. He concludes his early work in a moral tone, in which autonomy is defined as a "flaw" lending itself to correction in praxis (Freidson, 1970a, 370). The flaw is one of pride or hubris in the sense of classic Greek tragedy. He writes at one point that "It is the special status which is the villian" (Freidson, 1970a, 381). The problem, is related in Freidson's mind to the placement of the profession as the dominant one in the healthcare division of labor, incomplete though it might be (Freidson, 1970a, 369).

Freidson refuses to fall prey to the notion that autonomy is a purely economic device, choosing to see its development from a wide variety of social forces. In refuting the economic causal theory, he states that "Consulting professions are not baldly self-interested

unions struggling for their resources at the expense of others and of the public interest" (Freidson, 1970a, 370). Rather, they are deluded into perceptions of an entitlement to a superior level of resources as a result of the insularity of the profession and the protection it receives (Freidson, 1970a, 370).

To curb this fatal tendency, Freidson proposes that structural alterations be made. As he states, "It is time that their [the consulting professions'] autonomy be tempered" (Freidson, 1970a, 370). In a sense, the profession seems to suffer in Freidson's mind from a hubris or pride that elicits the reaction of a moralist. He writes that "Its very autonomy has led to insularity and a mistaken arrogance about its mission in the world" (Freidson, 1970a, 370). He continues in this vein, suggesting that "Their autonomy has created their narrow perspective of themselves and their work, their conviction that they know best what humanity needs" (Freidson, 1970a, 370. Given these reservations regarding the profession and its lack of ability to self regulate its interests as opposed to the interests of the broader society, it is not surprising that Freidson should turn to classically liberal solutions to check such defects in the professional character in the form of institutions for oversight and control. In this regard, then, Bosk's depiction of Freidson as a structuralist becomes more persuasive.

ATTEMPTS AT CONTROL WITHIN THE PROFESSION

Freidson has based much of his empirical research in the area of colleague relations within medical groups, presenting an opportunity to "ground" his theories regarding professional action in a contemporary setting. In *Doctoring Together*, his major research into the nature of group medical practice, Freidson focuses on the nature of control of action of group members by the *collegium*. He describes this model of organization in juxtaposition to the Weberian ideal type of the bureaucratic agency (Freidson, 1975, 8). In describing the distinction, he writes that "Given a monopoly over certain kinds of work, the profession is composed of a nominal company of equals, with internal differentiation based on specialization and prestigious skill rather than on official rank. Bureaucratic hierarchy and the authority of bureaucratic office are foreign to the profession. The *indirect* forms of social control exercised over work in the case of the professional model are fairly clear-- restrictive licensing, formal training and educational requirements, and the like" (Freidson, 1975, 9). What is less clear to Freidson is the source of direct control, which is presumed by codes of professional ethics and conduct to be self control or that of one's peers.

Weber had been quite aware of the collegium and its

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limitations in the face of bureaucracy. He traces the assemblage of experts in a collegial format by the ruler in traditional society to provide advice (Weber, 1946, 237). However, this quickly gives way to more tightly structured authority relationships. He writes that "Collegial bodies are rapidly decreasing in importance in favor of types of organization which are in fact, and for the most part formally as well, subject to the authority of a single head" (Weber, 1989, 170). He adds that the "decisive factor in this development has been the need for rapid, clear decisions, free of the necessity of compromise between different opinions and also free of shifting majorities" (Weber, 1989, 170). Thus there is ample precedent in the classical sociological literature for skepticism where the effectiveness of collegial enterprise is concerned.

Freidson's research makes this point more narrowly in the specific instance of the medical group and its discipline over its members. In his conclusion to his study of medical group action, he emphasizes that *"The collegium was a largely neutral force in the social control of its members' performance"* (Freidson, 1975, 237). Given the pattern of even the organized professional group to abdicate "the role of exercising organized sanctions", it is no surprise that even less success is achieved in promoting professional discipline with the solo

practitioner (Freidson, 1975, 237). In this instance, as in his earlier work, Freidson views this unwillingness as a reluctance to infringe upon the professional autonomy of individual practitioners-- an abdication of broader social responsibilities in Freidson's mind (Freidson, 1975, 246).

It comes as no surprise, therefore, that this insistence on non-intervention in the affairs of other practitioners by one's peers extends to the economic arena as well. Freidson applies the example of the establishment of Medicare and Medicaid in 1965 and the ensuing surge in expenditures for health services. At first, Freidson suggests that the central theme of this paper, the balance of social and economic forces on the actions of providers, must be given sufficient recognition. He writes that "The imputation of purely selfish economic motives does not explain enough to be, by itself, a reliable guide to policy, for providing and ordering services is as much a way of coping with problems of work as it is a way of making money" (Freidson, 1975, 246-247). Yet he continues that there is nothing in the structure of the collegial relationship to suggest that an "organized system of collegial influence" would arise in order to control claims (Freidson, 1975, 247). He concludes that in the area of cost control that there is even less potential for control in the mode of solo practice than in the group style which had also evidenced little control over members' actions.

He concludes that "There has in fact been little precedent for systematic professional self-regualtion in medicine in the past" (Freidson, 1975, 247).

Freidson's conclusion to his study of group practice was to restate a theme developed in his earlier works and which would continue throughout his writings, that of the need for public participation in the affairs of the profession in order to assure accountability. He writes that a blueprint for medical organization in the future "would have to do more than point out that a new, socially responsible etiquette must replace traditional medical etiquette based on entrepreneurial practice" (Freidson, 1975, 258). This statement is significant in its identification of the key element of "entrepreneurism" in the practice of medicine and the influence which this ideology-- whose roots are after all in the commercial sector of a capitalist economic order-- has on the organization of the medical profession.

The development of Freidson's work on autonomy may be seen as heavily influenced by the organization of medical practice which he considered dominant. In his earliest work, reflected in his 1970 publications, he focuses on an atomized model of solo or small office practice. Autonomy is the dominant ideology of the physician in a clinical and economic sense, and is protected by the presence of

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membership organizations designed to further these interests. In his middle period, the focus of his research shifts to the group, which he had identified in the later sections of *Profession of Medicine* as a vehicle for the introduction of public accountability through the breaking down of professional isolation. In his later work Freidson has continued the theme of professional autonomy from the setting of the group or collegium to that of the organizational structure in which the group shifts to a corporate structure and the relationship of the professional from that of member or partner to employee. His specific argument in this phase becomes one of sustaining the position that professional autonomy has not disappeared in the face of what some regard as control of the division of labor by the "corporate rationalizers", to borrow Alford's (1972) richly descriptive term. Rather, it is his agenda to show how autonomy has been preserved and fostered by the profession under a different guise, even in the face of what has been described by other commentators as "deprofessionalization" or even "proletarianization".

FREIDSON'S LATER THEORY: RETREAT FROM AUTONOMY

As his work has progressed, Freidson has tried to maintain a theory of autonomy which is cognizant of trends in organizational form which have occured at the micro level of practice as well as broader changes in health care finance and policy at the level of the state and society.

Freidson saw developments in group practice as directly influenced by the development of the Medicare and Medicaid programs, and the ensuing enhancement of the federal role in health care finance. At the same time, his work invariably makes reference back to his key concept of autonomy which had formed the parameters of his early analysis of the profession.

In a real sense, Freidson continues to deal with the problem of what constitutes sufficient constraint on professional autonomy, and under what circumstances ought it be invoked. At the level of the organization, Freidson had very early determined that such restraint would be in order at appropriate times. Noting that self-regulation within the collegium had proven "limited and contingent", he commented in an early study with Rhea that "It is very easy to see how, under some circumstances, administrative efforts at control of work are not mere bureaucratic aggrandizement, but conscientious efforts to fill a genuine vacuum engendered by the peculiarities of the professional system of self-regulation" Freidson and Rhea, 1972, 199). This is amplified to the policy level by his comments in *Profession of Medicine* in which he argues for external oversight of peer review and economic activities involving the profession to overcome its innate professional myopia. Yet even in this work, Freidson evidences some ambivalence on this point. He writes that "it is necessary to note the

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degree to which destructive ignorance and irrationality may be released by reducing professional autonomy-- the risk that what is good and useful about professions may be damaged" (Freidson, 1970a, 377). For the time being, he concludes that the system of professional support is so formidable that this risk is not a foolish one. Nevertheless, he continues to debate this point of the extent and desirability of professional autonomy in his own works and with subsequent authors.

Freidson identified this conflict in subsequent works growing from his earlier theoretical and empirical analyses. In discussing the organization of medical practice, he specifically identifies professional autonomy as an ideological theme central to independence of the profession and directly linked to the mode of solo practice (Freidson, 1989, 80). But he notes the isolation which results from the extreme independence of solo practice, and concludes that practitioners must band together in an organized manner to defend that very independence against encroachment. Autonomy in fee for service is characterized as "inherently unstable", and can exist "only under very special circumstances" (Freidson, 1989, 80).

Freidson suggests that at the time of his 1979 paper on "The Organization of Medical Practice" that the involvement of third party payers may yet have significance for the

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"nature of practice". He notes that to this point (1979) that "governmental third parties made little effort to change the nature of practice itself" (Freidson, 1989, 87). However, he notes in citing Colombotos that the majority of American physicians are concerned with the "political and economic forces now encroaching on the convenience and simplicity of their desired practice arrangements" (Freidson, 1989, 90). With growing dependence on the state for income in the form of third party payments, he reasons, will come pressure for practice in more organized forms, and a further departure from "a solo practice of a happier day that in fact could rarely be both financially secure and autonomous" (Freidson, 1989, 90). This latter comment is especially informative as Freidson notes the ideological basis of autonomy and suggests that its preservation may in fact not further economic gain but may in practice be in direct conflict as efforts are expended to maintain the ideology of autonomy.

ALTERNATIVES TO AUTONOMY: HAUG AND DEPROFESSIONALIZATION

Freidson turned directly to confront his critics in his paper "The Reoganization of the Medical Profession" which appeared in 1985. In this work he confronts the hypotheses of deprofessionalization associated principally with Haug which had appeared shortly after his pivotal 1970 publications, and the proletarianization of physicians argument attributed to McKinlay. These discussions are

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crucial to an understanding of professional autonomy, as in both challenges there is a clear assertion of the erosion of autonomy for medicine.

Haug is regarded as the main proponent of the deprofessionalization hypothesis, which questions the continued viability of professional status based upon consumer acceptance of the "expert" knowledge of the professional (Haug, 1988, 49). This acceptance "in trust", after all, was a vital underpinning of Parsons' theory of the nature of professions. This trust response on the part of the public is in turn partly a creation of the success of the profession in persuading the public of its expertise and the value it contributes, and partly as later developed in Fox's work in the rarified nature of the sphere of competence of the professional.

Haug's argument for deprofessionalization as applied specifically to medicine by suggesting an enhanced public awareness which has created a more informed and demanding consumer less inclined to accept medical direction on faith. This leveling of the asymmetry of patient and professional roles has been furthered by the emergence of alternative health providers and the information "revolution" which has made computer based information more widely available to professional and non-professional alike (Haug, 1988, 50).

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In refuting the hypothesis of deprofessionalization, Freidson argues from the framework of his position on professional dominance developed earlier in his career. He notes that dominance is created on two separate but interdependent bases-- one of which is cultural or ideological, and the other of which is economic and legal (Freidson, 1985, 16). Freidson suggests that the assumed loss of cultural hegemony is a matter of faith rather than empirical analysis. He dismisses this criticism in writing that "I do not believe that the thesis of cultural hegemony in its full-blown form can be settled by anything other than faith, which I lack. It is an idea to play with rather than a concept to address systematically and use analytically" (Freidson, 1985, 16).

Evidently Freidson considered his position on this issue to be a bit brusque in his dismissal of deprofessionalization. In order to overcome the lack of an empirical base, his argument has turned to public opinion polls which attempt to measure public confidence in occupational groups as a source of evidence to refute the argument. Citing a study by Lipset and Schneider, he argues that confidence in professionals has declined from 1966 to 1981, but not to the same degree to which confidence in other occupations has eroded (Freidson, 1986b, 112). He uses his conclusion in this area to serve as a springboard to his next point of

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attack when he writes that "There is no evidence of a sufficiently massive shift in public trust and confidence to motivate most clients to act much differently than they have in the past, *consumerism notwithstanding*" (Freidson, 1986b, 112).

It is Freidson's direct contention that an increase in consumer influence through the acquisition of enhanced knowledge formerly within the domain of professional expertise has in fact been quite limited. He states boldly that "the deprofessionalization theory makes far too much of the potential of the consumer movement" (Freidson, 1985, 18). He suggests elsewhere that the consumer movement has had significance only at "the margins of the licensed professions" (Freidson, 1986b, 112). He contends that the perceived shrinkage of the "knowledge gap" between professional and consumer is an illusory one as the knowledge base of the professions is continually expanded and renewed by the professions themselves or their attendant academic base. He writes that "the major professions continue to produce new, more esoteric specializations at the same time as the consumer's knowledge increases, so it is difficult to see any 'knowledge gap' closing. Nor does the computer help so long as its programs and the evaluation of its printouts remain in the hands of the professions involved, as they do" (Freidson, 1986b, 112). He does concede that consumers

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may attain a superior degree of knowledge in limited areas, but only if they specialize in their efforts as well. He cites women's health and childbirth education as two specific instances of such successful specializations (Freidson, 1985, 18).

In the above argument Freidson appears to also lend credence to Collins' argument that professional training does not extend simply to the technical aspects of work (Collins, 1990b, 37). In fact, in the creation of a professional elite possession of technical knowledge may well diminish rather than expand in importance as the knowledge base grows correspondingly. One may still maintain one's superior status in the division of labor through the judicious delegation of tasks deemed as technical and perhaps ultimately trivial as well.

McKINLAY AND ARCHES' CRITIQUE: PROLETARIANIZATION

It is in the area of economic and legal bases of professional dominance, the second and in Freidson's mind more consequential support for the theory, that he makes the most forceful argument for the continued superiority of the professions within the general structure of the division of labor. It is in this area that he turns his attention direcly to the proletarianization theory prominently associated with McKinlay, as this issue is more fully developed by Mckinlay than by Haug and her

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colleagues.

In advancing the thesis of proletarianization, McKinlay and Arches define the process as one in which *"an occupational category is divested of control over certain prerogatives relating to the location, content and essentially of its task activities and is thereby subordinated to the broader requirements of production under advanced capitalism"* McKinlay and Arches, 1985, 161). The authors are quick to point out that their thesis is one of a gradual erosion over time rather than an achieved state, a point which is more compatible with Freidson's later criticism (McKinlay and Arches, 1985, 163). Of particular interest to this study among the seven points advanced by McKinlay and Arches as indicators of advancing proletarianization is the loss of "*autonomy regarding the terms and content of work* (e.g., the ways in which what must be done is accomplished)" (McKinlay and Arches, 161-162).

It is their contention that bureaucratization of work has eventuated in the erosion of these prerogatives. Bureaucratization in this instance is used primarily to represent changes in work conditions of physicians, especially the loss of the romanticized autonomy of the solo practitioner who increasingly is replaced by employed physicians. In his later work McKinlay chooses to accentuate this trend, and adopts corporatization of

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medicine as a preferable and less emotionally charged label for the loss of professional self direction he observes than proletarianization. The direct consequence of this new economically driven ordering of practice is the erosion and breakdown of informal control structures emphasizing professional self-control. The assumption in this case is that hierarchical structures have usurped those elements of control of work previously reserved to the profession.

Freidson is quite harsh in his response to this position. It might well be argued that McKinlay's thesis is virtually identical to that advanced by conservative defenders of the traditional ideology of professional autonomy. Ironically, it is this ideology of professional self-control that Freidson has cited throughout his earlier work as the deceptive "flaw" of professional autonomy. He would argue that collegial self-regualtion has failed badly, and that in response to this failure some form of public regulation to act as a restraint on professional autonomy is critical. While Freidson might also agree that corporatization is the answer to this deficiency, he might also well agree that prior abuses of public trust by the profession might have broken the shield of autonomy and created an opening for outside forces, including corporate ones, to enter and assert control where none had existed previously.

Freidson undertakes an empirically based argument against

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the proletarianization thesis by arguing that the trend cited of increasing numbers of salaried physicians is in fact an exaggerated one. Freidson suggests that these numbers include numbers of physicians employed as researchers or administrators not engaged in actual practice. In addition, he notes that numbers of physicians have chosen for tax and liability advantages to organize as professional corporations with themselves as simultaneous owners and employees (Freidson, 1985, 19). He argues that the concept of self-employment in a market economy is a misleading one, and of little analytic value (Freidson, 1986b, 125).

Having suggested that factually employee status may be misleading, he proceeds to challenge the fundamental premise of the argument that "Employment is an important issue because it implies the loss of the capacity to control work" (Freidson, 1986, 119). Here Freidson reverts to the question identified earlier in this discussion of the place of the physician or other dominant professional within the hierarchy of the division of labor. Freidson summarizes the argument which advocates this position as one of bureaucratization of the work of the professional under the direction of capitalists or corporate rationalizers (Freidson, 1985, 20). He argues forcefully against this point with respect to the hospital setting, noting that physicians as members of organized medical

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staffs enjoy organized autonomy under the policies of the Joint Commission on Accreditation of Hospitals. These policies, adopted and enforced by the Board of an association which is comprised of a physician majority, ensure that the medical staff reports directly to the governing body of the institution and circumvents administrative management (Freidson, 1985, 21).

He continues his argument by stating that physicians still continue to control the mode of production, a critical point in refuting the proletarianization argument. His retort is that "In the case of medicine, both supervision and control and the creation of 'production standards ' are carried out by members of the same profession as those who perform the basic, productive medical work" (Freidson, 1985, 27). Members of the medical profession establish standards for the "rank and file of physicians", rather than some management group external to the profession. He notes that the judgment of "collective *collegial* practice" generates standards of professional care (Freidson, 1985, 28). He does note that increasingly standards are being established by elite clinicians and researchers in university settings, but based upon purported technical superiority rather than managerial hierarchy.

None of the above appears in Freidson's mind to make inroads against what Freidson had earlier regarded as the

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"flaw" of professional autonomy. In his early work, Freidson had championed and continues to advocate the involvement of public representatives in the review of medical work (Freidson, 1970a, 377). He notes in more recent articles a trend toward more formal methods of review, but suggests that these methods have not seriously compromised autonomy, although such compromise might well be beneficial to the public (Freidson, 1987, 142). Freidson retains a view of praxis with respect to the desirable involvement of entities outside the profession which should in fact occur. That they have not refutes the proletarianization thesis but also leaves medicine with an excessive degree of freedom in ordering work and in establishing the economic terms under which that work will take place (Freidson, 1985, 19).

FREIDSON'S SELF-CRITIQUE: SOFTENING OF AUTONOMY

In reviewing the span of his work in the 1988 Afterword to *Profession of Medicine*, Freidson acknowledges the element of praxis in his work when he describes his book as an evaluation as well as an analysis. His main focus in this effort has been one of attempting to enhance the public accountability of the profession. He is able to review his work and assess to what degree this transformation has actually occured.

He suggests in summarizing the concept of the book that

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autonomy is "the central concept of this book" (Freidson, 1988, 383). It is critical to note, however, that autonomy can have two different dimensions-- autonomy from the influence of others and autonomy to influence or to exercise power over others (Freidson, 1988, 383). The former can be viewed as the social and economic independence which the profession has enjoyed, while the latter is associated with the dominance of the profession in the occupational hierarchy and in the asymmetric relationship of the physician and patient. He suggests that the technical autonomy of the profession is key to retaining the ability to move "the economically and politically powerful" (Freidson, 1988, 384). In keeping with his earlier thesis of the critical role of elites in securing the high social and economic status of medicine, he argues that this autonomy with respect to professional work is based upon power *delegated* by others (Freidson, 1988, 385).

He suggests that the original work of analysis of autonomy was done at the conclusion of the "golden age" of American medicine, which he identifies as the period 1945-1965. While the work of other analysts keys off the loss of economic control experienced by the profession, Freidson in his retrospective attacks the central issue of clinical autonomy and control over work. While physicians themselves might contribute to the restructure of the

economic milieu of medicine through participation in profit making schemes and joint ventures, it is in clinical work that technical autonomy is threatened (Freidson, 1989, 217). He states that autonomy is being marginally eroded in a changed form under formal review and controls. What is pivotal is that technical autonomy is maintained in a *professionally controlled* system rather than as subordinates to managers as in industrial settings (Freidson, 1988, 386). The concluding irony is that to sustain autonomy of the private practice ideology, they must align themselves with larger organizations beyond the collegium.

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PERIOD THREE

REVISIONS TO PROFESSIONAL AUTONOMY: PLURALIST, ELITE AND MARXIST INTERPRETATIONS AND INTERNATIONAL COMPARISONS

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THE PLURALIST PERSPECTIVE: STARR AND PUBLIC PERSUASION

In his later work in which he cited professional autonomy as the central organizing concept of his early writings, Eliot Freidson acknowledged that his work had been grounded in a specific historical period, one which he labeled the "golden era of American medicine" (Freidson, 1988, 384). This historical period was to be altered by the enactment of Medicare and Medicaid in 1965, which Freidson identified as the pivotal event in altering the relationship of the profession and the general populace (Freidson, 1988, 384-5). A critical question in addressing the work of Freidson is that of the degree to which his sociological perspective on autonomy is a product of the particular social, political, and economic forces of the period in which his work is situated.

An alternative social theorist whose work also develops a position on professional autonomy is that of Paul Starr. With his publication in 1982 of the popularly acclaimed work *The Social Transformation of American Medicine,* Starr presented an historically driven perspective on the development of the medical profession which emphasized the role of the profession as an organized entity in creating a political framework of autonomy. His work fits well within a pluralist social theory in that it portrays medicine acting throughout the 19th and 20th centuries as a power block competing with others in a pluralistic democratic

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framework to further primarily its economic interests through political means. In contrast to Freidson, Starr downplays the role of elite sponsorship in furthering the claims to autonomy of the profession, choosing rather to see this effort as one undertaken by the organized profession as a self-directed entity occasionally enlisting support as required from other social groups for its strategic advantage.

In his major work Starr moves well beyond the temporal slice of Freidson's analysis to craft a comprehensive explanation of the social-historical development of the profession in America. Starr carefully traces at the micro level of the practitioner the changes in the broader social order of American society which allowed medicine to become economically viable for more than a select cadre of urban practitioners. These changes included the diffusion of the auto and the telephone, making contact with widely scattered patients in a rural society feasible (Starr, 1982, 69-71). He further chronicles the alliance of medicine with scientific advances and a subsequent consolidation of medical authority under the banner of allopathic medicine-- a phenomenon Starr attributes in large part to the activities of the American Medical Association (Starr, 1982, 100).

In discussing the AMA and its impact upon the development

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of the profession, Starr adopts a position not unlike that of Parsons cited early in this discussion in which the AMA becomes the major driving or impeding force behind factors influencing the medical profession. He describes the early activities of the AMA acting in guild-like fashion to influence the passage at state levels of licensure laws with the avowed purpose of protection of the public from unscrupulous practitioners. The work of Flexner is viewed as a substantial assist to the ongoing activities of the AMA to reduce the number of medical schools and subsequently limit the entry of new practitioners into the field in the early part of the twentieth century (Starr, 1982, 120). He portrays Flexner and the backing he received from the Carnegie Foundation as a fortuitous legitimization by an independent and dispassionate third party coincidentally directed toward the political outcome sought by the AMA as the voice of organized medicine.

THE "SELLING" OF "SOVEREIGN" STATUS

The key element in this discussion is the ability of the profession to limit entrants and presumably secure market control through domination of the educational process. Berlant has noted the dominance the AMA exercises over the accrediting process and the implications of this control for creation of an effective professional monoploy (Berlant, 1975, 57). This dominance was extended at the state level through the creation of licensure boards, the

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membership of which was drawn by law from the ranks of the profession.

Starr would suggest that these pivotal developments in securing the "sovereign" status, in Starr's words, of the profession were a direct consequence of the profession's self-promotional activities. He is at the same time quick to point out the complex of social forces operating in early twentieth century America which coalesced to allow the success of these efforts-- a "right place at the right time" phenomenon. Starr distinguishes his approach from that of two other theoretical sets, the functionalist (as in the earlier discussion of Parsons) and the power theorist citing the monopolistic practices of the professions (Starr, 1982, 144). Starr easily dismisses the first approach, indicating that the advance of scientific discovery is simply not an adequate explanation for the advance of this particular profession and its political and economic ends (Starr, 1982, 144).

He is less certain in dismissing the power theorists. He notes that numbers of occupational groups have not achieved autonomous status despite their efforts to do so. He writes that "The exponents of the monopolization thesis tend to presume the capacity of a group to articulate its collective interests over its competing interests" (Starr, 1982, 144). He then continues that "What must first be

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explained is how the group achieves consensus and mobilization" (Starr, 1982, 144). In an almost marketing sense, physicians proved to be able to "satisfy the felt needs of others", a necessary source of persuasive power to overcome what might be perceived by others as guild self-interest (Starr, 1982, 144). The real question posed by Starr's observation is that of whose approval they needed to win to secure dominance. Starr notes that physicians as a group in the early part of the century had little power. Yet in an illustration of successful group action within a pluralistic model of society, they were able to seize upon a fortuitous public need and secure their position. Starr summarizes this argument well when he writes "With widespread support, which they received because of complex changes overtaking the entire society, physicians were able to see social interests defined so as to conform to their own. This was the essence of their achievement" (Starr, 1982, 144).

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BROWN AND THE ELITE THEORY OF FOUNDATION INFLUENCE

The subtelty of Starr's argument is best highlighted by examination of the work of an author with a different approach to the same period, E. Richard Brown. Starr argues that the factors in the social environment in which its autonomy was initially established were multifaceted, to be sure. Nevertheless, the prime mover which seized the opportunities offered by the plethora of social conditions

operating at the time was the profession itself. As Starr suggests in the previous paragraph, muted though it might be, "*physicians were able to see social interests defined*" in accord with the vision of at least their own leadership. Thus one may surmise that at the very least physicians have proven to be an astute competitor with respect to the interests of other occupational groups, and their prize from society has been autonomy through legitimation of the profession's claims, ultimately by the state.

Brown sees the problem differently, choosing instead to emphasize the role of capitalist dominated elites as an essential patron in the creation of medicine's position of autonomy. Brown sees the attraction of medicine to the capitalist interests in the form of a common embrace of the values and methodology of science. In Brown's view, science is a "vital element" in creating conditions "for increased productivity and decreased labor costs" (Brown, 1979, 192). The monumental financial successess of industrial titans such as Carnegie in steel and Rockefeller in oil were facilitated in large part through advances in the production of industrial products from raw material through scientific application to the production process. This success in turn produced the financial resources which the foundations created by Carnegie and Rockefeller and other tycoons of the time were able to bestow on the creation of fledgling scientific medicine through the first

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decades of the twentieth century.

Brown sees the backing of the foundations, with the force of economic resources and moral influence, as critical to the success of Flexner and the elite medical schools in providing a scientific, university based program of medical education backed by the legal force of the state (Brown, 1979, 193). He summarizes this point by writing that "mobilizing the power of corporate wealth in the social sphere, foundations brought unprecedented aid to the promotion of scientific medicine and to the reform of medical education" (Brown, 1979, 193). He further suggests that the foundations played a pivotal role in developing social institutions "to serve the scientific, educational, and cultural needs of capitalist society" through the strategic use of subsidy financing to capital starved schools of medicine (Brown 1979, 193).

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The question of rationalization of medical practice is a critical one for both Brown and Starr. Both view a critical historical juncture in the development of the medical profession in the late 1920s through early 1930s. Brown notes a growing rift between the interests of the capitalist establishment and the advocates within the profession of the private practice of medicine over the future organization of medical practice. Here the key divisive issue in Brown's view is that of "commercialism"

in medicine. He suggests that the work of Frederick Gates and the Rockefeller Foundation supported General Education Board attacked the interests of organized medicine because "the interests of the organized medical profession conflicted with the goals of disseminating the technical benefits and ideological influences of medicine as widely as possible...."(Brown, 1979, 194).

THE PROFESSION'S RESISTENCE TO LOSS OF AUTONOMY

Starr and Brown's analyses of the role the medical profession in securing professional autonomy converge in discussion of the role of the Committee on the Cost of Medical Care and its 1932 report which called for the extension of universal health benefits to the population of the United States. As Starr notes, the report takes for granted the desirability of scientific medicine as well as the greatly expanded need for such care (Starr, 1982, 262). Yet the question of how medicine was to be provided to the public can be seen as the key turning point in the autonomy debate. At this juncture historical commentary joins developing sociological theory, for it is in his critique of the AMA and its role in fighting what may be viewed as the effort at rationalization of the Committee that Parsons steps out of his functionalist mindset and becomes a political critic (Parsons, 1964, 326). In his words, Parsons characterizes the report as "a rather typical foundation-supported economic study in its attempt to

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bridge considerations of academic economics and public policy" (Parsons, 1964, 325). The objections of the AMA are viewed as an overreaction by Parsons and troubling in retrospect, as the principal point of the study was extension of health care to underserved elements of society.

Brown views this development as one in which "The AMA, as an interest group, declared civil war against the corporate class-supported efforts to rationalize medical care" (Brown, 1979, 197). The curious outcome of this war, and one which Brown does not fully answer, is why this resistance succeeded, given his earlier thesis of the continuous success of the capitalist interests in imposing their viewpoint upon medical developments either overtly or covertly through foundations. Starr seizes upon this point in his introduction to *The Social Transformation of American Medicine*, when he suggests that capitalism might be compatible with a variety of medical care systems. He writes that "it is not entirely clear whether the development of American medicine followed the 'objective' interests of the capitalist class or the capitalist system. Although foundations set up originally by capitalists have made repeated efforts to rationalize medical care, Starr argues that "it is impressive how little these efforts have succeeded (Starr, 1982, 17). This point is a direct challenge to Brown's position in suggesting a direct

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connection between the economic interests of capital and the agendas of foundations.

Starr's work on autonomy concludes with the question of why, if it were in the interest of capital to rationalize the economic system for medical care delivery, why did this effort not succeed and appear to succumb to the efforts of the profession for legal and economic autonomy. Starr appears to close his discussion of this question, as well as his efforts to address the issue of autonomy directly, by pointing to the rise of insurance in the 1930s in the form of physician organized Blue Shield plans. He argues that these programs were controlled by professional boards as opposed to the "lay" business interests which sponsored company benefit plans during this period, notably the railroads and Kaiser Industries. These plans represented an "accomodation" to the wishes of the public, Starr suggests, in that some protections were provided against financial ruin from the costs of medical care by creating a community based fuding mechanism-- but one which maintained the profession's particular economic power (Starr, 1982, 307).

Starr writes that the doctors of the time "objected not only to private enterprise but to any middleman coming between them and their patients, whether that third party was a company, a fraternal lodge or union, or any other

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organization" (Starr, 1982, 217). Corporate enterprise in health care would expropriate profits from the medical care provider to capitalists, and would infringe upon the professional autonomy of physicians-- a result deemed "unprofessional" by the AMA in its 1934 Code of Ethics (Starr, 1982, 216). In a telling summation of the argument he advances for the position of physicians in resisting intervention from interests outside the profession, Starr states that "The AMA was saying, in short, that there must be no capital formation in medical care (other than what doctors accumulated), that the full return on physicians' labor had to go to physicians, and consequently, by implication, that if medicine required any capital that doctors themselves could not provide, it would have to be contributed by the community, instead of by investors looking for a profit" (Starr, 1982, 216).

On a micro level, the medical profession was able to resist the intrusion of capitalists, government, and other occupational groups as a result of nothing more complicated in Starr's analysis than the unique personal relationship of the patient and physician. In this throwback to Parsons' classic formulation of the patient/physician interaction, Starr writes that "The doctor's cultural authority and strategic position in the production of medical care create a distinctive base of power" (Starr, 1982, 217). It is this relationship that Starr suggests

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allowed medicine to resist the typical movement toward "hierarchical subordination" which emerges in other occupational groups. This conclusion is one which Navarro (1990) attacks as an historical justification of what has transpired rather than a sociological search for explanation in the forces of the political economy. In any event, it becomes an increasingly tenuous argument as government enters the scene as a major payor for services.

Starr confronts the problem of attempts to secure government control of the content of medical practice by noting that "medical research, like all scientific reasearch, demands autonomy as a necessary condition of free inquiry" (Starr. 1982, 351). This was important in retaining control of medical school curricula, and allowed the profession to continue in charge of its training processes. This spirit of unfettered scientific inquiry, coupled with appeals to the "privacy of the doctor-patient relationship", provided the basis for medicine's case that public financing should not entail government intervention (Starr, 1982, 351).

LOSS OF AUTONOMY UNDER NEW ECONOMIC AND ORGANIZATIONAL STRUCTURES

In his conclusion "The Coming of the Corporation", Starr predicts that the loss of significant professional autonomy is a virtual certainty under new organizational forms. He

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sees physicians losing autonomy as part of larger corporate chains gain control and make decisions away from the local hospital, which has served to shield professional autonomy in the past. In this regard, his view may reflect the economics of the early 80s toward provider centralization, which have faltered later in the decade. He suggests that conflict will inevitably arise between medical and business decisions, with an unclear indication as to who will resolve these conflicts (Starr, 1982, 447).

Most importantly, while earlier discussion in this section has dealt primarily with economic intrusions upon professional autonomy, Starr forsees increased control over "the rules and standards of medical work", which constitutes a fundamental attack on the recent medical division of labor (Starr, 1982, 447). He argues that this approach will socialize physicians into a new mode of thinking in which practice policies or guidelines will obscure loss of professional control (Starr, 1982, 448). Ironically, if this inroad on the traditional basis of autonomy of control of content of work is to be resisted, it may well be through professionals acting collectively through organizations. This is a significant retreat from the ethos of mid-century of the "sovereign" solo practitioner acting simultaneously as a care giver and entrepreneur and enjoying professional dominance in both aspects of her/his role.

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NAVARRO'S CRITIQUE: AUTONOMY AS A CREATION OF CAPITAL

An alternative perspective on the issues of autonomy raised by Starr and Brown may be found in the writings of Vicente Navarro. Navarro has directly criticized Starr's benign interpretation of the forces which led to professional autonomy. He argues that the popularity of Starr's work has resulted from its emphasis on the legitimation function of persuasion over interpretations which might instead have stressed the "power of coercion and repression" (Navarro, 1990, 218).

Navarro's argument that forces of coercion and repression have been at work in the establishment of an autonomous or "sovereign" position for medicine is consistent with his earlier writings on the relationship of medicine and advanced capitalism. Certainly, he does not accept the notion that the capturing of public opinion has been sufficient to achieve this outcome (Navarro, 1990, 219). Rather, the physician attains autonomy to the degree that it is complimentary to the goals of a broader cpitalist order. Increases in professional power are directly related to this relationship, and are similarly revocable should the capitalist order find that physician autonomy no longer supports profit goals (Navarro, 1980, 204).

Over time this interpretation has become more accepted in a range of commentators who would not be regarded as sharing

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Navarro's Marxist theoretical base. A prominent example is the critique of Arnold Relman, emeritus editor of *The New England journal of Medicine*-- a publication hardly identified as radical in orientation. Relman criticizes the introduction of overtly for-profit enterprises into health care, and draws attention to a wide range of industrial concerns which are heavily invested in health care activities. Most notable are pharmaceutical concerns and medical device manufacturers (Relman, 1980, 968). Nevertheless, Relman does not directly link the medical profession to this growth of profiteering, but argues instead that it is an ethical mandate for medicine to reassert its autonomy in the best sense and resist the inroads of capitalists who threaten to corrupt a noble professional ethic of patient before personal gain.

Navarro is less sanguine by far on this point, arguing that the interests of physicians ans capital are inextricably linked, however unknowingly to the typical member of the profession. This is a result of the pervasive ideology of capitalism, which permeates the way health care is delivered and medical technologies and devices are brought to market (Navarro, 1980, 205). Historically, physicians have been granted power within the social system as they can be relied upon to carry out the intent of capital to uphold and further the existing order. In this regard, the physician can be seen as a willing agent of social control

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who is accorded autonomy as long as this mission is faithfully carried out. The critical element here is that the autonomy of physicians has always been delegated by an "elite who selected, reproduced, and established the professions" (Navarro, 1988, 61). When one examines loss of autonomy in the current historical period, Navarro argues that physicians were never dominant within the medical order in the first place. Rather, that dominance was and is enjoyed by the capitalist class (Navarro, 1988, 61).

If medicine is now losing autonomy in certain areas, this does not mean that the proletarianization thesis of McKinlay and Arches is correct. Rather, Navarro sees physicians as still retaining control over elements of the occupational hierarchy of health care despite loss of some control over material means of production. Medicine, he argues, does in fact perform certain technical functions of benefit to society which are not mere political constructions and which will retain a status for medicine superior to that of the proletariat (Navarro, 1986, 241).

Navarro's critique of professional autonomy is one not easily dismissed, and which serves as an effective counterpoint to Starr's argument which would see medicine as having persuaded an otherwise neutral social order to grant autonomy to the profession. In his reliance on the

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dominance of an industrial elite, he is much closer to Brown in his critique of Starr. Navarro's argument partially resolves the issue left incomplete by Starr and Brown; namely that if it were in the interest of capital to rationalize the economic system for medical care delivery, why did this effort appear to have such limited success? The answer of Navarro is that clinical and economic autonomy have been granted and allowed to develop as far as they may be regarded as advantageous by the capitalist class. As this advantage is no longer as evident as was once true, Navarro argues that autonomy is being limited--but only to a degree which still allows a privileged position for medicine in the health care division of labor.

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CHALLENGES TO AUTONOMY: INTERNATIONAL COMPARISONS

Ironically, a key to understanding contemporary theoretical and empirical work on the subject of professional autonomy is provided by an economist, Uwe Reinhardt. In his work, he points to the tradeoff of economic advantage and clinical aspects of autonomy. He also notes the cultural relativism of autonomy and its variability across nations and time-- a theme repeated by other commentators. This work, based on increasing numbers of empirical and cross cultural studies, leads one to question whether an ideal type of the profession of medicine with autonomy as its compelling feature is any longer viable. This section will explore the recent work in the area of autonomy which have led to this need for reassessment and pose some possible alternatives for development of autonomy as a guiding paradigm for the sociology of professions.

In summary and review, the major alternative critique of autonomy which gained general awareness in the 1980s was the international comparative approach. The unifying theme of this comparative work is the sense of development of autonomy in a continuous interaction of the professional and professional groups with the state and in turn the political economy. In contrast to early theorists of autonomy such as Parsons and to a lesser extent the early works of Freidson, the emergence of state financing of medical care in the United States has altered the

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perception of the professional as small businessperson free to dictate economic terms to the patient within the confines of an asymmetric patient/physician relationship. The key question to be addressed is how sociological thinking on the ideal type of autonomy is bound to and reflective of specific political, cultural, and economic circumstances; and how it has been altered under conditions of change in these arenas.

REINHARDT'S DIAGNOSIS: THE TENSION BETWEEN CLINICAL AND ECONOMIC AUTONOMY

Reinhardt (1988) is particularly persuasive in calling attention to the connection of clinical issues of autonomy and economic conditions-- especially as viewed from within the profession of medicine. He cites a physician colleague who summarizes this theme as "the serious damage society inflicts upon patients when limits are placed on physicians' clinical freedom to compose medical treatments as they see fit and on their economic freedom to charge whatever honoraria they deem honorable" (Reinhardt, 1988, ix). As an economist, he is especially sensitive to the potential drift of Evans' "not only for profit" medical-economic ethic to one which is distinctly for profit first and foremost. He adds that the economic imperative of joint ventures in which physicians become economic partners of hospitals and lay capitalists or of direct ownership of imaging and laboratory devices to which

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the physician refers patients will further erode the trust basis of autonomy (Reinhardt, 1988, xvii). As Gray notes in the introduction to his study of for-profit health care, trust as a basis for professional autonomy is under attack as a myth of the profession to enhance status while at the same time preserving monopoly privilege and power in the economic sphere (Gray, 1983, 7). This is a significant criticism, for Freidson has defined on several occasions a service orientation of trust as a social contract of the profession with society which necessitates and legitimizes autonomy for the profession (Freidson, 1970b, 154). If this contract is violated, then what of autonomy for the profession can legitimately be sustained?

Freidson's early work provides a direction to which Reinhardt and others have provided an answer nearly twenty years later. In his 1970 comparative assessment of the position of the medical profession with regard to autonomy, Freidson writes that "Clearly, the economic and political autonomy of the medical profession varies from country to country. What seems invariant, however, is the technological or scientific autonomy, for everywhere the profession appears to be left fairly free to develop its special area of knowledge and to determine what are 'scientifically acceptable' practices" (Freidson, 1970b, 83).

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Reinhardt argues that while this might have been true at a point in time for physicians in the United States, it is no longer so. Rather, the physician's practice specifically in the clinical sphere has been eroded by the entry of persons Alford might describe as "corporate rationalizers" through a process of review of micro-transactions at the level of the individual physician's practice.

It is Reinhardt's assertion that the absence in the United States of an overall program of budgetary control over medical expenditures, as is characteristic of the prominent European systems, results in unparalleled micro-management at the clinical level to achieve cost control unattainable on a larger scale. He writes that "...if the bureaucrats cannot somehow impose upon the healers an overall budget constraint *ex ante*, then they will sooner or later be driven to control their outlays on an ongoing basis, by monitoring each and every transaction for which they pay--that is, by second guessing both the providers' clinical and pricing decisions" (Reinhardt, 1988, xxxii). This appropriation of the clinical dimension of autonomy would be regarded as intolerable by physicians in other medical care systems. He suggests that "European and Canadian physicians would be appalled at the numerous intrusions into clinical decisions now routinely made by these external monitors in the United States. They probably would rise up in arms over that loss in clinical autonomy"

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(Reinhardt, 1988, xxxiii).

It seems problematic that physicians in the United States would willingly and knowingly sacrifice the clinical element of autonomy which Freidson considered to be the more consequential element of his two part definition of autonomy. Clinical autonomy, after all, constitutes the primacy of the physician in the healthcare division of labor, and is the basis on which arguments for political and economic autonomy are formed.

Reinhardt's answer to this seeming paradox is that physicians in the United States have traded off clinical autonomy "in their tenacious fight to preserve the individual physician's right to price his or her services as they see fit" (Reinhardt, 1988, xxxiii). This observation has been distilled into a formula referred to as Reinhardt's Law or Irony. it may be summarized as follows: "In modern health care systems, the preservation of the healers' economic freedom appears to come at the price of their clinical freedom" (Reinhardt, 1988, xxxiii). The application of Reinhardt's Law to the late 20th century United States scene would appear to indicate a priority on the part of physicians to pursue economic betterment at the expense of clinical autonomy. If so, this would be critical in reformulating a definition of autonomy for the future, for this observation implies the

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willingness of physicians to sacrifice control of the division of labor. This strategy may also ultimately undermine the ability of physicians to continue their dominance of the political economy of health services as well.

THE UNITED KINGDOM: THE DOMINANCE OF CLINICAL AUTONOMY

Reinhardt's contribution has been to focus attention on the particular version of autonomy which has evolved in the United States with his division of the concept into business and clinical autonomy. He is not the first, however, to attempt to view this issue from a cross-cultural perspective. Of particular importance in the development of this work have been British writers. As early as 1970, Turner and Hodge argued against the tendency of "American and American-oriented sociologists" to form a professional ideal type and to view activities of other occupations as a gravitation toward that model (Turner and Hodge, 1970, 49). Turner and Hodge suggest that the quest of a professional group for monopoly status is subject to modification over time and is subject in part to legitimation by the state. At this relatively early point, corresponding with the publication of Freidson's two major works concerning professional autonomy in 1970, they observe the development of the opposite pattern in the United Kingdom of that which eventually emerged in the United States. They suggest that the practitioner has

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sacrificed economic autonomy to the state through the National Health Service in exchange for greater control of work life. They write that "The general practitioner, while losing a considerable degree of autonomy in respect of market conditions, has yet both acquired greater freedom to organize on a group practice basis, to routinize surgery hours, to employ administrative staff...." (Turner and Hodge, 1970, 40).

In the same year, Glaser published his study *Paying the Doctor,* in which he contrasted across Western Europe the systems in place for purchasing medical services. The relationship of these systems, either directly state controlled or negotiated through closely alligned sick funds, to physician autonomy in the economic arena did not escape his attention. He writes that in situations in which a national health insurance system is introduced that physicians argue for a cash benefit form of payment in which money is placed in the hands of the patient. The patient is then in turn accountable to pay the physician's charge to her/his satisfaction. The motivation for such a sytem, he noted, was that "The doctors believe the arrangement will preserve their autonomy in full: since the patient and not the physician communicates with the sick fund, the profession believes the funds can never limit its fees, regulate its clinical decisions, or influence the choice of doctors by patients" (Glaser, 1970, 179). While

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his work's orientation emphasizes the economic component of autonomy, Glaser also demonstrates the other elements which Freidson would consider necessary to an autonomous profession in this choice of payment system. Glaser projected an eventual clash in the United States resulting from attempts to include a scheme based on private practice within an insurance program funded by public sources (Glaser, 1970, 297). This conflict would eventually compromise autonomy of the profession in an attempt to sustain economic self-determination.

Tolliday examined the principle of clinical autonomy in the National Health Service as a distinct policy of the Service, granted and supported by the state. She suggests that clinical autonomy for the physician was a deliberate bargain entered into to secure the entry of the doctors into the NHS at the time of its establishment. She summarizes this position by writing that "...doctors have clinical autonomy in the NHS because they insisted on practising in a state-provided health service in an identical fashion to the way they practise privately" (Tolliday, 1978, 35). She rejects "traditional sociological thinking" which grants autonomous status to physicians on grounds of possession of estoeric skills and knowledge, citing Freidson's critique of Parsons in this regard (Tolliday, 1978, 35-36). Instead, autonomous or "unmanaged" status for the physician in the NHS results

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from the policy of the NHS that medical care, although state sponsored, will be "personalized care" (Cang, 1978, 67). As the state grants autonomy to the profession through this policy, so may it also remove autonomy and invoke traditional bureaucratic or managerial hierarchical structures of work if it chooses.

DEFINITIONS OF AUTONOMY IN THE U.K.: TOLLIDAY, HARRISON, AND SCHULZ

Tolliday summarizes autonomy in the British system in a heavily clinical and organizational rather than economic manner. She suggests that clinical autonomy encompasses a set of concepts which might be possessed to varying degrees by individual practitioners. Elements of the definition include exercise of clinical judgment without the scrutiny of others; free choice to accept or reject patients; prime responsibility for care given to a single physician; and the right to direct work of other professions based on presumed superiority of medical knowledge (Tolliday, 1978, 43-44). Her emphasis is on a definition of autonomy which assumes and is formed by the goals of the NHS, but which also acts as a limiting factor in the development of the NHS because it sacrifices fulfillment of its mission to support of the "prestige of the medical profession" (Tolliday, 1978, 52).

It is her contention that by breaking down the concept of

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autonomy into component parts, rather than dealing with it as a global condition as might a functionalist theorist, that primacy in the division of labor might eventually be granted to non-physicians in areas of specific expertise such as rehabilitation (Tolliday, 1978, 49). In any event, this redefinition would occur within the policies of the managerial hierarchy of the National Health Services, which has supported clinical autonomy as a trade-off for economic autonomy for the physicians.

Harrison and Schulz undertook a comparison of clinical autonomy in the United States versus the United Kingdom. Based on empirical research through interviews and questionnaires to individual practitioners, they conclude that respondents in their studies in the United Kingdom "regard overall financial limitations as being legitimate restrictions on their autonomy, and indeed a majority accept the principle of individual physicians being given budgets which may not be exceeded. In sharp contrast, respondents did not see a legitimate role for any mechanism, such as peer review or quality assurance, which restricted their freedom to decide how to treat individual patients" (Harrison and Schulz, 1986, 203). It is their observation that the reverse has historically prevailed in the United States, with American physicians enjoying less clinical autonomy in their patient care work due to the intervention of peer review bodies, but experiencing

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"considerably more economic autonomy than British doctors" (Harrison and Schulz, 1986, 203).

It is Harrison and Schulz's sense that a "convergence" of limits on autonomy will occur between the two countries' systems. In the UK pressure for cost containment under the Conservatives has resulted in the institution of micro-measures of control unlike previous global economic controls. These include management budgeting at the individual physician's level; performance indicators by physician; and a prescription blacklist (Harrison and schulz, 1986, 206). Conversely, in the US cost constraints have led to economic interventions through alternative payment arrangements through governmental and third-party sponsored controls on payment levels. Harrison and Schulz conclude that the corporate rationalizers in both systems will eventually dictate terms in both clinical and economic arenas, and hence eliminate the bases of autonomy in each nation (Harrison and Schulz, 1986, 209).

LARKIN'S PERSPECTIVE: THE STATE'S PROMOTION OF AUTONOMY

A somewhat different approach is taken by Larkin in discussing the development of medical dominance in the United Kingdom. In contrast to the view of Freidson derived from the United States experience that the medical profession continuously negotiated its social contract for domination of other profesional groups with the ruling

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elites of the time, Larkin argues that "In the British case, medical dominance was not achieved apart from but through and with the state" (Larkin, 1988, 120). Larkin argues that physicians in the twentieth century United Kingdom have been allowed medical dominance *within* the medical division of labor, but have never controlled "the development of the broader medical division of labor" (Larkin, 1988, 121). Limits are set on medicine's area of autonomy by the state, and this has always been true even in medicine's "prime" as an autonomous profession. Larkin writes that "The expansion and limits of its authority have both grown with state intervention, which may distinguish Britain from other countries with regard to the sequential rise and diminution of medical dominance" (Larkin, 1988, 130). Although Larkin would seem to support Harrison and Schulz in their contention that clinical autonomy is diminishing in recent years under NHS managerial control, the hegemony of medicine has been actually been promoted by the state during that period. That it is now being eroded should come as no surprise given the continuous involvement of the state in determining the bounds of medicine's autonomy.

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THE GERMAN ALTERNATIVE: A BLEND OF CLINICAL AND ECONOMIC AUTONOMY

A different perspective on autonomy as a cultural and historical construction is offered by comparisons to the continent of Europe and its systems. As Schulz and Harrison note, the continental experience provides an intermediate point with regard to clinical and economic autonomy to the notion of relative emphases on clinical autonomy in the United Kingdom and economic autonomy in the United States (Schulz and Harrison, 1986, 336).

In addition, Rueschemeyer argues forcefully for the importance of the state bureaucracy as a continuous formative influence on the professional occupations of the continent (Rueschemeyer, 1983, 47). The importance of this bureaucracy in action has recently been as a distributor of public funds to associations of physicians or to intermediary "sick funds", placing the state in a position as a negotiator of public monies (Glaser, 1970, 15-16). Notable examples of this approach are provided by the operation of sick funds in Germany and the Netherlands. The economic position of the state is neither so laissez-faire as in the US nor as directly controlling as in the UK.

In a comparative assessment of physician autonomy contrasting the UK, US, and West Germany, Schulz and

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Harrison propose a multi-faceted definition of autonomy which expands on Tolliday's four part definition based on the British system. They attempt to identify limits imposed on autonomy by society versus those spheres of control which physicians may exercise. These areas of control include control or self-determination of specialty and practice location; control over earnings; control over the nature and volume of tasks; control over acceptance of patients; control over diagnosis and treatment; control over the evaluation of care; and control over other professionals (Schulz and Harrison, 1986, 339-340). Schulz and Harrison regard the first three listed items as indicators of economic autonomy; the last four as reflections of clinical autonomy. They conclude that no simple comparison to the German experience to the US or UK can be made without reference to internal subtleties in each system. They note critical distinctions in determining autonomy, for instance, within the respective systems between outpatient and inpatient physicians in Germany; GP's and consultants in the UK; and fee for service versus HMO practitioners in the US (Schulz and Harrison, 1986, 342).

Reinhardt studied the German system from an economic perspective and concluded that physician interests are effectively represented through the negotiating process that takes place between the sick funds and the various

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physician associations throughout the country (Reinhardt, 1981, 10). The base for these macro-negotiations is a fee schedule formed in 1965 and subsequently amended which serves as a guideline for the entire nation. Physicians are obligated to accept payment as payment in full for sick fund participants. It would thus seem that economic autonomy is somewhat curtailed by the schedule. However, as Reinhardt himself observes, there is the potential for the added generation of individual income through the ordering and performance of added tests and/or procedures. In addition, growth in the number of physicians is cause for added concern in his opinion, as these new entrants will place added pressure on existing pools of money available for negotiation with physicians (Reinhardt, 1981, 12).

While it may appear that economic autonomy in Germany is at least partially compromised by the sick fund negotiation process, one might suppose that clinical autonomy would be preserved within the boundaries of the outcome of these economic negotiations. Yet at the micro level of the individual practitioner this is not totally true. As Schulz and Harrison have suggested in their theory of the convergence of economic and clinical autonomy in the UK and US; cost containment also appears to have played a significant role in introducing limits to clinical autonomy in Germany. As a consequence of the West German Cost

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Containment Act of 1977, Economic Monitoring Committees are established to monitor physician prescribing behavior. Reinhardt writes that "The Committee's monitoring system screens the charge profile of every physician. Physicians whose average number of services or prescriptions per case exceed their class average by 30 percent are selected for further examination. If the observed deviations are not justified the physicians' reimbursements are cut accordingly" (Reinhardt, 1981, 11). Clearly this example indicates economic sanctions for clinical behavior deemed excessive in comparison to standards which parallels the monitoring and economic penalization which Schulz and Harrison describe as a limit on clinical freedom in United States health maintenance organizations.

It should be noted that the previously cited studies of the German system concentrate on that found prior to German reunification in West Germany (FRG). An alternative perspective is furnished by Light, who in 1985 compared and contrasted the then two German systems. He argues that professional dominance has been achieved in West Germany through the sick fund structure, and that the physician can now be characterized as "the dominant member of the German health care system" (Light, 1985, 627). He argues that a change from payment of physicians by capitation to a fee schedule has favored income exhancement through the performance of greater numbers of procedures and employment

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of physician directed ancillary personnel (Light, 1985, 626-627). In this regard his ideas parallel those of Reinhardt concerning the ability of the physicians to enrich themselves through use of added testsand the resultant payment for them.

The pernicious effect of this system in Light's opinion is one in which the self interest of medicine eclipses that of society as a whole both with respect to clinical and economic autonomy. He writes that "German physicians have almost complete freedom to decide what tests to order or treatments to use. They have shown themselves readily able to increase services and therefore fees" (Light, 1985, 627). He concludes with a reflection on the West German case that parallels Freidson's discussion of the "flaw" of professional autonomy when he states that "The irony of professional dominance is that understandable and sincere motives and values lead to an imbalanced and self-serving health care system" (Light, 1985, 627). In direct contrast, the East German system has outlawed the development of an autonomous profession. Historical events and the consolidation of Germany have rendered these distinctions less critical. Nevertheless, Light concludes his discussion of both systems by noting with concern a move in each toward greater powerlessness for the patient due either to professional or bureaucratic control (Light, 1985, 642). In conclusion, Light's view of the German

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system is a less benign compromise between the clinical and economic autonomy of the UK and US respectively-- one which maximizes professional interests on both dimensions.

CANADA: AUTONOMY UNDER A CENTRAL PAYER AND UNIVERSAL ACCESS

A final comparative example of the development of professional autonomy is provided by the experience of Canada. The Canadian system has been built for purposes of physician payment around the principle of a provincial fee schedule. Wolfe and Badgley have argued that the design of the system has been one in which a public sector insurance mechanism "has been grafted onto an essentially fee-for-service private enterprise system of medical practice" (Wolfe and Badgley, 1980, 220).

Based upon the Schulz and Harrison criteria for clinical and economic autonomy, it would appear that Canadian physicians have generally maintained control over the key elements in spite of the existence of a national health scheme in all provinces since 1971. This is in good part a result of the decentralized pattern of provincial plans in which each plan negotiates a fee schedule with its respective provincial medical society (Taylor, 1980, 192).

Wolfe and Badgley found no slowing of expenditures for physician services under the medical plans as reflected in physician income relative to other professional groups.

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They observed this increase in physician income despite a shrinking ratio of physicians to the remainder of the population (Wolfe and Badgley, 1980, 224). While this may hold true in relation to the Canadian experience, Evans et al report that the rate of growth for Canadian physician expenditures has lagged considerably behind that of the United States. They note an increase of 40 percent of the share of US GNP going to physicians from 1971 to 1985, while Canada experienced only a 10 per cent growth in this period (Evans et al, 1989, 574).

Evans and his colleagues argue that two critical institutions have allowed the Canadian physician to maintain an economically autonomous position. These are the growth in use of services per physician, and the ability of the physician to bill at rates above the provincial fee schedule or "extra billing" (Evans et al, 1989, 575). The former case parallels that observed by Reinhardt in the German system in which physicians appear to attempt to maintain income levels through use of additional services. Fuchs and Hahn have also observed that while there are forty per cent more procedure oriented physicians per capita in the United States than in Canada, the number of procedures performed per capita is twenty per cent higher in Canada (Fuchs and Hahn, 1990, 889). They argue that higher rates of use of procedures and of office visits by Canadians may in part be explained by broader

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insurance coverage, but the remainder results from "demand induced by Canadian physicians" (Fuchs and Hahn, 1990, 888). The difficulty in this scenario is the accuracy of the attribution that added testing or use of procedures is in fact an attempt to preserve economic autonomy as opposed to an effort, however misguided, to maintain clinical autonomy through control of resource deployment.

Coburn points to state involvement in Canada as opening the work of physicians to "monitoring and manipulation" (Coburn, 1988, 109). This power to interpret the work of physicians is in large part a result of the monopsony payer status of the government, albeit with provincial variations. At the same time, he observes that medicine maintains its prerogatives in Canada to organize the work of other occupations and maintain dominance in the healthcare division of labor (Coburn, 1988, 111). While some drift toward proletarianization of the Canadian physician may have occurred as a result of state intervention, Coburn believes that further movement will only occur as an outcome of further struggle, with outcomes as yet unclear. He does suggest a resurgence of free enterprise economic ideology within at least a vocal minority of Canadian physicians which is being put forth as an alternative to a state controlled payment system in the current Canadian economy (Coburn, 1988, 110).

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CANADIAN PHYSICIAN DISCONTENT: EXTRA BILLING

Globerman has researched various dimensions of economic ideology among Canadian physicians by grounding her work in the second of Evans' identified sources of physician autonomy; that of billing beyond the fee schedule or "extra billing". Based on a survey of 313 physicians in the Toronto area, she studied the reaction of Ontario physicians to the enactment of a ban on extra billing and its subsequent impact upon their practices. She concludes that support for extra billing is predicated on a mixture of three factors; notably economic interests, free enterprise ideology, and professional ideology (Globerman, 1990, 22). She writes that support for extra billing is not justified based upon claims of professional expertise, which most closely equates to the factors of clinical autonomy identified by Schulz and Harrison. Rather, economic interests of the physicians surveyed were found to be of significant influence. She writes that "The results suggest that debates about ideology-- claiming that quality of care and control over medical decisions would be eroded with a ban on extra billing-- were, in part, threats that veiled physicians' other motives (the defense of a conservative free-enterprise ideology and the pursuit of economic self-interest). In other words, economic interests and antiwelfare views bolstered the professional defense of extra-billing as needed to protect the quality of health care" (Globerman, 1990, 22). Thus, in the light

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of Globerman's findings, Canadian physicians may couch the issue of extra billing in the rhetoric of quality of care or preservation of access, but in fact use it to enhance income and preserve economic autonomy.

The system of extra billing in Canada has been rendered obsolete through direct legislation at the national level. Nonetheless, the practice has had a significant history in the course of recent Canadian health policy. Evans has written that "there is a basic conflict in a policy that says government must control its budget, health care funding must be universally available, physicians must retain their professional autonomy, and consumers must have free choice of providers" (Evans, 1989, 79).

During the crisis of rampant inflation in Canada in the mid-1970s, controls were established on physician income and prices under the national health insurance plan. Iglehart notes that during this period the practice of extra billing grew significantly (Iglehart, 1986, 207). Physicians used extra billing as a means to recover income they had lost under economic controls within the health plan. Several provinces saw this as an opportunity to "off-load" costs to consumers which would otherwise strain provincial treasuries.

As a result of growing concern over denial of access to

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care resulting from extra billing, a Royal Commission was formed in 1980 to examine the problem. The Report of the Commission concluded that extra billing had had "harmful effects on quality of access to medical care" (Iglehart, 1986, 207). Consequently, the Trudeau Liberal government introduced a bill in 1983 entitled the "Canada Health Act" to eliminate extra billing by providing dollar for dollar reductions to provincial governments for each dollar extra billed to patients beyond schedule. The Act passed unanimously, despite bitter debate, in 1984. By 1990 all provinces had enacted legislation for their local plans carrying out the national intent (Iglehart, 1990, 565). This implementation has occured despite the transition in power to the Mulroney Conservative government, which might have been expected to be ideologically more disposed to listen to the opposition of professional groups such as the Ontario Medical Association's characterization of the Act as a "mortal attack on our professional freedom" (Iglehart, 1990, 565).

Thus, the issue in Canada has proven to be ideological as well as economic. Among the Ontario physicians who later provided the sample for Globerman's empirical study, Iglehart suggests that the objection couched by the physicians on grounds of loss of clinical freedom was in fact economically motivated by impending loss of income from extra billing (Iglehart, 1986, 208). In the face of

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widespread public support for a ban on extra billing, Ontario physicians undertook a two day general strike on May 29-30, 1986. A call for a more lengthy strike over the next 25 days fizzled as fewer than fifty per cent of physicians participated at any time (Iglehart, 1990, 565).

Public issues raised by the physicians included professional freedom and a challenge to the legality of limits on extra billing. As an alternative they proposed a prohibition on extra billing for poor and elderly patients only. This did not persuade the Ontario legislature, which passed an act banning the practice of extra billing in June 1986 in the face of the waning physician strike (Iglehart, 1986, 208).

As a result of actions of the separate provinces, extra billing in Canada as a means of income augmentation is no longer possible. Evans observes that sustained arguments for the reinstitution of direct payment by users of service in Canada from those who can afford to do so usually comes from physicians seeking to enhance income which can now be done only through use of extra services as noted earlier (Evans, 1989, 97). Whether economic pressures on provincial treasuries will reopen discussion of extra billing as a means of reducing fiscal pressure on the state by reprivatizing patient economic obligations remains to be seen.

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Iglehart suggests that physicians perceive a contradictory effort on the part of government "to squeeze spending while promoting universal access" (Iglehart, 1990, 567). This pressure is noted at all levels of the profession despite increased numbers of Canadian physicians in practice and no significant diminution of physician incomes relative to other professionals (Iglehart, 1990, 567). This underscores Globerman's point of the interrelationship of those elements of autonomy which are economically driven and those which pertain to the right to control work through acceptance of specific patients. Extra billing practices create an economic test which reinforces the freedom of the physician to select patients-- a practice which Canadians have concluded is socially intolerable.

INTERNATIONAL COMPARISONS IN CONCLUSION: THE SEVERING OF CLINICAL AND ECONOMIC AUTONOMY

This review of international experiences drawn from the limited sample of the United Kingdom, Germany, and Canada points to the cultural variability of autonomy in these nations in contrast to the United States. The UK provides a case in which clinical autonomy is preserved at the sacrifice of economic pursuit, while one might argue that in the US the opposite prevails. Germany and Canada offer middle points on the continuum, both raising the intriguing question of whether utilization of services is in part

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prompted by controls on physician icomes through the fee schedules of the sick funds or provincial governments respectively.

For purposes of this study, it is significant that the aspect of clinical autonomy can be separated from economic dimensions of autonomy and examined most readily in ideal type cases. However, it is also evident that rhetorical uses of arguments for clinical autonomy or freedom and the right to control terms of one's work may also provide a veil for economically driven agendas on the part of professional interests as well. The problem to be confronted through empirical analysis is better definition and refinement of the two elements. Based on the international comparison presented here, one may ask whether the Freidsonian definition of autonomy as inclusive of clinical and economic elements will stand up to the circumstances of these other systems or to changes in the United States which, driven by cost containment, impinge on one or the other.

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PERIOD FOUR

THE SEVERING OF CLINICAL AND ECONOMIC AUTONOMY: CHALLENGES FROM SOCIOLOGICAL THEORY ECONOMICS, AND EMPIRICAL STUDIES

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CONTEMPORARY CHALLENGES TO AUTONOMY: SOCIOLOGICAL THEORY

The late 1980s have been characterized by a resurgence of development of the theory of professions, especially in relation to the political economy and social arenas outside of the traditional boundaries of health care. In turn contemporary reinterpretations of autonomy have emerged as well. In so far as autonomy is regarded widely as the key concept in a definition of a profession wich separates it from other occupations, such scrutiny of autonomy is probably inevitable (Wolinsky, 1988, 44). As early as 1983, Rueschemeyer characterized sociological theory of the professions as "in turmoil" (Rueschemeyer, 1983, 38). Hafferty has also argued forcefully for revision of earlier theories in order to examine processes of professionalization rather than being bound to the views of a powerful theory such as professional dominance (Hafferty, 1988, 203). Much of the notable work in sociology of professions in the last decade can be seen as an effort to move to a reinvigorated theory which avoids excessive identification of theory with particular historical circumstances of the society and profession under study--typically American society in the case of recent study of the professions (Turner and Hodge, 1970, 49).

Rueschemeyer has written directly on the issue of professional autonomy and the need for a new theoretical base for theory of the professions which would break away

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from assumptions grounded in British and American recent history. He points to a very different point of departure for continental theorists of the professions, specifically the work of Max Weber in his description of the ideal type of bureaucracy. This acknowledgment of Weber, as well as an emphasis on the role of the state in forming the characteristics of professions would later be a significant influence on the work of Collins. Rueschemeyer invokes the tendency toward rationalization of society present throughout Weber's later writings, and argues that the states of Europe provided a focal point for organization of professions on the European continent which might have been left to market forces in the US and initially the UK. He writes that "Public bureaucracies were here far more important for the early developments of 'professionalisation', both as consumers of expert services and as supervising and controlling agencies" (Rueschemeyer, 1983, 46-47).

It is his belief that concerns over the erosion of professional autonomy in the United States are theoretically narrow in outlook and fail to consider other sociological traditions. He dismisses this concern when he writes that "This spread of bureaucratic employment of expert practitioners is seen as not easily compatible with professional work and even as a twentieth-century crisis of the professions in much of the Anglo-American literature,

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while similar alternatives to professional self-control were long taken for granted in continental social science, as, for instance, Max Weber's analyses of bureaucracy show. In a long-term historical and comparative perspective, then, the pattern of professional self-control is only one of several different forms of the social control of expert services and it is by no means the pattern toward which others converge in a long-run process" (Rueschemeyer, 1983, 47). Through Rueschemeyer's work one is reminded that the lessons of comparative system studies are valid for sociological theory as well, and that one must consider historical and cultural relativity in theorizing autonomy.

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Rather, alternatives to professional autonomy as classically defined by Freidson as self-control and regulation by the profession itself do exist with significant case examples. Alternative forms to the ideal type of the autonomous profession include consumer control of the professional, either by prominent individual clients such as corporations or by groups; and control by the state. To ignore these possibilities and assume instead an ideal type of the autonomous professional is, as Reuschemeyer scathingly writes, "an act of cultural and historical parochialism (Rueschemeyer, 1983, 47).

REVISIONISM IN THE UNITED STATES: MILBANK ON AUTONOMY

Freidson in his own more contemporary writings has taken

these observations to heart. In writing on the theory of professions in a companion piece to that of Reuschemeyer, Freidson comments on the "parochialism" of the developing study of professions. He suggests that professionalism as a phenomenon might be regarded as an "Anglo-American disease" (Freidson, 1983, 26). Reviewing what has been mainly an American literature on professions, Freidson concludes that "I would argue that as an institutional concept, the term 'profession' is intrinsically bound up with a particular period of history and with only a limited number of nations in that period of history" (Freidson, 1983, 26). Freidson concludes his argument by suggesting that further understanding of how occupations come to be recognized as professions is critical, as well as the process of acquiring official recognition for that status. The unanswered question in this article, later addressed in his *Professional Powers* is whether autonomy itself is a precondition of professional standing or is historically negotiable. By the time of the publication of *Professional Powers* in 1986, it appears that Freidson had softened his earlier definition to recognize autonomy as a relative notion which groups might possess in relationship to other groups and the state as opposed to a necessary outcome of the possession of expert knowledge (Freidson, 1986b, 210).

In the pivotal 1988 issue of *The Milbank Quarterly* dealing with the changing character of the medical profession,

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Wolinsky revisits at length the issue of professional dominance with reference to its development by Parsons and Freidson. Wolinsky suggests that the singular problem of the professional dominance theory of Freidson is that its litmus test is autonomy, and that "All other characteristics of a profession flow from it" (Wolinsky, 1988, 44). Wolinsky contends that at such point as society chooses to revoke its delegation of autonomy to medicine its autonomous condition will cease, for autonomy can only be granted "based on the avowed promise of the profession to self-regulate" (Wolinsky, 1988, 44)

Much as Starr had earlier argued that medicine's historical ascendence to autonomy could be traced to its superior persuasive ability in convincing the public, elites, and the state of its singular contribution; Wolinsky argues that in order to remain autonomous medicine must win again through public relations. He argues that it must resume the Parsonian role of fiduciary agent for the public; and that "the future of medicine's professional dominance may actually ride on the outcome of the manipulation of public opinion" (Wolinsky, 1988, 44). He concludes that current efforts of the federal government and third party payers which impinge on medicine's autonomy are simply a challenge to obtain a renewed effort at self-regulation by the profession, and that with such a change medicine's claim to autonomy will be reinvigorated (Wolinsky, 1988, 45).

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In the same *Milbank* issue, Light and Levine adopt a less expansive stance on the importance of autonomy in establishing dominance. They contend that many occupations have autonomy over work but not much power (Light and Levine, 1988, 12). Other necessary elements for dominance include control over work of others-- an assumption which presupposes some organizational or other hierarchy. A third element which they identify is cultural power, the beliefs and attitudes that people possess toward physicians. Light and Levine contend "that culture is the most fundamental source of professional power; but it is subtle, intangible, and may shift the ground from under the feet of the profession as deference is replaced by wariness" (Light and Levine, 1988, 12).

Their final source of professional dominance is institutional power, as embodied in Weber's theory of social authority. This theory holds that the occupation translates its claim of expert knowledge into cultural and legal authority and ultimately into institutional authority (Light and Levine, 1988, 12). This direction of course invokes the authority of the state and the process of legitimation identified by Weber. They conclude their discussion with the admonition that there is "great opportunity to investigate the changing nature of autonomy" (Light and Levine, 1988, 13).

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THE WEBERIAN POST-MODERNIST INTERPRETATION: COLLINS

Collins takes up the point of relations of the profession to the legitimation process and the state as well as the place of the professions in the overall Weberian theme of rationalization of modern society. Collins views the sociology of professions as emerging from an early dialectic between Parsonian functionalism stressing a service orientation on one hand and a Marxist viewpoint seeing professions under capitalism as motivated by no more than profit or wages to further one's self-interest (Collins, 1990a, 12). The next period, which has supplied the primary focus of this paper, emphasized power as the critical mark of the professional. Power was manifested in autonomy for the successful profession which prevailed in struggle (another particularly Weberian concept) with other occupational groups and societal forces (Collins, 1990a, 13).

A particular emphasis is placed in Collins' work on the creation of professional monopoly as a logical objective under capitalism, and as his surrogate concept for autonomy. He views Wilensky's classic 1964 formulation of occupational closure as a watershed in separating former classic theories of professions from later theories based on assessments of professional power (Collins, 1990a, 14). In this model, emphasis is placed on the ability of

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professions to control admission to practice and training of new members. The result is the establishment of an occupational monopoly in the instance of the highest status professions.

Unlike earlier theorists, however, Collins appropriates Weber's notion of struggle among status groups in Weberian theory and applies it to occupational groups. Markets are inherently unstable, and the closure of one market may lead to the creation of a new market which appropriates the monopoly enterprise and subsumes it (Collins, 1990b, 25). It is precisely this latter phenomenon that Mechanic describes when he writes of the imposition of new controls on the monopoly power of individual physicians and the medical profession by new and larger economic forces, such as insurers and pharmaceutical manufacturers (Mechanic, 1991, 487). This view of constant struggle causes Collins to reject the classic notion of the sociology of professions that all occupational development could be seen as the movement toward an ideal type possessing specific characteristics (Collins, 1991a, 15).

Collins suggests that Weber's dynamic of the removal of rights or privileges from the public realm to private ownership and back into the financial markets is applicable in the case of the professions. He concludes with Weber and the classical economists that "monopolies are temporary

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over the long haul", and will lose out in competition with other firms (Collins, 1990b, 27). He breaks with classical economic theory when he writes that market actions "do not consist of the familiar processes of adjustment of supply and demand to produce equilibrium prices. Rather, the key dynamic may be the up-and-down fluctuation of monopolization in various sectors" (Collins, 1991b, 29). This insight is critical in posing an alternative to classic economic explanations of physician economic activity on the one hand and monopoly theories on the other-- neither of which have proven fully satisfactory in explaining physician behavior.

Instead, a model of professions will examine pursuit of an elite status group which pursues autonomy in the furtherence of its elite standing rather than simply for economic advantage. Collins notes that this conclusion can be reached through two separate traditions discussed earlier in this study. These are the Anglo-American, with its emphasis on the freedom of the self-employed practitioner and her/his control of work conditions; and the continental model stressing elite practitioners holding office in professional bureaucracies on the basis of elite academic credentials (Collins, 1990a, 15). The state has been foremost in promoting the growth of the continental professions; while the market has been more influential in the United States until the state invokes legitimate market

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closure on its behalf.

Collins suggests that historical comparisons of professions be employed, with the caveat that one remain analytic and not simply produce multiple case studies. As an historically dynamic process, he suggests that studies observe and analyze "historical declines in the power of professions" (Collins, 1990a, 23). This is possible if one abandons the notion of professions moving inexorably toward possession of a set of ideal type characteristics and substitute a model of change and historical specificity. In this regard, the study of autonomy and its fluctuations over time and across societies is particularly well suited to test Collins' theoretical challenge.

ABBOTT: THE PLACE OF MEDICINE IN THE BROADER SYSTEM OF THE PROFESSIONS

Another recent theoretical approach to the question of professional autonomy is that of Abbott and his 1988 work *The System of Professions.* Like Collins, Abbott views the professions as undergoing continual change and redefinition in response to societal forces as well as competition from other occupational groups. In evolving his "system", he draws heavily upon the work of Hughes and interactionist approaches which view professions as engaged in constant negotiation with their environment (Abbott, 1988, 112). Unlike the model of professionalization which contemporary

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theorists have attacked as functionalist and ultimately teleological, Abbott chooses to look at continual negotiations as shaping the professions at the level of their respective jurisdictions with the state, public, and other occupations. He postulates that professions exist within a "system" which provides an interrelated context for professions; which finds the esence of a profession in its work rather than its organization; and involves many forces in the control and definition of that work (Abbott, 1988, 112).

An outstanding example of the last point in Abbott's system is the emergence of other professions which may affect or ultimately control the work of another group. In this respect he parallels the work of Collins and his thoughts on struggle. Collins interprets Weber to suggest that capitalism is moving inexorably toward societal forms which emphasize calculation and rationalization of all encounters on the model of the economic transaction (Collins, 1986, 41). Abbott draws a similar conclusion, seeing the ascendence of the new profession of accountancy as subsuming elements of autonomy previously enjoyed by medicine in the economic sphere. He suggests that "In particular, the jurisdiction of money requires the kind of attention long received by health", and continues that "surely accounting is today far more socially important than medicine" (Abbott, 1988, 325). As accountancy

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controls calculation and envelops medicine (and society in general), it becomes more worthy of sociological attention. In Abbott's scheme issues of perceived medicalization of society are secondary to the establishment of a society based on calculation.

Abbott suggests that a move toward standardization and routinization of work ultimately reduces the power of a given professional group. As the interpretive scope of the profession is delimited, as in the case of development of clinical protocols or practice policies in medicine, so too is the discretion of the group reduced and in turn its control of its work jurisdiction (Abbott, 1988, 51). Autonomy may be lost to other occupations or to managers from one's own occupational group through organizations. Abbott also notes that autonomy may be compromised through the increasing dependence of professionals on organizations for physical resources (new technologies) required for the performance of work (Abbott, 1988, 156).

Within Abbott's system of professions power is of considerable importance to the profession in maintaining its jurisdiction, which in effect can be nearly equated with Freidson's definition of autonomy. But this power is delimited by that of other professions (for example, the law in relation to medicine), clients and/or payers, and the state. His outlook for medicine and the historic

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autonomy it has enjoyed is pessimistic, as it would be for any dominant profession in his system. In a telling summary, Abbott argues that "a profession is not able to utilize its dominant position to build up a large reserve of power against the day of its trial by invasion. Dominant position confers short-run power, not long-run imperium. No profession can stand forever" (Abbott, 1988, 141).

Abbott suggests that medicine has lost clinical autonomy in its inability to continue to define and control its own work. He suggests that medicine "has lost administrative appendages that were not properly part of its jurisdiction of 'problems of the body'" (Abbott, 1988, 141). This sweeping statement would seem to dismiss the loss of much of the economic autonomy of medicine, although Abbott might regard it as superfluous. But it has also sacrificed clinical autonomy as "It has lost much of the flexibility it enjoyed in treatment. It has lost much of its right to police itself" (Abbott, 1988, 141). He concludes that medicine's structural power which it has enjoyed within the system of professions is on the wane, and that medicine has little residual power to resist the coalition of forces of the state, consumers, and competing professional groups arrayed against its traditional hegemony. These forces invariably lead to the ascendence of other dominant professions as the reign of any profession is finite.

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MECHANIC AND CHALLENGES TO AUTONOMY: THE POWER OF MEDICINE TO RESIST

A rejoinder to recent theories of professionalization and autonomy has been provided in the complimentary papers of Mechanic and Light. Both works start, as in the case of all of the contemporary works cited in this study, from the perspective of professional power and the manner in which it has evolved over the last twenty years. The sources of this shift in power differ between the two, however, and provide the crux of their respective arguments.

Mechanic argues that medicine has become a major factor in the macroeconomy of the United States, replacing the earlier atomistic model of the physician as small entrepreneur which better fit classic economic notions of multiple competitive firms (Mechanic, 1991, 487). He argues that the now considerable economic consequences of physicians' use of technology and services, estimated at between $500,000 and $800,000 per year beyond their own income, has created new economic forces which move in response to these expenditures. Yet, the medical profession is relatively united in advancing its economic agenda vis-a-vis multiple payers for service, as opposed to the European models discussed earlier of single or limited payers and consequent focused power (Mechanic, 1991, 488). He notes that the multiplicity of payers has made it possible for physicians to opt out of programs paying rates

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paying rates regarded as unattractive; notably the Medicaid program.

Controls on physician business practices are resulting in a perceived loss of autonomy in this sphere, at least among older practitioners. This is particularly true in decisions, he notes, to bill as the individual practitioner chooses. In order to maintain this freedom, the practitioner may be required to drop out of public or private insurance programs. He notes that few are able to afford this stance, and that restrictions or possible prohibition of extra billing under the Medicare program will make preservation of business autonomy more difficult (Mechanic, 1991, 491).

Significantly, Mechanic points to little perceived loss of clinical autonomy among employed physicians; reporting interference with decisions to hospitalize patients in less than 10% of respondents and questioning of orders of tests and procedures in only 14% (Mechanic, 1991, 493). He directly disputes the perception that clinical autonomy is being lost, writing that "The evidence is slim that physicians, whatever they fear or believe, are losing their clinical autonomy. Their feelings of loss are probably provoked by a sense that the amount of effort they expend is no longer tied to the payment they receive" (Mechanic, 1991, 493). Hence, Mechanic believes that economic factors

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dominate perceptions of clinical autonomy as well. He states that "The evidence is persuasive that money is the crux of the issue. If the payment is sufficiently large, physicians appear satisfied, whatever its form" (Mechanic, 1991, 493). Clearly, he places little faith in ideologically based arguments surrounding freedom of physicians to clinical self-determination; seeing instead the primacy of economic motivations which are masked by complaints based ostensibly on principle.

Mechanic's basis for rejection of the notion of proletrianization of physicians is that medicine still maintains a high economic standing relative to other professions-- a logic also advanced by Evans in assessing the status of Canadian physicians. Other professionals, he continues, have made insignificant inroads on medicine's control of the occupational hierarchy of health. Further, medicine has managed to rebuff attempts to redefine health away from its curative and disease driven model to a preventive public health based one (Mechanic, 1991, 496). Despite limited losses of autonomy, he concludes that physicians as a group still control the construction of social issues which impact medicine, and that sufficient countervailing power has not been achieved except for limited government inspired advances in the area of economic issues.

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AN ALTERNATIVE PERSPECTIVE: LIGHT AND COUNTERVAILING POWER

In his rejoinder to Mechanic, Light is much more impressed by the rise of countervailing forces in society which have ended the dominance of medicine grounded on professional autonomy. Light does not directly acknowledge Weber or Collins, but relies heavily on concepts of struggle and market closure cited earlier in this discussion of Collins' recent work. Light sees the end of the era of professional dominance and the emergence of an era of "countervailing power" as does Mechanic. Unlike Mechanic, however, Light broadens Mechanic's definition as well as his 1988 work with Levine cited earlier to view countervailing power as "a socioeconomic field of forces and their intersections" (Light, 1991, 500). It is the struggle between these forces, he asserts, that produced the era of professional dominance identified by Friedson (Light, 1991, 502). Light suggests, borrowing from the economic writings of Galbraith, that medicine has moved to function as a near monopolist at the societal level, a point identified earlier as controversial at the provider level in the economic discussion in this paper. At the macrolevel of society this situation is seen as no longer tolerable due to growth of expenditures for services, and countervailing powers on the form of government and industry have entered the picture to create forces paralleling those arrayed in opposition to medicine on the continent of Europe.

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The critical question for Light, borrowing again another Weberian theme, is who controls the process of rationalization? While Mechanic would contend that physicians are still fundamentally in charge of conditions of work and dominate the medical hierarchy, Light would appear to side with Alford's earlier observations concerning the influence of corporate rationalizers internal and external to the profession. In a telling passage, Light argues that the forces of rationalization of medical work have indeed passed by the profession and left it a reactor to the efforts of others. He writes "on the clinical side, even if doctors are presently figuring out how to circumvent or manipulate the efforts of buyers to control practices or expenditures, *it is no longer their game* but a buyers' game of countervailing power" (Light, 1991, 503). He concludes that it is necessary to see medicine's drive for professional dominance in an historical framework and as the outcome of interaction of economic, symbolic, and political forces. It is the recent historic weakness of economic constraints due to lack of a competitive market and their reintroduction in the form of rationalizing systems which has altered the balance of power against medicine (Light, 1991, 505).

CONCLUSION: CONSISTENT THEMES IN CONTEMPORARY THEORY

Consistent themes are emerging which point the direction for contemporary theory of the medical profession. The

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emphasis on the autonomy of the medical profession as a culturally and historically specific phenomenon is a key motif. A second is that of medicine within the broader systems of the state, economic interests (typically corporate), and the public which is dynamic and subject to redefinition. In this context, autonomy appears as a temporary delegation from these forces rather than a professional birthright. A third is the consideration of power as an explanatory device in fashioning the degree of autonomy which medicine or any given profession might enjoy. Fourth, the "ideal type" portrayal of the professions in general as moving toward the attainment of identifiable traits (including autonomy as foremost) is generally discredited in favor of either a power/struggle or negotiation driven model in which a group secures and holds autonomy temporarily. Finally, the blending of clinical and business elements of an all encompassing definition of autonomy is unraveling, and requires separate examination of autonomy in each sphere.

All of the above trends occur within the context of a society stressing rationalization of the medical system and a reintegration of medical economics into the broader economy. It is the demonstrated effect of these trends identified so far theoretically on the lives of social actors which requires examination through empirical study.

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ECONOMIC PERSPECTIVES ON AUTONOMY

The principal challenge in the realm of the social sciences to sociologically grounded explanations of professional autonomy has developed from economics. Starr has summarized the dilemma of apparent contradictions between economic and sociological interpretations in explaining physician behavior in economic matters. He writes that "The contradiction between professionalism and the rule of the market is long-standing and unavoidable. Medicine and other professions have historically distinguished themselves from business and trade by claiming to be above the market and pure commercialism. In justifying the public's trust, professionals have set higher standards of conduct for themselves than the minimal rules governing the marketplace...." (Starr, 1982, 23). Yet in recent decades this traditional view of the professions' relationship to the marketplace has come under scrutiny and eventually criticism from economists. In a 1974 address, Uwe Reinhardt could ask his audience "whether standard economic theory is at all helpful in the analysis of professional services...." (Reinhardt, 1975, 139). By the end of the decade, such an apology would no longer be necessary as economists moved to become the dominant resource for policy formation regarding physician behavior.

CLASSICAL ECONOMIC MODEL AND ITS LIMITATIONS

A good amount of the credit for this shift, in addition to

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the widespread fascination of social scientists and Americans in general for the predictive powers of economists, can be attributed to a movement by health economists beyond classical models based on supply, demand, and price (Evans, 1984, 24). The assumptions which underlie the application of classical economic models to health care are weighted heavily toward the importance of consumer demand as pivotal. Evans summarizes this approach as identifying "the amount and mix of care consumer/patients choose to accept, in response to their own preferences and incomes, and the costs to them of care. This behavioural construct is then identified, by assumption, with utilization" (Evans, 1984, 23). Price will serve to control the balance of supply and demand, and if prices are correctly established utilization will not be a problem as supply will equal demand.

It is somewhat ironic that this model has enjoyed renewed vigor in the 1980s under the guise of competition in health care. Enthoven has applied the competive model at the meso or organizational level arguing that, while providers at the micro level of service encounters with discrete patients cannot fully apply the demand and supply transactions required in the classical model, organizations such as health maintenance organizations can indeed evidence competition at the level of the firm (Enthoven, 1980, 10).

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In shifting his analysis to the level of the plan or insuror, Enthoven is at least attempting to avoid the social dilemma identified for economists by no less a figure than Adam Smith. Reinhardt cites the following statement by Smith on the necessity of a broader interpretation of the economics of the physician and patient beyond that of simply price predicated upon supply and demand. Smith writes that "We trust our health to the physician; our fortune and sometimes our life and reputation to the lawyer and attorney. Such confidence could not be safely reposed in people of a very mean and low condition. Their reward must be such, therefore, as may give them that rank in society which so important a trust requires" (Smith, 1937, 105). Here we see an acknowledgement on the part of the founder of classical economic thought of the fiduciary element in the physician-patient relationship which Parsons and his sociological successors have long stressed. The fascinating element in Smith's statement is the justification of a higher level of income for the practitioner than might otherwise be sustained solely by the marketplace on the basis of the critical importance of the trust relationship and the possibility for abuse of the trust otherwise by those of "mean and low condition." Reinhardt views this statement as the identification by Smith of medical services as a "luxury good", but one which

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appears effectively to exempt the professional from usual market forces (Reinhardt, 1975, 143).

SHORTCOMINGS OF COMPETITION IN HEALTH CARE

Evans has articulated a position that reflects the dominant direction in contemporary health economics, toward understanding "in what ways this commodity [health care] fails to meet the conditions under which private market institutions would govern its production and allocation satisfactorily" (Evans, 1984, 25). He identifies three critical elements which differentiate the health care economic sphere from other markets. These unique features include uncertainty of illness incidence; external effects in consumption; and asymmetry of information between provider and user (Evans, 1984, 26). Two of these points have direct sociological counterparts which have been addressed earlier in this study; namely asymmetry as developed by Parsons and his critics and uncertainty as developed by Fox. Each may be said to be reflected in the development of professional autonomy, and is related to the third characteristic of external effects on consumption through the insurance mechanism.

THEORIES OF PROVIDER MONOPOLY

If the physician service market defies, as Evans convincingly suggests, the usual competitive model of supply and demand, an attractive alternative explanatory

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model is that of monopoly in the marketplace. Certainly it might appear logical that the consequence of unchecked physician autonomy in economic terms would be some form of monopolistic practice, and economists have pursued this explanation as well. On a macro basis, this study has already noted the activities of organizations on a national scale, notably the AMA, to advance their members interests through anti-competitive strategies.

At the level of the individual provider, the monoplistic model has been employed in an attempt to explain physician pricing by a sliding scale of fees, resulting in higher charges to patients with higher incomes (Jacobs, 1980, 170). The assumption here is that the monopolist is free of competitive pressures which would otherwise force the provider to charge all patients equally in a perfect market. Instead, the monopolist is able to control supply at a level to supply himself maximum profits (Jacobs, 1980, 173). It is argued in this model, whose application to physician behavior admittedly predates much of the spread of health insurance coverage, that the physician obtains the maximum profit from each patient through "price discrimination" or differential pricing to each patient based on her/his ability to pay (Jacobs, 1980, 175). Jacobs notes that monopoly pricing can occur "whenever demand conditions are different in separate markets [such as poor versus wealthy patients], and when the product

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cannot be resold by those paying the lower price" (Jacobs, 1980, 175). The second criteria is clearly met in the case of medical care, while the first is not under conditions of group purchase of service through insurance plans rather than individual negotiations.

The major objection to the monopolistic model is the presence of multiple suppliers, especially in certain geographic areas, who might logically become competitors for patients. Certain health manpower strategies have in fact been based upon the supposition that the best means to control cost of physician services is to increase the available supply. This strategy, pursued through the 60s and early 70s, endorsed increased production of physicians through expanded medical education at home and abroad. This strategy has largely been abandoned as a failure (Schulz and Johnson, 1990, 161).

Reasons cited for the sustained power of some form of monopoly model despite the presence of multiple providers who might otherwise assure competition are severalfold. An evident problem is the dominance of specialization among physicians, making skills less than interchangable and detracting from competition. Another prominent explanation is the lack of price information on which consumers can make reasoned comparisons among physicians for given services. The Federal Trade Commission has singled out

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medicine for scrutiny on this point.

Yet even with the erosion of the traditional position of the profession that advertising was unethical, little real price information has become available to the public (Jacobs, 1980, 176-177). Ramsey has questioned whether this price ignorance of the consumer is not partially offset by ignorance of the actual demand curve by physicians, potentially leading to lower fees than a true monopolist might charge (Ramsey, 1980, 7). Technological change, which may place certain procedures in the hands of limited numbers of providers has a potential effect on demand. Finally, demand behavior of the consumer with insurance coverage varies from that of the consumer without coverage or whose coverage excludes certain procedures (Ramsey, 1980, 8).

Despite these objections to the monopoly model, it is informative that objections still exist to other models based on the ability of the profession as a whole to control the terms on which competition takes place and which spoils the functioning of the market. The autonomy of the profession with respect to its ability to exercise self-direction is seen as a device which enables the profession on behalf of its members to pursue goals of economic maximization. Jacobs writes that "what is unethical has coincided with what is unprofitable for

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physicians. By curbing competition and other non-fee-for-service forms of medical practice, the physicians' profession has been able to provide a work environment for itself in which competitive tendencies were reduced" (Jacobs, 1980, 176). He concludes that "the profession has been able to allow practitioners to act as monopolists, at least to some degree" (Jacobs, 1980, 177). It is the specification of the "degree" to which the medical profession deviates from a standard market model which is critical in searching for an alternative theory of physician economic behavior as a profession and as individual providers.

THE TARGET INCOME HYPOTHESIS

Evans provides a useful alternative perspective on the question of professional monopoly in his description of the "target income hypothesis", which implies some elements of monopolistic behavior on the part of physicians in response to consumer demand. In this theory, a *positive* correlation exists between physician availability and increased prices as they modify practice behavior to achieve "target" incomes. In this theory, "When average workloads and incomes fall, due to exogenous increases in supply, physicians change their practice patterns to increase utilization" (Evans, 1984, 85). At this point, the physician is able to exploit his/her unique position as agent of the consumer to manufacture demand. This ability

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of the physician to induce demand has led to studies by health services researchers such as Leape in which it is posited that as much as thirty per cent of all surgery performed in the United States may be unnecessary (Leape, 1989, 351). If the "target income" cannot be met by increased demand, prices will then be increased to meet the target level (Evans, 1984, 85). In this respect, the model clearly defies standard economic assumptions, which would ordinarily dictate price reductions to enhance volume.

The target income hypothesis has been controversial among economists, to say the least. Arguments regarding the hypothesis have been made somewhat more difficult as a result of a relative lack of empirical testing of the hypothesis, or even the ability to effectively quantify it for that matter (Hixson, 1980, 1). Hixson characterizes "the flimsiness of the theoretical basis and the empirical support for a belief that the phenomena [target income behavior and supplier induced demand] exist", preferring to view them a political constructs (Hixson, 1980, 2).

Feldstein traces empirical support for the hypothesis to studies in which "physician/population ratios are positively related to physician fees, after adjusting for other variables" (Feldstein, 1988, 190). As early as 1966, Fuchs and Kramer used an econometric model to conclude that "physician supply, across states, is positively related to

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price, the presence of medical schools and hospital beds, and the educational, cultural, and recreational milieu" (Fuchs, 1986, 107). For our purposes, the important variable in this statement is the association of higher prices with increased physician supply, a point Feldstein observes is clearly contrary to traditional economic theory (Feldstein, 1988, 189).

Pauly and Satterthwaite have attempted to formulate a variation on the target income hypothesis, which they have labeled "the increasing monopoly" theory. In this theory, the major obstacle to the attainment of standard market model behavior is a decrease in available information to consumers regarding physician quality and prices as the number of providers *increases* (Pauly and Satterthwaite, 1980, 26). Their analysis based upon primary care pricing patterns in 100 metropolitan areas supports their model in which "the income maximizing price may well increase" as more physicians are added in an area. The solution to this problem which will restore an effective competitive market is enhanced information to the consumer comparing physicians (Pauly and Satterthwaite, 1980, 36).

Evans summarizes the paradox of physician pricing and demand inducing economic behavior when he characterizes physician practices as "Not Only For Profit" firms (Evans,

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1984, 127). Viewed from a microeconomic perspective, professional practice varies from the standard market model's assumption that the rational economic actor will seek whenever possible to maximize profit (Evans, 1984, 75). Evans observes that the professional acts in an asymmetric relationship to the patient, citing the sociological studies of Arrow on this count; and serves as the patient's agent in the selection of options for care. These roles make a simple economic interpretation of the physician's behavior problematic. He comments that "Economic analyses which assume self-interested, profit or income maximizing providers must ...assume away the asymmetry of information problem and the agency relationship entirely" (Evans, 1984, 75-76).

Just as Evans is critical of the assumptions of the standard economic model, he is also critical of the professional monopoly alternative. He writes that "The monopoly model also adopts the conventional assumption that the professional 'firm' is a profit-maximizing entity, responding either to fixed input and output prices or to input and output supply and demand schedules" (Evans, 1984, 142). He believes that the monopoly model also ignores the agency role of the professional on behalf of the consumer; and argues that it erroneously suggests that the consumer responds purely to price of services (Evans, 1984, 141). Clearly in suggesting the complex of actions implied in his

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"not only for profit" description of professional behavior, Evans is arguing for a complex view of economic action which on the one hand gives physicians inordinate market control over price and demand; yet also sees them fail to fully exploit this advantage as assumptions of profit maximization would dictate.

Thus one is left with the target income approach as the most potentially satisfying, albeit least popular, explanation of physician action which accounts for physician autonomy in the economic sphere without total abuse of that autonomy in a social sense. This position was summarized by Dyckman at the conclusion of an HEW sponsored conference held in 1980 specifically on the target income hypothesis. He states that "The target income hypothesis has few supporters. Physicians do not like it because it implies, at least to them, that physicians are greedy. They just decide how much they should be earning and adjust their fees and, perhaps, quantity or service mix accordingly. Economists do not like it because it suggests that the price and quantity of physician ' services are not determined primarily by the interaction of supply and demand forces, and that physicians are not profit maximizers" (Dyckman, 1980, 96). A forceful example of such criticism is the position taken by Ramsey, who criticized the Evans model of target income as neither explaining "observed data nor providing any

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insight into behavior", and concludes that it is a "non-explanation" (Ramsey, 1980, 16).

PUBLIC POLICY IMPLICATIONS OF MODELS OF PHYSICIAN ECONOMICS

Feldstein suggests that the public policy implications of the target income hypothesis are profound. More physicians will generate more demand in pursuit of income targets, or attempts will be made to increase prices (Feldstein, 1988, 192). In fact, this assumption has already been built into policy in the proposed regulations to implement the Resource Based Relative Value Scale. Lee and Ginsburg write that "HCFA assumes that medical practices experiencing a reduction in revenues will offset 50% of the reduction by increasing volume of services or changing billing practices, while those experiencing an increase in revenues will not respond" (Lee and Ginsburg, 1991, 1563). In effect, the target income pursuit by physicians is already anticipated in this policy.

The economic models considered in this study, notably the target income and monopoly or modified monopoly models, pose significant questions for a theory of professional autonomy. In any of these approaches, autonomy can be viewed as a cover for income pursuit or enhancement, either by individual physicians or as a professional group. Yet perhaps a theory of autonomy can help explain where the economic models fall short-- where revenue maximization

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does not take place as the monopoly models suppose.

The problem to be addressed by research of physician revenue generating activity is the relationship of price, demand, and supply as it evolves with government assuming a more assertive role as the major single purchaser of physician services. In the traditional theory of autonomy, it has been argued that physicians controlled supply through control of the educational process; controlled demand through ordering activity through the role of the patient's agent; and controlled price through unimpeded ability to set fees within the framework of the community. All of these privileges are consistent with and supported by a theory of autonomy, yet may serve primarily to sustain income at some level of "guild", if not individual monopoly. A review of the empirical literature will examine how adjustments to these components of business autonomy have been affected by changes in the Medicare program. It is clear that there is ample room for empirical research to examine the relative interrelationship of supply, demand and price for physicians.

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PUBLIC POLICY CONCERNS OVER PHYSICIAN EXPENDITURES

The development of economic research on physician business autonomy has been furthered in recent years by the public policy work of the Physician Payment Review Commission (PPRC). The PPRC was charged by Congress at the time of its creation in 1985 to carry out four roles. These included indelpendent expert advice to Congress and the Secretary of HHS; solicitation of views of beneficoiaries and providers regarding physician payment issues; objective analysis of policy decisions for Medicare; and implementation plans for such policies (PPRC, 1988). Much of the initial work of the Commission focused on consideration of a fee schedule based upon a relative value methodolgy developed by Hsiao and his collaegues (Hsiao et al, 1988, 2347). This work can be seen as a direct effort at economic control on the part of the nation's largest single purchaser of physician services. By the time of the expansion of the Commission's mandate in 1988, the Medicare program accounted for 24 per cent of gross income to physicians in the United States (PPRC, 1988, 32). Its efforts represent a move to rationalize price as an element of physician payment which is directly reflected in business autonomy.

In 1988 the role of the Commission was broadened to examine options to moderate cost growth without impairing the quality of care. This mandate was brought about in part by

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concern over rising expenditures for physician services during the preceding decade. Examination of these trends revealed growth in payment under Part B Medicare of 18 per cent per year from 1975 to 1986, making it the fastest growing element of the program. Increases were viewed as resulting primarily from increases in services per enrollee (44 percent), price (42 percent), and lastly enrollment increases (14 percent) (PPRC, 1988, 19). The activities of the PPRC can be seen as an effort to intervene in at least two of the elements of the classical economic equation of supply, demand, and price rather than leaving these in the hands of the patient and physician. This discussion will examine recent research findings in each of these areas, looking at the PPRC targeted areas of price and demand for services as well as supply of practitioners.

CONTROL OF PRICE: THE RESOURCE BASED RELATIVE VALUE SCHEDULE

The major outcome to date of the work of the PPRC has been the creation of the Resource Based Relative Value Schedule (RBRVS), which took effect on January 1, 1992. This program operationalizes the intent of Congress expressed in the passage of the Omnibus Budget Reconciliation Act of 1989 (OBRA) that there be a single fee schedule that would be equitable across geographic and specialty boundaries. The methodology developed by Hsiao formed the basis of the system, which sought to achieve several goals. These

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included a increase in payments to primary care physicians and a corresponding decrease in payment to procedural based specialists; adjustment of geographic disparities; and reduction in payment for certain overpriced procedures (PPRC, 1990, 3). This system replaces the historic "usual, customary, and reasonable" fee basis under which Medicare had operated since its inception.

In effect, physician payment reform has established prices within the Medicare program for physician services and effectively removed this area of autonomy from the physician. Prices for services are now established on the basis of a national conversion factor, and are computed based on a formula reflecting work value, overhead, malpractice costs, and a geographic factor reflecting cost of practice. The system is geared to protect against over-utilization through an annually adjusted volume performance standard, which will determine the total funds available for physician payment under Medicare and result in an updated conversion factor (PPRC, 1991, xi-xvii).

BALANCE BILLING AS AN ALTERNATIVE PRICING STRATEGY

As a consequence of this major change, the most significant pricing decision left to the physician is that of extra billing patients within the newly set limits on this practice specified under the new system. Even before the enactment of Medicare payment reform, the physician has

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been presented since the enactment of the Deficit Reduction Act of 1984 with three possible choices under the program These are: 1. to participate and accept assignment (payment in full from Medicare) under a binding agreement. 2. not to participate but to accept assignment on a case-by-case basis. 3. Not to participate and not accept assignment. In effect, these decisions represent pricing decisions on the part of the physician. The varible elements are the total amount to be billed and the portion which will be the patient's direct liability.

Under the revised schedule based on implementation of balance billing limits in OBRA 1989 and 1990, balance billed charges will be limited to 120 percent in 1992 of the allowed charge for nonparticipating physicians (95% of that paid to participating providers). In 1993 the allowed amount will shrink to 115 percent of the payment amount for nonparticipating physicians (PPRC, 1991, 20). The net effect of these changes is to make balance billing a marginally attractive economic alternative when one takes into account extra costs and potential for bad debt versus assured payment associated with participation.

Balance billing may have been reduced as an attractive option, but it has been highly charged politically as organized medicine has argued that it is necessary to retain the right of a physician to set fees (prices) within

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the context of a governmental program. It is argued by the profession that Medicare does not pay its fair share of costs. Physicians argue for the right to undertake discriminate pricing for services to the well to do, as well as the ability to command premium prices for special skills or services (Law and Ensminger, 1986, 3-4).

Based on survey data, McMenamin argues that physicians will oppose elimination of balance billing whether they actually do so or not (McMenamin, 1987, 357). Indeed, the practice has diminished gradually since the enactment of the Participating Physician Program in 1984. Edwards and Fisher note that balance billing accounted for 12.3% in 1982 of total expenditures for physician services per Medicare enrollee, and had declined to 7.7% by 1987 (Edwards and Fisher, 1989, 117). At the same time, the percentage of claims submitted as assigned jumped from 55% in 1983 to 73% in 1987 following the enactment of the Participating Physician Program (Burney and Paradise, 1987, 108). The percentage of physicians participating in the program increased from 28.4% at the inception of the program to 30.6% at the time of Burney and Paradise's study, to 44.1% in 1990. (PPRC, 1991, 19). This indicates that nonparticipating physicians are likely accepting Medicare payment as payment in full as claims paid exceed the percentage of participants by a considerable margin.

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The PPRC attempted to study physician reactions to this pricing question, and suggested that the motivation to participate or not is more often "philosophical" than economic. The 1988 report asserts that 80% of nonparticipants conclude physicians should have a "right" to set prices-- a clear demonstration of support for economic autonomy (PPRC, 1988, 145). The socioeconomic status of beneficiaries is not a definitive indicator of whether assignment will be accepted. It appears that beneficiary income is not a predictor of whether or not to balance bill (PPRC, 1989,). The Commission did report considerable variation in assignment rates by specialty and by geographic area as well inner city, ruaral and suburban practice settings (PPRC, 1988, 141).

Holahan and Zuckerman have cautioned against creation of a mandatory assignment policy for Medicare, arguing that physicians will demand higher fees from within the Program to offset the loss of extra billing income. They also cite the moral hazard argument common to insurers that the removal of balance billing will create added demands for care that is presumably unnecessary (Holahan and Zuckerman, 1989, 153). Holahan and Zuckerman support the contention that physicians will leave the Program and refuse to treat Medicare recipients if balance billing is lost as a release for the individual physician from the fee schedule. This argument appears to support the importance of control of

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fees to physicians, and once again points to the complex interrelationship between autonomy and preservation of the potential for direct economic advantage to the physician.

THE PHYSICIAN INDUCED DEMAND CONTROVERSY

The issue of control of demand for physician services has been a notable one for researchers with direct implications for autonomy. In the role of purchasing agent of services for the patient under the fiduciary ethic, the physician is placed in a unique role of potentially generating demand for services to offset income loss through price regulation or increased competition from other providers. Evans is perhaps the earliest proponent of this approach, having put forth a model in which physicians are able to influence demand for their services and the resulting possibility that price limits would lead to volume increases (Evans, 1974).

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This work was followed in the United States by studies to review the Economic Stabilization Program of the early 1970s and its effect on physician fees. Paringer analyzed the effect of the program, and concluded that price controls limited average fees for physician services. However, they were not effective in restraining the growth of physician incomes as physicians successfully altered the number and mix of services provided to offset lost fee increase opportunities (Paringer, 1979, 51). Holahan and

Scanlon reached a similar conclusion to Paringer's in assessing the impact of Economic Stabilization on the California Medicaid program. Unit costs were effectively controlled, but mix and number of tests and visits were altered (Holohan and Scanlon, 1979).

Rice and McCall examined payment changes which took place in Colorado in 1977. The authors concluded that physicians whose Medicare payments declined furnished more intensive services to offset the decline. The authors were quick to point out that this does not mean that unnecessary services were furnished, but rather that different ones were (Rice and McCall, 1982, 67).

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Wilensky and Rossiter examined insurance coverage of individuals in relation to amount of services received. They conclude that lower out of pocket expenditures by the patient lead to more visits to the physician and related expenditures. They conclude that "Our findings indicate that not only would individuals have increased their demand for medical care, but that physicians would have initiated more visits as well" (Wilensky and Rossiter, 1983, 271). Cromwell and Mitchell reached a similar conclusion in analyzing increases in discretionary services, including some surgical procedures (Cromwell and Mitchell, 1986, 293).

A more recent study by Mitchell, Wedig, and Cromwell dealt with service levels during the Medicare fee freeze from 1984 to 1986. During the freeze period, Medicare physician expenditures increased 29.5 percent, with major increases occuring in surgeries and diagnostic tests. The authors concluded that services which physicians initiated grew at a relatively higher rate during the freeze period than other services (Mitchell, Wedig, Cromwell, 1989).

A contrary view is that of Feldman and Sloan, who argue based on a review of the literature that they can find little demonstrable evidence to support physician generated demand for service as an offset to lost income (Feldman and Sloan, 1988, 239). This finding is based on the contention that researchers advocating physician induced demand theories have not been sufficiently rigorous in their methods. The authors advocate as an alternative a competitive model with more consumer information as an adequate safeguard against creation of unwarranted demand (Feldman and Sloan, 1988, 239).

Rice and LaBelle criticize Feldman and Sloan as incomplete in their own analysis. Rice and LaBelle characterize Feldman and Sloan's position as one in which "one need not fear a utilization response on the part of physicians because they either cannot or will not induce demand" (Rice and LaBelle, 1989, 594). To the contrary, they argue that

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"Our interpretation of the Canadian evidence is that physicians can, and do, generate demand in response to real fee reductions" (Rice and LaBelle, 1989, 595).

In sum, most attempts to examine the issue of physician generated demand empirically conclude that there is a basis for regarding demand as under the control of the physician at least to a limited extent. This power resulting from the clinical autonomy of the profession to act on behalf of the patient may in turn be used to the economic benefit of the provider when modification of price (fees) is no longer possible due to external policy.

SUPPLY OF PHYSICIANS AND ITS IMPLICATION FOR PAYMENT

The PPRC has not dealt specifically with the issue of increased supply of physicians, but the question has been a matter of health policy analysis and action since the 1960s. Physician manpower has been viewed as a solution to problems of access to physicians and as a means of cost containment through increased supply which would break the potential of monopoly behavior on behalf of physicians. Yet if one acknowledges the Target Income Hypothesis, it would seem that the addition of physicians to the manpower pool might merely generate additional demand as access problems are addressed, or move up price and volume of service to meet target income goals. In either event, cost containment from increased manpower does not appear likely

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as an outcome.

The most noteworthy study of physician manpower, that of the Graduate Medical Education National Advisory Committee (GMENAC) of 1980, estimated a physician surplus by 2000 of 140,000 physicians (Light, 1986, 522). These estimates, it is believed by former chair Alvin Tarlov, may be understated due to increasing practice in HMOs and other organized practice settings (Nash, 1987, 3). It has been anticipated by health policy analysts that this growth in numbers of physicians will stimulate competition, eventually leading to cost decreases. One obvious result from the growth in number of physicians is the increasing ease of recruitment of physicians into alternative delivery organizations and away from standard fee for service practice (Office of Technology Assessment, 1986 75). Since the start of the 1980s the typical practice setting of physicians has moved from solo practice to groups of two or more practitioners.

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At the same time, questions have arisen regarding the applicability of these increased numbers to problems of access such as geographic and specialty maldistribution. The PPRC has observed some betterment of access problems through the movement of physicians to rural and urban areas once considered less attractive for practice (PPRC, 1988, 35). Yet Colwill has shown that steady declines have

occured in primary care manpower production as graduates are attracted to potentially more lucrative specialties, particularly the medical subspecialties (Colwill, 1992, 387). This is in spite of perceived shortages in primary care areas with an abundance of specialists. Contrary to earlier hopes for reduced expenditures as competition among physicians develops, Colwill argues that "more and more specialization and an increasing supply of physicians will contribute to escalating health care expenditures" (Colwill, 390, 1992). He concludes that with an abundance of physicians, a nation would be better served by an excess of generalists rather than specialists-- the opposite of the situation in the United States.

INCOME AS A REFLECTION OF MAXIMIZATION UNDER CONDITIONS OF ECONOMIC AUTONOMY

The issue which is closely related to that of supply of physicians is that of income. The PPRC has observed that organized medicine argues that incomes will decrease as supply increases, but empirical evidence does not support this assertion (PPRC, 1988, 33). Based on constant dollars, physicians' incomes rose on average by six percent between 1975 and 1986, while wages in the remainder of the workforce remained constant (PPRC, 1988, 34). Monitoring surveys by the AMA reported average income gains of 10.71% from 1986 to 1987; 9.37% from 1987 to 1988; and 7.67% from 1988 to 1989. These gains were achieved in a period of

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maximum annual inflation of four percent, resulting in significant increases in real income (AMA, 1991, 154).

At the same time, the AMA noted marked increases in real income for certain specialists, including Ob-Gyn, Surgery, and Radiology. Significantly lower gains were achieved by psychiatry and pediatrics, with family medicine achieving less than one-half (34.31% vs. 73.02%) the rate of increase of surgery from 1982 to 1989 (AMA, 1991, 154). The effect of these differences has been to attract more applicants from medical school to lucrative specialties. Shulkin writes that "Although specialty selection is a multifaceted process, monetary reimbursement appears to be a more important influence than previously thought" (Shulkin, 1989, 1630).

The result of these empirical assessments is to underscore the complex interface of economic factors in physician practice. If autonomy in the clinical arena allows freedom in selection of tests on behalf of the patient, at what point can this be used to offset adverse price decisions by payers? That the economics of paying for physician services strains conventional economic models is evident from the relationships of price of, demand for, and supply of physician services and their attendant corollary of physician income. These will be tested empirically in further analysis of extra billing decisions of physicians.

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DIFFICULTIES IN DEFINING AUTONOMY FOR ANALYSIS

It is curious that autonomy, having been identified as the key defining characteristic of a profession, should have received relatively little attention in the form of empirical studies. Rather, the concept has remained generally within the realm of theory with the limited exceptions noted in this review. A significant contributor to the problem may well be difficulty in creating an operating definition of the concept which lends itself to measurement and evaluation. A second factor is the use of the term at the aggregate level of the profession of medicine in relation to society in general and perhaps the state in particular.

The problem may stem from the fact that autonomy is a concept which exists only in relation to other social actors and institutions. As has been observed throughout this study, a profession is autonomous in relation to the patient, the state, other professionals, and institutions such as third party payers in the clinical and business areas of its endeavors. Furthermore, these relationships may be defined at the macrolevel of the interaction of organizations, but will ultimately be reflected in the interaction of individual professionals and in day-to-day decisions. Empirical assessments have tended to focus on one end of the continuum or the other, with only limited success in relating policy determinations to the perceived

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autonomy of practicing physicians. This section will review that literature and its implications for further analysis.

REVIEW OF EMPIRICAL FINDINGS: EFFECT OF GROUP PRACTICE ON AUTONOMY

Initial credit for attempting to analyze the impact of autonomy in the field must be given to its theoretical champion, Eliot Freidson. As his work has pervaded this study, it is no surprise to find that his exploratory work on group practice and its impact on physicians and patients would consider this concept. In *Doctoring Together,* Freidson assesses the effects of group practice on medical practitioners working within an urban group setting. His findings included a differentiation of administrative and professional authority. Based primarily on qualitative investigation, he reported an attitude on the part of practitioners which resented the use of formal authority in clinical matters, and resultant deemphasis of its use by those in positions of presumed authority such as departmental physician chiefs (Freidson, 1975, 116).

Freidson's research concluded on the basis of interviews that the structure in group practice which might evaluate performance and thus infringe on autonomy was not a structure of formal officeholders but rather the collegial judgment of the group of physicians (Freidson, 1975, 119).

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His work showed a prevailing attitude in which physicians resisted administrative intervention into practice or "professional decisions" (Freidson, 1975, 108). Evaluation which did occur at the time of entry to partnership and thereafter centered on issues of professional ethics, etiquette (colleague relations), and general professional reputation. These elements might be inferred from hearsay as well as formal evaluative processes such as chart review. These findings were later replicated in large part in Bosk's (1979) study of a surgical training program and its standards for residents and faculty.

In his conclusion Freidson notes that the intrusions on autonomy reported in this study might be regarded as limited in their generalizability beyond the group practice which was the subject of the study. He acknowledges the unique nature of the group under examination, but argues that the group was studied because it was special and "because it represented a comparatively rare type [multi-specialty group practice with significant pre-paid care] lauded by the avant-garde of medical policy-makers" (Freidson, 1975, 272). He also notes that the observations from the field contained in the study were gained ten years before its publication, leading to some question of its continuing validity. Nevertheless, it is significant to note that the precursors of the theoretical formulation of autonomy published in his two 1970 books may be found in

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the conclusions based on this data and gathered through interviews in 1965. One might also suppose that Freidson's continuing interest in professional self-regulation and discipline might be traced to this work and the evident absence of such checks on an otherwise model physician organization.

STUDIES OF PHYSICIAN ECONOMIC AND POLITICAL IDEOLOGY

Harrington employed content analysis of medical articles published in 1972 to differentiate several groups of physicians on the basis of ideology. These groups were identifed as traditionalists, liberals, and radicals (Harrington, 1975, 905). On the basis of her analysis, she concluded that physician attitudes toward medical care which defined the three groups included professional unity, authority, and self-regulation. The traditionalists in her research supported the most rigid positions calling for preservation of physician autonomy on each of these dimensions. The liberals indicated some willingness to negotiate these issues with the broader society, while the admittedly small (2 to 4 per cent of physicians) radical group advocated abandonment of autonomy on behalf of the profession in favor of shared decision making with workers and consumers (Harrington, 1975, 908).

An extensive 1973 national survey of 2713 physicians was analyzed and published in 1986 by Colombotos and Kirchner.

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Based on their analysis, they reported significant variation among physicians on the dimension of political ideology, including attitudes toward national health insurance (Colombotos and Kirchner, 1986, 182). They reported that physicians represented a range of political opinions toward NHI and other causes which were more liberal than traditional fee for service medicine advocated by the AMA (Colombotos and Kirchner, 1986, 184).

When specific regression analyses were performed to assess the influence of specific physician characteristics on political attitudes. When questions of autonomy were introduced, the authors found a positive correlation between higher incomes for practitioners and conservative social and economic views when considering national health insurance (Colombotos and Kirchner, 1986, 105). The authors concluded that variables such as age and sex of the practitioner had less explanatory power in this regard than did income; noting that older practitioners often enjoyed higher incomes and females lower.

Practice organization proved to be the most significant predictor of attitude toward government involvement in medicine and alternative payment mechanisms. The authors found that solo fee for service practitioners displayed the most conservative attitudes, with group fee for service being more liberal and salaried fee for service most

liberal. They also reported that the distance between the groups, based upon unstandardized regression coefficients, varied by issue. The middle group, group fee for service practitioners, were closer to individual fee for service physicians on economic issues of salaried reimbursement and prepayment; but are closer to salaried group physicians in terms of attitudes toward non-economic issues such as group practice, peer review, and task delegation (Colombotos and Kirchner, 1986, 106). This division is significant in that the categories of economic and non-economic factors which the authors employ approximate the major building blocks of autonomy described by Freidson.

Specialty choice was found to have little predictive power with respect to attitudes. The authors pose the question "Why specialists differ in their attitudes remains an intriguing question" (Colombotos and Kirchner, 1986, 106).

Colombotos and Kirchner conclude their research with several intriguing comments regarding the future of professional autonomy. In making these comments, they project forward their 1973 data to project attitudes into the mid-1980s and the actual publication of their findings. They comment that the two most distasteful proposals for the future practice of medicine as viewed by physicians are the DRG concept for treatment and the direct control of physician fees by government. They suggest that DRGs will

result in explicit protocols and standards for care, which will in turn limit the clinical autonomy of physicians. Direct government control of fees will obviously limit their economic autonomy (Colombotos and Kirchner, 1986, 198).

Their prediction is that physicians will adapt to both forms of infringement on their historic autonomy in the 1990s. They project that "During the next decade clinical protocols and standards, spearheaded by the DRG concept, will probably exercise an increasing influence on the clinical decision-making of physicians. In addition, the fees of physicians will probably be fixed, first under Medicare, and then under other government-financed programs, such as NHI" (Colombotos and Kirchner, 1986, 198). They then proceed to construct a specific scenario for the future of clinical autonomy and its economic counterpart. They state that "The clinical autonomy of physicians-- and their pocketbooks-- are likely to fare better if clinical protocols and physicians' fees are negotiated between government and organized medicine than if they are left to the whim of market forces, a market in which the for-profit chains would have the upper hand over individual physicians competing with each other. Collective autonomy would replace individual autonomy in both clinical decision-making and in physician reimbursement" (Colombotos and Kirchner, 1986, 199).

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This statement, of course, refutes the conservative ideology of a classical economic model of physician competition at the level of multiple small providers and purchasers. Instead, the authors make the ironic proposition that physicians will find greater remnants of their autonomy preserved by cooperation with government than with less benign powerful large payers who concentrate economic power against the profession.

PRACTICE ORGANIZATION: AUTONOMOUS TO BUREAUCRATIC

Wolinsky and Marder were heavily indebted to Freidson for providing a point of departure in their 1985 study *The Organization of Medical Practice and the Practice of Medicine.* They review Freidson's conceptualization of medical practice at a time when solo practice could still be considered the norm for medical organization. Solo practice created a special dependence on client relationships in Freidson's model, especially for primary care providers. Group practice physicians, by contrast, might be characterized as colleague rather than client dependent, particularly in the case of specialists who rely on referrals from other physicians (Wolinsky and Marder, 1985, 4). They note that total autonomy of individual practice is a rare occurance found only in limited circumstances. Otherwise, as Freidson has stated, client choice infringes upon autonomy in solo practice, while

colleague choice intervenes in group settings.

Wolinsky reported that his research employing multiple regression analyses found that sociodemographic, environmental, and attitudinal characteristics have a significant inflence on choice of practice organization. He reported that self selection of practice location is evident in those choosing solo practice settings. Among these physicians, autonomy in practice is of paramount importance, "perhaps to the point that they consider the quality of care and other professional concerns unimportant in making the medical practice setting choice...." (Wolinsky and Marder, 1985, 27). Conversely, his research showed that physicians entering large group practice are less concerned about issues of personal autonomy and earnings potential than the solo practitioner. Those in small group practices fall between the two extreme positions.

In an attempt to move beyond Wolinksy's earlier findings, Wolinsky and Marder created a continuum of practice settings against which physician practice choices could be tested. The ends of the continuum were identified as "bureaucratic" at one extreme and "autonomous" at the other. Moving from most bureaucratic to most autonomous, they array the continuum of practice models as: 1. Kaiser group model HMO; 2. Non-Kaiser group model HMO; 3. Staff

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model HMO; 4. IPA model HMO; 5. Group fee for service; 6. Solo fee for service. Practice patterns of 3555 primary care physicians were then studied to test the model, using data gleaned from the Periodic Survey of Physicians routinely conducted by the AMA and a subsequent special survey of HMO physicians.

This model was in turn tested against several variables of medical practice. for purposes of this paper, it is important to note those findings associated with maximum autonomy of practice with respect to style of practice; practice organization; and income/expense of practice. The authors had anticipated a continual increase in patient waiting time for appointment as one moved toward the bureaucratic end of the model, but found instead that while solo practice patients might face the shortest waits, patients of group fee for service physicians waited longer for an appointment than patients of group model HMO physicians (Wolinsky and Marder, 1985, 139). Time spent per patient generally conformed to the model, with greatest time per patient being spent in the "autonomous" styles of practice; the least in the "bureaucratic" (Wolinsky and Marder, 1985, 139).

Less support for the theoretical model of practice organization is found in assessment of work week and income. The authors conclude that "None of the practice

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setting characteristics produced statistically significant effects on either the total number of hours that physicians worked per week or the number of hours in direct patient care that they provided per week" (Wolinsky and Marder, 1985, 140).

Physician income distribution does not support the model if one assumes a desire for income maximization at the autonomous end of the scale and lesser emphasis on income at the bureaucratic end. The authors found little difference between solo and group fee for service providers' income, although the authors had hypothesized that the group members would earn more. Of even greater surprise to the authors was the finding that Kaiser model group physicians earned slightly, though not statistically significantly, more than their group fee for service counterparts. Non-Kaiser group model and staff model HMO physicians reported significantly lower incomes than did the other groups (Wolinsky and Marder, 1985, 140). In contrast to the authors' findings on income levels, the observed levels of practice expense corresponded to the model with greatest level of expense incurred by solo practitioners and least by Kaiser HMO physicians with descending levels for intervening models.

In the Wolinsky and Marder study, autonomy is an assumed or defining characteristic of certain forms of practice,

closely aligned with a fee for service payment system. The danger of this conceptual approach lies in the assumption that a dichotomy can be identified which will align "autonomous" characteristics with organizational forms of practice. For example, there is emerging a perception that physicians within a Kaiser form of organization, with its affiliated Permanente Medical Groups, enjoy a greater degree of freedom in making clinical decisions than do their fee for service counterparts. Similarly, incomes for these primary care providers (the subject of the Wolinsky and Marder study) are known in certain areas of the United States to have significantly outstripped those of fee for service providers.

Much of the empirical base for this model appears to have been Wolinsky's own 1982 study referenced earlier in this discussion which identified certain attitudes with specific practice organization. He states that attitudinal characteristics, especially the importance of personal autonomy, are the most important in choosing a medical practice (Wolinsky, 1982, 415). The problem in this statement is that the perception of autonomy on the part of those surveyed may shift over time as the external realities of medical practice change. The perception may be time-bound to specific circumstances, such as relative income or freedom from external scrutiny and supervision which may and have shifted with time, rendering the

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organizational settings Wolinsky studied more or less attractive to the practitioner seeking autonomy as a primary motivating concern in practice selection.

The theme of influence of organizational type on physician autonomy was carried forward in the study by Burns, Andersen, and Shortell (1989) on the influence of corporate structures on physician participation and inclusion. In their study of physicians in one Western urban county, they sought to measure by survey method whether participation in for-profit and multi-hospital organizations would influence traditional independence of physicians from hospitals in income generation and decision making. For the purpose of the study, inclusion was defined as acceptance of salary from or limitation of practice to a given facility. Physicians might seek inclusion given a perception of physician oversupply and be willing to trade autonomy for income and/or institutional privilege (Burns, Andersen, Shortell, 1989, 969). Participation is defined as the ability of the physician to shape hospital practice, policies, and outputs.

Based on a regression analysis of participation and inclusion, Burns, Andersen and Shortell report that contrary to popular perception, physicians in for profit hospitals report "the lowest level of inclusion and dependence on the primary hospital, and the greatest

involvement in hospital governance [participation] (Burns, Andersen, Shortell, 1989, 979). Investor-owned hospitals are thus evidently most sensitive to issues of physician autonomy and move deliberately to promote it and thus benefit from physician use of their facilities. By contrast, these hospitals appear to reject more direct and heavy handed control strategies of direct payment to physicians and denial of policy making influence which would constitute a denial of autonomy. The authors found little to support a significant influence on either physician participation or inclusion resulting from hospital involvement in a multi-hospital organization.

Schulz, Scheckler, Girard, and Barker (1990) examined the relative degree of autonomy reported by physicians in a somewhat different organizational form, the health maintenance orgaization, in a study of Dane County, Wisconsin physicians. They sought to measure the response of this physician population to the widespread growth of HMOs which occured with startling rapidity during the mid-1980s. The study posed questions of the expected nature of change in practice resulting from HMOs and which physicians were most likely to report declines in earnings, autonomy, and quality of care delivered and thus be least supportive of the change in organizational form. In setting the stage for the study, the authors note that insurors and employers aggresively promoted the shift to

HMO controlled payment schemes, virtually forcing primary care physicians out of solo and small partnerships into larger groups in order to support the economic risk demanded by these organizations (Schulz et al, 1990, 59).

Survey data was compared from two surveys of physicians taken in 1983 and resurveyed in 1986. The authors found limited decline in earnings as a result of shifts to predominantly HMO practice, with such declines being reported by only 17 per cent of internists and 23 per cent of family physicians. Significantly, 40 per cent of physicians who remained out of the network reported earning declines.

More directly to the subject of this study, the authors reported a perceived loss of autonomy on the part of all physician groups studied (IPA panel, group, and staff models) as a consequence of increased HMO activity. Significantly, however, physicians who did not join HMO plans during this period also reported a perceived loss of autonomy as well (Schulz et al, 1990, 57). The authors surmise that this occured as a result of limitation of referral patterns or discounting of charges. Noting that 84 per cent of physicians in group model A noted loss of autonomy while only 44 per cent in group model B reported such loss, the authors report that actual controls on practice were ironically more stringent in group B. They

opine that "Perhaps autonomy is more a feeling than a fact. Perceived autonomy may be a function of factors other than actual autonomy-- for example, expectations, changes in the status quo, achievement of goals, feelings of control, and earnings that appear to be high" when viewed in relation to the community (Schulz et al, 1990, 57).

A subsequent unpublished study by Schulz, Girard, and Scheckler (1990) sought to measure physician satisfaction in managed care environments. In this study, the authors found a perception of reduced clinical freedom at a moderate but statistically significant level in those settings having 25 percent or greater HMO patients (Schulz, Girard, Scheckler, 1990, 14). Neither solo nor group practice settings revealed perceptions of difference in perceived autonomy. Group practice, however, did afford more clinical freedom than perceived by those in hospital based specialties (Schulz, Girard, Scheckler, 1990, 15). Schulz and his colleagues in both studies attempt to assess through use of survey data and regression techniques

ATTITUDES AND AUTONOMY

Globerman (1990) explored the nature of the Canadian medical profession's response to encroachments on professional autonomy through a survey of 313 Toronto physicians. This study has been discussed at length from a policy viewpoint in the section of this paper dealing with

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international perspectives on autonomy. For the purpose of discussion of empirical issues, Globerman identified the introduction of a ban on balance or extra billing of patients for fees beyond allowable payment levels of provincial insurance as a unique opportunity to examine physician attitudes on autonomy, free enterprise ideology, and economic self interest. Employing regression techniques, she sought to learn from survey data which allowed physicians to rank attitudes on a one to five (strongly agree to strongly disagree) scale the basis of their support for extra billing and also their actual willingness to engage in the practice (Globerman, 1990, 11). This distinction is critical to her argument as physicians who might politically support this option did not necessarily act to benefit economically from the choice as an individual actor.

Through her study, Globerman concluded that "economic self-interest, free-enterprise ideology, and professional ideology were all significant predictors of extra-billing behavior" (Globerman, 1990, 21). She distinctly notes that extra billing practices were not explained by beliefs about loss of autonomy, although this argument had been advanced by the Ontario Medical Association. as a justification for the practice (Globerman, 1990, 21). As far as support for extra billing is concerned, her study revealed relative deprivation of income to be the significant additional

predictor of support while not actually extra billing. She notes that this sympathy on the part of some physicians may also be prompted by economic self-interest as the threat of extra billing provides leverage in fee negotiations with the government (Globerman, 1990, 21).

Globerman's study is of significance for its attempt to relate perceived autonomy or the loss thereof to an event with economic consequences; namely the decision to extra bill the patient or not and the decision to support such an option politically. While the prior empirical studies cited here have generally tied autonomy or the relative lack thereof to organizational forms of practice, Globerman is the first to look at autonomy in relation to its economic impact, and to attempt to differentiate the two in the decision of physicians as individual actors. In this regard, she attempted to move beyond a simple assumption that economic freedom is a necessary characteristic of autonomy to show that autonomy may be a shield for deeper economic concerns which are at the root of the extra billing controversy.

INCOME VS. AUTONOMY

A final study which attempted to assess willingness of physicians and other health care policy makers was conducted by Louis Harris and Associates (1990). This study posed trade-off choices to survey respondents which

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asked what they would accept in exchange for a hypothetical benefit. The survey included 201 "physician leaders", identified primarily through official positions such as medical society officeholders. The question was posed to this group of whether they would accept a 10% reduction in net income in exchange for "substantially increased physician autonomy, with less utilization review and less regulation" (Harris and Associates, 1990, 67). According to the respondents, 81% agreed with the propsed reduction, hypothetical though it might be, in exchange for enhanced autonomy as defined in the question. Ten per cent would not accept the reduction, and nine per cent responded "not sure". This appears to be a ringing endorsement for more "autonomy" on the part of physician leaders, but it is important to note that two other choices posed against a ten per cent income reduction drew proportionately greater support. These choices were a very substantial reduction in paperwork which 89% would accept; and malpractice reform with limits on punitive damages and pain and suffering, which 88% would approve (Harris and Associates, 1990, 67).

How these responses support or contradict each other is unclear at best. The authors suggest that since large majorities would accept a ten per cent reduction in fees for any one of these, "a substantial majority of physician leaders would probably also be willing to accept an even bigger reduction in fees for two, or three, of these

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proposed benefits" (Harris and Associates, 1990, 67). This conjecture would seem to fly in the face of the target income hypothesis discussed earlier in this study, as the questionnaire does not suggest that the results would necessarily be cumulative. As a further test of this finding, the Harris group asked whether physicians surveyed would accept all three benefits cited above in return for entry into a national health insurance program requiring negotiation with the government in exchange for the right to increase fees. Sixty three per cent indicated they would not support such a tradeoff; indicating an ideological bias toward maintenance of classic marketplace freedom versus greater clinical autonomy. This ideological bent should be carefully weighed against the position of "medical leaders" in traditionally conservative organized medicine. A different sample of physicians such as the more general group studied by Colombotos and Kirchner would approach this question with quite different results.

SUMMARY OF EMPIRICAL RESEARCH FINDINGS AND CONCLUSION

Empirical research on physician autonomy, then, has revolved primarily around questions of practice organization, or what might be considered the clinical aspect of the typical two part definition of autonomy. More recent studies have attempted to introduce the economic dimension of autonomy in assessing the impact of certain practice forms which limit economic action on the

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part of individual physicians through partial dependence on a financing organization, specifically the health maintenance organization. Finally, studies have emerged which attempt to isolate specific economic decisions which can be idenified as proxies for autonomy in the economic sector, specifically the decision to balance bill patients beyond the payment limits of governmental programs.

In earlier studies, one might readily assume a congruence of certain practice forms and levels of income. Solo or small group practice might be regarded as a haven for economic maximizers, who might at the same time be seen as protecting autonomy of practice from unwanted colleague scrutiny. In recent years these assumptions have been severely challenged by changes in payment systems and the external oversight applied to physician practice by public and private review organizations. No longer can solo or small group practice necessarily be seen as economically most lucrative. For example, a 1992 study of compensation for primary care providers in the San Francisco area found highest incomes attained by members of the Permanente Medical Group and other large group practices (UCSF, 1992, 1-2). While traditional autonomy is eroding on the economic front, observers are also questioning whether greater clinical autonomy is not now enjoyed by members of large groups who undergo scrutiny of their practice patterns from familiar colleagues rather than remote and in

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some cases non-physician review organization personnel (Gray, 1991, 306). Physicians complain of the growth of the "hassle factor in medicine" which encompasses mant of the complaints of private practitioners over the loss of cherished freedoms from interference of external agents in practice and the increased (and in their view onerous) linking of these interventions to payment. The net result is a cascading effect in which clinical autonomy is compromised in order to effect financial goals of expense reduction by third parties. In the end, autonomy is compromised both clinically and economically.

In conclusion, the empirical problems posed by the singularly important concept of autonomy are those of definition and measurement. Practice organization and billing practices at the micro level of the individual practitioner have been shown to be two methods to accomplish these analyses. Yet as has also been noted, the traditional assumptions regarding relative degrees of freedom in practice organization and the financial significance of decisions in practice may no longer hold true, but may instead be the very conditions which gave rise to the ideal type of autonomy in the first place. In turn, these have shifted on the clinical and economic fronts over the last two decades. Future research agendae need to identify and explicate these changes in the concept of autonomy.

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IMPLICATIONS FOR FUTURE RESEARCH

A significant difficulty noted throughout the discussion of professional autonomy has been the problem of definition of such a pivotal sociological concept-- one which may be the foremost defining characteristic of a profession. The elusiveness of the concept is, in part, a reflection of the fact that autonomy is in part a negatively defined idea, represented as freedom from certain controls of society as well as an empowerment in a positive sense. To review the initial characteristics as identified by Freidson, one observes four principal characteristics. These are organized autonomy in the sense of the profession striving for its own interests in society; dominance of the occupational hierarchy; control of education and training of new initiates for entry into the profession; and regulation of its clients (Freidson, 1970a).

These identifying traits of autonomy give rise to the criticisms that have been lodged against medicine as a profession in interaction with society. Issues seen as resulting from the privileged status of medicine have included suppression of views of health and healing which do not coincide with the medical model; concentration of resources on biotechnology; and a general trend toward identification of medical origins for social issues, or medicalization.

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SUMMARY: IMPLICATIONS OF THE LITERATURE FOR RESEARCH ON AUTONOMY

The key problem for this study, however, has been the problem of unchecked economic power potentially arising out of an autonomous state. Parsons had noted with distress the activities of the AMA to derail the efforts of the Committee on the Cost of Medical Care in the thirities, although he overlooked this troubling occurence as a challenge to his functionalist view of the place of medicine in society.

Freidson was aware of this tension as well, and foresaw the possibility of conflict over economic issues as one of the foremost flaws of professional autonomy in his early writings. He noted this contradiction when he wrote that "the profession cannot insist on freedom and autonomy in the marketplace at the same time as it insists on having the protection of a monopoly: within the limits of a monopoly, a free market merely means license to the profession without the economic benefits of competition to the consumer. Without regulating its members' economic practices, the profession's autonomy cannot fail to violate the public interest...." (Freidson, 1970a, 364). This is a clear warning of the dangers which were to emerge over time under the pressure of expenditure growth and ensuing pressures from the state for cost containment. The freedom

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created by clinical autonomy can have untoward economic consequences if the profession is allowed corresponding economic autonomy which appears to be a derivative of clinical autonomy.

Operationalizing this conflict for empirical study has been difficult. The most promising typology identified in this study is that of Schulz and Harrison in identifying areas of control of the profession in both clinical and economic dimesions. The clinical dimensions parallel those identified by Freidson and elaborated in the case of the United Kingdom by Tolliday (Tolliday, 1979, 43-44). The clinical elements include control over acceptance of patients; control over diagnosis and treatment; control over evaluation of care; and control over other professionals (Schulz and Harrison, 1986, 339-340). These elements reflect the privileges deemed necessary for the profession to carry out its scientific mandate free of intervention and with assured dominance of the occupational hierarchy of health care, a set of characteristics Freidson identified as constant across nations (Freidson, 1970b, 83).

It is the list of economic elements of autonomy which are of interest for purposes of this study as one examines the consequences of autonomy. The economic or business elements identified by Schulz and Harrison include

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self-determination of specialty and pratice location; control over earnings; and control of nature and volume of tasks (Schulz and Harrison, 1986, 339-340) The first of these points clearly relates to the economic research on physician control of supply of practitioners and distribution; the second to control of price; and the last to control of demand by the profession.

Opportunities to examine these elements at a given historical point are rare. However, the work of the Physician Payment Review Commission has given rise to commissioned surveys assessing beneficiary and provider attitudes under the Medicare program. Medicare is the largest single purchaser of physician services in the United States, and sets direction for its intermediary carriers and eventually other insurers as well due to the force of its market presence. The Commission's attempt to assess attitudes and practices of physicians with respect to balance billing of Medicare beneficiaries provides the opportunity which will be developed in the remainder of this study.

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CHAPTER III

HYPOTHESIZED MODEL FORMULATION AND RESEARCH METHODS

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The purpose of this chapter is to develop a hypothesized model formulation and describe the research methods used in this study. The hypothesized model formulation is based on the extensive literature review found in Chapter II. This literature review has provided a theoretical basis for proceeding to examine the specific application of the theoretical concepts of autonomy in its clinical and economic forms to the Medicare participation and assignment problem. In formulating the models employed in this chapter, the author is indebted to the 1983 work of Rice and McCall in which Medicare assignment is modeled under the operating rules of case by case assignment of claims which prevailed prior to 1984.

The second section of this chapter addresses the research methods. This study was based upon the 1988 National Survey of Physicians commissioned by the Physician Payment Review Commission and used with the permission of the Commission. This study, from which the secondary data used in these models was obtained, was a cross sectional mail survey to a stratified random sample by medical specialty of the population of all physicians serving Medicare patients in 1988.

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THEORY CONSTRUCTION: BALANCE BILLING AS A RESEARCH OPPORTUNITY TO EXAMINE AUTONOMY

As part of its work with physicians, the Commission attempted to assess attitudes and practices of physicians with respect to balance billing of Medicare beneficiaries. This area had been targeted for reform with the establishment of the Participating Physician Program in 1984, and its evolution has continued through the establishment of Congressionally mandated limits on balance billing implemented in 1992. The _1988 National Survey of Physicians_ measured a number of demographic elements as well as attitudes of physicians toward changes or limitations in balance billing policy under Medicare on the part of 2828 physicians nationally. This question is regarded as having considerable policy implications not only for physicians but also for the elderly and disabled who receive bills beyond the Medicare allowance which they must then attempt to meet out of personal disposable income.

The survey examines a critical issue regarding the physicians' ability to control a key element of their economic autonomy--price--after a binding choice to participate or not has been initiated but as a precursor to institution of a national fee schedule under Medicare. Three possible alternatives for action were available to

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physicians at the time of the survey. The first and most economically advantageous, from the perspective of economic maximization for the practitioner, was the option to remain nonparticipating for purposes of the Medicare Program and balance bill the patient for the remainder of one's customary fee (Feldstein, 1988, 193). This option is no longer attractive given limitations on balance billed amounts beyond Medicare payments initiated in 1992 as a result of legislation. The second and next most attractive available option was to participate in the Medicare Program, receive higher levels of program payment at a more rapid rate than did nonparticipants, and receive certain marketing advantages such as inclusion in Medicare directories as well as patient goodwill.

The third option is problematic from the perspective of a model of economic maximization, having none of the advantages of either of the above options. This is the decision to neither participate in the Program by signing a formal participation agreement, nor to balance bill the patient. A key element of the "sociological imagination" is identification of the unusual or exceptional as a test case of general theory. This is certainly evident in the case of this group, representing approximately 10% of physicians surveyed by the PPRC. One might hypothesize that these individuals forego economic advantage in deference to ideological values of autonomy and resentment

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of external intervention in either clinical care or free enterprise.

An instructive comparison can be built from analysis of the respondents who do not participate and balance bill as opposed to those who do neither. The first group should represent economic maximizers while the latter are willing to suboptimize for reasons which may be related to autonomy concerns. Predictors of economic maximizing behavior among physicians have been presented in this study, and include specialty and location choice; type of practice organization (solo, small group, or large group); dependence on Medicare or other third party payers; and actual income attained.

In addition to this quantitative information, qualitative information is available on the point of reasons cited for nonparticipation and wishes for future design of the balance billing policy. One might expect to find more reports from the balance billing group about the practical economic advantage than ideological defense of autonomy.

The relationships underlying economic autonomy are complex in nature based on the theoretical and limited empirical literature presented in this study. Nevertheless, it is projected here that relationships can be identified which might lead to identification of physicians in either of the

two groups of nonparticipants who do or do not balance bill Medicare beneficiaries. This difference in the use of balance billing is unexplained in the opinion of executive staff of the PPRC (Conversation with P. Ginsburg, 11-12-91). With this in mind, this study will proceed to the establishment of expected relationships which may be identified and which can then be measured in relation to physician participation and assignment choices.

EXPECTED RELATIONSHIPS

The following expected relationships are stated for each independent variable as well as the predicted direction of the anticipated relationship. For the convenience of the reader, these are summarized in tabular form in Tables 3.1 and 3.2. The first set of expected relationships examines the question of those physician characteristics which are associated with the decision to become a participating physician within the Medicare program; or to reject participation and maintain the option to balance bill the patient.

1. Physician practice in large urban areas is hypothesized to be positively associated with participation. This subject has been explored by Paringer, who determined that urban physicians were more likely than rural physicians to accept assignment based on a study of general practitioners (Paringer, 1980, 85). Mitchell and Cromwell reached a different conclusion using a wider range of specialists than did Paringer, and found that physicians in non-metropolitan SMSAs were more likely to accept assignment than those practicing in urban SMSAs (Mitchell and Cromwell, 1983, 66). Rice and McCall found residence in small SMSAs resulted in assignment rates seven percent lower than those in urban areas (Rice and McCall, 1982, 83). This finding, identified by the authors as

TABLE 3.1

EXPECTED RELATIONSHIPS UNDER HYPOTHESIZED MODEL I

	Definition and Expected Relationship to Dependent Variable	
	Participant	Non-Participant
Dependent Variable: Participating Physician under Medicare	Positive (+) Relationship	Negative (-) Relationship
Independent Variables		
Sociodemographic Characteristics		
Location	Urban and suburban	Rural
Board Certification	Non-certified	Certified
Specialty	Specialized	Primary Care
	RAP and Surgery	Internal Medicine
		Family Practice
Practice Size	Large Practice	Solo
Practice Type	Multi- and Single Specialty Group	Solo
Economic		
Income	Low Dollars	High Dollars
Medicare Practice Share	High Medicare Caseload	Low Medicare Caseload
Medicaid Practice Share	High Medicaid Caseload	Low Medicaid Caseload
Practice Costs		
Hassle Factor	Low Hours	High Hours
Entrepeneurship		
Billing	No Electronic Billing	Yes - Electronic Billing
Equipment	No Diagnostic Equipment	Yes - Diagnostic Equipment

TABLE 3.2

EXPECTED RELATIONSHIPS UNDER HYPOTHESIZED MODEL II

	Definition and Expected Relationship to Dependent Variable	
	Low Assignment (High Balance Billing) Negative (-) Relationship	High Assignment (Low Balance Billing) Positive (+) Relationship
Dependent Variable: Percentage of Patients of Non-Participating Physicians for Whom Assignment is Accepted		
Independent Variables		
Sociodemographic Characteristics		
Location	Urban and suburban	Rural
Board Certification	Certified	Non-Certified
Specialty	Specialties RAP and Surgery	Primary Care Internal Medicine General Practice
Practice Size	Large Practice	Solo
Practice Type	Multi- and Single Specialty Group	Solo
Economic		
Income	High Dollars	Low Dollars
Medicare Practice Share	High Medicare Caseload	Low Medicare Caseload
Medicaid Practice Share	Low Medicaid Caseload	High Medicaid Caseload
Practice Costs		
Hassle Factor	High Hours	Low Hours
Entrepeneurship		
Billing	Yes - Electronic Billing	No Electronic Billing
Equipment	Yes - Diagnostic Equipment	No Diagnostic Equipment

statistically significant at the one percent level, supports Paringer's conclusion.

The importance of this issue on public policy is examined by the Physician Payment Review Commission, which incorporated locational considerations in its study of balance billing policy. The Commission reported in 1988 that rural physicians participated at a level six percent less than that of their urban counterparts (PPRC, 1988, 141). Thus, the preponderance of available studies suggest that urban practice should be positively associated with participation.

2. Board certified physician status is hypothesized to be negatively associated with participation as a participating physician. Board certification has been examined to determine the willingness of physicians to accept assignment of Medicare claims. Wilensky and Rossiter (1983) identified the economic advantages of board certification for physicians, reporting that board eligibility carried an annual income premium of $8000. The advantage associated with board certification was found to be even greater, averaging $13,000 annually over non-boarded physicians (Wilensky and Rossiter, 1983, 93). Rice and McCall found that board certified physicians were five percent less likely to assign claims than non-boarded physicians, an association identified as significant at the

one percent level (Rice and McCall, 1983, 52).

From the perspective of political ideology, board certification has not appeared to create a significant commitment either to supporting or opposing assignment. Mitchell and Cromwell reported that 39 percent of board certified physicians supported mandatory assignment of all cases, while 37 percent favored no assignment in any case (Mitchell and Cromwell, 1983, 76). Holahan and Zuckerman argued that the better quality of care presumably provided by board certified physicians should be regarded as a justification for higher fees and therefore for balance billing (Holahan and Zuckerman, 1989, 75).

Yet for the extensive study and commentary on board certification, its influence on the behavior of physicians remains unclear. In the most recent study to address the question, Mitchell, Rosenbach, and Cromwell argued that no evidence was found in their study that board certified physicians were any less likely to sign participation agreements than were physicians without board certification despite the loss of potential economic advantages (Mitchell, Rosenbach, and Cromwell, 1988, 23).

3. Physician specialization in a RAP (Radiology, Anesthesiology, or Pathology) is hypothesized to be positively associated with participation as a participating

physician, while the status of family physician or general practitioner is negatively associated with participation. Physician specialty choice has been perhaps the most extensively studied of possible predictors of assignment choice. Ferry et al. (1980) reported that the assignment rate of individual claims varied by specialty (Ferry, Gorniok, Newton, and Hackerman, 1980, 59). Paringer (1980) noted a greater willingness of surgeons to accept assignment, and suggested that the higher relative values of surgical fees as opposed to medical fees under Medicare allowable charges made assignment more attractive given higher initial return. In addition, surgeons might be willing to sacrifice extra billing for assured payment (Paringer, 1980, 84).

Rodgers and Mussachio found specialty to be a significant predictor of assignment at the five percent confidence level for surgeons and at a one percent level for internists (Rodgers and Mussachio, 1983, 66). McMillan, Lubitz and Newton noted minimal increases in assignment across specialty lines with the major exception of internal medicine. In this case, charges assigned increased from 43 percent of charges in 1975 to 47 percent in 1982 (McMillan, Lubitz and Newton, 1985, 69).

Rice and McCall found that medical specialists were least likely to assign charges of the four specialty groups they

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studied; while surgeons and family physicians showed comparable rates of assignment. Hospital based or RAP specialties were most likely to assign charges, probably reflecting the influence of institutional policies in some instances (Rice and McCall, 1983, 51).

4. Practice in a large physician group is hypothesized to be positively associated with participating physician status, while solo practice is negatively associated with participation. The size of organization in which the physician practices has been studied for its impact on clinical and economic behavior. Wolinsky observed that larger group practices tend to contain multiple specialties, while "most groups of seven or less physicians are extended versions of the single specialty partnership or association" (Wolinsky, 1982, 413).

Based on his research findings, Wolinsky cites a strong concern for personal and professional autonomy in those opting for solo practice, which is not emphasized by members of either large or small group practices. The business side of practice was considered unimportant by physicians choosing solo practice, but a positive motivator to choose large group practice with regard to avoidance of business related problems (Wolinsky, 1982, 413). Interestingly, Wolinsky found earning potential to be an insignificant motivator for solo and small group

practitioners, and negatively associated with large group practice membership. This would appear, then, to support the notion that larger group practice members would accept assignment and forsake earning opportunities presented by balance billing.

5. Practice in multi-specialty groups is hypothesized to be positively associated with participating physician status; while solo practice is negatively associated with participation. Practice organization is another variant on the question of the influence of practice environment on assignment behavior which has been studied previously. Rice and McCall found group practice to be significant at a five percent confidence level when comparing the acceptance of assignment of claims by physician group members as contrasted with solo practitioners. This finding was influenced by the heavy preponderance of assignment within specific single specialty group practices, however, in the case of radiology group members versus solo radiologists (Rice and McCall, 1983, 53). When radiologists were removed from the comparison of solo practitioners and group members, no significant difference between the remaining classes of physicians was found. In his own research Rice found no relationship between increased reimbursement rates and group practice in predicting assignment decisions (Rice, 1984, 41).

6. Lower income of the physician is hypothesized to be positively associated with participating physician status, while higher income is negatively associated with participation. The income of providers has not been discussed extensively in the literature of assignment behavior. In discussing the varying levels of acceptance of assignment by providers, the PPRC (1988) has relied extensively on considerations of physician specialty and location. These attributes may be regarded to some extent as proxies for income given the general pattern of descending earnings from suburban to urban to rural practice locations.

A more precise predictor of physician earnings appears to be specialty of the physician, which has been associated with typical earning levels by specialty. When applied to assignment practices, generalizations have proven difficult. Some specialties with higher typical incomes have shown high rates of acceptance of assignment, such as general surgery and some medical specialties. General practitioners, with lower average incomes than any other specialty group also have lower rates of assignment than do most other specialties. Assignment rates for relatively high earners such as otolaryngology, urology, orthopedics, and anesthesiology, however, are below those of general practitioners, again rendering generalization hazardous (PPRC, 1988, 142).

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Ebell reinforced this perception, arguing that income potential is the primary motivating force for specialty elections among graduating medical students. This trend has in turn diminished the attractiveness of primary care disciplines where perceived need for medical care is greatest (Ebell, 1989, 1630).

7. A physician practice with a high percentage of Medicare patients is hypothesized to be positively associated with participating physician status on the part of the physician; while a low percentage of Medicare patients is negatively associated with participation. Dependence of the physician on the Medicare program has been regarded as a possible predictor of physician assignment decisions. Feldstein's (1988) economic model of physician assignment has suggested that physicians with practices which allow the physician to see private patients, for whom the provider controls the fee or price, will attempt to minimize Medicare or other fee controlled patients who represent a discount from his or her customary charges. Initially, these patients will be accepted and balance billed in Feldstein's model in order to obtain full fee payment, but may eventually be replaced by assigned Medicare patients representing a discount from full fee. This occurs if the demand for services by fee paying patients is limited as in a managed care environment;

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supply of competing physicians increases; or payments under the assignment program are made sufficiently attractive to remove the economic advantage afforded by private patients (Feldstein, 1988, 193).

In an analysis made after the enactment of the Participating Physician Program, Mitchell, Rosenbach, and Cromwell argue that "Physicians with trivial Medicare caseloads will lose less by having their allowables frozen, and they can shift out of Medicare more easily" (Mitchell, Rosenbach, and Cromwell, 1988, 18). Their analysis indicated an association between the amount of Medicare patients in the physician's caseload and the decision to sign a participation agreement, which was significant at the one percent level. In their conclusion, they note that physicians for whom Medicare patients represent fifty percent or more of their caseload were 33 percent more likely to sign participation agreements than were those physicians with ten percent or fewer of their patients derived from Medicare (Mitchell, Rosenbach, and Cromwell, 1988, 22).

8. A high percentage of Medicaid patients in a physician's practice is hypothesized to be positively associated with participating physician status on the part of the physician; while a low percentage of Medicaid patients is negatively associated with participation. A different

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problem from the expected relationship between participating physician status and Medicare dependence is presented in the instance of those physicians whose patients receive supplements to their Medicare coverage from Medicaid. For these individuals, whose number is gradually declining as supplementary payments under Social Security and Medicare benefits supplant Medicaid coverage, the collection of charges in excess of Medicare allowable payment levels is prohibited by law (PPRC, 1990, 254).

In addition, collection of co-pays and deductibles normally associated with Medicare coverage is also forbidden (PPRC, 1990, 254). McMillan, Lubitz, and Newton suggest that as the percentage of elderly covered by Medicaid as well as Medicare declines, the overall assignment rate will decline as well since mandatory assignment will decrease (McMillan, Lubitz, and Newton, 1985, 74). This observation corroborated the study of Rodgers and Musacchio, who found a significant correlation between an increasing percentage of patients covered by Medicaid and higher physician assignment rates (Rodgers and Musacchio, 1983, 68).

9. The "hassle factor" experienced by a physician, as measured in lower relative hours per week devoted to paperwork, is hypothesized to be positively associated with participating physician status. A factor associated with the notion of cost of practice, both economic and psychic,

for the physician is the so-called "hassle factor" associated with business elements of contemporary medical practice (American Society of Internal Medicine, 1990, 7). This phenomenon includes, but is not limited to, completion of insurance forms, obtaining treatment authorizations, billing, peer review, and personnel or financial issues which are perceived as resulting from a complex and bureaucratic payment system of multiple insurors. Lewis and his colleagues reported a widespread dissatisfaction with the practice of internal medicine based on an increase in administrative burdens (Lewis, Prout, Chalmers, and Leake, 1991, 1).

No specific application of this perception has been made to assignment and participation decisions, although it is reasonable to infer that these concerns might be reflected in part by a measure such as cost of collection studied by Mitchell, Rosenbach, and Cromwell (1988) in which higher costs of collection led to a greater rate of assignment. This could be a result of attempts on the part of physicians to avoid the "hassles" associated with extensive (and expensive) collection efforts. A Louis Harris survey (1990) reported a willingness on the part of "physician leaders" in response to "trade-off" questions to sacrifice ten percent of income in exchange for a reduction in administrative burdens of practice (Harris Associates, 1990, 67).

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10. Electronic billing capability on the part of the physician is hypothesized to be negatively associated with participating physician status. Closely related to the concept of practice administration and efficiency is billing sophistication of the physician in dealing with a potential myriad of individual and corporate payers. Yet it is the experience of the author that these systems can facilitate collection efforts involved in the added transactions of balance billing. In turn, this added revenue can be used to justify the initial investment by the physician in electronic billing systems. This topic has not yet been studied in relation to participation and assignment decisions, but appears worthy of consideration based on the above theory of physician entrepreneurship.

11. Physician ownership or lease of in-office diagnostic equipment is hypothesized to be negatively associated with participating physician status. Physician investment in diagnostic equipment through either lease or purchase has not been directly applied to examination of balance billing and participation. Luft (1986) has written on the impact of economic advantages of equipment operation and its relation to physician ordering behavior. They reported positive associations between ownership of radiological or laboratory equipment in the physician's office and the likelihood the patient will receive examinations using the

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equipment (Luft, 1986, 509).

Relman has also noted that incentives for referral to one's own testing facilities provide a clear economic temptation to the physician which may influence his or her ordering practices (Relman, 1992, 1522). Incentives clearly exist for ordering such services in a fee-for-service system, which Medicare payment coupled with a balance bill payment by the patient effectively provides and which allows the physician to collect his or her full fee (Luft, 1986, 509). Gray agreed with Luft's assertion, and suggested that although empirical study on the subject is limited that "physicians' investments in testing equipment and facilities do affect their patient care decisions" (Gray, 1991, 188).

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In presenting the above expected relationships, which are summarized in Table 3.1, the approach has been to postulate that those directions which represent opportunities to maximize income will be elected by physicians who do not participate so that they may balance bill. These variables include board certification, low Medicare dependence, low Medicaid population, high hassle factor associated with extra billing efforts, electronic billing, and in-office diagnostic equipment. Exceptions to this principle are made in cases in which prior analysis in the literature contradicts this general approach. Specific examples include location, in which rural physicians earn less than urban practitioners but are also less likely to participate. A second instance is specialty, in which general practitioners are among the lowest earners but also least likely to participate. Finally, practice size and type appear to discourage participation for solo practitioners, even though they earn less than their counterparts in group practice.

The second set of expected relationships results from the fact that a nonparticipating physician is allowed on a case by case basis the decision to either accept Medicare's payment as payment in full or balance bill the patient. The independent variables which comprise these expected relationships are identical to those applied in the first set of expected relationships which evolved from the

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question of whether a physician would choose to become a participating physician by signing a participation agreement.

The independent variables, which comprise the second set of expected relationships, are proposed to support that the earning of added income will be positively associated with balance billing. As noted previously, most empirical studies on the subject of case-by-case assignment predate the creation of the Participating Physician program, which has dramatically altered the assignment decision process on the part of the provider. Therefore, an economic theoretical model is employed consistently throughout the development of expected relationships, except where previous studies have found contradictions.

The second set of expected relationships are summarized in Table 3.2. Those expected relationships pertain to the actual percentage of cases in which nonparticipating physicians elect to balance bill the patient:

1. Physician practice in urban locations is hypothesized to be positively associated with balance billing of patients; while physician practice in rural areas is negatively associated with balance billing.

2. Board certified physician status is hypothesized to be positively associated with balance billing of patients; while non-board certified status is negatively associated

with balance billing.

3. Physician specializtion in a RAP or surgical specialty is hypothesized to be positively associated with balance billing; while the specialty of Family Physician or general practitioner is negatively associated with participation.

4. Practice in a large physician group is hypothesized to be positively associated with balance billing; while solo practice is negatively associated with balance billing.

5. Practice in multi-specialty groups is hypothesized to be positively associated with balance billing; while solo practice is negatively associated with balance billing.

6. Higher income of the physician is hypothesized to be positively associated with balance billing; while lower income is negatively associated with balance billing.

7. A physician practice with a high percentage of Medicare patients is hypothesized to be positively associated with balance billing; while a low percentage of Medicare patients is negatively associated with balance billing.

8. A low percentage of Medicaid patients in a physician's practice is hypothesized to be positively associated with balance biling; while a high percentage of Medicaid patients is negatively associated with balance billing.

9. The "hassle factor" experienced by a physician, as measured in higher relative hours per week devoted to paperwork, is hypothesized to be positively associated with balance billing; while lower relative hours of paperwork is negatively associated with balance billing.

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10. Electronic billing capability on the part of the physician is hypothesized to be positively associated with balance billing; while lack of electronic billing capability is negatively associated with balance billing.
11. Physician ownership or lease of in-office diagnostic equipment is hypothesized to be positively associated with balance billing; while the absence of such ownership or leasehold is negatively associated with balance billing.

The final set of expected relationships to be addressed pertains to the residual category of physicians who elect not to participate in Medicare through the completion of a participation agreement, but who nonetheless forego the option to balance bill on a case-by-case basis. From an economic perspective, this pattern of decisions appears irrational. The physician is twice disadvantaged economically by first accepting lower payments from Medicare as a non-participant, and then choosing not to balance bill which would potentially move his or her revenue above the level allowed by Medicare.

The problem posed by these individuals pertains to their attitudes toward governmental control of medical care and particularly medical economics. The anticipated relationship in this case is that individual physicians who do not exercise their ability to balance bill will display significant ideological preference toward independence from

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external (especially governmental) interference with clinical practice and prservation of clinical autonomy. It is further expected that these considerations will outweigh economic considerations in the decision not to balance bill.

This set of expected relationships is of theoretical significance. Although the number of physicians involved is relatively small (approximately ten percent of those accepting Medicare patients), they provide an opportunity for a focused examination of the trade-off between economic and clinical autonomy. This question will be assessed through frequency of responses to questions which ask these specific physicians to articulate their reasons for non-use of the balance billing option.

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HYPOTHESIZED MODEL FORMULATION

The body of literature on professional autonomy suggests a fundamental distinction between clinical and economic autonomy. These two manifestations of professional autonomy have emerged historically as separate and definable in the latter part of the twentieth century. In a condition of system stress, brought on by historical change, members of a profession will emphasize one aspect over the other.

The theoretical model of this paper conceptualizes the preservation of economic autonomy over clinical autonomy has become the key objective of physicians in the United States. If it is correct that economic autonomy is a desired value by a significant segment of the population of American physicians, as argued by Reinhardt (1988), these physicians would presumably resist any efforts to control, reduce, or externally dictate a fee or price for their professional services. Presumably a physician valuing economic autonomy would make decisions in order to maximize economic gain. This economic maximization would be expected to occur even at the expense of enhanced economic certainty or predictability, administrative efficiency, and patient convenience.

This leads to the following assumption which is

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subsequently developed into hypotheses:
Economic autonomy is associated with the decision of the physician whether or not to enter into a binding agreement to become a participating physician under the Medicare program.

This relationship can be expressed more succinctly in the following way:

Economic autonomy = F (Decision whether or not to participate)

This research examines the decision of the physician to participate in the Medicare Participating Physician program and thus accept mandatory assignment of all claims and consequently no balance billing of patients. This decision is then applied to characteristics of physicians that may be associated with the participation decision. As noted by Rice and McCall (1983), regression analysis applied to case by case decisions of physicians to assign claims found physician characteristics to be the most influential factor in predicting assignment. The question to be considered is whether this relationship is sustained following the 1984 enactment of the Participating Physician Program, which required the physician to make an annual election which would prospectively commit him or her to assignment of all claims in exchange for specific economic benefits. This generalized relationship may be expressed as follows:

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Decision to participate = F (Physician characteristics)

Insofar as the physician agrees to accept assignment, he or she irrevocably waives the ability to determine the fee for the period in which the participation agreement is in effect. The ability to determine one's fee, as opposed to its determination elsewhere as the price a third party will pay for the service, is the keystone of economic autonomy.

The physician decision whether or not to participate was examined using a discriminate analysis. Rosenbach, Hurdle, and Cromwell (1985) examined this problem through a sampling drawn from 51,160 physicians electing to participate in the initial year of the program. Physicians identified altruism in 25.9% of responses as grounds for the decision. A second grouping totaling 33.8% of the respondents cited economic justifications; such as an increased Medicare charge profile (8%), maintain or increase patient load (14.4%), or reduction of administrative costs (11.4%). A third set cited organizational considerations indicating that a group or employing organization had made the decision which they then executed as an individual by signing (18.7%). A final grouping cited no reasons _not_ to participate (15.3%); Including 9.9% who already accepted assignment as a matter

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of course previously, and 5.4% who could see no particular advantage to non-participation (Rosenbach, Hurdle, and Cromwell, 1985).

Nonparticipants significantly outnumbered participants and presented their own reasons, at the outset of the Participating Physician program in 1984 . A total of 102,944 nonparticipants were available for survey purposes (Rosenbach, Hurdle, and Cromwell, 1985). Fully 25.9% cited economic undesirability of the program as their reason for non-participation, while 27.3% cited maintenance of control over their fee as their rationale. Control of the fee may be interpreted as indicative of a desire of the physician to maintain his or her economic autonomy as well.

The second major grouping of nonparticipants cited clinical autonomy as a justification, including 20% who noted philosophical opposition to participation, and 2.5% who cited quality of care concerns. A small percentage, 2.6%, noted pressure from peers not to participate. Finally, 7% saw no advantage to participation, while 6% claimed a lack of information to participate and hence withheld participation (Rosenbach, Hurdle, and Cromwell, 1985).

These rationales may have changed in importance after the development of the Participating Physician program and creation of a different structure of incentives and

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disincentives to participation. What has not veen studied is the interrelationship of physician characteristics which Rice and McCall (1983) identified as of greatest importance in influencing physician assignment decisions under the former case by case system of assignment. Either the decision to participate or not and balance bill the patient for revenue beyond the Medicare allowable fee can be studied through a model of economic maximization which includes consideration of risk avoidance for those choosing to participate.

STATEMENT OF HYPOTHESES

The two general propositions bring together the issues surrounding professional autonomy with theoretical constructs to explain why physicians choose to maintain or forego economic autonomy. The following three hypotheized models are developed to test empirically these expectations.

DECISION OF THE PHYSICIAN TO AGREE TO BECOME A PARTICIPATING PHYSICIAN

This model addresses the characteristics of physicians who decide to agree contractually to become a participating physician under the Medicare program. This annual election is formalized in a binding agreement which the physician

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signs obligating him or her to accept Medicare allowable payment as payment in full for services provided, minus applicable co-pays and deductible amounts which are the patient's obligation through program design. The model is stated in negative terms concerning the participation decision, since it is postulated that those physicians who elect not to participate will be those committed to preservation of economic autonomy through continued control of their fee.

Hypothesized Model I: Those physicians who decline to enter agreements to become participating physicians, will be associated with a higher proportion of Board certification, primary care specialty, solo practice size and type, higher practice income, lower Medicare dependence, lower Medicaid coverage of patients, greater hassle factor as indicated by hours spent in administrative tasks, higher use of electronic billing, higher ownership or lease of in-office diagnostic equipment than will be associated with physicians who elect to enter agreements to become participating physicians.

The rationale for the above model is contained in the statement of expected relationships stated previously in this chapter. The general theoretical premise is that physicians choosing to maximize economic autonomy and revenue will choose not to become a participating

physician. In each instance, justification for each independent variable which comprises the hypothesis is found in the literature of assignment decisions under the Medicare program. The hypothesized relationships for this model are summarized in Table 3.1.

DECISION OF PHYSICIANS WHO DO NOT PARTICIPATE TO BALANCE BILL

Hypothesized Model II:

Of those physicians who decline to enter agreements to become Participating Physicians under the Medicare program, those who do not exercise the option to balance bill will be associated with a higher proportion of physicians practicing in rural locations, lacking board certification, practicing primary care specialties, solo practice size and type, lower relative Medicare dependence, higher relative Medicaid dependence, lower hassle factor as measured in hours spent on administrative tasks, and lower proportions of use of electronic billing and ownership or lease of in-office diagnostic equipment than will be associated with those physicians who do not participate and do exercise the balance billing option.

This hypothesis does not lend itself to ready examination through a strictly economic model, and holds considerable sociological interest for the study of autonomy for this

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reason. A majority of physicians from the inception of the Participating Physician program in 1984 elected not to enter agreements to become participants, a situation which was not altered until 1992 when for the first time a majority became participants (PPRC, 1992, 16). If income maximization were their objective in not participating, a logical consequence would be a decision to balance bill each patient to the extent of recovery one's own full fee.

Yet the Physician Payment Review Commission observed that nonparticipating physicians do not necessarily avail themselves of the opportunity to balance bill their Medicare patients despite the absence of any contractual prohibitions (PPRC, 1988, 145). Analysis of a sample of physicians accepting patients under the Medicare program indicated that an identifiable group of providers did routinely accept assignment and yet did not balance bill. Berk, Kutzin, and Mohr (1989) reported that on avaerage 24.8 percent of all Medicare patients were accepted on assignment by nonparticipating physicians, but an unusual subset could be identified which submitted greater than fifty percent of its Medicare claims on an assigned basis.

Berk, Kutzin, and Mohr found that twenty percent of their total sample of nonparticipants accepted greater than half of their patients on assignment (Berk, Kutzin, and Mohr, 1989, 24). Under the pre-1984 design of the Medicare Part

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B program such a practice carried no economic penalty other than the threat that the patient might not pay and a bad debt would result. With the enactment of DEFRA 1984, however, penalties then appeared in the form of a lesser payment rate than that received by participants, fee freezes, and a slower processing time for claims.

The model presented here hypothesizes that there are distinct physician characteristics which may be identified as characteristic of the nonparticipating physician who does not balance bill and which will separate him or her from those who do. The hypothesized relationships for this model are summarized in Table 3.2.

DECISIONS OF PHYSICIANS WHO NEITHER PARTICIPATE NOR BALANCE BILL

The remaining group of physicians who do not balance bill despite the opportunity to do so represent a group for whom the motivation of economic autonomy is secondary to other factors. At this point, social factors associated with clinical autonomy, or the right of the physician to practice free from external controls from outside the profession should become dominant. Harrington's research identified attitudes on the part of physicians which clustered around ideologies of professional unity, authority, and self-regulation (Harrington, 1975, 908).

While not necessarily conforming to these categories, it is hypothesized that factors which pertain to the ideology of clinical autonomy rather than economic autonomy and consequent maximization will appear more powerful among those physicians who choose neither to participate nor balance bill.

Hypothesized Model III: Physicians who do not participate yet do not balance bill patients (accept assignment) in fifty percent or more of their Medicare cases will cite ideological rather than economic justifications as the predominant basis for their action. This ideological basis for action is linked to a desire for preservation of clinical autonomy.

In their study of nonparticipating physicians, Berk, Kutzin, and Mohr (1989) identified several possible rationales for such behavior based on their survey findings. The most commonly cited was "the belief in the principle of fee-for-service medicine, and that those who can afford fees should pay them. A second set of reasons given dealt with the physician's freedom of choice in accepting or declining assignment on a case by case basis. The third most commonly cited common group of reasons was their distaste for government or other third party intervention in their practices" (Berk, Kutzin and Mohr, 1989, 21-22). These reasons, taken by themselves, appear

to support an interpretation of physicians striving to maintain autonomy against an increasingly controlling government program. Yet it is not evident how these particular physicians who appear to sacrifice income maximizing opportunities for ideological principles differ from those who might share these principles but balance bill in addition.

In examining this question, there may be pragmatic factors other than ideological justifications which account for failure to balance bill. These factors might include competition for patients; patient expectations based on a sustained relationship between the patient and physician; and lack of training of office staff. These issues are not explored in this study because of limitations in the secondary data used for this analysis. As the research question centers on those physicians who declare that they accept fifty percent or more of their Medicare patients on assignment, it is assumed that this occurs with forethought on the part of the physician and represents a deliberate choice on his or her part.

VARIABLE DEFINITION

The conceptual model identifies several classes of characteristics regarding physicians and their practices which are major determinants of willingness to participate

in the Medicare assignment program. The following discussion identifies the dependent and independent variables used in this study and describes how they were measured.

Table 3.3 sets forth the three dependent variables used in the three models tested in this study. The first dependent variable, physician participation, is a nominal level measurement and indicates the choice of the physician whether or not to sign the agreement to participate. The second dependent variable is a continuous variable described in precentage terms that deals with the percentage of Medicare patients accepted on assignment in the absence of a contractual obligation to do so. The dependent variable in the third model is the identification by the physician of the primary reason they do not balance bill patients despite the opportunity legally to undertake such billing. Responses in this case are grouped into five subcategories under the headings of clinical and economic autonomy.

Five sets of independent variables hypothesized to influence the dependent variables in Hypothesized Models I and II are described in Table 3.4. The first set of independent variables consider selected sociodemographic characteristics of physicians. These sociodemographic factors are measured by three variables-- geographic

TABLE 3.3

DEPENDENT VARIABLES

VARIABLE	DEFINITION
I. Status of the physician as participating or non-participating provider	Physician reported identification of participation status for 1988 based on the physician's completion of a Medicare participation agreement
II. Degre of balance billing by non-participating physicians	Percentage of Medicare patients accepted on assignment (at Medicare rates) by physicians in absence of contractual obligation to do so as reported by the physician. A higher percentage of patients accepted on assignment indicates lower incidence of balance billing
III. Reasons physicians do not balance bill despite opportunity to do so	Statement of principal reason identified by physician respondent for not balance billing patients when the physician accepts assignment in fifty percent or greater of his/her cases

TABLE 3-4 - INDEPENDENT VARIABLES

VARIABLE	DEFINITION
SOCIODEMOGRAPHIC FACTORS	
LOCATIONS:	
LARGE SMSA	A dummy variable indicating that the physician practices in a standard metropolitan statistical area (SMSA) of more than one million population
SMALL SMSA	A dummy variable indicating that the physician practices in a smaller SMSA
SEMI-RURAL OR RURAL	Control group for location; physician practices in a semi-rural or rural location
BOARD CERTIFICATION	A dummy variable indicating whether the physician is board certified in a specialty(ies)
SPECIALTY	
INTERNAL MEDICINE	A dummy variable indicating that the physician practices internal medicine or a subspecialty thereof
SURGERY	A dummy variable indicating that the physician practices surgery or a subspecialty thereof
"RAP" SPECIALTY	A dummy variable indicating that the physician is an anesthesiologist, pathologist, or radiologist
FAMILY PHYSICIAN OR GENERAL PRACTITIONER	Control group for specialty, indicating that the physician is a family physician or general practitioner
PRACTICE ORGANIZATION	
PRACTICE SIZE	The number of physicians with whom the physician practices

TABLE 3-4 - INDEPENDENT VARIABLES (continued)

VARIABLE	DEFINITION
PRACTICE TYPE	
SOLO PRACTICE	Control group for practice type indicating that the physician practices alone
MULTI-SPECIALTY GROUP	A dummy variable indicating the physician practices in a group including members of multiple specialties
SINGLE-SPECIALTY GROUP	A dummy variable indicating the physician practices in a group comprised solely of his/her own specialty
ECONOMIC FACTORS	
INCOME BY SPECIALTY	Median income of physicians by specialty as reported for 1988 in Physician Marketplace Statistics, Ed. Martin L. Gonzales, AMA Center for Health Policy Research. Income figures are assigned to each individual physician by specialty
MEDICARE PRACTICE SHARE	Percentage of the physician's practice represented by patients with Part B Medicare coverage
MEDICAID PRACTICE SHARE	Percentage of the physician's Medicare Part B covered patients who are also covered by Medicaid
PRACTICE COSTS	
"HASSLE FACTOR" Hours of time per week spent in administrative activities	Self-reported hours per week spent dealing with completion of insurance forms, billing patients, peer review, and personnel or financial issues

TABLE 3-4 - INDEPENDENT VARIABLES (continued)

VARIABLE	DEFINITION
PHYSICIAN ENTREPENEURSHIP	
PHYSICIAN OWNERSHIP OR LEASE OF IN-OFFICE DIAGNOSTIC EQUIPMENT	A dummy variable indicating that the physician owns or leases any or all of laboratory, x-ray, EKG, electro-cardiographic monitoring, non-invasive vascular studies, or mammography equipment for use in his/her office location
BILLING EQUIPMENT	A dummy variable indicating that the physician bills electronically by computerized means or does not

location, board certification, and medical specialty of the physician.

The next set of independent variables addresses the practice organization characteristics of the physician. The two variables included in this dimension are practice size and practice type. The third set of independent variables is related to economic factors, and addresses four financially related aspects of physician practice. These are imputed income of the physician, percentage of Medicare patient volume, and percentage of Medicaid patient volume. The fourth independent variable is measured in one dimension, the "hassle factor" experienced by the physician. Specifically, this is defined in terms of the number of hours per week which are devoted to administrative tasks.

The final set of variables examines physician entrepreneurship, and is measured in two ways. These are the incidence of physician ownership or lease of diagnostic equipment, and the billing sophistication of the medical practice as determined by the use of electronic billing equipment in the physician's office as opposed to the manual production and submission of hard copy claims to Medicare and other insurers.

DESCRIPTION OF THE DATA SET

This study is a secondary analysis of a larger nationwide study of physicians in the United States. The larger study was commissioned by the Physician Payment Review Commission (PPRC) and conducted in 1988. The larger study, "The National Survey of Physicians - 1988", was one of the largest national surveys of physician practice. In their final report on this survey to the PPRC, the authors (Berk, Kutzin, and Mohr, 1989) noted only two other comparable earlier national surveys including the 1977 Physicians Practice Survey conducted by the National Center for Health Services Research, and the 1983 Physician Cost and Income Survey commissioned by the Health Care Financing Administration.

This larger study was designed to investigate physician attitudes and practices surrounding Medicare assignment and balance billing behavior among several key policy issues. It is the most comprehensive survey of physician attitudes toward balance billing, and is the first such study to be undertaken following the 1984 enactment of the Participating Physician program which fundamentally altered physician choices in this area.

Permission was obtained to conduct a secondary analysis of the data resulting from the PPRC survey from the Executive

Director of the Physician Payment Review Commission. The goal of this study was to test hypothesis regarding Medicare participation among physicians in the United States. In 1991, the data from the PPRC were received from Social and Scientific Systems, Inc., which had maintained the files since the completion of the PPRC contract.

The data set used for hypoothesis testing of assignment and balance billing was drawn from the larger original survey of 2,828 national physician respondents which was drawn as a stratified random sample. Stratification was based on the specialty and the practice location of physicians serving Medicare patients (with selected exclusions to be discussed below). The study, designed to rely primarily on mail response, was supplemented by phone follow-up of non-respondents (Berk, Kutzin, and Mohr, 1989, 2-10).

TARGET POPULATION AND SAMPLE SELECTION

The population for the PPRC study was drawn from the American Medical Association (AMA) Master File, with notable exceptions made to exclude physicians not engaged in direct patient care. Retired, semi-retired, disabled, and inactive physicians were dropped. Physicians in training such as residents and fellows were excluded as well as administrative physicians, researchers, teachers, and those engaged in other activities or considered

"unclassified" (Berk, Kutzin, and Mohr, 1989, 2-2).

Physicians in selected specialties were also eliminated from the sample. These included various pediatric specialties, plastic surgery, dermatology, psychiatry, occupational medicine, critical care medicine, legal medicine, and miscellaneous other specialties. In addition, physicians employed by the federal government were excluded except for those employed by the U.S. Public Health Service. Physicians residing outside the United States or in its territories were also omitted (Berk, Kutzin, and Mohr, 1989, 2-3).

As reported by Berk, Kutzin, and Mohr, the primary stratification variable employed in the survey was the specialty of the physician. From a total choice of 85 non-excluded specialties, the listing of physicians was collapsed into 14 specialty classes. These consolidated classes included Anesthesiology, Cardiology, Gastrointestinal Medicine, General/Family Practice, General Internal Medicine, General Surgery, Opthalmology, Orthopedic Surgery, Pathology, Radiology, Rheumatology, Urology, Other Internal Medicine, and Other Surgery (Berk, Kutzin, and Mohr, 1989, 2-16).

The principal stratification of specialty was then further stratified into urbanity classes based upon an AMA assigned

code based on county of location. These classes included large SMSAs for counties located in SMSAs greater than 500,000; small SMSAs and large nonmetropolitan counties; and rural for nonmetropolitan counties with less than 50,000 people.

In the case of two specialty classes, those of general/family medicine and general surgery, the specialty/urban cells were further subdivided by board certification. The result was a total of 48 strata in the sample (Berk, Kutzin, and Mohr, 1989, 2-4).

Sample selection was achieved by ordering the physicians in the target population, and a random start was generated to initiate sampling in each stratum. Physicians were selected using equal probability systematic sampling. The description of the target population and the manner in which the desired sample was achieved is depicted in Table 3.5.

Berk, Kutzin, and Mohr provide a detailed description of how the sample target of 2,828 physicians was achieved. The sample size was allocated to the 14 specialty classes "proportionate to the physician universe sizes for the specialty classes" (Berk, Kutzin, and Mohr, 1989, 2-4). For all specialty classes, the minimum sample size was established at 124 completed interviews with the notable

TABLE 3.5

TARGET POPULATION,
STRATIFIED SAMPLING TECHNIQUES
AND PERCENTAGE OF SURVEY RESPONSE

Target Population
(N = 478,511)

Total Survey Questionnaires Generated
(N = 6,930)

14 Strata by Specialty (N = 4,532)

Stratified by Urbanicity and Board Certification

Total Sample Survey Respondents (N = 2,828)

Survey Respondents Minus
Non-Respondents to
Participation Status Questions (N = 2,717)

Data set for Secondary Analysis (N = 1,988)
(73% of possible
Survey Respondents)

exceptions of General Surgeons and Family/General Practitioners. In the latter two instances, the allocation was established at 372 completed interviews. Following this stratification, specialties were distributed among urban and board certification classes (Berk, Kutzin, and Mohr, 1989, 2-5).

DATA COLLECTION AND RESPONSE RATE

The collection of data was conducted primarily through a mail survey with telephone follow-up as required. Survey questionnaires were mailed to all respondents, and this was followed by calls from trained interviewers, who called to elicit completion of the forms or assist in completion over the phone. A total of 6,930 questionnaires were mailed, resulting in a total of 4,628 responses.

Of these responses, approximately 75 percent were completed through the mail survey while 25 percent were gathered through telephone assisted completion. This resulted in a response rate of 66.8 percent of those surveyed, a figure comparable to other major national surveys of physicians (Berk, Kutzin, and Mohr, 1989, 2-20). By contrast, the _1977 Physicians Practice Survey_ concucted by the National Center for Health Services Research attained a response rate of 74.4 percent, while the _1983 Physicians Practice Cost and Income Survey_ conducted by HCFA attained a

response rate of 69.1 percent (Berk, Kutzin, and Mohr, 1988, 2-20). Given the length of the survey, this response rate is regarded as quite acceptable. Berk, Kutzin, and Mohr reported that an analysis of nonrespondents for the primary report to the PPRC did not indicate systematic bias among nonrespondents (Berk, Kutzin, and Mohr, 1989, 2-12).

QUESTIONNAIRE DESCRIPTION

The data for this research were collected through collection of a twenty-one page confidential questionnaire mailed directly to the physician sample. The questionnaire was divided into six principal sections. Table 3.6 describes the six sections comprising the instrument. These elements include general information regarding the physician; assignment policies; work schedule of the physician and time allocation; costs associated with practice; and ownership or lease of diagnostic testing equipment. A specific form of the questionnaire was also tailored specifically to the needs of the RAP specialties. A total of eighty-one separate items containing 250 total questions for response were included under the six general section headings.

The secondary analysis used in this current study draws upon information collected from each of the sections of the questionnaire with the exception of malpractice costs.

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Table 3.5 delineates the items from each section used for the secondary data analysis. Five items relating to demographic information were chosen; as were four related to assignment policies. The latter set included both dependent variables used in the regression models employed in the research. One item each was selected from those sections pertaining to work schedule, costs of practice, and diagnostic testing equipment leasing or ownership. The omission of malpractice costs occured as a result of a high level of missing resonses, and will be addressed subsequently.

PHYSICIAN INCOME DATA

The study also included secondary information concerning physician income derived from the Socioeconomic Characteristics of Medical Practice 1988 produced by the American Medical Association's Center for Health Policy Research. This information was drawn from the AMA's Socioeconomic Monitoring system survey conducted with the participation of "approximately 4000 physicians" throughout the United States (AMA, 1988, 135). The sample, drawn from the AMA Master File of Physicians, was comparable to the sample drawn from the 1988 PPRC survey. Median income by specialty from the AMA data set was used in the secondary data analysis as a proxy for actual physician income.

TABLE 3.6

Physician Payment Review Commission

Survey of Physicians

Questionnaire Construction Description

Section	Total Items/Issues	Subset Used in Study Data Set
Sociodemographic Characteristics	5	5
Assignment Policies	30	4
Malpractice Insurance	6	0
Work Schedule	13	1
Cost of Practice	14	1
Diagnostic Testing	18	1
Subtotal	81	12

Those questions used in the secondary data analysis are reproduced in total in Appendix A. These questions are summarized under the headings used in creation of the models for this study of dependent and independent variables in the case of Hypothesized Models I and II. In the instance of Hypothesized Model III, which does not employ regression techiques, variables are derived from subjective sentence responses from the participants which were then grouped by this author for the purpose of secondary analysis.

NONRESPONSE TO SPECIFIC QUESTIONS AS A METHODOLOGICAL PROBLEM

Since this secondary research relies on responses to a subset of the total number of questions, nonresponse to questions was a specific problem. Berk, Kutzin, and Mohr have written that "Missing values for key variables are a major problem of physician surveys" (Berk, Kutzin, and Mohr, 1989, 2-13).

Berk, Kutzin, and Mohr reported that "Item nonresponse rates were generally low for questions on assignment policy, practice arrangements, and most components of practice costs. Item nonresponse rates, however, were high for questions relating to equipment purchase and maintenance costs" (Berk, Kutzin, and Mohr, 1989, 2-13).

To address this issue, the investigator developed an inclusion rule. In no instance was a question retained for inclusion in the secondary analysis when nonresponse exceeded twenty percent in the original sample.

The validity and generalizability of research results depends upon the integrity of the sample used and its replicability with other populations. The regression techniques employed for the purpose of analysis of the interaction of multiple independent variables with a dependent variable demand complete responses from study subjects or the imputation of summary values through use of median or mean values derived from known responses. Imputation of data is less than an optimal approach in that use of a mean or median score for missing data is a statistical proxy for an actual response, and may result in an understatement of significance in conjunction with multivariate techniques.

Two alternative responses to this problem were employed in this study. In order to assure the comparability of those respondents not included and those retained for purposes of secondary analysis, statistical tests were undertaken to examine the hypothesis that these samples were drawn from the same population without significant bias. Analysis of the included subjects and those excluded were compared statistically in relation to the critical dependent

variable of this study, participation in the Participating Physician Program. Due to the large size of the two groups, two statistical tests were employed; namely T test and chi square analysis. The T test compares the variances and central tendency of these two groups and shows that there is no statistically significant difference between the included and excluded respondents with respect to participation (T=1.88, p>.05). This result is displayed in Table 3.6.

The dependent variable, participation, is a nominal level measurement that may also be analyzed with the chi square statistic. Table 3.7 shows this test based on a comparison of included and excluded respondents with regard to participation. The analysis shows no significant difference for these groups as well. These analyses suggest that there is no methodological bias posed by the exclusion of respondents deleted as a result of missing responses. In addition to the tests performed to assess relationship to the dependent variable, each independent variable was also tested as a paired group of respondents and nonrespondents. No significant differences were found.

In order to include only complete patterns of physician response to all questions retained for the secondary analysis, a total of 111 physicians were discarded from the final sample as a consequence of nonresponse to the key

TABLE 3.7

T-Test Analysis of Excluded Respondents
Dependent Variable: Participation

$T = 1.88$

$P > .05$

T-Test Category	N	Mean	S.D.
Included Respondents	1828	.49	.50
Excluded Respondents	889	.53	.49

TABLE 3.8

Chi-Square Analysis of Excluded Respondents
Dependent Variable: Participation
Chi-Square Analysis

$x^2 = 3.55$

DF = 1

$P > .05$

Category	Participation Yes	No	Total
Included	934	894	1828
Excluded	420	469	889
	1354	1363	2717

defining question of whether or not they had agreed to become a participating physician. Of the remaining 2,717 eligible respondents, 729 were excluded for missing responses to one or more of the independent variables which constitute the basis of the regression model. This decision was made on the basis of an examination of each proposed independent variable and its impact on the remaining sample size. This resulted in the exclusion of two initially proposed variables [malpractice insurance cost and practice costs] which had resulted in the previously analyzed nonresponse rate of 916 of the total eligible physicians. The opportunity to restore these observations to the secondary study sample was deemed to be appropriate grounds for the exclusion of these potential independent variables from the regression models. Table 3.5 describes in detail the relationship of the sample retained for purpose of secondary analysis in this study to the original population from which the 1988 National Survey of Physicians was derived.

USE OF SAS PROGRAMMING LANGUAGE

All data analysis for this study was completed through application of SAS programming language. The SAS software package is a standard and widely used at academic and research centers. SAS programming techniques allow the researcher to access data and perform analyses without

extensive technical documentation as this is already available through the system.

As such, the researcher has access to programs to perform statistical analyses for the most common statistical tests, explanation of the computer product, and interpretation of results. SAS is available for both main frame computing and personal computer applications, with the latter employed in this study.

The applicability of SAS software to the social sciences is based in part on its ability to provide a comprehensible guide to analysis and interpretation of data from a non-technical perspective. This allows one to focus on the substance and theory of the study rather than on computational details. SAS programs routinely feature data statements, which tell the program about the specific data set; followed by the specific data; and finally the analyses to be performed (Cody and Smith, 1987, 5). SAS is used in this study as it is a useful tool in the easy and accurate calculation of summary statistics and frequency distributions of the type require in social research involving large sample data (Cody and Smith, 1987, 21).

ANALYTIC TECHNIQUES

Preliminary examination and description of the data was

conducted with frequency distributions, measures of central tendency, and cross tabulation of relevant variables. The hypothesized models were tested with two multi-variate data analytic techniques. These were a logit analysis in the care of the model with a nominal dependent variable; and an Ordinary Least Squares (OLS) regression analysis in the instance of the model containing an interval level dependent variable. Finally, an analysis was conducted through use of a frequency distribution of the select subset of respondents who chose not to balance bill in a majority of their cases. These responses were then grouped and analyzed for statistical significance using a chi Square test.

A thorough description of the multiple regression analytic technique employed in this research is provided by Lewis-Beck, and will be used as a reference point throughout this discussion (Lewis-Beck, 1990, 13). Multiple regression was the statistical technique of choice to test both models in this study. It is a general statistical technique through which the relationship may be explored between a dependent variable and a set of independent variables. Multiple regression is both a descriptive tool by which the dependence of one variable on others is summarized and decomposed; and an inferential tool by which the relationships in the target population are evaluated. It is a powerful tool as a result of its

common application to causal theory through describing the entire structure of linkages between the dependent and independent variables.

Statistical inference in regression problems involves estimating population parameters from sample regression statistics. In the case of the Ordinary Least Squares (OLS) regression technique used to test both models in this research, beta estimates are determined from the sample data and statistical hypotheses are tested for the population parameters.

Generalization to the population refers to estimating population parameters from sample regression statistics by testing statistical hypotheses. Statistics computed for the regression analysis have known sampling distributions which allow the testing of hypothesized relationships. The first two models in this research are tested by assessing the null hypothesis that all regression coefficients are equal to zero in the population, or:

$$Ho: B1= B2=...Bk= 0.$$

The alternative hypothesis, stated in terms of the population regression coefficients, is:

$$Ha: B1= 0 \text{ for one or more i.}$$

The specific application of the linear regression model to this research is outlined in the detailed model development in Table 3.9.

TABLE 3.9

Linear regression model:

Let $Yi =$ degree of balance billing by the ith non-participation, physicians, where i = 1,2...N and

$Xi =$ $1, X_{i1}, X_{i2} \ldots . X_{iK}$, where the X_i are K characteristics of the ith physician that affect the degree of balance billing and

$\beta''' =$ $\beta_0, \beta_1 \ldots \beta_K$ are the parameters associated with each of the independent variables.

If we assume a linear relation between the Yi and Xi, then $Yi = \beta' Xi + \varepsilon i$ are normally distributed error terms and

$E(\varepsilon i) = 0$

$Var(\varepsilon i) = 0^2$

$+ Cor(\varepsilon c \varepsilon j) = 0$ where $i \neq j$.

That is, each Yi are a linear combination of the Xi or

$$Y_1 = \beta c + \beta_1 X_{11} + \beta_2 X_{12} + \qquad + \beta_k X_{1K} + \varepsilon_1$$
$$\vdots$$
$$Y(= \beta c + \beta_1 Xi_1 + \beta_2 Xi_2 + \qquad + \beta_k Xi_K + \varepsilon i$$
$$\vdots$$
$$Y_N = \beta c + \beta_1 X_{N1} + \beta_2 X_{N2} + \qquad + \beta_k X_{NK} + (_N$$

Using ordinary least squares estimation methods we can produce

$\hat{Y}i =$ $\beta' Xc$ where Yi is the predicted value for the degree of balance billing for the ith physician + β' are estimates of parameter values associated with the independent variables.

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The multiple regression approach assumes that the dependent and independent variables are interval level measurements. The regression analysis is a robust statistical tool, and nominal level measurement may be used in large samples. This is accomplished by statistical transformation of nominal categories into dummy variables.

When the dependent variable does not meet the assumptions of interval level measurement, either logit or discriminant analysis may be applied as the statistical technique of choice. In this research, logit analysis was conducted to test the model containing a nominal dependent variable, Hypothesized Model I. The logistic function is depicted in this case in Table 3.10.

While the logit function is the analysis of choice for a nominal level dependent variable, extensive statistical analysis has shown that comparable results can be obtained using Ordinary Least Squares regression under appropriate conditions. Comparisons of logit and OLS have concluded that : (1) the logit analysis is only marginally superior to OLS; "(2) when the observed proportions on the binary variables are between 0.25 and 0.75, OLS and multiplicative odds models reach the same conclusions; and (3) overall, with large samples, probit, logit, discriminant and ordinary least squares (OLS) did not differ substantially ...with respect to bias or (minimum or error) variance"

TABLE 3.10

Logistic model:

The logistic function is

$$f(\theta) = \frac{e^{\theta}}{1+e^{\theta}}$$

Suppose θ is replaced by a linear combination, $\theta = \beta'X$

where β is a vector of parameters that equals β_0, β_1, β_K
and X is a vector that equals 1, $X_1, \ldots X_K$. The X_K are the independent variable that affect the status of the physician's participation.

The logistic model specifies that the probability of a physician participating is given by:

$$\text{Prob (participating)} = \frac{e^{\beta'X}}{1 + e^{\beta'X}} \quad \text{and therefore}$$

the probability of not participating is given by

$$1 - \frac{e^{\beta'X}}{1+e^{\beta'X}} = \frac{1}{e^{\beta'X}}$$

The likelihood function formed is

$$L = \prod_i \frac{e^{\beta'Xi}}{1+e^{\beta'Xi}} \prod_j \frac{1}{1+e^{\beta'Xj}}$$

where i are the physicians that participate and j are the physicians that do not participate. Maximizing this likelihood with respect to the vector β produces the maximum likelihood estimate of β.

(Wolinsky, 1982, 409-410). Rice and McCall reached a similar conclusion after completing both logit and OLS analyses of their large sample of Colorado Medicare claims (Rice and McCall, 1983, 51). Their subsequent argument in their article summarizing their findings, having established equivalency of the techniques, is presented based upon OLS for the explanatory benefit of wider reader understanding cited by Wolinsky.

In this study, both the OLS and logit techniques were used to test Hypothesized Model I, which contains a nominal level dependent variable. The results were found to be nearly identical when the two test results were compared. Every estimated coefficient had the same sign under OLS as under logit analysis, and significance levels under both methods are identical in all observations. Table 3.11 demonstrates this observation by showing the significance levels determined though each method for Hypothesized Model I.

The statistical comparison justifies the substitution of OLS for the logit technique. Following the precedent established by Wolinsky (1982) and Rice and McCall (1983), the OLS is reported and discussed in this research as a result of greater familiarity of researchers in general with this technique. Moreover, by using the OLS technique to test both Hypothesized Models I and II, a comparison of

TABLE 3.11

Significance Level Comparing OLS and Logit Analysis
for Hypothesized Model I
Physician Participation Under Medicare

Variable	DF	OLS Regression Probability of + Test	Logit Analysis Probability of + Square
Intercept	1	0.0003	0.0001
Urban Location	1	0.0039	0.0037
Small Urban Location	1	0.9982	0.9726
Board Certification	1	0.0189	0.0191
Medical Specialty	1	0.1174	0.1031
Surgical Specialty	1	0.0476	0.0438
"RAP" Specialty	1	0.6934	0.7346
Single Specialty Practice	1	0.3591	0.3538
Multi Specialty Practice	1	0.0001	0.0001
Practice Size	1	0.9685	0.9458
Income	1	0.1045	0.1068
Medicare Practice Share	1	0.0345	0.0379
Medicaid Practice Share	1	0.0001	0.0001
Hassle Factor	1	0.0642	0.0631
Electronic Billing	1	0.0001	0.0001
Ownership of Equipment	1	0.4202	0.4223

the relative predictive powers of the two models may be attained. This technique is acceptable in situations in which the categorical sets are approximately equal in magnitude. In the case of Hypothesized Model I, this test is satisfied given the presence of 1012 physicians as nonparticipants and 976 physicians as participants under the Medicare program.

The third hypothesis tests the relationship between autonomy and the decision not to participate yet not balance bill the patient either in fifty percent or more of possible chances. The expected relationship and the null hypothesis would reveal an equal preference for each of the five major cited motives for nonparticipation. The null hypothesis may be stated as follows:

$$Ho: P1 = P2...P5$$

The alternative hypothesis is:

$$Ha: P1 \neq P2...P5$$

A chi square "goodness of fit" technique permits the researcher to determine whether a significant difference exists between the observed number of cases falling into each category and the expected number based on the null hypothesis for each category.

LIMITATIONS

There are significant advantages with regard to the magnitude of sample size, national basis of the sample, research design sophistication, and economy of time and expense which are direct benefits of the use of secondary data derived by the 1988 National Survey of Physicians. Moreover, interpretive analyses of the data beyond the interpretation of descriptive statistics have not been undertaken to date.

At the same time, certain elements which might have been included in the development of primary data were not included in the PPRC survey. Moreover, the assurance of confidentiality provided to each participant by the PPRC as a condition of their participation precluded subsequent contact with those participants to develop further information, however desirable it might be.

This study focused on the impact of physician characteristics in relation to the decision to accept assignment or to balance bill the patient. Practice characteristics provide the greatest number of independent variables considered in this study, and in previous studies of assignment and balance billing as well.

Unfortunately, the demographics of physicians were not

complete. A prominent exclusion was the gender of the respondent. Rice and McCall found gender of the physician submitting claims to be a significant predictor of willingness to accept assignment and not balance bill. They found that female physicians were strongly positively associated with acceptance of assignment, showing a positive association in their model at a one percent confidence level (Rice and McCall, 1983, 52). Thus, this was in important omission from the PPRC survey.

A second standard element of major physician surveys has been age of the physician. This element would be especially helpful in identifying differences in attitudes toward either clinical or economic autonomy as the physician ages, and whether ideological shifts can be detected across generational categories. There is also prior application of this parameter to other studies of physician assignment behavior. Mitchell, Rosenbach, and Cromwell have hypothesized that the older physician is more likely to assign claims than his or her younger, less experienced counterpart (Mitchell, Rosenbach, and Cromwell, 1988, 23).

A third limitation of the study was the exclusion of practice costs as a factor in the assignment decision. This was included in the PPRC survey of physicians, but was excluded from the secondary data set for this study because

of a high incidence of nonresponse to this question.

Practice costs have been an item for consideration in prior studies of assignment decisions, but with weak empirical support. Paringer hypothesized that physicians with higher practice costs for staff would be less likely to assign claims, presumably as a result of the need to generate greater revenues to cover these costs. Her research, however, found no significant association between practice costs and assignment of physician claims (Paringer, 1980, 84-85). A somewhat related finding was that of Mitchell and Cromwell, who noted that physicians with higher practice costs specifically related to collection efforts were more likely to assign than those reporting lower costs (Mitchell and Cromwell, 1982, 62).

The earlier hypothesis of Paringer was tested again after the implementation of the Participating Physician program, with similar results. The fact that physicians paid higher wages and incurred higher costs were not found to have significant effects on Medicare participation (Mitchell, Rosenbach, and Cromwell, 1988, 20). Given the fact that the variable of practice cost has been tested on several occasions and has been found to be inconclusive, its exclusion from the current study does not appear to be a major limitation. Its inclusion would, however, have been of interest to determine if similar results would prevail

given the available data set and the specific models tested here.

An exclusion similar to that of practice cost is that of malpractice insurance cost. As noted earlier, this subject constituted a distinct section of the 1988 National Survey of Physicians, and has been a topic of considerable interest to policy makers in the area of physician costs of service. Malpractice costs have been identified by Mitchell, Rosenbach, and Cromwell to have contributed to assignment decisions of physicians. They found a significant association between higher malpractice costs and physicians' unwillingness to sign participation agreements (Mitchell, Rosenbach, and Cromwell, 1988, 20). However, the impact of this variable proved to be small in their regression analysis of assignment decisions, and may well reflect overlap with other factors associated with high malpractice expense such as location and specialty which are included in this study.

One variable which was included in the secondary data analysis in a form less than optimal with regard to study design was that of income of the physician. An income question was not included in the 1988 National Survey of Physicians, yet it has an obvious and critical relationship to the question of economic autonomy. Because these data were not available from the PPRC, an extrapolation was made

from the reported median incomes of physicians as cited in the AMA Center for Health Policy Research's <u>Socioeconomic</u> <u>acteristics of Medical Practice 1988</u>. This method ed the income of physicians within a specialty ding using the AMA categories used in the <u>1988 National Survey of Physicians.</u> The indirect nature of this relationship is a limitation of this study, as there is no assurance that surveyed physicians would necessarily equal the aggregated incomes reported through the AMA's research.

A methodological limitation of the study is its design as a cross-sectional study rather than one based on time series. This research is designed to assess physician attitudes and characteristics at one point in time as depicted in the 1988 survey. To the extent that important decisions related to participation and the use of balance billing may have been made years earlier, the the respondents may not have an accurate recollection of motives underlying the participation decision. In addition, given the gradual increase in the participation rate from 1984 to present, it would also be desirable to assess the changes in attitudes which have resulted in the changed responses to the assignment and participation decision.

In summary, four limitations pertaining to the elements of the data set which constitute information on the physician respondent, and one related to the methodological design of

the study, constitute the identified limitations of the secondary analysis.

The literature review developed the concepts of professional autonomy and noted the development of the substrands of clinical and economic autonomy in the recent history of the medical profession. The research problem confronts the difficulty involved in grounding a theoretical scheme in a form which lends itself to empirical analysis. The development of balance billing as an expression of physician economic autonomy was developed in the theory construction section of this chapter, and does not directly address the attendant question of clinical autonomy.

It was beyond the scope of this study to measure and analyze the full dimension of professional autonomy in both its clinical and economic spheres. It is reasonable to conclude that professional autonomy can be implied or inferred given the presence of economic autonomy. The issue of economic autonomy can be tested to an extent in the regression models used in this study, which address those factors influencing decisions to participate or not and whether or not to balance bill. The measurement of expressions of clinical autonomy is best accomplished in the attitudes voiced in the subjective responses of nonparticipating physicians who do not balance bill.

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CHAPTER IV

DATA FINDINGS

DESCRIPTIVE FINDINGS

Before looking at hypothesized relationships, descriptive data were examined. The descriptive data were examined prior to the model testing in order to gain an appreciation of underlying trends. This section presents the dependent and the independent variables used later in the analytical model.

MEDICARE PARTICIPATION RATES

Table 4.1 shows a frequency distribution of participation in the Medicare program by respondents to the survey included in the secondary data set. The table shows that 49.1 percent of the respondents participated in the Medicare assignment program at the time of the survey in 1988, while 50.9 percent did not. (It is important to note that the rate of participants exceeds the national reported rate for 1988 of 41.5 percent of physicians who indicated they did participate.) A portion of this difference is accounted for by exclusion from the sample of certain low participating specialties, such as psychiatry (PPRC, 1989, 15).

An illustration of the percentage of patients accepted on assignment by the subset of surveyed physicians who do not participate in the Medicare program is provided in Table

TABLE 4.1

Frequency Distribution of Surveyed Physician Participation in Participating Physician Program

Participation	Number	%
Yes	976	49.1
No	1012	50.9
	1988	100.0%

4.2. The analysis shows that nearly nine percent of nonparticipants accept no patients on assignment. Of those physicians not participating, approximately 25 percent accept more than one half of their patients on an assigned basis. This group will provide the basis for further analysis beyond the two regression models through use of chi square analysis, as these individuals appear to defy rational economic models of maximization of gain.

PRACTICE CHARACTERISTICS

In Table 4.3 the mean score and range for the five interval level independent variables used in this study are displayed. The results indicate that the average size of the group in which physician respondents to this survey practice is 4.6 members. The range of practice size extends from solo practice to 400 members.

The average physician income based on application of median income by specialty included in this study is $143,000, with a range of median incomes from $85,000 to $204,000 annually. These figures are medians by specialty group rather than individual observations. Since median values are used, the range reported here may considerably overstate or understate the actual range of earnings were individual observations available rather than the statistical grouping used here.

TABLE 4.2

Percentage of Patients Accepted on Assignment By Non-Participating Physicians

Acceptance Percentage	Number	Percent	Cumulative %
0	88	8.7	8.7
1 - 9	210	20.7	29.4
10-19	209	20.7	50.1
20-29	143	14.1	64.2
30-39	68	6.7	70.9
40-49	40	3.9	74.8
50-59	84	8.3	83.1
60-69	16	1.6	84.7
70-79	33	3.3	88.0
80-89	28	2.8	90.8
90-99	25	2.5	93.3
100	25	2.5	95.8
Other Responses	45	4.2	
Total	1012	100.0%	

TABLE 4.3

Mean and Range of Continuous Level Independent Variables

Variable	$\bar{X}$	Range
Number of Physicians in Practice	4.6	1 - 400
Physician Income	$143,400	$ 85,000 to $204,000
Percent of Medicare Patients	44.9	0 - 100
Percent of Medicaid Patients	12.2	0 - 98
Hours Administration	4.3	0 - 50

The percentages of Medicare and Medicaid patients included in a physician's practice are deemed to be important predictors of physician behavior in Hypothesized Models I and II. The average percentage of Medicare patients included in practices of respondents in this study was 45 percent, with a range of no Medicare patients to practices which consist totally of Medicare patients. Medicaid coverage in addition to Medicare accounts for a considerably lower percentage of practices of respondents, averaging twelve percent of practices. Medicaid coverage ranged from no Medicaid patients to 98 percent of a physician's practice.

Respondents reported an average of 4.3 hours spent each week on administrative tasks. A reported range of zero to fifty hours was noted, possibly reflecting the differing practice settings of physicians and the corresponding administrative demands placed on them.

Table 4.4 shows the frequency distribution and percentage of physician characteristics, which were reported as nominal level independent variables. Board certification is an attribute of a significant majority of the respondents, totaling 1,536 physicians or 77.3 percent of the group surveyed. Only 457 respondents, or 22.7 percent of the survey group, were not responded. This finding may

TABLE 4.4

Frequency Distribution of Nominal Level Physician Characteristics

Variable	N	%
Board Certification		
Yes	1536	77.3
No	452	22.7
Total	1988	100.0%
Location		
Rural counties	374	18.8
Small SMSA	567	28.5
Large SMSA	1047	52.7
Total	1988	100.0%
Specialty		
Family Practice	267	13.4
Medical Subspecialty	678	34.1
Surgical Specialty	844	42.5
Hospital Based (RAP)	199	10.0
Total	1988	100.0%
Practice Type		
Single Specialty	740	37.2
Multi Specialty	211	10.8
Solo Practice	1037	52.2
Total	1988	100.0%
Electronic Billing		
No	961	48.3
Yes	1027	51.7
Total	1988	100.0%
Diagnostic Equipment		
Yes	1102	55.4
No	886	44.6
Total	1988	100.0%

well reflect the stratification of the sample which included significant categories of medical subspecialists as well as an exceptionally large grouping of general surgeons, both of which would be more likely to attain board certification as a condition of sustained specialty or subspecialty practice.

Practice location indicates a smaller representation of physicians in rural counties, with 374 respondents or 18.8 percent of the total. Physicians located in smaller SMSAs with populations under one million included 567 respondents, or 28.5 percent of the sample. Physicians in large SMSAs comprised the majority of respondents, representing 52.7 percent or 1047 individuals.

For the purposes of this study, four major specialty groupings were identified. The category of general practitioner and family medicine specialist comprised 13.4 percent of respondents; medical specialists include 34.1 percent of the total; general surgeons and surgical subspecialists include 42.5 percent of respondents; while RAP (Radiology, Anesthesiology, Pathology) specialists constituted 10 percent of the sample.

Three practice organizational types were examined. Multi-specialty groups included 37.2 percent of respondents; while single specialty group members included

10.8 percent. Fully 52 percent of respondents identified themselves as solo practitioners.

The last two variables represent physician entrepreneurship. Table 4.4 shows that 48.3 percent of respondents do not engage in electronic billing; while 51.7 have the capability to bill patients or insurers through electronic modalities. With respect to ownership or lease of office-based diagnostic equipment, 55.4 percent of respondents reported that they owned or leased one or more prominent items of equipment for use within the office. Such equipment included for purpose of this study included laboratory equipment, X-ray machines, EKG machines, non-invasive vascular equipment, and mammography equipment. The presence of such equipment might reflect the technological sophistication of a physician's office as well as the ability to generate fees through use with patients in the office.

The descriptive data provides a profile of the variables used in this study. The next section of the findings will proceed to test the hypothesized models through application of multivariate statistical analyses.

HYPOTHESIZED MODEL I: PHYSICIAN DECISION TO PARTICIPATE

This model tests characteristics of physicians who elect

either to sign a binding agreement to participate or decline to participate in the Medicare program as a participating physician. In participating, the physician waives his or her ability to balance bill any patient for Medicare covered services, and may collect only co-pays or deductibles. A rational choice argument may be made for either option, as the participant is paid at a higher rate by Medicare than the nonparticipant, and receives faster payment as well as listing in a directory of participating providers. Those who do not participate but do balance bill may achieve a higher level of payment at the risk of bad debt should the patient not pay the billed amount or the balance. In addition, patients may be disuaded from seeking care from a nonparticipating physician for fear of added personal expense as well as the paperwork involved in filing the claim for the service provided.

The model used here borrows from the approach used by Rice and McCall in assessing the characteristics of physician assignment of Medicare claims on a case by case basis prior to the enactment of the Participating Physician program (Rice and McCall, 1983, 50). The total sample (N=1,988) used in the Ordinary Least Squares regression model was drawn from a target population of all physicians billing the Medicare program, including those who participate and those who decline.

The results of this regression analysis are displayed in Table 4.5. The model will be analyzed through discussion of the independent variables which comprise the model, followed by a summary analysis of the explanatory power of the model as a whole.

TABLE 4.5

Ordinary Least Squares Regression for
Participating Provider Status:
Hypothesized Model I
(N = 1988)

Y Intercept .23
R^2 .062
F 8.78
P < .0001
N = 1988

Predictor	Beta Coefficient	S.E.	T Test
Rural			
Urban	.091*	.031	2.88
Suburban	-.0007	.033	-0.002
Non Board Certified			
Board Certified	-.064*	.027	-2.35
General and Family Practice			
Medical Specialist	.064	.041	1.56
Surgical Specialist	.101*	.050	1.98
RAP Specialist	-.023	.060	-0.39
Solo Practice			
Multi-Specialty Practice	-.024	.027	-0.91
Single Specialty Practice	-.215*	.042	-5.05
Practice Size	.000	.000	0.04
Income	.000	.000	1.62
Medicare Practice Share	.000*	.000	2.11
Medicaid Practice Share	.004**	.000	5.54
Administrative Hours (Hassle Factor)	-.004	.002	-1.85
No Electronic Billing			
Electronic Billing	.120**	.025	4.88
No Diagnostic Equipment			
Diagnostic Equipment	.020	.026	-0.80

*Significant at the 5% level

**Significant at the 1% level

LOCATION

Location and the physician's practice was hypothesized to have a relationship to the decision to agree to become a participating physician. It was suggested that rural practitioners would be immune to the competition present in urban areas with multiple providers. Further, practitioners in smaller population areas were hypothesized to be more politically conservative and hence resistant to "governmental" programs.

One of the two location dummy variables, urban practice location, is significantly different from the reference group [rural location]. The coefficient for small urban is not significantly different from zero; that is, this participation behavior did not differ significantly from that of rural physicians.

BOARD CERTIFICATION

This model hypothesizes that board certification would be related to participation in that non-board certified physicians would be more likely to participate in the program. The findings show that the dummy variable for board certification is significantly different than that for non-certification with board certified physicians less likely to participate. Specifically, the results show that

board certified physicians participate in Medicare assignment 6% less often than non-board certified physicians. This supports the hypothesis that non-board certified physicians accept assignment. They are probably less able to control price for their services than are board certified specialists. This latter may be perceived as offering services of demonstrably inferior quality or in restricted specialties.

SPECIALTY

The model predicts that the specialty of the physician will be related to the decision of the physician to participate or not as a Medicare participating physician. Specialty choice has been extensively studied as a predictor of assignment behavior in earlier studies. On the basis of previous research findings related to case by case assignment decisions, it had been proposed that specialization in a RAP (Radiology, Pathology, or Anesthesiology) specialty, in which physicians might be subject to institutional policies and less able to control their own billing practices, would be more likely to participate. Surgeons would also be likely participants as a consequence of the large dollar amount of surgical charges and the threat of loss of the total bill to bad debt if a patient did not pay either the balance or the otherwise assured Medicare amount. Competition among

surgeons was also thought to be an influence in this determination. Primary care providers, on the other hand, were thought less likely to participate due to lesser magnitude of bills, lack of competition, and a depressed fee structure for their services which made balance billing economically essential.

Table 4.5 shows that of the three dummy variables only surgical specialty is significantly associated with the decision to participate in the Medicare program. This is possible because surgical specialties are deemed to be competitive and clustered in urban areas. In addition, the literature has identified that surgeons are likely, as a result of their larger bills, to accept assignment in order to avoid the risk of loss of the total fee which might result if payment is expected directly from the patient (Rice, 1984, 39).

PRACTICE TYPE

These results show that one of the practice type dummy variables, single specialty group, differs significantly from the control group for this set, solo practice. It had been hypothesized that multi-specialty group membership would produce a significant difference from solo practice. However, this did not prove to be true. In fact, the single specialty status of physicians has the largest

single effect on the likelihood of participation of any finding. Specifically, single specialty groups participate in Medicare assignment 21% less often than solo practitioners. A likely interpretation is that limited competition occurs for members of these small specialty groups (radiologists, anesthesiologists, pathologists) that offer exclusive services (monopoly over practice.)

However, the results in this model show that RAP specialty membership is not associated with participation. Therefore, this leads to the conclusion that non-hospital based single specialty groups are less likely to participate. These would include diagnostic specialists who may also enjoy the benefit of monopoly through limited availability of services. It is possible that single specialty groups are isolated from specific market forces that affect given competitive specialties such as surgery.

PRACTICE SIZE

This model hypothesized that the size of practice would be related to the decision to accept assignment. Specifically, as the size of the practice increased, the likelihood of participation would also increase. Suprisingly, the results show that the size of the medical group does not relate to the decision to participate. This contradicts certain prior studies which had found this

association. Wolinsky (1982) had pointed to strong concerns for personal autonomy among solo practitioners which were not shared to a similar degree by members of large group practices. This finding, however, does not seem to have carried over into the participation decision.

However, it does correspond to the previous finding which suggested no significant difference between multi-specialty (presumably larger) groups and solo practices.

INCOME

This model hypothesized that physicians with higher incomes were less likely to participate than those physicians with lesser incomes, as this would be consistent with the theoretical assumption of income maximization through balance billing. The finding in Table 4.5 shows that this hypothesis is not supported, and income does not appear to be related to the participation decision.

This area of inquiry was not heavily supported by the literature in development of the hypothesis, although there is an intuitively pleasing dimension to the assertion that income should influence participation insofar as it reflects a decision with economic consequences. This finding may in part be accounted for by the variations in specialty response to participation, in which members of a

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more highly compensated groups (specifically surgical specialists) tend to be more likely to participate. Surgeons represented a significantly higher income level in the AMA study of physician incomes for the sample year, and may thus be presumed to have influenced this finding (AMA Center for Health Policy Research, 1988, 128).

MEDICARE PRACTICE SHARE

The hypothesized model predicted that large percentages of Medicare patients in a physician's caseload would lead to greater likelihood of participation. This was based in part on Feldstein's model of Medicare participation in which physicians with low percentages of Medicare would attempt to offset these patients with full fee paying patients wherever possible (Feldstein, 1988, 193). This model was supported in research findings obtained by Mitchell, Rosenbach, and Cromwell in their assessment that physicians with significant Medicare caseloads were more likely to participate than those without (Mitchell, Rosenbach, and Cromwell, 1988, 22).

The percentage of Medicare patients seen by a physician should be among the most clear and direct predictors of participation. This results from the desire of the provider for assured payment, the presence of a large service population in his/her practice, and the lack of

opportunity for full fee paying patient to replace these patients.

This hypothesis is supported by the research findings, which identify a significant association between the share of Medicare patients in the practice of a physician and the willingness of that physician to participate. A significant finding in this case is not surprising in that the relationship between participation and Medicare volume appears quite plausible. It may be that physicians view participation in the program as an accomodation to the needs and wishes of their existing patients if their Medicare share has been historically large. An alternative explanation is that physicians have sought participating status as a means of attracting more patients in a competitive physician market environment, viewing payment under assignment as more attractive than the absence of such patients or the acceptance of patients paying lesser fees such as Medicaid or certain group contracts.

MEDICAID PRACTICE SHARE

The percentage of Medicaid caseload is significantly related to participation, even more so than the effect of Medicare practice share as noted above. The specific finding in this case regarding Medicaid was not unanticipated given the likelihood that Medicare payment

rates for participating physicians would exceed those paid by Medicaid programs, and would therefore cause physicians to view them as attractive as predicted by Feldstein's model of the participation decision (Feldstein, 1988, 193). In this model, assured payment from Medicare would be preferable to replacing a Medicare patient with a Medicaid patient, so the physician will accept assignment as a strategy to retain the Medicare patient.

ADMINISTRATIVE HOURS (HASSLE FACTOR)

One of the underlying core concepts in the theory of professional autonomy, commentators argue, is the tradeoff physicians are willing to make between clinical and economic autonomy. It stands to reason that the amount of hours devoted to administrative duties would take away from the time devoted to clinical medicine and would consequently be related in some way to professional or economic autonomy.

The findings in this research show the amount of hours spent in administrative issues has no significant effect on the decision to participate. It was anticipated that physicians experiencing fewer hours per week in administrative tasks would be participating physicians, as their administrative burdens would be reduced by the amount of time saved from activities associated with balance

billing and the advantages of claims administration offered by Medicare to participating physicians. Either, the time savings realized are perceived as negligible or the physician may have obligations to other insurance carriers which require extensive administrative work.

This is interesting in that the amount of reported administrative time ranges from zero to fifty hours per week, with a mean of 4.3 reported hours per physician. It might be plausibly argued that this level is not an inordinate number of hours spent in administration, and that perhaps the "hassle factor" argument is overstated or has increased dramatically as an obligation for physicians or a rhetorical device since the gathering of this data in 1988. Despite the range, this does not affect the predictive model.

ELECTRONIC BILLING

The decision to electronically bill has one of the strongest effects on the participation decision, and is positively associated with participation.

This interesting finding reflects other influences such as the economic sophistication of the physician which prompt the investment in billing equipment in order to submit bills more promptly to insurers and to minimize paper

handling. At the same time, it should be noted that a problem exists in attempting to attribute causation to this capability. Given that the Medicare participating physician explicitly rewards physicians who submit bills electronically through prompt payment, it may be that physicians who decide to participate for other reasons are encouraged to obtain electronic billing equipment to enhance their gains from participation. The addition of electronic billing may thus be a sequel to participation, and account for the strength of the positive association reported here.

DIAGNOSTIC EQUIPMENT

The presence or absence of diagnostic equipment is not related to the decision to participate. This relationship had been predicted in that physician operators of such equipment were anticipated to maximize income needed to justify these investments through balance billing, thus choosing not to participate. This finding shows no relationship between participation and operation of such equipment.

SUMMARY: HYPOTHESIZED MODEL I

The model hypothesized that eleven independent variables would have a significant effect on a physician's decision

to participate through execution of a binding participation agreement with the Medicare program obligating the physician to accept assignment of claims in all cases. The hypotheses were derived from the various research studies discussed in the expected relationships developed in Chapter III.

The findings show that seven of the variables --urban practice location, board certification, surgical specialty, single specialty group, high Medicare practice share, high Medicaid practice share, and electronic billing-- are associated with participation. A consistent theme represented in these variables is that of practice in a competitive environment which one would associate with urban location and surgical specialty. Board certification appears to support this effect, since it was correctly hypothesized that board certification would provide a competitive advantage which a physician might choose to exploit economically through nonparticipation. This expected relationship was verified in the findings. The negative association of single specialty group practice to participation is most plausibly explained by the presence of such groups in non-competitive practice situations in which the members may be the sole possessors of a specific diagnostic or therapeutic skill in a given community.

In the instance of the three other variables found to be

significant, economic factors may also be paramount in influencing the participation decision. The presence of a large Medicare volume of patients in a physician's practice may lead the physician to participate in the interest of good patient relations, or conversely to participate in order to attract such patients into the practice and further increase his or her Medicare practice. Physicians with large Medicaid practices may choose to participate in order to maximize Medicare rather than Medicaid patient volume. Electronic billing may be related to structural benefits offered under the Medicare program through more rapid payment of claims and the ensuing financial advantage for the physician.

This model was intended to examine two factors: (1) The effect of each of the independent variables on the dependent variable, and (2) The explanatory power of the entire model to predict assignment behavior of the physician. The total explained behavior of the model was low, $R^2=.062$ ($p<.0001$). This finding was disappointing because the variables did not have greater predictive power on the decision to participate. This will be considered in greater detail in the summary and conclusion.

HYPOTHESIZED MODEL II: NONPARTICIPANTS AND BALANCE BILLING

This model tests the decision of physicians who do not participate in the Medicare Program to maximize income through balance billing of the patient. A rational model of economic maximization would postulate that a physician, having made the decision to forgo the benefits of participant status (higher assured payment rate, prompt payment, directory listing, and assurance of payment) should in all cases pursue the patient for the balance of his/her full fee. Wide variations in this practice have been observed and commented on by policy analysts who suggest that this behavior does not predictably occur. The question to be addressed in this model is a definition of the characteristics of physicians who do not balance bill despite the opportunity to do so and thus forego income which would be available to them as a participant or as a nonparticipant "balance biller."

The dependent variable in this model is comprised of those individuals who do not agree through formal participation agreements to accept all Medicare patients on assignment as measured by the percentage of patients accepted on assignment on a case by case basis. This continuous variable reflects, in other words, the decision of the physician to either balance bill or refrain from balance

billing even though he or she is legally entitled to do so. Thie group from whom this percentage is derived consists of 1,012 physicians drawn from the total sample for secondary data analysis of 1,988 physicians. The results for this model are shown in Table 4.6.

LOCATION

The location of the physicians practice was hypothesized to be an important determinant of balance billing by nonparticipanting physicians. The literature suggests that urban and suburban physicians, having made the election not to participate, will be more likely to pursue balance billing than will rural physicians.

The findings show that this hypothesis is contradicted in the case of urban physicians, who are significantly less likely to balance bill than is the control group of rural physicians. Urban physicians were found to be more likely to participate in the test of Hypothesized Model I, a position which may reflect the competitive forces of an urban market. This finding demonstrates that those physicians who do not participate remain subject to the competitive forces, and may be less inclined to balance bill as a consequence of economic influences which exist in an urban marketplace.

TABLE 4.6

Ordinary Least Squares Regression
for Non-Participating Physicians
(by Percentage of Balance Billing)
Hypothesized Model II
(N = 1012)

Y Intercept	-0.97
R^2	.1174
F	8.442
P	<.0001
N	1012

Predictor	Beta Coefficient	Standard Error	T Test
Rural			
Urban	5.17*	2.46	2.10
Suburban	1.73	2.49	.70
Non Board Certified			
Board Certified	4.81*	2.17	2.21
General and Famiily Practice			
Medical Specialist	7.10*	2.98	2.37
Surgical Specialist	2.99	3.87	.77
RAP Specialist	-0.09	4.74	- .02
Solo Practice			
Multi-Specialty Group	-1.40	2.07	- .67
Single Specialty Group	-1.24	3.08	- .40
Practice Size	-0.14**	.06	-2.50
Income	.00*	.00	2.04
Medicare Practice Share	.06	.04	1.79
Medicaid Practice Share	.64**	.07	8.79
Administrative Hours (Hassle Factor)	.13	.18	.73
No Electronic Billing			
Electronic Billing	-2.87	1.94	-1.48
No Diagnostic Equipment			
Diagnostic Equipment	-2.96	1.97	1.50

*Significant at the 5% level

**Significant at the 1% level

BOARD CERTIFICATION

Economic maximization theory would suggest that a Board certified physician who has made the decision not to participate will in all cases balance bill the patient because he/she has concluded that his/her services are sufficiently differentiated on the basis of special training to support full price payment. The results in Table 4.6 show that the hypothesized relationship regarding board certification and balance billing is contradicted in a very major way. The percentage of acceptance of assignment by board certified physicians is four times as great as that of non-board certified physicians.

This finding has significant ramifications for the theory of economic autonomy. It suggests that those physicians who can "charge what the traffic will bear" on the basis of specific training and restricted expertise do not appear to take advantage of that opportunity to realize full price capture whenever possible.

SPECIALTY

This model hypothesized that primary care physicians who do not participate will be less likely to balance bill than specialty physicians. Arguably, specialists are in a position to extract full price as a result of referral to

them for specific limited needs. In theory, a patient may have a more direct choice of primary care providers which would allow him/her to "shop" for a physician who will offer favorable economic terms. In addition, primary care providers are more likely to be familiar with family economic circumstance and then make allowances to economically compromised patients who may rely on family physicians to a greater extent than referral specialists.

The results in Table 4.6 partly reflect this hypothesized relationship. There is evidence to suggest that the hypothesized relationship is contradicted with respect to one specific group of specialists. Internal medicine subspecialists balance bill patients at a rate 6 times less than of the reference group of primary care providers. In contrast, there is no difference between balance billing patterns of the control group, family physicians and that of surgeons or RAP specialists. Clearly this points to the need to breakdown this hypothesis into more precise categories for analysis. In this case, internal medicine subspecialists receive patients on referral from other physicians. Their charges, while significant, are lower for a patient than those attributed to a surgical fee (OTA, 1986, 104).

PRACTICE TYPE

The model hypothesized here suggested that physicians practicing in either multi-specialty or single specialty groups will be more likely to balance bill patients than will their solo practice counterparts. This relationship was presumed because organized groups, having chosen not to participate, are more likely to follow uniform financial policies which would mandate balance billing than would solo physicians, who would entertain exceptions on a case-by-case basis. In additon, groups would be more likely to contain referral specialists who might set price for service.

Table 4.6 does not support the hypothesized relationship, no relationship exists between practice type and percentage of balance billing by non-participating physicians.

PRACTICE SIZE

The size of the medical group in which the physician practices was believed to be an important predictor of balance billing. The model suggested that physicians in large practices would be more likely to balance bill if given the opportunity than would solo practitioners.

In support of the hypothesized model, Table 4.6 shows there

is a strong relationship between the size of the group in which the physician practices and the percentage of balance billing by nonparticipating physicians. It appears that physicians in larger group organizations are indeed significantly more likely to balance bill than are the reference group of solo practitioners. These physicians, having made a decision as a group not to participate (for instance, as in the case of the Mayo Clinic), are not likely to break with group policy which supports balance billing. If the group has made a decision as a total organization to balance bill, choice regarding individual patients may well be removed from the individual physician and placed with group business staff and handled by policy or restricted exception.

INCOME

The model hypothesized expected a relationship between income of the provider as identified by specialty and the decision to balance bill patients for added income. In this instance, the findings support this theory. A significant relationship between income of the physician and the decision to balance bill is reflected in the findings. This is not suprising given the common sense assumption that balance billing would result in greater income. It should be noted that this finding is in distinction to the finding regarding income and its

influence under Hypothesized Model I. In that instance, income was found to have no significant effect on the one time determination to participate or not. However, on a case by case basis it does become significant among nonparticipants, indicating that the policy of mandating a choice prospectively by physicians of acceptance of assignment may reach the desired objective of more patients seen on assignment than under a case by case system.

MEDICARE PRACTICE SHARE

It was hypothesized that higher Medicare caseloads would lead to a lesser use of balance billing, although one should also note that the existence of a high Medicare population is an indication of a likelihood to participate in the first place. Interestingly, the results show that there is no relationship between the two variables of Medicare patients served and acceptance of assignment. This is inconsistent with the general theory of this study. However, it is interesting that a significant association was seen earlier between Medicare patient load and the participation decision under Hypothesized Model I. This may reflect the general notion that a physician who is sensitive to issues surrounding Medicare patients and develpment of a Medicare practice would be inclined to sign a participation agreement at the outset rather than waiting to make such determinations on a case by case basis, as

might a physician with a lesser Medicare patient share.

MEDICAID PRACTICE SHARE

The hypothesis posed that individual physicians with lower levels of Medicaid dependence will engage in balance billing as they are able to fill practices with fee paying patients. The results in Table 4.6 support the hypothesized relationship, as the percentage of Medicaid caseload increased as a percentage of the total caseload of the physician, the acceptance of assignment by the physician increased. The magnitude of this relationship is much more pronounced than with the percentage of Medicare caseloads (a beta coefficient of .64 compared to a slope of .06 in the instance of Medicare).

ADMINISTRATIVE HOURS (HASSLE FACTOR)

The hypothesis suggested that physicians evidencing high "hassle factor" as measured by hours of administrative work per week will be more likely to pursue added income through balance billing than will those showing lesser hours in administrative matters. The findings do not support the hypothesis, showing no association between these variables.

ELECTRONIC BILLING

The model hypothesized that those physicians engaged in electronic billing will be more likely to balance bill patients as they will have sufficient technical expertise and motivation to affect costs associated with electronic billing. The findings reveal no association between these variables, indicating that billing sophistication is not a contributing factor in this model.

DIAGNOSTIC EQUIPMENT

The model hypothesized that those physicians who own diagnostic equipment will engage in balance billing at a significantly higher rate than those who do not. The results in Table 4.6 show no relationship between equipment ownership and balance billing by nonparticipating physicians, indicating that individuals are equally likely or unlikely to balance bill in spite of the presence or absence of such equipment.

SUMMARY: HYPOTHESIZED MODEL II

This model was based on an economic behavior model for physicians. The choice of a physician to accept assignment has great implications for professional autonomy as exemplified through clinical and economic autonomy.

Prior research on physician economic behavior provides considerable direction on what type of factors would determine the amount of balance billing for those physicians who do not participate under the Participating Physician program. Specifically, Rice and McCall (1983) have noted that physician characteristics are the single most influential set of predictors in their study of case by case Medicare assignment decisions.

This hypothesized model consisted of eleven independent variables examined in relationship to the dependent variable of the percentage of patients accepted on assignment and not balance billed by nonparticipating physicians. Six of the eleven variables in the the research results display a significant relationship with balance billing among nonparticipants. Table 4.6 shows that a total of 11.7% of total variance is explained in this model as evidence is its achieved R^2 value ($p<.0001$). The explanatory power of this model is nearly twice as great as the first hypothesized model which examined the participation decision.

HYPOTHESIZED MODEL III

Greater understanding of the motivation of those physicians who defy classical economic models of profit maximization

through failure to balance bill can be gained from an inspection of additional empirical data analyzed in this research. The hypothesis developed in Chapter III in conjunction with this problem is that physicians who do not participate yet do not balance bill patients (accept assignment) in fifty percent or more of their Medicare cases will cite ideological rather than economic justifications as the predominant basis for their action. This ideological basis for action is linked to a desire for preservation of clinical autonomy.

Table 4.7 contains a frequency distribution in addition to an accompanying statistical analysis of all nonparticipating physicians who accept Medicare assignment on 50-100% of their Medicare patients. The analysis shows that 196 (10% of the total sample) of the physicians in this study do not participate in the Medicare Participating Physician Program, yet accept assignment in more than half of all opportunities. It should be noted that the payment they received in such instances was at least four percent lower at the time of the survey (1988) than that of participating physicians.

Five major groupings of responses were identified on interview to explain what would appear to be an economically disadvantageous choice by the physicians involved. These responses were elicited by the specific

TABLE 4.7

IDEOLOGICAL VIEWS OF NON-PARTICIPATING PHYSICIANS WHO ACCEPT ASSIGNMENT ON 50-100% OF THEIR MEDICARE PATIENTS

Chi-Square Analysis

$X^2 = 13.8$ Ho: $K_1 = K_2 \ldots K_5$

DF = 4 Ha: $K_1 \neq K_1 \ldots K_5$

$P < .01$ (2 tail test) DF = K-1

CATEGORY	N	%
Classic Autonomy	33	22.8
Economic Autonomy	49	33.8
Anti-Government Ideology	28	19.3
Hassle Factor	21	14.5
Inadequate Payment Level	14	9.6
	145	100.0%

(Other responses or Non-Respondents totaled 51)

question "If you currently accept 50-100% of your Medicare patients on assignment, which is a fairly high rate, what have you not chosen to become a participating physician?

The first of these response groupings is identified for summary purposes as classical autonomy, pertaining primarily to the individual physician's control of his/her work. Typical responses derived from the Data Codebook of the Physician Payment Review Commission developed by Westat, Inc. (1989) included "Solo/ independent/want to accept/decline choose assignment on an individual level/ freedom of choice/accept for some patients/procedures." The second grouping was classified as representative of economic autonomy, and includeed such responses as "Principle/believe in fee for service/those who can afford fees should pay them/prefer to set own fees." The third grouping was labeled "anti-government ideology", and consisted of such responses as "Don't wish to submit to or work for Federal government/to protest government/third party intervention." The fourth group, clustered around the "hassle factor" in medicine, included responses such as "Too much paperwork/headaches/pain/confusion/collection problems/promises broken." The fifth grouping cited payment inadequacies, and included "Payment/reimbursement is too low/costs/overhead is too high/my profile/MAAC is low?I can bill more if not participating." (Westat, Inc., 1989, B-5).

The findings in Table 4.7 based upon the above categories of responses indicate that the most often cited motivation is preservation of economic autonomy. Fully one in every three respondents (N=49) cited preservation of economic autonomy as their greatest reason not to participate. These reasons included principle, belief in fee for service, those who can afford fees should pay them; and a preference to set one's own fees. These beliefs, while supportive of maintenance of an economic independence, are actually not carried out in practice. In effect, the physician states that he/she wishes to control price, but does not pursue full attainment of price as this can be achieved only by balance billing of the patient--a practice that physicians forgo at least fifty percent of the time. For this group on a practical level economic autonomy does not equal economic maximization.

The second most prominent reason may be described as "classical autonomy." Nearly 23% of respondents (N=33) indicated that the reason for accepting assignment for the majority of their patients was due to considerations of freedom of choice. Under this rubric, physicians indicated that they wished to participate on an individual basis, and to accept specifically in the instance of some patients or procedures. This corresponds to the classic profile of physicians who did not accept assignment prior to the

enactment of DEFRA 1984.

Twenty percent of respondents (N=20) cited "anti-government ideology" as the primary reason for not particpating but not balance billing. This attitude reflects that of "traditional physicians" identified by Harrington as "supporting the status quo of the health care system by advocating fee-for-service; pluralistic delivery system; volunteerism by the medical profession; and the use of private insurance companies as intermediaries" (Harrington, 1975, 913). Again, this response raises the question of why these physicians do not simply proceed to balance bill the patient given that this action does not appear to contradict their ideological set.

A very small minority of the respondents cited "hassle factor" or payment level as a practical basis for their decision not to balance bill. In this case, fifteen percent (N=21) cited hassle factor considerations; while the percent (N=14) cited payment inadequacy. The interesting aspect of this set of findings concerns the pragmatic nature of these objections versus the more abstract ideological objections cited in the three previous examples. This appears consistent because if a physician wished to avoid as fully as possible administrative "hassle", he or she should logically simply choose to participate. Conversely, if inadequacy of payment is the

primary objection, he or she can remedy this by not participating but balance billing to achieve full fee collection.

When subjected to chi square analysis, the findings show there is a significant difference in the motives reported for not balance billing. The test reported in Table 4.7 (x^2,two tail) shows a chi square result of 13.8, resulting in a probability of less than .01 of random distribution.

The most intriguing discrepant finding is the high interest in economic autonomy as the most prominent reason for not participating coupled with the failure of the respondents in this group to pursue maximization. This constitutes a consistent adherence to economic autonomy despite disadvantageous consequences. In this instance, the physician is paid less for the privilege of preserving his or her economic freedom. One can conclude that the emphasis in this apparent contradictory behavior is on "freedom" rather than "economic", in the sense that preservation of the choice is of greater importance than maximization of revenues. Either of the other two strategies discussed in this paper, participating or not participating but balance billing, would produce a superior economic return. This finding demonstrates a strong if perhaps misdirected resistance within a limited segment of the medical profession to external intervention in what are

perceived to be issues traditionally controlled by the physician.

A somewhat different picture develops, however, when the primary reasons physicians did not choose to balance bill were supplemented by their stated second preferences. Second responses were obtained from 29 of the 145 physicians in the original data set. When these responses were added, the percentage citing the classical autonomy grouping as a reason for not balance billing increased from 22.8% when only first responses were considered to 25.9% as reported in Table 4.8. Similarly, the relative importance of economic autonomy is diminished as second level responses are included.

When the revised sample including secondaary reasons for not balance billing is subjected to chi square analysis, the findings also indicate a significant difference in motives for not balance billing. The test reported in Table 4.8 (x^2, two tail) displays a value of 21.8, resulting in a probability of less than .01 of random distribution.

The critical observation in this instance is the increased expression of concern for for values of classical autonomy, or non-interference in the clinical aspects of medical practice. This concern reflects the expected relationship

TABLE 4.8

Ideological Views of Nonparticipating Physicians
Who accept Assignment on 50 to 100% of Medicare Patients
Including Second Reason
Chi-Square Analysis

$x^2 = 21.8$ Ho: $K_1 = K_2 \ldots K_5$

DF = 4 Ha: $K_1 \neq K_2 \ldots K_5$

$P < .01$ DF = K-1

Category	N	%
Classic Autonomy	44	25.3
Economic Autonomy	52	29.8
Anti-Government Ideology	35	20.2
Hassle Factor	25	14.4
Inadequate Payment Level	18	10.3
	174	100.0%

hypothesized at the outset of thise section, in which it was proposed that physicians who do not balance bill waould be more concerned with these ideological issues rather than economic ones. However, it should be noted that this is clearly a result of a significant expression of secondary preference for this position after economic reasons have been stated. In this instance, the ideological position may well reinforce the economic objection to participation in Medicare as a participating physician, no matter how disadvantageous such a position might prove economically.

This chapter has reported the data findings associated with the three hypothesized models developed in this study. The data described here do not consistently support the overall predictive power which had been anticipated in each of these models. The implications of these findings for the theory of autonomy, the development of future research, and the application to health policy will be developed in the concluding chapter.

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CHAPTER V

INTERPRETATION AND CONCLUSIONS

This study was designed to examine at a specific point in time (1988) the state of physician autonomy as reflected in the response of physicians to a national survey. The specific problem addressed was the response of physicians to a fundamental change in Medicare policy which created the opportunity for physicians to declare themselves participating physicians and forgo their freedom to set prices with patients through balance billing of total fees.

It may be argued that this represents the institution of the first step of the gradual imposition of a program of fee control by the state over physician practice. If this is so, a critical element of professional autonomy will have been removed with regard to the ability of physicians to control practice through the setting of their prices. This blend of economic freedom into the profession's ability to self-regulation constitues the "flaw" of professional autonomy that Freidson identified.

The key question is whether the debate over economic interests has eclipsed the preservation of clinical autonomy for the profession. As early as 1970, Glaser observed that "if they obtain enough income and clinical autonomy in hospitals, polyclinics, and other organized establishments, most doctors in the world seem happier without the expense and trouble of equipping and managing their own enterprise" (Glaser, 1970, 293-294). The initial

derivation of autonomy is, after all, the control of the conditions of one's work on an organized basis without intervention of forces outside the profession. As Reinhardt would argue, economic concerns of the profession have often surpassed concerns for clinical autonomy and resulted in levels of interference European physicians would consider intolerable (Reinhardt, 1988, ix).

The critical policy problem is the linkage of the profession's concept of autonomy to a specific model of payment; namely that of fee-for-service. As the physician enters into specific programs where payment is set contractually, he or she becomes a "price taker" rather than a price setter, and power is transferred to other entities such as the state or private insurers. The creation of the Participating Physician Program represents the largest nationwide experiment in securing this transformation, given that Medicare payments accounted for 24 percent of all physicians service expenditures nationally in 1990 (PPRC, 1992, 6).

SUMMARY OF FINDINGS

The precursor study for the development of the Hypothesized Models I and II in this work was that of Rice and McCall (1983), which featured a model designed to predict physician acceptance of assignment on a case by case basis

using the elements of physician characteristics; service characteristics including economic consequences; and beneficiary characteristics. In contrast, Models I and II in this study examined only physician characteristics. This was done in part due to the theoretical focus of this study on physician autonomy; but also in part in response to Rice and McCall's finding that "characteristics of the physicians themselves proved to be the most important determinant of assignment rates" (Rice and McCall, 1983, 54).

The first model testing produced an explained variance of R^2=.062. To the extent that this leaves 94 percent of unexplained variance, this model is of low value in its explanatory power. When compared with the R^2 achieved by Rice and McCall of .23, it suggests that other factors in the Rice and McCall model may be influential in determining the participation decision of physicians. These factors include economic influences and characteristics of beneficiaries.

It is important to remember that Hypothesized Model I is testing a problem which did not exist at the time of the Rice and McCall study, as their 1983 work predated the establishment of the Participating Physician Program and the necessity of a binding decision on the part of the physician to commit to accept all Medicare patients or

assignment. Instead, the Rice and McCall model dealt with multiple assigned claims put forth by individual physicians, so that the dependent variable is claims assigned rather than participation.

It is probable that with the establishment of the 1984 Participating Physician Program that economic determinants of the physician are dealt with at the time of the once a year decision to commit to participate or not. The individual physician will commit him or herself on a one time basis to a choice that is in effect played out in every Medicare patient encounter in the Rice and McCall study, as well as in Hypothesized Model II--namely, whether to balance bill the patient.

On examination of those independent variables in Hypothesized Model I which were found to be significant--urban location, surgical specialty, electronic billing, the presence of a large Medicaid percentage in one's practice, and the presence of a large Medicare portion of one's practice were found to be positively associated with participation. Negative association existed between participation with board certification and single specialty practice in contrast to solo practice.

In examining this set of findings, certain patterns emerge which point to an economic interpretation of the

information. One pattern may be identified as an urban/competitive cluster in which physicians practicing in urban areas, espcially those with significant Medicaid populations are inclined to participate and accept assignment in part to avoid the risk of nonpayment which is entailed in accepting patients on a nonassigned basis. A second possible explanation is competition in urban areas, which may require the physician to accept patients and avoid pricing him or herself "out of the market" through balance billing.

Feldstein (1988) argues that assignment is a function of gradually diminishing payment alternatives. If a physician can bill his or her patients with full fee paying patients, he or she need not accept any patients at less than full fee, as is true if he or she participates. The only way that full fee payment can be attained from a Medicare patient is balance billing. In the instance of a Medicaid patient, the payment is almost assuredly below Medicare's payment to participating physicians, which will cause the physician with a large Medicaid population to accept the Medicare assigned patient as marginally more attractive in an economic sense than the Medicaid patient already in his or her practice. This hypothesis appears to be supported by the finding that both high Medicare and Medicaid practice shares are positively associated with participation.

A corroborating phenomenon is the finding that surgeons are more inclined to participate. This finding confirms two widely accepted hypotheses among economists that surgeons are likely to avoid risk of non-payment due to large relative sized of surgical bills. (Feldstein, 1988, 192). As a result, surgeons willingly accept the lesser but assured payment of Medicare rather than risk total loss of payment through depending on the patient for the Medicare portion of the fee and the balance as he or she must as a nonparticipating provider.

Conversely, the negative relationship of board certification to participation may result from the ability of the board certified physician to pick and choose among possible patients as his or her certified state makes his or her services more attractive. As noted previously, Wilensky and Rossiter (1983) identified a 13 percent fee premium which board certified physicians command over their non-certified collegues. The result is that physicians with board certification are still able to set price rather than accepting lesser payments if they can remain exempt from competitive forces.

Members of single specialty groups comprise a relatively small portion (ten percent) of the sample. Their lesser rate of participation in Medicare may be due to the lower

incidence of competiton for those individuals. Insofar as a group represents the only source of a specific medical or surgical specialty capability in a community, or exists under contract as an exclusive provider of service to a given institution (as in limited privileges for cardiac catheterization services in many settings), the single specialty may be in a position of "price setter" able to dictate economic terms in the absence of competition from other physicians.

The interpretive finding in this case is that economic influence may become of greater consequence when the individual is presented with a commitment decision based on a one time choice. McMillan and collegues (1985) reported that assignment rates would fall by ten percent if participation were placed on an all or none basis. In effect, Medicare policy has avoided the all or none dichotomy by providing incentives to participate, which avoid direct sanctions to nonparticipants.

The institution of maximum allowable rates for balance billing, however, has effectively introduced a de facto if not de jure limitation which makes nonparticipation increasingly econmically unattractive. As the allowable recovery from balance billing has been limited to the lower of the 1991 limiting charge or 120 percent of the fee for nonparticipating physicians, the rates of participation

jumped by a dramatic 4.5 percent of all physicians between 1991 and 1992, or from 47.6 to 52.2 percent of physicians. In 1993, charges are limited to 115 percent of the Medicare allowed payment (PPRC, 1992, 16).

At this point, nonparticipation is effectively eliminated as a rational economic choice by physicians, as the fifteen percent margin beyond Medicare allowable fees barely covers the cost in a typical physician practice costs of billing, collection and bad debt (American Society of Internal Medicine, 1990, 8). Thus, after the time frame of this particular study, policy changes have confirmed the interpretation of economic forces in participation decisions through the evidence provided by dramatic increases in participation rates.

The second hypothesized model identified considered nonparticipating physicians' willingness to balance bill patients based on the rate of claims assigned by each provider. In effect this is similar to the pre-DEFRA research studied by Rice and McCall, with a profound policy difference. In the pre-DEFRA era, Rice and McCall's sample of physicians included all physicians accepting Medicare patients.

In this analysis, all participating physicians (totaling 49.1 percent of the sample) have been eliminated as their

choice concerning assignment has been irrevocably made. The remaining physicians are free, as was true before DEFRA, to decide on a case by case basis whether to balance bill or not. A model of economic maximization suggests that balance billing should occur as frequently as possible in order to offset the lower rate of Medicare payments to nonparticipants and achieve full fee recovery.

In this instance, the explanatory ability of Hypothesized Model II is twice as great as that of Hypothesized Model I. An explained variance of R^2=.1174 results from the testing of the model, indicating a moderate level of explanatory ability with respect to case by case assignment decisions. This compares to the explained variance R^2=.23 reflected by Rice and McCall.

It is noteworthy that the physician characteristics used in Hypothesized Model II has an explanatory level approximately half of that attained by Rice and McCall, who used the added factors of service and beneficiary characteristics. The implication is that characteristics of the physician become of greater significance in predicting situations in which decisions are made on assignment. In these cases, economic concerns appear of lesser influence when decisions are made on a case by case basis, rather than under a one-time binding election model of Hypothesized Model I.

Six of the eleven independent variables in the second model proved to have a relationship with the percentage of patients accepted on assignment by nonparticipating physicians. Urban physicians are significatly more likely to accept patients on assignment and omit balance billing than are rural physicians. Similarly, board certified physicians are four times more likely than non-board certified physicians to forgo balance billing.

This is very surprising in both instances in that it was expected that urban and board certified physicians would be able to extract full fee payments. Urban physicians are more likely to refrain from this practice even though legally entitled to do so; perhaps in response to the competitive pressures of urban practice that also make urban physicians significantly more likely to become participating physicians in the first place. It has also been noted that board certified physicians are significantly less likely to participate in the first instance, through a participation agreement. It may be, therefore, that board certified physicians who do not participate and do not balance bill are pursuing ideological values rather than economic return. The second model has uncovered a finding which is inconsistent with previous research. To the extent that this model examines a unique subset of physicians (nonparticipants), a

phenomenon exists which was not expected based on the theoretical relationships.

Nonparticipating internal medicine specialists were seven times more likely than the control group of family physicians not to balance bill. This finding is partially consistent with the predicted relationship, in that internal medicine reflects a blending of general and subspecialty internists. A theory of economic maximization would suggest that internists would exploit an advantage based upon differential training over family physicians. The fact that they do not may point to a more competitive referral driven market for their services.

Income level of the physician emerged as a significant finding when considered in relation to balance billing. In this instance, those physicians with higher attributed incomes proved more likely to balance bill as predicted. The effect of a large proportion of a physician's Medicaid caseload was consistent with the theoretical model. The findings for Model II are consistent with previous research in identifying greater significance for characteristics of physicians and their practices in determining whether on a case by case basis they will accept assignment or balance bill the patient. In this regard, the model draws upon and replicates earlier findings from studies undertaken in the late 1970s.

The development of Hypothesized Model II leads directly to the problem identified in Hypothesized Model III, which asks why a physician, who does not participate but yet accepts assignment (does not balance bill) for greater than fifty percent of patients, does not choose to participate. These individuals, it is speculated, should represent those--for which clinical autonomy is of greatest significance as they are acting in a manner which is economically the least advantageous option when compared with either participating or not participating but balance billing.

Paradoxically, this research shows economic autonomy is cited most frequently by those physicians who do not participate but do not balance bill. This finding, coupled with the apparent lack of interest in the payment level by non-participating physicians, seriously questions the theoretical explanations of classical autonomy, which would have suggested that physicians choosing not to balance bill would be making a statement against intrusion into clinical decisions at the expense of economic gain. Clearly economic autonomy is a critical factor in maintaining non-participating status as demonstrated by these research findings.

Mitchell and Cromwell (1983) reported that 31 percent of physicians would refuse to see Medicare patients if

assignment were made mandatory, and that 29 percent would reduce their caseloads (Mitchell and Cromwell, 1983, 62). Holahan has suggested that "an all or nothing arrangement may result in large numbers of physicians choosing not to participate" (Holahan, 1986, 116). It is possible that the individuals who cite economic considerations are physicians who would cease their involvement with the Medicare program if participation were made mandatory. Indeed, it has been a concern throughout the history of the Medicare program that access will be limited through the loss of providers who object to conditions of the system and withdraw as a result (Blumenthal, 1988, 13).

By creating a policy option in which these individuals have the appearance of choice, which they evidently value over economic return, their involvement with Medicare patients is continued. At the same time, one must remember that this is a small subset of all physicians surveyed, representing approximately ten percent of the total sample. It is unfortunate that these physicians cannot be identified by age, as they may represent an older group of providers who profess conservative economic ideologies, as well as ideologies of the freedom of the profession, but choose not to act on them in relation to individual patients and so do not balance bill.

It would be incorrect to conclude from this research that

clinical autonomy is not important to this group. When all responses reflecting values of clinical autonomy are totaled together and compared to the total of all responses stressing economic circumstances, the results are virtually equal. The fact remains that a surprising proportion of these physicians stress the economic dimension of autonomy given that they have the opporunity to legally and ethically carry out in action their philosophy through balance billing.

ECONOMIC VS. SOCIOLOGICAL PARADIGMS AND THEIR EFFECTS

While the economic forces reflected in the independent variables employed in the models tested in this study result in findings of significance with respect to individual variables, it is important to recall that the total explanatory power of the respective models is limited. This summmary has proposed an economically motivated rationale in which competition or the absence of competition is seen as an explanatory principle.

It is, however, clear that other factors weigh heavily in the decision of individual physicians to participate under the Participating physician program, or to accept assignment in those instances in which they do not participate. This study has not been able to assess the relative influence of social forces which may impact upon

these decisions as these have not been comparably definable and tested to the extent of the economic factors considered in this study. As a result of the weakness of the overall models in this study, one might suggest that economic policy has been so effective that variation has been reduced among physicians, and decisions are made primarily in response to price and market forces.

The earlier study of Rice and McCall (1983), however, reported an R^2 value of only .23 when a more comprehensive range of variables, including not only provider characteristics but service and beneficiary characteristics as well were considered. Thus, in either this study or the study of Rice and McCall there is a considerable unexplained variance when the overall complexity of the participation decision is considered. Those social forces which were not tested within these models may well be responsible for the shortcomings of the interpretative power of the models developed in this study.

POLICY IMPLICATIONS OF THIS RESEARCH

One objective of policy research is to identify factors that can be controlled and manipulated. Several factors are responsible for the increase in health care budget reductions, and the rising price of medical services is one. Through reform of its physician payment system,

Medicare has taken important steps toward restraining growth in program expenditures.

Historically, the way in which the profession would have addressed limitations on price would have been the reallocation of those costs, popularly known as "cost-shifting", to other payers. In the case of the elderly, the relationship is a very direct and clear one--where Medicare has limited payments under Part B, the elderly are directly liable for cost shifting in the form of balance billing.

The study of physician balance billing practice is of policy as well as practical importance. Welch has written that from a public policy perspective that balance billing is "perhaps the most important political issue involved in the prospective payment debate" (Welch, 1989, 34). Balance billing exacerbates the problem the older Americans often experience in affording health care. Income declines 36% for those between ages of 65 to 69 as contrasted to those 85 years and older. At the same time, out-of-pocket costs for medical services increased 77% when the younger group is contrasted with the older (Torrey, 1985, 377).

Berk and Wilensky have suggested that substantial out-of-pocket expense beyond Medicare's coverage may account for the comparatively low level of health service

utilization by elders lacking added insurance coverage (Berk and Wilensky, 1985, 311). Blumenthal and Hsiao have written that the costs of balance billing fall excessively on poor and low income Medicare beneficiaries, and add to their out of pocket costs for medical services (Blumenthal and Hsiao, 1988, 119). The result is a practice of balance billing, which elder advocates deplore as exploitative of those with limited means and a barrier to access to care.

The political response of advocates for the aged has been a call for an outright ban under state licensure laws on balance billing. As of 1991, mandatory assignment as a condition of licensure had been enacted in Massachusetts, New York, Pennsylvania, Vermont, and Rhode Island (Health Systems Review, 1991, 20)). The more moderate Federal response has been the enactment of limits on balance billing in OBRA 1989 and 1990.

The opportunity for research was to examine a policy and its election by multiple physician actors which reflects attitudes toward economic autonomy. Certain aspects of practice may contribute to the choice to balance bill and maximize income, or the paradoxical choice of having the right to balance bill but choosing not to do so. The 1988 Survey results display a practice in transition from relatively unencumbered physician choice to controlled and limited options. As a policy objective, one hopes this

practice is of ultimate benefit to the consumer of physician services under Medicare.

As noted earlier, this study examined physician response to changes in Medicare policy following the discrete event of the enactment of DEFRA 1984. From the time of the enactment of this legislation through the time of the 1988 survey on which this study is based, there was a pronounced decline in the percentage of physician services paid for through balance billing of beneficiaries. Edwards and Fisher reported that in 1984 beneficiaries were paying for 11.5% of total physician obligations out of pocket in response to balance billing, but that this had fallen to 7.7% by 1987 (Edwards and Fisher, 1989, 118). Another significant policy change has taken place as reported in this chapter, in the establishment of balance billing limitations through OBRA 1989 and 1990. This has resulted in the attainment of participation by more than fifty percent of United States physicians in 1992 for the first time since the program's enactment (PPRC, 1992, 16).

The opportunity exists for a new research initiative into these policy changes to reexamine physician attitudes toward balance billing limitations. Now physician publications are discussing what has been evident to observers of physician payment for the last year, namely that balance billing as a rational economic strategy is on

the verge of elimination (Part B News, 1992, 1). A physicians' business newsletter reported that by 1992, "the ostensible margin of not participating in Medicare averages 9.2%, but that assumes you never accept a Medicare patient and never write off bad debt, which is not realistic." Philip L. Beard states "Overall, I think you're being bludgeoned into participation" (Physician's Payment Update, 1992, 210).

As this transformation occurs, only those physicians commited to an ideology of total economic self-determination will remain nonparticipants. A study of the characteristics of these physicians would be instructive to answer the questions of seemingly irrational pursuit of autonomy raised by the small group of nonparticipaing and non-balance billing physicians.

A second directly policy-related argument for further study is the likelihood of extension of health care payment reform to all payers which will emphasize price controls. In effect, the Resource Based Relative Value Schedule with its accompanying limits on balance billing has introduced a strategy of de facto price control which has to this point been remarkably successful in maintaining the appearance of physician economic autonomy in choosing to participate or not in the system. As the reality of the loss of control of pricing decisions by the medical profession becomes more

evident, the reaction of physicians will be critical and should be taken into account in policy design. It should be recalled that the prohibition in balance billing resulted in the Ontario physicians' strike of 1986 (Igelhart, 1986, 207). To date, the multiple payer system of the United States has offered most providers, with the notable exception of rural and inner city providers, the opportunity to select patients from preferred payment sources, or to play such health plans against each other in contract negotiations. With the advent of a single fee schedule, if not a monopsony payer, this opportunity which has sustained economic growth for the profession will be lost or reduced. The policy implications provide the opportunity for future research.

FUTURE RESEARCH

At least three types of follow up research are needed from this study. First, some specification error exists in the models formulated for this research. Specification error can occur in two cases--when a variable is included that is not relevant and when a variable that should be included is omitted (Berry and Feldman, 1985, 18). The empirical findings in this study provide information for both types of specification error. Subsequent models can be developed which refine the variables included in the models, and consequently provide greater specification of the

determinants for the independent variables.

In this regard, several recommendations can be used to improve the methodological techniques in this study. A first and obvious question for all physicians is why do they chose to participate or not, rather than addressing this question only to nonparticipating physicans who do not balance bill frequently.

A second significant problem has been the reliance in this study on relatively indirect economic data. Given that the results of Hypothesized Model I testing point to the importance of economic concerns in predicting the participation decision of physicians, it is important to have specific physician income data as well as data regarding the payer mix of the physicians so that the opportunity represented by accepting Medicare patients on assignment could be assessed. Relative physician fee data would also be valuable in that comparisons of physicians with lower charge structures (notably rural physicians and primary care providers) to those with higher charge structures (urban and specialty providers) could be made.

Another highly valuable but under utilized research technique in physician economic behavior would be qualitative research methology. The qualitative approach has much to offer the complex arena of professional

autonomy, economic constraints, and national health care policy. Specifically, qualitative techniques could be used to ascertain physician ideological stances toward government involvement, price determinations, and imposition of third party economic mandates in what has previously been a perogative of the medical profession. This perogative, the historical review has shown, has gradually eroded throughout the later part of the twentieth century.

CONCLUSION: THE DIVERGENCE OF PROFESSIONAL AND PUBLIC INTERESTS

At the time of the enactment of the Medicare program in 1965, Congress mandated in Section 1801 of Title XVIII that "Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided...." (Blumenthal, 1988, 13). This initial intent showed the desire of the Federal government to avoid conflict with the perceived sphere of influence of medicine which guaranteed wide protection of both clinical and economic autonomy.

As Medicare has increased as a payer of significance, to the point of accounting for thirty percent of all payments to physicians on an annual basis, its ability to control

economic terms and curtail economic autonomy of the profession has resulted in a very different picture in 1993. The de facto if not de jure disestablishment of the practice of balance billing has been a manifestation of this changed policy direction.

This research has demonstrated the continued concern of physicians with economic implications of the reduction in economic autonomy at a time when alternatives to participation in the Medicare system were more attractive and viable. As awareness of the reduced range of options available to physicians grows, it is possible that physicians will choose if they can afford to do so to opt out of the Medicare system and refuse to see such patients altogether. This issue has plagued the recent past experience of numerous state Medicaid programs.

Alternatively, the ability of government to tax to a level adequate to support these expenditures may wane, resulting in renewed attractiveness of direct user fees, as reported in Canada (New York Times, 3-7-93, 1). In this case, the state may find it attractive to minimize its own expenditures by placing this financing conflict directly between the physician and patient through relaxation of balance billing limits. Physicians interested in economic autonomy may concur in such an approach, and consider the renewal of balance billing strategies as a victory over

government restrictions.

A more likely long term direction is renewed and sustained interest in preservation of clinical autonomy. Lewis and his associates reported "growing dissatisfaction with the practice of internal medicine, primarily related to concerns over loss of clinical autonomy...." (Lewis, Prout, Chalmers, and Leake, 1991, 1). However, the current study did not succeed in convincingly establishing this direction. Perhaps the historical point of the study in 1988 was too early for this issue to have matured. Another possibility is that the survey methodology used here was not sufficiently attuned to capture these concerns on the part of physicians. Any plan for long term health reform which chooses to form a partnership with physicians for significant and sustained participation will do well to balance perceived economic loss with support of renewed autonomy in the clinical arena.

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APPENDIX A

QUESTIONS USED TO PROVIDE DATA FOR SECONDARY ANALYSIS

All questions are derived from the 1988 Physician Payment Review Commission Survey of Physicians conducted by Westat, Inc. Survey performed under PPRC Contract T53644235.

DEPENDENT VARIABLES

VARIABLE	SURVEY QUESTION
I. Status of the physician as participating or non-participating provider	B4. Several years ago, Congress enacted new legislation concerning Medicare Medicare patients and assignment of benefits. Assignment is when Medicare pays you directly and you agree to accept Medicare's reasonable charge/allowed amount as full payment. Physicians have also been given an opportunity to sign a Medicare participation agreement to accept assignment of benefits for ALL their Medicare patients. Have either you or your main practice signed a Medicare participation agreement that is still in force to accept ALL of your Medicare patients on assignment? Yes ___ 1 -- Please continue with B5 No ___ 2 -- Please skip to B7 8 DK 9 "Not stated"
II. Degree of balance billing by non-participating physicians	B7. What percentage of your Medicare patients do you currently accept on assignment? Percent of Medicare patients accepted on assignment......______% Don't know.........______

III. Reasons physicians do not balance bill despite opportunity to do so

B8. If you currently accept 50-100% of your Medicare patients on assignment, which is a fairly high rate, why have you NOT chosen to become a participating physician?

Less than 50% on assignment .... _____

Why not a participating physician?

____
____
____

INDEPENDENT VARIABLES

VARIABLE	SURVEY QUESTION
DEMOGRAPHIC FACTORS	
1. Location	No question - Drawn from AMA master file by zip code of individual physician respondent
2. Board Certification	A2. Are you board certified in this specialty? YES.................___ 1 NO..................___ 2
3. Specialty	A1. Please check the box beside your primary specialty. Anesthesiology..............___ 01 Cardiology..................___ 02 Gastrointestinal Medicine....___ 03 General/Family Practitioners.___ 04 General Internal Medicine....___ 05 General Surgery.............___ 06 Ophthalmology...............___ 07 Orthopedic Surgery..........___ 08 Pathology...................___ 09 Radiology...................___ 10 Rheumatology................___ 11 Urology.....................___ 12 Other Internal Medicine......___ 13 Other Surgery...............___ 14 Other (please specify) ______________________________ ______________________________

PRACTICE ORGANIZATION

4. Practice Size

A3. Please fill in the number of physicians associated with your practice, including yourself, for the following categories.

Number of physicians who practice MORE THAN 20 hours per week ..._____
15:17

Number of physicians who practice LESS THAN 20 hours per week ..._____

Total physicians associated with practice......................_____

5. Practice Type

A4. Are all the physicians in your practice in the same specialty or are they in different specialties?

All in same specialty............._____
Different specialties............._____
Solo practitioner ...._____

ECONOMIC FACTORS

6. Income by Specialty

No question: survey uses median income of physicians by specialty as reported for 1987 in Socioeconomic Characteristics of Physicians, 1988, AMA Center for Health Policy Research. Income figures are assigned to each individual physician by specialty.

7. Medicare Dependence

About what percentage of the patients in your main practice have Medicare Part B coverage? (If you are not sure, please note that almost all elderly patients have this coverage.)

Percent of main practice patients with Medicare Part B ...._____%

Don't know ...._____

8. Medicaid Coverage of Patients

B2. Of the Medicare Part B patients in your main practice what percentage are covered by Medicaid?

Percent of Medicare Part B patients with Medicaid................_____%

Don't know .... _____

COSTS OF PRACTICE

9. Total Cost of Malpractice Coverage on an Annual Basis

C2. How much do you and/or does your practice currently pay annually for YOUR PORTION of your malpractice insurance coverage?

Amount per year .... $_________

Don't know .... _____

"HASSLE FACTOR"

10. Hours of time per week spent in administrative activities

D1. The next questions ask about your work schedule during your last full work week, that is, the 7 days from Monday through Sunday of the last full week. First, please record the number of hours you spent performing each function; then record the number of patients you saw while performing that function. If you saw a particular patient more than once, please count EACH contact.

k. Administrative activities connected with your practice, such as filling out insurance forms, billing patients, peer review, and dealing with personnel or financial matters. .... _______

PHYSICIAN ENTREPRENEURSHIP

11. Physician ownership or lease of in-office diagnostic equipment

F. In the last section, we ask about diagnostic testing equipment you may have. In the first column, please fill in the name of the diagnostic testing machine you use most often, and answer the questions going down the page for that machine. Then, if you have any of the other machines listed, please answer questions F1 to F10, going down the page, for those machines. If you have more than one of a particular machine, please answer the questions about the most recently-acquired machine.

Do you have an X-RAY machine?
YES _____ 1
NO _____ 2

Do you have an EKG machine?
YES _____ 1
NO _____ 2

Do you have an Electrocardiographic Monitoring machine?
YES _____ 1
NO _____ 2

Do you have a Non-Invasive Vascular Studies machine?
YES _____ 1
NO _____ 2

Finally, do you have a mammography machine?
YES _____ 2
NO _____ 1

12. Billing Sophistication

E14. Do you submit your claims to Medicare or other insurers through a direct electronic (computer) hook-up?
YES _____ 1
NO _____ 2

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