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Between Mission and Market:
The Contested Commodification of Hospital Care

By Adam Dalton Reich

A dissertation submitted in partial satisfaction of the

requirements for the degree of

Doctor of Philosophy

in

Sociology

in the

Graduate Division of the

University of California, Berkeley

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Fall, 2012

Abstract

Between Mission and Market: The Contested Commodification of Hospital Care

by

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While hospital care has become more market-driven over the last thirty years, the commodification of hospital care remains uneven and incomplete. There are three persistent problems with the commodification of hospital care: our understanding of hospital care as a right; our understanding of hospital care as connected to moral values and emotional commitments; and our uncertainty about the value of care. Using participant observation and in-depth interviews across three not-for-profit hospitals in the same California city, I demonstrate how the commodification of hospital care is contested but done so differently, and with different effects, in different organizational contexts.

TABLE OF CONTENTS

Introduction..... 1

Chapter One: Evolving Missions and Markets..... 15

COMMUNITY HOSPITAL

Chapter Two: Health Care for Everyone……. 26

Chapter Three: The Professional Ethic……. 46

Chapter Four: Feels Like Home……. 55

MEMORIAL HOSPITAL

Chapter Five: Sacred Encounters……. 66

Chapter Six: Good Business……. 83

Chapter Seven: The Martyred Heart……. 94

KAISER

Chapter Eight: Thriving……. 105

Chapter Nine: Disciplined Doctors……. 121

Chapter Ten: The Partnership……. 140

Conclusion……. 155

Bibliography……. 158

References……. 167

INTRODUCTION

It is widely accepted that the last forty years have born witness to the market transformation of American medicine, as public health concerns, professional autonomy, and charitable impulses have given way to a focus on profit and the bottom line (Light 2004, pp. 18-20; Scott et al 2000; Starr 1982; Stevens 1999[1989]).

The pernicious effects of the market for healthcare are also well established. Perhaps most obvious is the extent to which, under a market system, access to care depends on an ability to pay. In 2010, 49.9 million people in the United States (16.9 percent of the population) were uninsured, the highest number (and rate) since the Current Population Survey began its record in 1987.[1] Large numbers of people in the U.S. are also *under*insured, meaning that their insurance coverage leaves them exposed to significant out-of-pocket medical costs relative to their incomes. One recent study suggested that as many as 42 percent of working adults were either uninsured or underinsured (Schoen et al 2008). All else being equal, those without health insurance are about 40% more likely to die than those with insurance (Wilper et al 2009), and are less likely to receive necessary care for a wide variety of acute and chronic medical conditions (Institute of Medicine 2009). In a market-driven health system, those without resources pay a physical penalty for poverty.

Limited access to care is only one consequence of a market for health services. As significantly, a market model of heath care often privileges profit making over patient care. Low-cost, high-value interventions like smoking cessation programs or primary care visits get short shrift while lucrative services and specialists abound (Cutler 2004, pp. 80-81). Recent books in the popular press have documented in great detail the ways that drug companies aggressively market their products to consumers and physicians while downplaying drugs' risks (see Angell 2004; Moynihan and Cassells 2005); the ways that for-profit insurance companies circumvent government regulation in order to maximize revenue (Potter 2010); and the ways that doctors' treatment decisions get driven by economic incentives (Brownlee 2007; Elliott 2010; Klaidman 2007). As one particularly troubling example, a recent story in *The New York Times* described how a publicly traded hospital debt collection agency sent its representatives to patients' bedsides, dressing like hospital employees and demanding that patients pay before being seen by their doctors.[2] All of these examples suggest ways in which the market exerts pressures anathema to patient care.

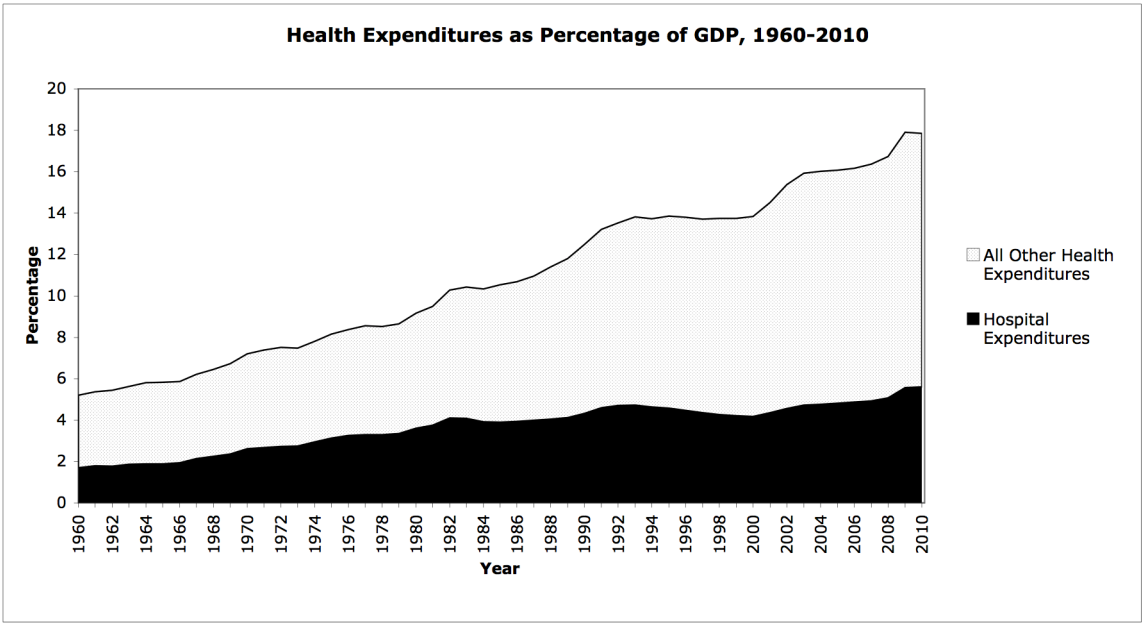
Perhaps unsurprisingly, the marketization of health services has occurred alongside an attenuation of the vocational ethics and intimate relationships that were once so central to care. Physicians, once regarded as community leaders and granted an almost religious authority, have increasingly come to be regarded as technicians for which health care consumers must shop (Imber 2008; Shorter 2009[1985]). Large bureaucracies mediate the relationships between patients and their caregivers more than ever before. Hospitals have merged, physicians have joined groups, and insurers have consolidated all in order to extract more advantageous rates for themselves from one another; and these three types of organizations have negotiated many different sorts of relationships with each other in order to negotiate more favorably with health care buyers—whether they be employers or individuals.

In a free market utopia one might expect market forces to exert downward pressure on prices through competition, yet the market transformation of U.S. medicine

has occurred at the same time health spending has continued a seemingly inexorable increase as a proportion of gross domestic product, reaching nearly 18 percent in 2010. While growth in health spending is not inherently problematic, particularly if it leads to improvements in health, cross-national comparisons suggest that while we spend much more on healthcare than other OECD countries, we do not attain much value for this additional spending (Anderson and Frogner 2008; Muennig and Glied 2010).

Hospitals have not been immune from market pressures, which have led to a degree of convergence or isomorphism among all hospitals in the industry. Since all hospitals today must compete for the dollars that accompany patient utilization, all are compelled to engage in the same sorts of practices, including reducing the amount of charitable (free) care they provide, investing heavily in capital, increasing their provision of profitable services, negotiating more aggressively with insurance providers and physicians' groups, and using staff more efficiently (Scott et al 2000). The local ties that made some voluntary hospitals "community" organizations have also been frayed: most hospitals are now connected with large state or national hospital systems, derive very little money from local foundations or charitable giving compared to government or private insurance reimbursement, and spend much more money on capital investments than on supporting any kind of community program (Stevens 1999). Since the 1960s, hospital spending has made up a consistent proportion of all health spending (approximately one third), and made up 5.6 percent of gross domestic product in 2010 (see figure 1).

Figure 1.

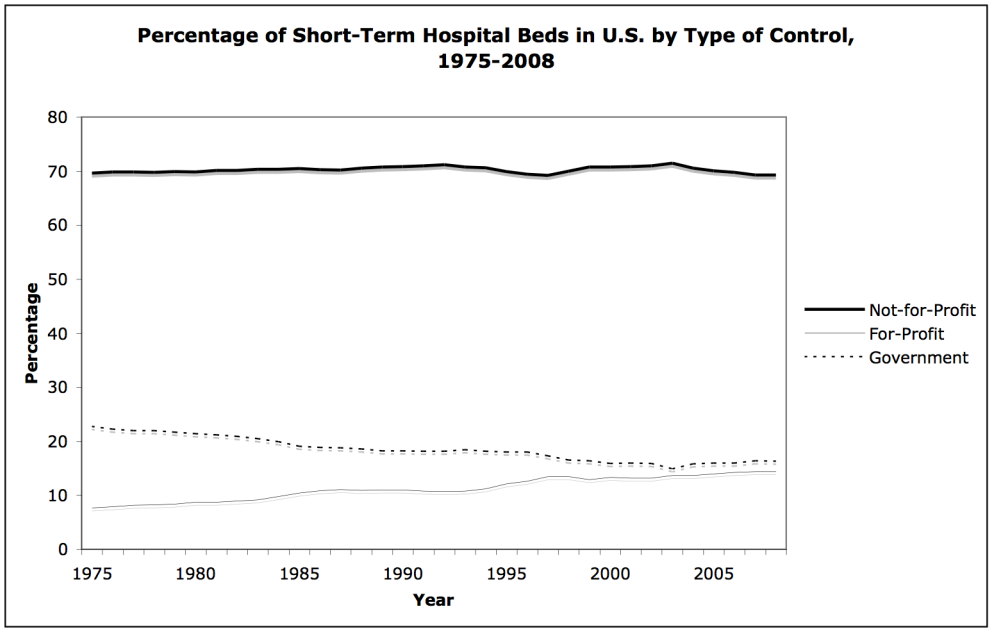


Centers for Medicare & Medicaid Services

Yet despite these isomorphic pressures, there continues to be enormous variation in contemporary hospital practice—both across different geographic areas and across

different hospitals within the same communities (Sirovich et al 2005; Wennberg 2010). Moreover, despite market pressures, between 1975 and 2008 the percentage of hospital beds under the control of not-for-profit organizations remained virtually unchanged at around 70 percent (see figure 2). While market forces and market actors have become increasingly important to contemporary hospital practice, the commodification of hospital care remains uneven and incomplete. As hospital historian Rosemary Stevens puts it, many hospital organizations continue to "carry the burden of unresolved, perhaps unresolvable contradictions" (1999, p. 361) between mission and market. These contradictions are given life by those within hospitals who work to re-embed the market for hospital care within social relations—but do so in different ways and with different success.

Figure 2.



American Hospital Association

This dissertation examines three hospitals in Santa Rosa, California, a medium-sized city with a population of approximately 167,000 in 2010.[3] The city is majority white, with a substantial minority (approximately thirty percent) Latino. The three hospitals in the city, all not-for-profit organizations, serve as the only major hospital organizations in the 500,000-person Sonoma County, and currently compete with one another for the same pool of insured patients (see table 1).

Each of these three hospitals began in a different era of American medicine, and in the service of a different class constituency. Community Hospital (Community) was founded in 1887 as the first modern hospital in the city in order to provide care to those unable to afford a private doctor's home visit. In 1996 the hospital was leased to Sutter Health Corporation, a private non-profit health system. Santa Rosa Memorial Hospital (Memorial) was founded in 1950 by an order of nuns at the urging of private doctors and the local Chamber of Commerce. As the first modern private facility, it was intended to

serve those upper-class patients capable of paying for their care. While the nuns no longer work in or manage the facility, they continue to own it. Kaiser Santa Rosa (Kaiser) was opened in 1990 as the first pre-paid group practice organization in the area in the midst of rising concern about the runaway costs of care in the county. Kaiser traditionally has catered to the working class through its associations with large employers and its historical affinity with labor unions.

Table 1. The Hospitals of Santa Rosa

	Community	*Memorial*	*Kaiser*
Type	Not-for-Profit	Not-for-Profit	Not-for-Profit
Founding Date	1886, transf. 1996	1950	1990
Net Income (2009)	($11.9 million)	$5.7 million	N/A
Rate of Indigent or No Insurance (GAC 2009)	47.4%	25.4%	7.3%
Occupancy Rate (GAC 2009)	45.5%	54.8%	75.4%
Average Length of Stay (GAC 2009)	4.1 days	4.7 days	3.5 days

California Office of Statewide Health Planning and Development

While the three hospitals share not-for-profit status, the hospitals differ widely in terms of the patients they see, the services they offer, the ways in which they utilize resources, and the organizational and financial relationships they have established with insurers and physicians. While Community lost $11.9 million in 2009, Memorial made $5.7 million. Given its status as a pre-paid group practice organization, Kaiser did not report its earnings in 2009. Yet there are several indications that it was the most financially successful of the three. In 2009, Kaiser saw the least number of uninsured or underinsured patients (7.3% compared to 25.4% at Memorial and 45.5% at Community); had the highest occupancy rate (75.4% compared to 54.8% at Memorial and 45.5% at Community); and had the shortest average length of stay (3.5 days compared to 4.7 days at Memorial and 4.1 at Community).

How are we to understand the persistent variation among these three hospitals? This dissertation suggests that we might usefully understand each hospital as contesting the commodification of hospital care in a different way.

Contested Commodification

In recent years there has been a vibrant discussion within economic sociology about the social "embeddedness" of economic life. Extending Polanyi (2001[1944]), Granovetter (1985) famously argued that social ties provide the institutional framework within which market transactions are able to take place. Sociologists have demonstrated the multiple ways in which networks of social relationships enable (and in some cases constrain) actors' capacities to engage in market activity (Baker 1990; Powell 1990; Powell and Smith-Doerr 1994; Uzzi 1996). Others, unsatisfied with a network approach that they understand as "submerg[ing] the asocial market construct in social relations…." (Krippner 2001, p. 778), have deepened this conception of embeddedness by demonstrating how commodity exchange is always shot through with cultural meanings and social values (Healy 2006; Zelizer 1989; 1994; 1997). Exchange may not only be

made possible by social ties; exchange may also be one of the mechanisms through which ties are maintained and strengthened (Zelizer 2011).

These understandings of the embedded economy have provided powerful tools with which to challenge the individualistic orthodoxy of neoclassical economics. Somewhat paradoxically, however, these analyses have also blunted Polanyi's critical edge (Steiner 2007). Like many contemporary economic sociologists, Polanyi recognized the inextricability of the market from social life. But he maintained that "market fundamentalism" (Somers and Block 2005)—the ideal of anonymous exchanges by self-interested buyers and sellers—*did* pose a threat to society (and to itself!) by commodifying things that are not commodities—his "fictitious commodity" (2001[1944], p. 75). For scholars like Zelizer, the market in practice does not have pernicious consequences because people remain firmly in control of it, using "different payment systems and exchange tokens to express and define different social relations" (Healy 2007, p. 11). In stark contrast, Polanyi emphasized the danger of the market ideal as it affected the realities of the social world—and stressed the ways in which social actors actively must work to resist this ideal, *re-embedding* the market in society.

No sooner than we return to Polanyi, however, than we crash into new shoals, since Polanyi's conception of the fictitious commodity—so central to his criticism of the market—is surprisingly underdeveloped. Polanyi regards commodities as "objects produced for sale on the market" (2001[1944], p. 75). He then argues that land, labor, and money are "obviously not commodities" because "the postulate that anything that is bought and sold must have been produced for sale is emphatically untrue in regard to them" (ibid). Yet many commodities are not exactly produced for sale (e.g. fish, spring water) and yet function perfectly well as commodities nonetheless. More precisely, we might argue that the production of all commodities involves an interaction between human activity and a world that pre-existed humans, the latter of which was emphatically *not* "produced for sale." In this light the training of labor power and rearing of cattle, the cultivation of land and the procurement of lumber *all* involve both a moment of intentional production and a moment of preexisting nature. Polanyi's conception of the fictitious commodity thus seems to rely on our intuitive agreement with him. We might agree that labor is not a *real* commodity in the same way that cows are; that land is not a *real* commodity in the way that lumber is. But we are hard pressed to legitimize these distinctions using Polanyi's argument on its own.

The power of Polanyi's analytical framework, then, derives from his insight into the "grave dangers to society" (p. 204) posed by the commodification of certain things; as well as his analysis of the counter-movements through which these things become re-embedded into society. We can thus abstract from the particular commodities on which Polanyi focused and explore, in relationship to hospital care, two more general questions. First, what are the particular problems posed by commodification? And second, how might we understand different sorts of organizational responses to these problems?

The Problems with Commodification

I define a commodity quite generally as a good or service that has both a utility (or use-value) and a price (or exchange-value). It is something that satisfies a want or desire, and it is something that can be bought and sold. Over the course of his analysis Polanyi offers three related but distinct dangers in the commodification of labor, land,

and money. Below, I differentiate these dangers and then relate them each to the commodification of hospital care.

A Threat to Social Rights

Polanyi's account of the development of the market for labor power demonstrates how the commodification of certain things (specifically, the process of giving some things an exchange-value or price) depends upon the denial of social protections or social rights. For most of human history, Polanyi observes, labor had no exchange-value, as it had not been sold on a market but rather had been embedded within "noncontractual organizations of kinship, neighborhood, profession and creed" (p. 171). Thus a person's capacity to subsist had been independent of his or her participation in wage labor. In order for a labor market to emerge in England, workers had to be separated from their capacity to survive *outside* of wage labor. The market could only be established "with the application of 'nature's penalty,' hunger. In order to release it, it was necessary to liquidate organic society, which refused to let the individual starve" (p. 173). Polanyi suggests that primitive societies were thus "more humane," if "less economic," in that there was no "threat of individual starvation" (p. 172). Similarly, early in the Industrial Revolution, the Speenhamland Law (1795) prevented the establishment of a labor market by guaranteeing the "'right to live'" (p. 82). It was only through the vitiation of the right to live, the estrangement of the laborer from any means of subsistence outside of the labor contract, that a market for labor was finally established with the Poor Law Reforms of 1834.

Under certain circumstances, Polanyi implies, things should not be bought and sold on the market because this commodification depends on the denial of social protections or social rights. Fred Block (2001, p. xxv), in his introduction to *The Great Transformation*, calls this Polanyi's "moral argument," and it is an idea prevalent in economic and moral philosophy (Satz 2010; Walzer 1983). The economic philosopher Debra Satz suggests that there are "universal features of an adequate and minimally decent human life" (Satz 2010, p. 95), and argues that the commodification of certain things makes this life impossible. For her, social rights must necessarily place boundaries on what can be for sale. The political philosopher Michael Walzer makes a similar argument but relates it more specifically to medical care: "Doctors and hospitals have become such massively important features of contemporary life that to be cut off from the help they provide is not only dangerous but degrading" (Walzer 1983, p. 89). He continues, "Needed goods are not commodities" (Ibid, p. 90). In order for hospital care to be turned into a commodity, according to this argument, it must be denied to those people unwilling or unable to pay for it. Yet this would mean an erosion of basic social protections and the denial of basic social rights.

Debasement

But Polanyi goes beyond the recognition that the commodification of some things requires the vitiation of social protections or social rights. It is not only that some things *should* not be commodities; some things *cannot* be commodified. If land and labor are sold as commodities, he argues—if they are given exchange-values—they ultimately *lose* their use-values. Disembedded from the social and cultural institutions that give them

stability and meaning, "human beings would perish from the effects of social exposure; they would die as the victims of acute social dislocation through vice, perversion, crime, and starvation" (Polanyi 2001[1944], p. 76). Left to the market, land would be rendered useless: "Nature would be reduced to its elements, neighborhoods and landscapes defiled, rivers polluted, military safety jeopardized, the power to produce food and raw materials destroyed" (Ibid). When land and labor are turned into commodities they lose their utility and destroy themselves.

Labor and land cannot be commodified, Polanyi implies, because these things are inextricably linked to social relationships and sacred values and so are debased through commodification. Labor "goes with life itself" (Ibid, p. 75) and cannot be commodified without "dispos[ing] of the physical, psychological, and moral entity 'man'" (Ibid, p. 76). Land "invests man's life with stability; it is the site of his habitation; it is a condition of his physical safety; it is the landscape and the seasons" (Ibid, p. 187). Turned into a commodity, and estranged from these social foundations, land loses not only its social value but ultimately its economic value (Ibid, p. 193).

This line of argument has, in recent years, been pursued in relationship to the commodification of other things, like blood (Titmuss 1971). Titmuss found that a system of blood allocation based on blood donations was associated with blood of a higher quality than a system in which donations were coupled with financial incentives. The commodification of blood, he suggested, eroded the social values and social institutions through which it was otherwise given and received. When blood was treated as a commodity it became degraded. Even Healy's (2006, pp. 89 ff.) compelling critique of Titmuss's findings maintains the idea that market incentives can "crowd out" other sources of motivation like altruism (see also Satz 2010, pp. 192-193; Gneezy and Rustichini 2000; Frey and Oberholzer-Gee 1997).

From this perspective, hospital care might be understood as a social and moral good. Hospital care is a deeply emotional experience. It depends on vocational ethics and emotional connections that are given voluntarily (private hospitals are still often classified as "voluntary hospitals," a phrase derived from their origins in philanthropy or religious charity). To the extent that hospital care is commodified, then, the hospital might be unable to foster the non-economic values central to care itself.

Uncertainty

Distinct from the problem of social rights and the threat of debasement is the problem wrought by uncertainty in the value of certain things. Polanyi illustrates this problem in relationship to currency. Treated as a commodity, money would wreak havoc on the economy through deflationary pressure and subsequent mal-coordination. Under the gold standard, increases in productivity and trade would lead to declining prices, while the costs of production (like wages) would be slower to adjust to the declining price level. As a result, "business would be in danger of liquidation accompanied by the dissolution of productive organization and massive destruction of capital" (Polanyi 2001[1944], p. 201). The problem was one of uncertainty about and instability in the use-value of a unit of currency over time.

The problem with assessing the use-value of a commodity is also applicable to hospital care. The uncertainty surrounding the use-value of hospital services derives from at least three different sources. First, commodity exchange presumes a market of

buyers and sellers with equal amounts of information. But patients are almost by definition dependent on the authority of doctors to tell them what they need (Starr 1982, pp. 14 ff.; Richmond and Fein 2005, p. 137; Arrow 1963, p. 949)—what economists call *supplier-driven demand*.

Second, on the supply-side, even doctors themselves often do not know the use-value of the services which they provide (Fox 1980; Eddy 1984; Arrow 1963, p. 951). For example, as Shorter (1991) so powerfully suggests, for most of medical history doctors have been remarkably *incompetent* in a technical sense. And despite huge social investments in recent years in medical research, information technology, and evidence-based medicine, there is still (and will always be) much uncertainty in the diagnosis and treatment of particular conditions (Bursztajn et al 1990).

Finally, the use-value of health, and by association hospital care, is remarkably difficult for people to assess in a rational and calculating way, meaning that weighing costs and benefits in relationship to it is fraught. This is not to say that people *do not put a price* on these things implicitly or explicitly (Zelizer 1994; Cutler 2004). But it is challenging for people to weigh preferences in relationship to them.

Social Economies

For Polanyi, the market economy was a utopian project that could never fully be realized, since its achievement would lead to the destruction of society. In the face of the dangers of the market, "protective counter-moves… blunted the action of this self-destructive mechanism" (Polanyi 2001[1944], p. 79). Much of Polanyi's account, then, focuses on these counter-movements, on the wide variety of organizations and policies, undertaken across different countries and spurred on by different groups, through which society reacted "spontaneously" against the dangers of the market (Ibid, p. 156).

Likewise, the development of a market for hospital care has been mitigated by a variety of institutional rules and norms that can be understood as a response to the dangers of commodification, and which structure all hospital practice (see Fligstein 2002). Regarding social rights, for example, the passage of Medicare and Medicaid in 1965 signaled a right to a degree of care for the elderly and some segments of the poor. Since 1972, those with end-stage renal disease have also been entitled to Medicare coverage. And the Emergency Medical Treatment and Active Labor Act (1986) gives anyone in the United States the right to emergency room treatment.

Regarding the debasement of non-economic values, professional licensing requirements ensure, at least nominally, that healthcare practitioners maintain an extra-economic commitment to their work. The non-profit status of the vast majority of hospitals in the United States may also help to preserve the social relationships between various stakeholders in the hospital as something more than market actors (Ben-Ner and Gui 2003); and, through processes of entrepreneurial sorting (Steinberg 2006), may encourage those motivated by non-economic values to take part in hospital leadership. Since 1994, with the passage of SB 697, not-for-profit hospitals in California have had to document annually the "community benefit" they provide, documenting the ways in which their missions transcend the market.

Finally, regarding the problem of uncertainty, the non-profit's prohibition from the distribution of financial surplus is understood by some scholars as a response to the problem of consumer trust (Hansmann 1980). Regulative oversight by organizations like

the Joint Commission and Healthcare Facilities Accreditation Program (HFAP) also mitigate the problem of contract failure through some degree of measurement and accountability. Finally, the fact that employers and insurance companies mediate the relationship between most "consumers" and "producers" of hospital care can also be understood as a response to the problem of medical uncertainty. Coalitions of business groups like the Pacific Business Group on Health and The Leapfrog Group have been at the forefront of research into evidence-based medicine to enhance healthcare efficiency (and reduce employer healthcare costs). Similarly, insurance companies have the incentive to provide only that care which is necessary, and increasingly have access to patient data that can help them make such determinations.

Yet the problems with the market for hospital care are not expressed only at the market's margins, setting boundaries on a social arena within which the market is able to function autonomously. As I explore throughout this dissertation, these dangers are also incorporated into the understandings and practices of medical administrators and practitioners, shaping their approach to care but doing so in different ways and with different effects.

It is in this vein that I explore the "social economies" within the three hospitals of Santa Rosa. By "social economy" I mean a set of ideas and practices through which the market for hospital care is contested, or re-embedded in social relations. Actors within each hospital in Santa Rosa responded chiefly to one problem with the commodification of hospital care. They did so with different sets of understandings about the dangers of the market, did so in relationship to a different class constituency, did so through different organizational practices, and did so with different results (see table 2). And since each hospital responded primarily to one problem at the exclusion of the others, each organizational response was necessarily incomplete.

Table 2. Social Economies among Santa Rosa Hospitals

	Community	*Memorial*	*Kaiser*
Perceived Danger	Rights Threatened	Debasement	Uncertainty
Class Constituency	Lower	Upper	Middle
Organizational Response	Insurgent (Bottom-Up)	Ideological (Top-Down)	Integrated
Result	Market Rebuffed	Market Moralized	Market Tamed

RIGHTS: CARE AGAINST THE MARKET AT COMMUNITY

At Community Hospital, many practitioners were committed to the idea of providing care as a social right to those in need. They worked against the interests of the upper administration of the hospital, who had been trying since the facility's privatization to make the organization financially viable. The providers of care thus waged a kind of insurgency against the financial interests of hospital administration. Among these practitioners, the market was viewed as anathema to mission and was kept—as much as possible—at the periphery of medical practice. Physicians there were not incentivized to

practice in any particular way, and conversations among practitioners used the language of duties and reciprocal obligations.

Yet care at Community was also distinctive for its disorganization and inefficiency. This was due in part to practitioners' suspicions about and resistance to organizational reforms proposed by hospital leaders. But it was also connected to practitioners' commitments to providing care as a right to those in need. Need, as an organizing logic, is "radically incomplete" (Walzer 1983, p. 25), offering little direction in terms of how to allocate scarce resources across the organization. Doctors, nurses and ancillary staff worked side-by-side with relatively little role differentiation among them. Many practitioners discussed being resourceful in the face of a lack of resources, but practitioners' resourcefulness as individuals was accompanied by a significant amount of organizational inefficiency.

Overall, while practitioners had been able to sustain a degree of care for the poor and uninsured at Community Hospital, the long-term viability of their strategy was questionable at best. The hospital had been losing money ever since it had been privatized in 1996, and seemed likely to close in the near future. Nevertheless, the hospital's historical commitment to the provision of care as a right gave practitioners some degree of leverage over hospital administration through the channels of local government.

DEBASEMENT: THE MORALIZED MARKET AT MEMORIAL

At Memorial Hospital, administrators, hospital leaders, and a few select categories of nursing staff expressed most clearly the hospital's mission of preserving the moral and spiritual dimensions of care, but they worked to do his *through* the market rather than against it. This hospital was the most explicitly mission-driven, given its close connection to the Catholic Church and its conscious investment in its Department of Mission Integration and Spiritual Care. Yet, paradoxically, the mission served as a framework that made possible some of the most clearly market-driven behavior among the three hospitals in Santa Rosa—both by the organization itself (in relationship to the medical environment) and by its medical staff (in relationship to their patients and the hospital).

At Memorial, the hospital's attention to the spiritual dimensions of care was what allowed care to be commodified. Like many private facilities of both religious and secular origins, Memorial Hospital exploited the social and emotional significance of care for its financial gain. The extensive chaplaincy program, like the oak chairs in the facility's cafeteria, helped to give patients the feeling of personal attention and luxury, and so attracted a wealthy clientele. This luxurious setting also seemed to allow doctors at Memorial to behave as entrepreneurs: their professional roles elided almost seamlessly into their roles as economic actors. Unlike doctors at either Community or Kaiser, most of the doctors at Memorial did their own billing, meaning they were paid based entirely on the number of paying patients they saw. According to doctors at the other hospitals, doctors at Memorial tended to maximize the care they gave in order to make money. Within the hospital, doctors at Memorial were conscious of competing for those patients who paid the most. Outside the hospital, doctors based at Memorial also seemed more likely to convert their professional expertise into financial gain.

Where staff roles were relatively undifferentiated at Community Hospital, at Memorial there was a clear demarcation between the medical staff and the nursing and ancillary staff. The vocational values espoused by hospital leadership were used to secure an obedient and subservient workforce. Ancillary staff members were encouraged to be "good stewards," martyring themselves for the mission of the hospital, meaning that wages at Memorial tended to be lower than at either of the other two hospitals. When workers made claims for organizational power, then, they were most successful when they made these claims on the terrain of Catholic ethics and Catholic values.

Nevertheless, despite accusations among other doctors in the county that those at Memorial over-treated their patients in order to increase revenue, many practitioners at all three hospitals said that they would rather be treated at Memorial than anywhere else. Not only was it the nicest looking hospital of the three (several interviewees compared it to a hotel), but it also had the reputation for being the facility where patients received the highest quality care. Memorial historically had been quite financially successful, but was so not because it contested the market so much as because it concealed it.

UNCERTAINTY: TAMING THE MARKET AT KAISER

The mission at Kaiser, an integrated health management organization, was to overcome the uncertainty inherent in medicine through its extensive bureaucracy and technical infrastructure. Whereas the mission at Community was insurgent, espoused by practitioners against the market; and the mission at Memorial was ideological, espoused by administrators to frame the market; the mission at Kaiser was *integrated* across the facility's administration, its physician staff, and its nursing and ancillary workers. Through bureaucratization, standardization, and the creative use of technology, several different constituencies worked together to tame the market.

In the name of scientific medicine, Kaiser generated protocols based on the latest medical evidence, and conducted small experiments with changes in procedure that—if successful—were diffused across the entire organization. Given its focus on an efficient use of medical resources, more resources were focused on ensuring that patients managed chronic health conditions and avoided the hospital than were invested in acute care. Within the hospital, there was an emphasis on avoiding costly medical mistakes and on eliminating redundant tests and interventions. Given that Kaiser depended for its survival on patient-members, however, it had to balance its own conception of efficiency with the desires of patients themselves. Patients, in turn, were expected to play an active role in their health. Membership satisfaction scores and surveys were used to incentivize doctors and change procedures; and members were encouraged to take part in hospital-sponsored educational seminars and fitness classes.

Doctors at Kaiser seemed to understand themselves to some extent as line-workers, sacrificing professional identity and entrepreneurship for the security and stability of a nine-to-five job. With that said, the organization worked to discipline doctors in such a way that their professional identities could be reconciled with bureaucratic subordination. Relations between doctors and staff were bureaucratic and rule-bound: doctors and staff shared some degree of power, as they did at Community. Yet where this egalitarianism was informal and relational at Community, at Kaiser it was formal and bureaucratic. Workers were fully incorporated into the organization's

decision-making structure through a strong union and innovative labor-management partnership.

Kaiser—as a planned economy—in some ways offered the most promising long-term possibility for containing the commodification of hospital care. Yet it did so in part by excluding the uninsured, who received less care at Kaiser than at either of the other two hospitals; and did so in part by reducing health to a set of discrete and quantifiable variables and reducing healthcare to a series of technical interventions. The system's bureaucracy also left room for the emergence of a class of bureaucrats who used it for purposes other than the perfection of scientific medicine. And since there are (and will always be) limits to the reach of evidence with regard to medical practice, the system was only able to prescribe behavior within relatively narrow parameters. Finally, and perhaps most problematically, the organization did not explicitly grapple with the extent to which it inevitably *rationed* care in the process of rationalizing care—thus in some sense concealing difficult organizational decisions about the value of life itself.

Methods and Approach

In order to understand the social economies within each hospital, my approach differs from the prevailing field-level studies in organizational sociology. For example, the seminal sociological work on the market transformation of American health care is Scott et al's *Institutional Change in Healthcare Organizations: From Professional Dominance to Managed Care* (2000). Directed by Richard Scott, one of the leading scholars of the new institutionalism in organizational theory, the book demonstrates in exacting detail many ways in which market actors and market logics have come to predominate in the health care field. Yet the framework of the "field," as it is used here, is much better at explaining organizational similarity (or isomorphism) at any given moment in time than it is at explaining organizational variation or struggle (see Dimaggio and Powell 1983; Emirbayer and Johnson 2008). Scott and his colleagues recognize that, in the face of market pressures, "old forms and practices coexist alongside the new" (Scott et al 2000, p. 1). To the extent that hospitals have resisted market pressures it is because of their "strong roots in the communities they serve" (Scott et al 2000, p. 73), or because "older organizations and forms of organization exhibit substantial inertia" (Scott et al 2000, p. 113). But the particular ways in which organizational histories differently structure ongoing perceptions and practices is impossible to grasp at such height.

In this dissertation I return to the nine-county San Francisco Bay Region that Richard Scott and his colleagues examined, but I do so with a different theoretical and methodological approach. Rather than explore the dynamics of the health care field as a whole, I analyze variation in the cultures and structures of practice that have emerged within three different hospitals in the same community.

I begin by examining the ways in which each organization's historical trajectory has shaped its contemporary structure and culture. Organizational histories matter not only because of structural inertia (Stinchcombe 1965, p. 154), but also because these histories shape the ways that organizations (and the actors within them) understand the possibilities for action in the present (Emirbayer and Johnson 2008, p. 17). While each of the hospitals in this study must navigate the social limits to market for hospital care, the *primacy* given to one particular danger emerged as a result of the particular era of American medicine during which it was founded. Community Hospital was established

at the end of the 19th to provide the poor with some social protection. Memorial Hospital was established in the middle of the 20th to provide a framework of sacred values necessary for the establishment of a market for hospital care. And Kaiser was founded in the late 20th century in an effort to rationalize and standardize (and reduce the uncertainty inherent in) hospital practice.

The three hospitals in this study have always understood themselves in relationship to the others. Memorial Hospital was established in order to create a hospital for wealthy patients, as distinct from Community Hospital and its focus on the indigent. Kaiser Hospital was founded to offer efficient care to working-class patients (through their employers) as distinct from Community's service to the poor and Memorial's service to the rich. To some extent, then, these hospitals' different responses to the dangers of commodification might be understood as having a *class character*. The problem of rights is particularly relevant to the poor, who depend on Community Hospital as a broad social safety net. The problem of debasement, of the erosion of care's meaning, might be understood as a concern of the wealthy, who can afford to think of care in broader, more holistic terms. And the problem of uncertainty is particularly relevant to the working class (or, more precisely, their employers) for whom uncertainty and inefficiency in medical care is a business liability. Formally, the class character of each hospital has changed, as all three hospitals now compete for the same group of insured patients. But these legacies continue to have significant power.

After reviewing the history of these three social economies, I explore how these social economies influence three dimensions of contemporary organizational practice (see table 3).

Table 3. An Outline of the Project by Chapter

	Community	*Memorial*	*Kaiser*
Conception of Care	(2) Social Right	(5) Sacred Encounter	(8) Population Health
Physician Orientation	(3) Vocational	(6) Entrepreneurial	(9) Disciplined
Labor Relations	(4) Informal	(7) Hierarchical	(10) Integrated

First, I analyze the ways that each hospital conceives of and organizes the care of its patients. In so doing I elaborate in detail the ways that each hospital organization navigates the market in both theory and practice. Second, I examine how each hospital structures the work of the physicians within it, and how these structures relate to physicians' professional identities. As the medical experts within the hospital, doctors play a critical role in shaping the care that is provided. Finally, I discuss how each hospital structures the relationships among the different constituencies within it. While the same classifications of employees (from physician-administrators to certified nursing assistants) work within all three facilities, the way that power is allocated (and contested) varies considerably across the hospitals.

The dissertation makes use of one hundred and six interviews I conducted with administrators, physicians, nurses, and ancillary workers who work within (and across) the three hospitals; and an additional fifteen interviews I conducted with community leaders in Santa Rosa. These one hundred and twenty-one interviews all took place between September of 2009 and December of 2010, and lasted between forty-five and

ninety minutes. All took place either at interviewees' homes or in private settings at work.

An advantage of conducting my research within a relatively self-contained community such as Santa Rosa was that the three hospitals (and the people who worked within them) used the other hospitals as explicit points of comparison. I was thus able to examine both the objective position each hospital occupied in relationship to the others, and also how these relationships were understood by the actors who worked at each. I was also able to analyze the trajectories of practitioners as they moved across the three facilities. Of the one hundred and six administrators and practitioners I interviewed, thirty-two had worked at two of the hospitals in Santa Rosa, and three had worked at all three. Table 4 summarizes these interviewees according to their positions and the hospitals at which they had experience. Given some interviewees' experiences at multiple hospitals, they are counted multiple times in the table.

Table 4. Summary of Interviews with Administrators and Practitioners

	Community	*Memorial*	*Kaiser*
Administrators	6	11	11
Physicians	21	18	22
Nursing and Ancillary Staff	8	23	16

Interviews were transcribed, imported into an electronic database, and coded systematically using the qualitative software ATLAS.Ti. I undertook both open coding and focused coding in order to determine prominent themes among the interviews (Emerson, Fretz, and Shaw 1996, pp. 142-144; Weiss 1994, pp. 154-156). In order to verify the results I obtained from interviews, I triangulated using three other sources of data (Miles and Huberman 1994, pp. 266-267). First, I spent approximately two hundred hours conducting participant observation within the three hospitals. Most of this time was spent "shadowing" individual doctors within the emergency rooms and medical wards of the three hospitals. I also attended several physician and departmental meetings, as well as meetings with groups representing workers at the three hospitals. Second, I supplemented my qualitative research with quantitative data on the three hospitals collected by California's Office of Statewide Health Planning and Development (OSHPD). Finally, I drew on primary and secondary source material to understand the history of the three hospitals within Santa Rosa and these hospitals' relationship to the history of hospital care in the United States more generally.

CHAPTER ONE: EVOLVING MISSIONS AND MARKETS

U.S. health care spending reached nearly two and a half trillion dollars in 2009, according to the U.S. Census Bureau, and health care jobs continue to be one of the fastest growing occupational categories in the nation (see Lockard and Wolf 2012). The health care industry is now central to the health of the nation's economy. Yet this centrality is all the more surprising for its relative novelty.

This chapter traces the history of the hospital as an organizational form that—over time—has had three quite different relationships to the economy as a whole. Each of the three hospitals in this dissertation was founded in a different era of American medicine, and with a different orientation to the market. As is explored throughout this dissertation, these different orientations have been carried into the present both through the organizational structures that remain and through leaders' and providers' ongoing understandings and practices.

The Public Hospital: Social Rights and Social Responsibilities

Throughout the early history of the hospital, hospital care sat in opposition to the market in three related ways. First, institutional care was intended primarily for those sick-poor unable to participate in an expanding market economy. The fact that most people of all classes were reluctant to turn to these organizations was part of a strategy among community leaders to distinguish the truly needy from those able-bodied poor who should turn to the labor market for their subsistence. As the historian Charles Rosenberg writes, "the hospital's patients were seen as genuinely needy almost by definition and less likely than recipients of free food or fuel to be impostors, for none but the ill and desperate would willingly seek the dubious comforts of a hospital ward" (Rosenberg 1987, p. 22).

Second, what little market there was for physicians' services took place almost entirely *outside* the hospital. While hospital appointments were coveted status-markers among ambitious members of an emerging medical elite, and a minority of medical students learned their trade by treating the poor in voluntary or municipal hospitals, paying patients almost always received their care at home; and physicians were almost always prohibited from collecting professional fees in the hospital—even from those patients who paid the hospital for their care (Starr 1982, pp. 163; Vogel 1980, p. 107). Finally, the labor force within the early hospital consisted mostly of recovered patients who "differed little in background from their charges" (Rosenberg 1987, p. 17). Most of these workers were recruited informally, lived within the hospital, and gave the organization an anarchic feel. As a house physician at Massachusetts General Hospital put it in 1857, "There is no system or order & no one knows precisely his duty or keeps to it" (Rosenberg 1987, p. 39). Paternalistic impulses and scientific ambitions were certainly present in the 19th century hospital; but by and large the market was not.

As it did throughout the rest of the United States, hospital care in Santa Rosa emerged out of the almshouse, tied deeply to the needs of the dependent poor. It emerged at a time when the categories that would come to distinguish different sorts of dependency from one another—physical and mental illness, illness and old age, disability and poverty—had not been firmly established. And it emerged at a time when the curative capacities of an embryonic medical profession were questionable at best.

The first hospital in Santa Rosa was built in 1859 in the center of town as the second story of the small city jail. According to the local paper, the lower story of the building consisted of "six dark cells, a room for the jailer, and one for petty offenders," while the upper story was "arranged to accommodate, as comfortably as possible, such indigent persons as may need the assistance of the county, in their sickness."[4] Between 1860 and 1867, the years during which records are available, use of the small hospital grew substantially—from only nine admissions in 1860 to sixty by 1867. All told, between 1860 and 1867, 201 admissions and 37 deaths were recorded. Syphilis, a venereal disease suggestive of moral turpitude, was the most common disease recorded among patients, while the most common cause of death recorded was from consumption (or tuberculosis).[5] By 1866, however, the county Board of Supervisors had come to regard the facility as inadequate for medical care, and, because of its central location, a risk to a public increasingly concerned with contagion. The Hospital Physician reported of this facility, "A more unfavorable location could not well be conceived of, either for the protection of the sick within, or the well without."[6]

The Board of Supervisors ordered a new stand-alone hospital constructed in the northern suburbs of town. This hospital was completed in 1866, and consisted of two stories and separate wards for male and female patients. And while no doubt an improvement from the previous facility, this organization was still a far cry from the hospitals with which we are familiar today. A reporter visiting the hospital in March of 1868 was "highly pleased with the neatness of the surroundings," but nevertheless noted "the necessity of having a dead-house." As it was, "when of the patients dies his body is placed in the passage-way, where the sick cannot help but see it—anything but a pleasant site—and which does not tend to the improvement of the remaining inmates."[7] A report from the Hospital Physician emphasized moral as opposed to medical concerns (see Vogel 1980, p. 23). Of utmost importance, he wrote, was a "suitable library… for the use of patients… as a most wholesome governmental measure, because even in sickness, idleness breeds dissatisfaction and mischief."[8] A reporter in 1872 highlighted the facility's social, rather than medical, purposes. After a "careful examination," during which the reporter spoke with patients "when none of the officers were there," the only complaint was "in regard to the regulation which requires only two meals a day to be supplied."[9] The hospital was still, by and large, indistinguishable from a homeless shelter or nursing home; the facility offered medical care, moral training, and basic subsistence simultaneously.

Yet this second facility was similarly short-lived. Both the Hospital Physician and the Board of Supervisors had expressed concern about the need to distinguish among different categories of the sick and dependent, all of who had been relying on the single organization. There was also worry that this second hospital—which only recently had been on the outskirts of town—had already been enveloped by the expanding city. According to one local history, neighbors had been "passing petitions asking that [the facility] be relocated outside the city limits, citing its odors, the danger of contagion and the loitering of ambulatory patients."[10]

During the 1870s, then, the county began to shift its care for the poor to a site even further from downtown, a hundred-acre farm where Community Hospital sits today. And it was here where the county consciously undertook the work of distinguishing various categories of dependency. In 1874, the Board of Supervisors first bought the

property to serve as the County Farm, an almshouse meant to house the poor and thus distinguish them from the sick. In 1882 it was reported that there were 30 "inmates" at the County Farm, while 25 still remained at the hospital.[11] A farmer, hired by the county, grew vegetables that could both feed the residents of both facilities and be sold as cash crops to help defray the costs of the facilities. His wife served as the matron of the almshouse, tending to its occupants. And as early as 1877 the county had built a "pest house" on the property of the County Farm meant to isolate those with contagious disease, while the Board of Supervisors began to plan for a new hospital on the same grounds.

Over the course of 1887, a new hospital facility was built on the land. A newspaper article on May 14 of that year gushed with pride about the new facility: "If there is any one thing more than another of which Sonoma county may justly be proud and to which her citizens may point with pardonable pleasure it is her public institutions…. far from being least, her new County Hospital, which is made the subject of this article." The reporter continued,

> As the brow of that long and tedious hill is reached and the low, long roofs of the farm buildings, come into view, the pathetic lines of Will Carleton's poem, with which all are familiar are brought vividly to mind. It is certainly "Over the Hills to the Poorhouse," but the scene presents none of the aspects of the bleak and desolate places about which we read in the old New England tales.

The article went on to describe the "gleaming white walls of the new Hospital building," the "brilliant green of the window-blinds and shadows cast by the ornamental framework of the verandas which afford delicious shade on three sides of the building." The new hospital boasted a dining-room, kitchen, sitting and reception rooms; multiple wards for both male and female patients; an operating room "located with a view to securing a true and even light"; offices for doctors and a room for the resident steward; and, throughout, "the latest improved ventilating aparatus [*sic*]." Standing apart from the facility was now a dead house, also to be used as a "dessecting-room [*sic*]." The reporter concluded that the "building is an ornament to the county, a compliment to the Board of Supervisors and a sanitarium most propitious in its location and purpose."[12]

Throughout this period, the Board of Supervisors appointed a single County Physician to be responsible for the patients at the hospital. This physician was paid an annual salary to tend to the indigent in the hospital and continued to see paying patients in their own homes. The steward and matron, meanwhile, lived on premises and took care of the non-medical concerns of patients and almshouse residents. The distinction between those in the almshouse and those in the hospital was still somewhat ambiguous (see Rosenberg 1987, p. 27; Vogel 1980, pp. 34-35). As late as 1928, reports from the County Physician discussed several patients being transferred from the almshouse to hospital or hospital to almshouse. In December of 1928, for example, thirteen men from the hospital (out of forty-five discharged) were transferred to the poor farm; seven men from the poor farm (out of fourteen discharged) were transferred to the hospital.[13] The line between illness and delinquency was also somewhat ambiguous. In 1894 the county built a two-room building on the property to serve as a "discipline home." A reporter described its purpose:

> Occasionally some old inmate or feeble-minded persons stray off in search of the fountain of eternal youth or walk to the nearest saloon where bitters are dispensed, and some times [*sic*] get arrested for vagrancy, which costs the county good money. Such stray sheep have to be punished in some way, and it is proposed to confine them in the two-room house with a high fence around it as a salutary lesson.[14]

These facilities may not have been "bleak and desolate places" like the poorhouses of the big cities on the east coast, but they were still very much a part of movement away from "outdoor relief" or welfare benefits characteristic of the second half of the 19th century. As discussed by historians of social welfare and hospital care, early public institutions were erected often with the explicit purpose of deterring the "able-bodied poor" from seeking welfare payments (Katz 1986; Starr 1982, p. 150; Stevens 1999, p. 19, p. 42; Vogel 1980). The almshouse and early municipal hospital embodied the "[i]rreconcilable contradictions" (Katz 1886, p. 25) in the early modern welfare state between the provision of basic rights and the fear of generating dependency. As Jeremy Nichols, a historian of Santa Rosa, put it, the county was "proud of the fact that they took good care of the poor people. At the same time, it's not exactly something that the Chamber of Commerce is going to advertise. So they've always been of two minds."

The question of moral hazard is one as old as state social welfare programs. If the state provides too much in the way of social entitlements, the perennial argument goes, then people will lose all sense of work ethic or personal responsibility. In Polanyi's account, the Speemhamland Law of 1795, which guaranteed a minimum income to all men in England regardless of employment, was intended to mitigate the social destruction of industrialization but actually wrought economic havoc since "no laborer had any financial interest in satisfying his employer" (Polanyi 2001[1944], p. 83). By the time of the repeal of Speenhamland in 1834, according to Polanyi, huge swathes of the country had been "pauperized," driven from the labor market into dependence on state entitlements (p. 84). By the same logic, the movement away from "outdoor relief" towards various types of institutional care in the United States was meant to provide for the poor without enabling the pauper.

The Voluntary Hospital: Pay and the Personal Touch

By the early decades of the 20th century the hospital had established itself more certainly as a center of medical authority and medical practice. Because of the new technology available in hospitals, and because of physicians' increasing reliance on these facilities for their own practice, the wealthy had begun to consider these institutions for their own inpatient (and especially surgical) care (Rosenbeg 1987, pp. 245-246; Starr 1982, p. 159; Vogel 1980, pp. 60-62). And as the medical profession formalized itself over the first decades of the twentieth century, physicians began to exert increasing authority over admissions to the hospital and over the inner-workings of the organization more generally (Starr 1982; Vogel 1980, p. 68).

In order to attract the paying patient to its halls, the hospital consciously worked to dispel popular understandings of it as an impersonal, dehumanizing place in which the poor and desperate were warehoused or reduced to clinical material. And so if the

almshouse was concerned with the provision of care as a right, the voluntary hospital of the early 20th century focused energy on the emotional and spiritual *meanings* of hospital care. Some early voluntary hospitals opened special wards for paying patients meant to honor the "dignity" of the patient. For these patients, "private rooms offered the comfort and convenience of a hotel with the ambience of a home" (Rosenberg 1987, p. 245). Paying patients were spared from the gaze of medical students, since "[p]rivacy and payment seemed naturally allied" (Rosenberg 1987, p. 259).

Paradoxically, then, the emergence of the market for hospital care was accompanied by efforts at imbuing this care with practices and symbols that reaffirmed the paying patient's humanity and *distinguished* the hospital from other sorts of business practices. If understood in this light, it is unsurprising that the Catholic Hospital played an important role in growth of the market for hospital care. During the first half of the 20th century, sisters throughout the U.S. fluidly combined vocational devotion with shrewd political and economic calculations. Sisters found deep meaning in the care they were able to provide for their patients. The sisters (and some brothers) who ran these hospitals "conceived of illness… within a spiritual framework, and they viewed themselves as spiritual agents of care" (Wall 2011, p. 55). Yet these same sisters turned "overwhelming social need into opportunities for the development of health care services to the American public," and established themselves as the earliest female entrepreneurs in the United States (Nelson 2001, p. 55). Indeed, it was Sisters' religious identity, sexual chastity, and relative anonymity that allowed them the institutional space to build their own organizations within a broader patriarchal society (Nelson 2001, p. 13), freeing them up to act "like men" well before other women of their time (Wall 2005, p. 42).

And while many Catholic health systems could trace their origins to acts of charity and self-sacrifice, by the turn of the 20th century religious hospitals were actively pursuing those patients who could pay for hospital services (Rosenberg 1987, p. 240; Vogel 1980, p. 101). Income from paying patients made up approximately three-quarters of the revenue of religious hospitals in 1904, compared with approximately half the revenue of nonsectarian hospitals (Stevens 1999, p. 23).

As the market for hospital care expanded through the 1930s and 1940s, the Catholic Hospital Association (CHA) played an important role at the national level in putting forward a "voluntary ideal" of hospital care that was strategically positioned as opposed to both the heartlessness of the market and the dehumanization of state bureaucracy. In opposing the Wagner-Murray-Dingell bill for universal health insurance in 1943, the Catholic Hospital Association argued that, under the bill, patients would become "wards of the state as opposed to wards of society," that the bill would undermine the "dignity of the patient" and destroy the "Catholic attitude toward the patient" (Wall 2011, pp. 111-112). Instead, along with the American Hospital Association, the CHA lobbied in favor of the Hospital Survey and Construction Act of (or Hill-Burton Act), which passed in 1946 and offered grants and guaranteed loans to support hospital construction and expansion with minimal government oversight (Wall 2011, p. 113).

The voluntary hospital grew alongside—and in close relationship with—the formalization of the medical profession. As paying patients became a more important source of revenue for hospitals, hospitals in turn became more dependent on the physicians who could refer those patients (Starr 1982, p. 166). In the almshouse and

early voluntary hospital, the hospital had provided doctors a small salary or paid them only in room, board, and prestige; they were not allowed to charge for their services (Rosenberg 1987, p. 63; Starr 1982, p. 163). But by the first decade of the 20th century, increasing numbers of voluntary hospitals allowed doctors to collect fees from patients and had created "open staff" systems, meaning that any certified physician could practice within them (Starr 1982, p. 167). The voluntary hospital had become a physicians' workshop. Paul Starr trenchantly observes the wider economic context of the profession's emergence: "In the same period as the crafts were being subordinated to large corporations, the medical profession was institutionalizing its autonomy. The doctors escaped becoming victims of capitalism and became small capitalists instead" (Starr 1982, p. 25).

There was another parallel between the growing importance of the voluntary hospital and the emerging medical profession. As the hospital emerged, some doctors expressed concern that an impersonal organization might jeopardize the "spiritual nature of the relationship between patient and physician" (Vogel 1980, p. 94). Indeed, the physician's power in the early 20th century was based largely on the patient's emotional dependence on the doctor and the doctor's capacity to "cure" by suggestion (Shorter 2009[1985], p. 151, p. 159; Starr 1982, p. 11). There was an important resonance, then, between the aura of mystery associated with an emergent medical profession (see Wilensky 1964) and the symbols and practices prominent in Catholic and other voluntary hospitals. Rosemary Stevens writes that these hospitals were "visible expressions of broad, non-monetary, community expectations about social virtue and moral worth, to be set against the crass materialism of business. The essential nature of any profession (and its institutions), it was claimed, was to be 'socially victorious over selfish interest'" (Stevens 1999, p. 123). While hospital care had become a service sold on the market, this market could only exist in conjunction with professional and spiritual values irreducible to the market.

There was a final convergence between the emergence of the market for hospital care and the religious or voluntary hospital, in that notions of religiosity and voluntarism helped inspire a subservient, low-wage nursing staff that facilitated the work of physicians without making demands of their own (Rosenberg 1987, p. 240; Stevens 1999, p. 164). When voluntary hospitals as a group were seeking exemption from the National Industrial Relations Act in the early 1930s, the voluntary hospital lobby argued "low pay was a virtue, since it attracted staff who were motivated by the 'right values'" (Stevens 1999, p. 164). The role of Catholic hospitals was essential to this argument because "it extended, by analogy, the dedicated service of Roman Catholic nuns to the jobs of all hospital workers" (Stevens 1999, p. 164).

By the 1940s, Santa Rosa was confronting the problem of the paying patient. Throughout the early decades of the 20th century, the County Hospital provided the most state-of-the-art medical care in the area. In 1937, another hospital building had been constructed on the Poor Farm property, funded in large part by a grant from the Public Works Administration (Finley 1937). This same year the University of California established a family residency program at the County Hospital, and many of the graduates of the program stayed in the county as private practitioners, helping to establish the area's "reputation as a medical center for the North Coast" of California.[15]

Yet as of 1940, the County Hospital—with 178 acute care beds—was the only hospital north of San Francisco to meet the certification requirements of the American College of Surgeons; and this hospital treated indigent patients almost exclusively. According to a 1940 report on the facility, prepared for the Board of Supervisors, the County Hospital provided an annual average of 118,883 patient days to indigent patients compared to an average of 5,204 patient days to those who could afford to pay (Cohen 1940, p. 166). A second report in 1940, this one to the Sonoma County Medical Society, bemoaned the fact that the County Hospital, "in spite of the publicity to the contrary… does not accept pay patients other than those who can not pay a part of the cost."[16] Meanwhile, the two small private hospitals in Santa Rosa—Santa Rosa General Hospital and Eliza Tanner Hospital—had only fifty-two acute care beds combined.[17] The report described both private hospitals as having a "lack of facilities," made worse by the fact that the competition between them had forced patients to "pay for two complete sets of overhead." If the wealthy needed more intensive care, they would have to travel almost sixty miles to San Francisco. The report continued,

> It is a matter of some irony when we truthfully state that the indigent patient is able to command hospitalization without cost to himself which meets the standards accredited by the American College of Surgeons, while those who have money with which to pay for the service are unable to procure that service within this county.[18]

The report to the Board of Supervisors echoed the sentiments of the report to the medical society when it suggested that the medically indigent were being cared for "at the expense of, and in a better manner than the middle class income group—except that their mythical pride is not pampered to any costly extent" (Cohen 1940, p. 182). Private physicians were also frustrated with the private hospital practice in the area: "With inadequate records, absence of clinical and laboratory facilities, barest diagnostic equipment, minimal nursing standards being characteristic of these [private] hospitals, he (the doctor) admits a deplorable situation" (Cohen 1940, p. 175)

The choice facing the county, then, was whether to expand the County Hospital and open its doors to paying patients, or alternately to subsidize the construction of a private facility for paying patients. The report to the Board of Supervisors strongly recommended that medical services in the county be centralized in a public facility: "All expensive equipment should be centralized in a health facility, so located as to allow purchase of the finest (equipment) most comprehensively and economically through the avoidance of duplication" (Cohen 1940, p. 172). The report continued, "If anything should be democratized, certainly the right to receive adequate medical care and facilities should be" (Cohen 1940, p. 172). Yet the report also recognized that the "specious propaganda of owners of private hospitals" (Cohen 1940, p. 172) had influenced the debate, as had physicians' narrow conception of their interests: "Our present unplanned, anarchistic, ruthlessly competitive system of medical practice requires the physician to keep an eye too much on the patients [sic] purse and not enough on his health, and a long-view plan" (Cohen 1940, p. 182).

Private interests would prevail. Physicians had been making "many… attempts to induce sectarian (Catholic) institutions to build and operate a hospital of accredited standards" (Cohen 1940, p. 175). And in 1946, the town's Chamber of Commerce found

a cherry and walnut orchard near downtown Santa Rosa on which it proposed to develop such a facility. The fundraising effort that followed, according to one local history, was "one of the most successful in Santa Rosa's history" (LaBaron and Mitchell 1993, p. 318). The town also succeeded in its pursuit of a Catholic order of nuns, the Sisters of St. Joseph of Orange, to operate the hospital. As legend goes, the mayor of the town "climbed a cherry tree in the orchard" to pick some fruit for the head of the order, "a nice hometown touch to begin a business venture" (LeBaron and Mitchell 1993, p. 318). Memorial Hospital opened its doors on January 1, 1950. It quickly became the "ultra-professional" hospital in the area (LeBaron and Mitchell 1993, p. 281), the hospital that brought the "Age of the Specialist" to Santa Rosa (LeBaron and Mitchell 1993, p. 280).

The middle decades of the 20th century—from the establishment of Blue Cross insurance and the passage of Social Security in the 1930s, to the Hill-Burton Act of 1946 and labor's successful post-war negotiations for health insurance coverage, to the establishment of Medicare and Medicaid in the 1960s—were bountiful years for the voluntary hospital and the medical profession as a whole. As recounted in the detailed histories of Rosemary Stevens, Paul Starr, and others, throughout this period hospitals and physicians—appealing to the twin ideals of voluntarism and professionalism—were able to secure large amounts of public funding with minimal amounts of public oversight. Demand for private hospital beds consistently exceeded supply in Santa Rosa during these years. And the passage of Medicaid and Medicare in 1965 meant that the right to care—previously institutionalized in the public hospital—would now become somewhat unmoored from any particular organizational form. The infusion of public money into medical insurance for the elderly and indigent thus also helped to reorient the County Hospital, which had previously only accepted those patients unable to pay. In 1966 the Board of Supervisors changed the name of the County Hospital to "Community Hospital," and began to accept paying patients.[19]

The Health Maintenance Organization: Predictable Practice

Beginning in the early 1970s, however, there were growing calls for restraint and rationalization in what had become—in the minds of many—an unwieldy and unreasonably expensive health system. Patients' rights advocates, business-leaders, and political figures on both left and right began to mobilize against the autonomy and excess of the medical profession and the hospital industry. On the advice of Paul Ellwood, in 1971, the Nixon administration began to advocate for grants and loan guarantees for the establishment of "health maintenance organizations," or HMOs, integrated health systems that would combine health insurance with health provision and so provide medical organizations with incentives to manage the health of patients (or members) in a cost-efficient manner (Light 2004; Mechanic 2004; Starr 1982, p. 395). With a similar logic, in 1983, President Reagan signed legislation that incorporated prospective payment into Medicare, meaning that hospitals would get a set amount of money by type of diagnosis (Stevens 1999, p. 323). As Stevens suggests, this reform meant that Medicare would treat patient care "in terms of standardized 'products,' reinforcing the image of the hospital as a factory. 'Scientific management' was finally to be achieved. The question was, at what cost?" (Stevens 1999, p. 324).

While the public hospital was founded in order to guarantee a limited right to care; and the voluntary hospital offered patients an emotional framework that helped

reconcile their "dignity" with hospitalization; the HMO was founded as a medical organization meant to bring hospital care in line with ideals of standardization and cost-efficiency. So while the public hospital was founded in opposition to the market, and the voluntary hospital framed the market in moral terms, then the HMO sought to bring medical care into line with market norms. And if the public hospital was founded for the indigent, and the voluntary hospital accommodated the wealthy, the HMO began as the medical organization for the industrial working class (Hendricks 1993, p. 209).

The HMO gained prominence in the 1970s and 1980s as a technique for rationalizing care and reducing medical expenses, but the idea had originated much earlier among employers and health practitioners as a strategy for maximizing wellness across populations of patients and workers (Greenlick 1972; Luft and Greenlick 1996; Somers 1961). Kaiser Permanente was one of the earliest of these organizations, emerging in the 1930s and 1940s as an industrial health program for workers employed by Henry Kaiser's construction, shipyard, and steel companies (Hendricks 1993; Starr 1982, pp. 319-320). Like Henry Ford and other industrialists of the early-to-mid 20th century, Kaiser recognized the economic benefits of a stable and healthy workforce—there was always a "powerful utilitarian determinant at the core of this merger of industrial and population health" (Hendricks 1993, p. 51). And in the years after 1945, when Kaiser Permanente opened its doors to the public, membership grew quickly on the west coast among union members, government employees, and university workers (Hendricks 1993, p. 88). Yet these early pre-paid group programs relied on a salaried physician staff, and so threatened the autonomy of the medical profession. From as early as 1939 the AMA had lobbied to discredit such plans and reassert the profession's leadership over the ethical organization of medical care (Hendricks 1993, p. 79). Yet by the late 1960s and early 1970s the pre-paid group model in general—and Kaiser in particular—were receiving renewed attention. Since its inception the Kaiser plan had treated healthcare as an industrial input, illness as a technical problem that could be solved through efficient management and standardized treatment. By the 1970s this conception of care was becoming more widely accepted.

Santa Rosa's first HMO, the Community Health Association, was a short-lived endeavor spearheaded by a coalition of labor unions in 1959 (Simons 1965). And while the organization planned on constructing its own hospital facility, the organization dissolved in 1968.[20] Kaiser Permanente arrived in Santa Rosa in 1979, when it bought the twenty-three acres on which its hospital and clinics are now situated. The organization began seeing patients in 1980. Since Kaiser did not initially own its own hospital, its arrival in Santa Rosa was a boon for Community Hospital, which contracted with Kaiser to provide its members with hospital services. One nurse at Community remembers that period as particularly intense: "To go through three code blues on an 8-hour day shift was… just another day, because there were so many patients here." A Kaiser doctor remembers how Community was "way buoyed up by Kaiser patients" during that time.

Among many observers, the growth of managed care is understood to be a key indicator of the market transformation of American medicine. Yet it is, on its face, somewhat paradoxical that we consider these two phenomena as so intimately related. Outside of health care we think of *management*, with its bureaucratic connotations, as anathema to a *market* made up of autonomous buyers and sellers. Indeed, the first

managed care organizations (like Kaiser) were impugned not for being excessively market-driven but rather for being *socialistic*. During its early years in Santa Rosa, Kaiser did not have its own hospital or much of a medical staff. A long-time Kaiser physician remembered that Kaiser's philosophy in Santa Rosa was that it could create a system staffed only by family practitioners "who would be able to do everything." The physicians were all paid the same amount, he recalled, and as late as the 1980s were "considered commies" by the established medical community.

While many different forms of managed care emerged in the 1980s, what was common to them all—and distinct from the past—was a focus on cost efficiency. Integrated systems like Kaiser, which combined insurance with service provision, were able to achieve these efficiencies with less conflict than those HMO plans that contracted with various service providers. Threatened by the competition from Kaiser, the Sonoma County Medical Association established its own not-for-profit health maintenance organization in 1980, Health Plan of the Redwoods (HPR). Like Kaiser and other HMOs, HPR would offer a range of services for a pre-paid fee. In turn, the organization would negotiate reduced rates with providers like hospitals and physicians' groups.[21] But unlike Kaiser, HPR had limited strategies for allocating health resources, and continued to pay medical providers on a fee-for-service (as opposed to a capitated) basis.

By all indications, by the early 2000s, the market transformation of medicine in Santa Rosa was complete. In 1990 Kaiser opened its own hospital facility, meaning that Community Hospital lost the business it had been getting from Kaiser members. Community Hospital was now in deep financial distress, and in 1996 the Board of Supervisors decided to lease the hospital to Sutter Health Corporation, the largest not-for-profit health system in the state. That same year, Health Plan of the Redwoods—the local HMO initiated by the Sonoma County Medical Association—began a period of financial difficulty that would lead to its dissolution in 2002. Members of HPR were now compelled to join Kaiser or one of several national insurance companies that competed for business in the county.

HPR, the "home-grown health plan that doctors and patients alike viewed as akin to the neighborhood grocery" was replaced by for-profit insurers.[22] In the 2000s, Kaiser's membership continued to grow, while Community and Memorial engaged in a medical arms build-up for the shrinking pool of insured patients that remained. Memorial established a neonatal intensive care unit in order to take business away from Community; in turn, Community established a heart center to take business away from Memorial. As a physician administrator at Kaiser put it, Community and Memorial were "circling the wagons and shooting each other…. You just kind of shake your head, you know? I mean, it's a mess out there. It's really a mess."

But the market transformation of medical care in Santa Rosa was not complete, and could never be complete. The past remained in the present; the ideas and ideals that had guided the three hospitals from their inception remained. Despite its privatization, Community Hospital still wrestled with the tension between social rights and the market. Memorial Hospital continued to express the market in moral terms. And Kaiser continued to focus on reducing the uncertainty inherent in medical care. These projects did not melt into air as competitive pressures set in; instead, actors in the three hospitals continued to articulate social economies that—respectively—challenged, framed, and tamed the market that all considered to be dangerous if left out of their control.

COMMUNITY HOSPITAL

CHAPTER TWO: HEALTH CARE FOR EVERYONE

Sandra Lacks, a social worker at Community Hospital, was an African American woman in her forties with braided hair tied in a bun behind her head and an authoritative stride. As a child growing up in a poor section of New Haven, Connecticut, Sandra was introduced to a social worker that "took a liking" to some of Sandra's writing and entered her into a citywide speaking contest. After Sandra won the contest, the social worker helped secure a scholarship for Sandra to attend a prestigious east coast boarding school. "She saw more of me than I saw of myself," Sandra said. Making sure Sandra got into boarding school was the social worker's way of "pulling [her] out of the ghetto." The commitment and dedication of that social worker had stayed with Sandra: "I remember when she did it, it touched me so much, and it really changed and started where my life had began. And I decided at that point I was going to be where she was; I was going to help people out, just like she helped me out. Ergo, social worker."

At Community Hospital, Sandra worked across all departments of the facility to help patients find resources or to provide them with emotional support. The morning of our interview, she was trying to find funding for a homeless diabetic in need of medications; was working to find a placement for a chronic alcoholic who had walked away from the multiple facilities Sandra had previously found for him; was in the midst of figuring out what to do with a schizophrenic patient who had broken down the door of her parents' house and run down the street naked; was attempting to find care for a developmentally disabled woman whose mother had been sick in the hospital for a month ("I'm working to make sure that her daughter is safe on the outside, even though her daughter's not a patient"); and was helping to arrange burial services for a baby who had died *in utero* at forty weeks, while providing comfort for the grieving mother. Every few minutes Sandra's telephone would ring and she would dash out of the break room where we were speaking. At the other hospitals in Santa Rosa, social workers had narrower responsibilities—either they were in charge of a particular part of the patient experience (i.e. discharge) or they were responsible for a particular department in the hospital. At Community, however, "it's not one particular assignment, it's everything." This suited Sandra: "It breaks up the monotony of knowing that you're not always dealing with alcoholics, you're not always dealing with death and dying… You get to change up a little bit, which reduces the burnout."

Sandra saw social dimensions to cases that others would have treated purely as medical problems. On one morning at Community Hospital there was a patient who, having been an IV-drug user, had contracted hepatitis that was gradually destroying her liver. The patient was shaking and feverish, and seemed constantly on the verge of tears. The doctor did not think there was much that the hospital could do for her aside from continuing a course of IV antibiotics, and was trying to figure out whether he could discharge her to a specialized nursing facility that would administer IV antibiotics despite her history of drug-use. Within the next few hours, Sandra spoke to the patient as well. She learned that both of the patient's daughters had died early deaths—one at the age of 15 from a seizure, and the other as a baby from sudden infant death syndrome. She thought that some of the patient's fragility was due at least in part to undiagnosed post-traumatic stress disorder, and recommended that the doctor refer the patient to psychiatry. The doctor was reluctant, thinking that the psychiatrist would not want to see the patient

before her medical issues were cleared up. But Sandra was adamant: "Just write the order, I'll take care of psychiatry," she said. The doctor relented.

According to Sandra, her own commitment to the poor and underprivileged was widely shared among the doctors and staff at Community: "We fall under the true motto of… health care for everyone. We really try to follow [it]." Sandra sometimes worked shifts at Memorial Hospital, but despite her similar job descriptions at the two facilities she found the work quite different. At Memorial, Sandra's role was primarily that of a discharge planner, coordinating patients' transfers out of the facility. At Community, on the other hand, she felt able to use different aspects of her social work training, got to spend "a lot more time with patients." At Community, "If we really need to advocate [for patients] and they need to be here, we're going to keep 'em here. [At Memorial we] get 'em out no matter what." At a personal level, Sandra described how her work at Community allowed her to live out her ideals:

> I know why I'm here. I know what my purpose is. I don't know what my purposes is [there]… My purpose over [at Memorial] is to move 'em out, get 'em out, get 'em out. My purpose here is to treat them, you know? Not just them, but the whole them. [At Memorial it's] a medical model. There's a difference. This is a spiritual, medical, holistic approach.

When Memorial had recently asked Sandra whether she would move there full-time, she answered, "Never in a day would I ever work [at Memorial] full-time."

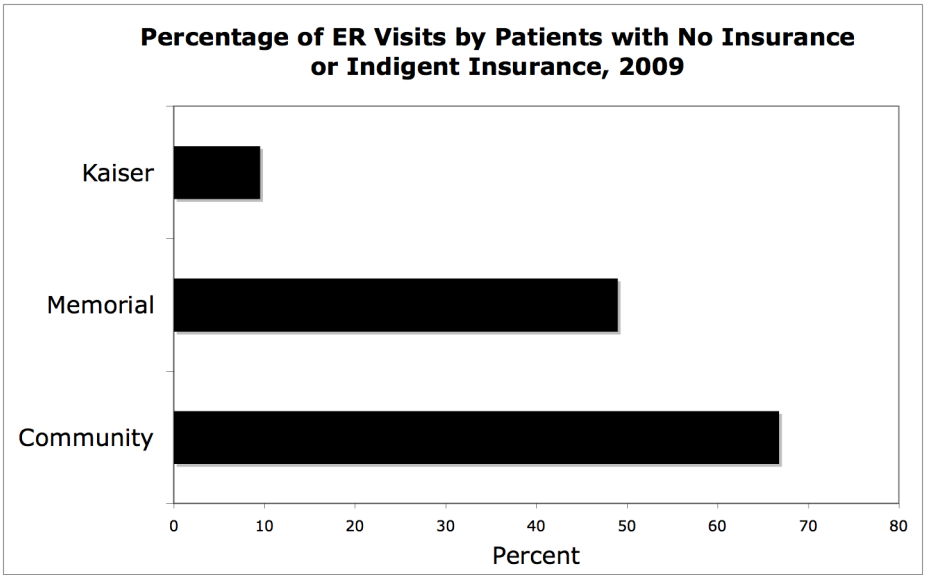
But the generality of Sandra's job inevitably had its drawbacks. For example, while Kaiser had an extensive palliative care program, which focused on helping patients with terminal disease discuss their treatment options and prepare for dying, Community Hospital had nothing like it. Sandra and other social work staff would do what they could, but there was only so much time they had. For terminally sick patients, a charge nurse said with a shrug, "We just wait for them to die, we don't care about their living well with pain." Another nurse chimed in about a case in which a husband "blew his brains out" in front of his infant son while the mother was coming home from the store. The mother came to the hospital and "we gave her Ativan to calm her down. That's palliative care, right?" Doctors would often be left to talk with terminal patients or their families without professional assistance. On one occasion I observed, a doctor took aside the grown son of a woman who had just had a major stroke and was also struggling with dementia. The son mentioned that he had already gone through the painful process of keeping his father alive on a feeding tube for nine months, and that he was not planning on going through the same thing again with his mother. As we prepared to leave the room, the doctor signaled his approval by saying, "So you learned with one parent not to torture the other." Such a conversation almost certainly would not have happened with a trained palliative care physician.

The Right to Care

Among practitioners across the three hospitals in Santa Rosa, those at Community Hospital struggled most obviously with how to reconcile the right to care with care as a commodity. Since the passage of the Emergency Medical Treatment and Active Labor Act (EMTALA) in 1986, federal law has prohibited any hospital emergency room from turning a patient away regardless of that patient's ability to pay. The law thus guarantees

a minimal amount of care to everyone, citizen or non-citizen, in any emergency room in the United States. But despite the formal openness of all three emergency rooms in Santa Rosa, the percentage of uninsured or underinsured patients arriving at Community Hospital's ER was always higher than those arriving at either Memorial or Kaiser Hospitals (see figure 4).

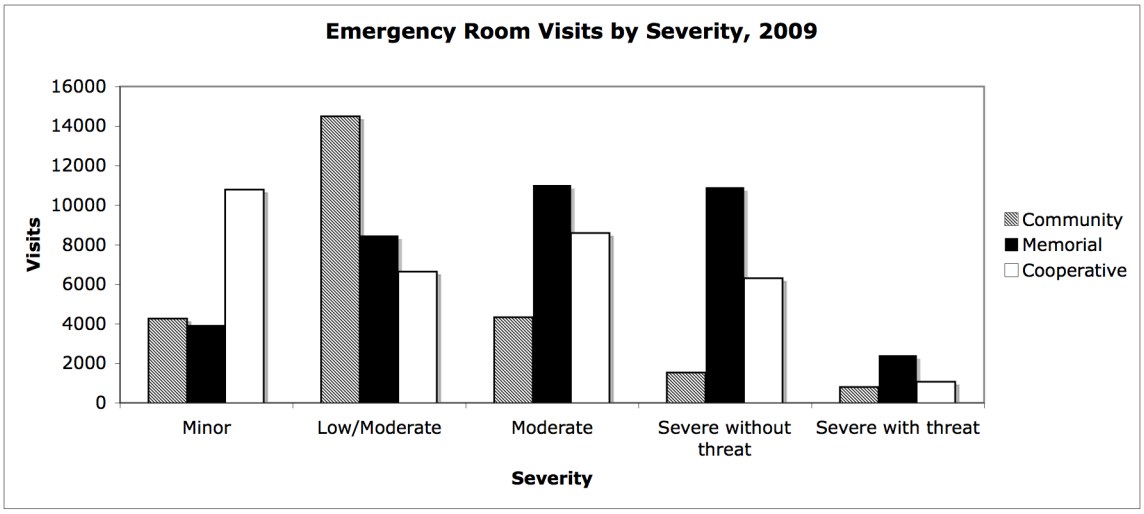
Figure 4.



California Office of Statewide Health Planning and Development

Furthermore, the ER at Community Hospital treated the largest number of non-emergency patients[23], and by far the highest proportion of non-emergency patients, in spite of having the smallest emergency room of the three hospitals (fifteen stations as opposed to nineteen at Memorial and seventeen at Kaiser) (see figure 11).

Figure 5.



California Office of Statewide Health Planning and Development

Those who used the emergency room at Community Hospital were more likely to be poor and uninsured or underinsured, and were more likely to use the emergency room for conditions that were not of acute medical importance, than those who showed up at either Memorial or Kaiser. As one ER doctor put it, a fair amount of what Community Hospital saw in its emergency room was "stupid, clinic, why-are-you-wasting-my-time stuff. You never say that, but I'll tell you [at] three in the morning you're more inclined to ask that than you are at three in the afternoon."

Explaining the overrepresentation of the poor at Community Hospital, many pointed to the hospital's legacy as a county hospital. Until 1996, Community had been governed by the local Board of Supervisors and had focused specifically on care for the poor and underserved. According to some, then, the poor relied on Community Hospital simply because they always had. One nurse-administrator at Kaiser pointed out that for many years Community Hospital was "county supported, county owned. And that's just where [the poor] went… And since that's where they've always gone, that's where they always go." An emergency room doctor at Community also suggested that the poor's reliance on Community Hospital had historical roots. When Community Hospital was the public hospital, "certain people who could afford it [went to Memorial], and certain people who could not afford it [went here.]" In recent years this stratification had changed but not disappeared: "We're a little bit more politically correct today, so we won't say it that way, but it still goes on." A second emergency room doctor at Community Hospital said, "There's definitely a whole contingent of the county hospital population that comes here because that's what they are used to… even though it's been ten years since it was a county hospital."

But an invocation of the hospital's history obscured the ongoing role that physicians and other health practitioners—at Community Hospital and at other hospitals in the area—played in the poor's disproportionate utilization of Community. An emergency room doctor at Community recognized that the unemployed had "been made to feel like the emergency room at [Community] is the place they should come and can come, and also not be treated poorly." "On a mechanical level," he suggested, the other hospitals "could probably take care of everything that we take care of here." But "what

might be lost in the translation is the feeling that patients who've been coming here a long time are comfortable coming here and we get back stories of being treated poorly when they go elsewhere." A second emergency room doctor at Community affirmed that indigent patients "go down [to Kaiser] and don't feel welcome…. I think they're treated like second-class citizens." Those working at Community Hospital created an environment in which poor patients felt welcome.

In an effort to distribute patients equitably across the three hospitals in Santa Rosa, the local emergency medical services (EMS) agency had developed a point-of-entry plan that divided up the city into three geographic areas. All else being equal, if an ambulance picked up a patient in a particular part of the city it would be directed to take that patient to a particular hospital.[24] Yet this system did not change the distribution of patients significantly since, as one nurse at Kaiser put it, "the first [criterion] on the point of entry plan is always patient's request." A nurse in Community's ER said, "If a patient requests us, [the ambulance] will cross all those [geographic] lines to come to us." Those who felt more comfortable at Community hospital would likely find their way there.

Furthermore, the staff at the other two hospitals in the area also seemed to depend on Community Hospital for negotiating the problems of the indigent and underinsured. A nurse at Community recalled an incident in which a "fifty-one fifty"—the code used for a patient on involuntary psychiatric hold—had been brought to Kaiser, but "the nurses didn't know how to handle this patient." At the time, Community did not have any beds available. But those at Kaiser "called [Community] every single day to get that patient moved out of there." The nurse concluded, "We know how to take care of these people, you know? And they don't. They get all flustered and lost." Because of Community's capacity to deal with difficult patients, several practitioners at Community implied, ambulance drivers sometimes overrode the point-of-entry regulations and taken these patients to Community instead of the appointed facility. A social worker at Community suggested that, despite regulations, when ambulance drivers picked someone up who is "down and drunk," they often say to themselves, "We can't take him to Memorial or Kaiser, we better take him over [to Community.]" A case manager recalled being at the farmer's market in downtown Santa Rosa the day before our interview and seeing a homeless man being picked up by the police. While Memorial Hospital was closer, she remembered thinking to herself, "That's my new project for tomorrow." Sure enough, she was negotiating placement for the man on the day of our interview. She spoke of the poor's dependence on Community with a mixture of regret and pride: "I think it's jut been a stigma or a stereotype, or it's jut how it's always been that they come here. And they're used to it here… They know it here, they're comfortable here, we know them, we know how to handle them, I think, quite well." A nurse administrator at Community remembered a paraplegic patient who "refused to poop anywhere but in his pants" and would always come to the emergency room for his care. No matter where the ambulance drivers found him, they would always bring him to Community. "And finally we looked at the paramedics and we're like, 'You know, this isn't fair.'" She continued, "You know, the County Hospital often is the dumping ground. And even though we're *not* county, we've always been county and we've always had that label." One emergency room doctor at Community suggested that since Memorial was the "base hospital" for local EMS services, communicating with the ambulances as they transported patients, it

had a history of directing a disproportionate share of the uninsured or underinsured to Community: "There was a little conflict of interest there," he chuckled.

Several nurses and social workers at Community pointed out that, on occasion, workers at Kaiser would try to send their uninsured or underinsured patients to Community. A manager responsible for utilization review and case management recalled how the social work department at Kaiser would sometimes call her saying, "We have one of your patients." She would respond, "Is it a Sutter Medical Foundation patient?" referring to Community Hospital's associated physicians' group. The social worker would respond, "Well… no, the patient's unfunded." She would tell the Kaiser social worker that it had the responsibility to care for the patient. But social workers at Kaiser would sometimes call multiple social workers at Community, "shopping for an answer," hoping to dump the patient on Community. Another discharge planner at Community said she had seen this practice from Kaiser as well, and that it was "basically illegal" given the responsibility of every ER to stabilize the patients that arrive there. She had to coach her colleagues not to take these patients when Kaiser came asking.

Similarly, some health practitioners in the other emergency rooms, and even within some primary health clinics, had encouraged the uninsured and underinsured to come to Community Hospital in order to get specialty follow-up treatment. For example, according to many practitioners, the only way for uninsured or Medi-Cal patients to get orthopedic care was for them to show up at Community's emergency room to see the orthopedist on call. One nurse explained how she sometimes saw discharge orders from Memorial Hospital's emergency room that read, "Go to Community's ER to have your cast changed in two weeks." At any given time, there were often two or three patients in the ER for what nurses wrote on the patient board as "ERFU," or "emergency room follow-up."

Community Hospital was no longer a public hospital at least in part because the county had been losing significant amounts of money on treating the uninsured and underinsured without making money on paying patients. As a result, in 1996, the county had signed a twenty-year lease with Sutter Health, the largest not-for-profit health care corporations in the state. According to a report on the privatization of public hospitals prepared for the Henry J. Kaiser Family Foundation, the philosophy behind these transitions was relatively simple:

> To preserve the institution for indigent patients, for whom it was the provider of last resort, those responsible for the public hospitals decided it was necessary to operate the institution for *everyone*—that is, to use the market to make the hospital financially viable by attracting not only patients who cannot afford to pay, but also those who can.[25]

In an analysis of Community Hospital specifically, the report said that the county did not have the resources to make the capital expenditures necessary to attract insured patients; that the hospital had been too small an entity to negotiate with organized insurers and physicians' groups in the area; and that it was at a disadvantage because the leaders of the hospital were "forced to develop and implement long-term competitive strategies in a public forum (because of California's open meetings act), and their competitors [could] sit in on their planning meetings."[26]

One ER doctor was even more critical of the hospital under county governance, attributing its failures to a combination of incompetence and deliberate neglect. On the one hand, he suggested, the hospital's insulation from the market meant that it was fiscally irresponsible—in a socialized system, he said, "no one takes responsibility." He described how at one point it was discovered that millions of dollars worth of Workers' Compensation bills had not been filled out because the county had not hired the staff to do it. Yet this doctor also believed that the county had deliberately underfunded the public hospital "because the theory in those days was [that] the public did not compete against the private sector." He believed that powerful interest groups in the county thought that investments in the public hospital would erode the private market for care: "Anything that we asked for… like social services, or an improvement to the OB wing… was lobbied [against] by the private sector…." While many other doctors were concerned that Sutter Health was "going to kick out all of the homeless and uninsured patients because [Sutter was] a big corporation," this doctor thought that at least Sutter Health had "dedicated themselves to doing this." In his mind, the public mission of the hospital had never been embraced fully by the county: "The county [was] not supporting this hospital, they [didn't] want this hospital." The only alternative was for the hospital to try to sustain its mission as a participant in the private market.

At the time, however, many residents of Santa Rosa bemoaned the privatization, worrying that it would undermine the hospital's mission of providing care to the poor and make the hospital less publicly accountable. A community coalition led by the area's largest public-sector union organized a ballot initiative calling for a public vote on the plan. Despite the opposition, however, the county Board of Supervisors was set in its decision. At the time, one county supervisor said of the petition, "They might think that they are going to win. But if they win, they lose. The hospital just won't make it much longer."[27] When the petition had secured enough signatures for a referendum, the Board unsuccessfully challenged the validity of the ballot measure in court, arguing that the management of the hospital was "too complicated and time-sensitive to turn over to the electorate."[28] A vote finally occurred almost eight months after the hospital had been leased to Sutter Health, at which point voters decided on a three-to-two basis to continue the lease.[29]

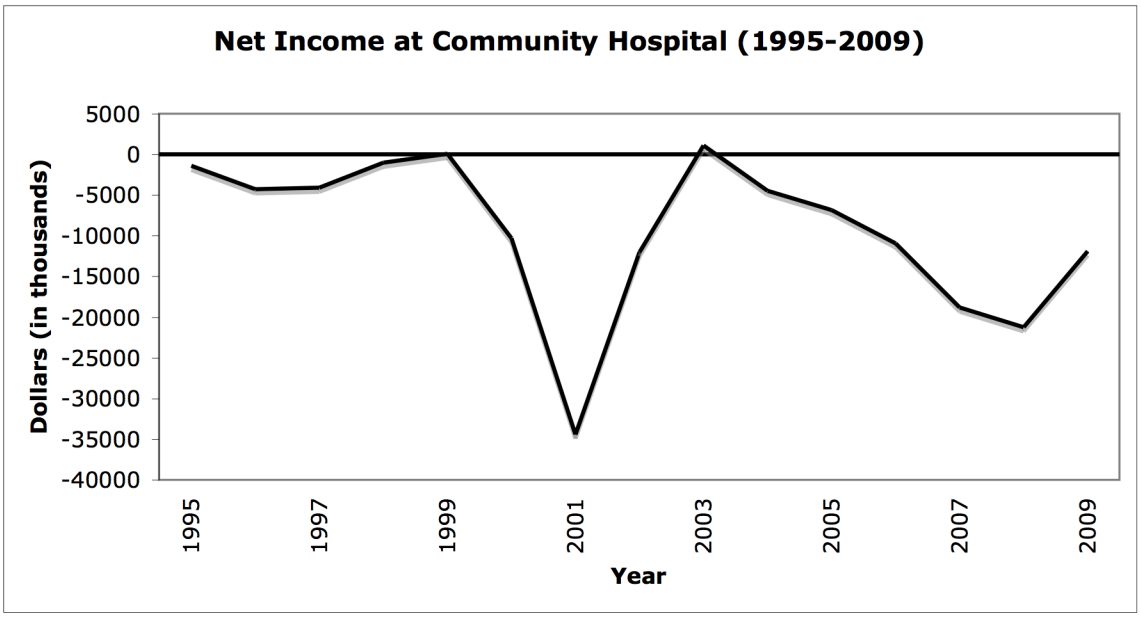
In making the transition to private ownership, however, the Board of Supervisors had sought to be discerning about buyers. It refused a proposal from a large for-profit corporation because the "hospital's medical staff was afraid [it] would 'turn the hospital upside down to make a buck.'"[30] And it believed it had found in Sutter Health a corporation that could pay attention to the bottom line while remaining committed to the hospital's public mission. In turn, Sutter Health was interested in taking over the facility because it "had a relationship with a physician group in the area, but no local hospital; the lease of Community Hospital was a way to get into the local inpatient market."[31]

The conditions of the lease were articulated in a health care access agreement, in which Sutter Health committed to working "cooperatively and in good faith"[32] to ensure that all residents of the county had access to a "full range of women's health services (e.g., preventive care, birth control, sterilization, pregnancy termination procedures, labor and delivery) and treatment of HIV/AIDS and other communicable diseases."[33] Yet Sutter Health also committed not to "seek additional sums from [the county] to subsidize

the cost of Services provided to beneficiaries"[34] of government programs like Medicare and Medicaid.

At the beginning of their report on public hospitals' transitions to private ownership, the authors asked whether the "'public goods' that public hospitals provide [could] survive the hospitals' conversions to private ownership or management."[35] The answer, for them, was yes—that the market for healthcare could be made consistent with poor people's right to care. But the relationship between the market for care and the right to care was not as easily reconcilable at Community Hospital as the report suggested. In spite of millions of dollars invested in upgrading the hospital to attract paying patients, Community Hospital had been losing money (excluding capital expenses) under the management of Sutter Health in all but two of the fourteen years since the lease had been signed (see figure 9).

Figure 6.



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And while there were several possible explanations for why Community Hospital has continued to lose money despite its new investments and new management, the antagonism between the right to care and care as a commodity——in both organizational policy and in practitioners' understandings and practices—is an important dimension to the story. One manager exemplified this tension when she spoke of the challenge at Community Hospital: "We're viewed [as an indigent hospital], even though we try to not to be—not trying to not be insomuch as we don't want to take care of the indigent, but people always think of us when think indigent." She felt pride about the hospital's public orientation at the same time she sought to distance herself from it. Restating her position later in the interview she said: "Somebody has to take care of [the indigent], and we're proud to do it, but we don't want to only be seen as, oh that's where all the poor people go. We want everybody to use us. And we still want to do our part of the indigent." Even one of the hospital managers responsible for utilization management—whose job

was focused largely on ensuring the hospital was not giving excessive amounts of care that could not be reimbursed—expressed a commitment to the right to care: "I am an old sixties person and I believe that everybody deserves care…. I don't care what your income bracket is. And I believe that everybody deserves the same level of basic care…. I believe it's our obligation to pay for that for everybody within our community." It was sometimes difficult for her to balance this commitment with her job responsibilities.

The Hospital as Almshouse

Ruth Malone (1998) described the emergency department in today's health care system as having a "hidden role as a public 'almshouse'" (p. 797), which certain marginalized populations depended upon not only for medical care but also as "a place to receive 'help' much more broadly defined" (p. 801). She argued that the problem of over-utilization of emergency services must be couched within the broader question of "how and where we as a society and as individuals care (or fail to care) for those who cannot or will not care for themselves in socially sanctioned ways" (p. 821). As other institutions of social welfare have folded, moreover, the demands on hospital care only increased. Nowhere were these issues more pertinent in Santa Rosa than at Community Hospital—not only in the ER but throughout the facility.

Patients at Community Hospital often arrived there as a last resort. One emergency room doctor put it bluntly: "The patients who come here are at the bottom of the barrel, they have nowhere else to go. They don't have a primary care doctor. They've burnt their bridges with their family, many of them. The social system has had it up to here with them. The cops drop them off here; they don't even take them to jail anymore." One nurse administrator recalled how the prison would sometimes release critically ill inmates onto the streets after their sentences only to have them end up at Community. She recalled a case of a sex offender with dementia "whose last memory was that he had lived in Santa Rosa… And the prison put him on a bus and sent him back to Santa Rosa." The police found him wandering outside of a church, and brought him to Community Hospital. "We had a terrible time finding a place to put him," she recalled.

Another group of uninsured patients treated the hospital's emergency room as a primary care clinic. An emergency room doctor said, "Many people have no primary care provider, other than the emergency room. So we do see an inordinate number of people that could be taken care of in the office. They can't seem to get into an office or don't know how to, or they have nothing better to do than wait five hours to be seen." One patient I observed—an African American woman with sickle-cell anemia and several other health complications—had been seen in the ER by the same physician for approximately fifteen years. The rumor was that the doctor could do his dictation on her from memory, without referring to her chart. Many of the uninsured or underinsured waited to come to the ER until they were quite sick. According to one nurse, many patients at Community's ER wound up "being really, really sick people… because they didn't have the money, they didn't have the insurance, so they stayed home until it was… almost too late." Another emergency room doctor echoed this sentiment: "A lot of people are much sicker because of their lifestyles and because they wait a long time before they seek medical care, some of them."

It was thus often difficult to disentangle patients' medical and non-medical needs (see Malone 1998, p. 816; Padgett and Brodsky 1992). As one nurse manager said, "I find that a lot of times when the social things fall apart, then it builds on the medical things falling apart. First the social things fall apart and then the medical things fall apart. And you'll find that forever." When a poor person could not afford her medication, or an elderly person did not have family or friends nearby to help him shop for groceries, the line between illness and other forms of social distress was blurry.

Overall, then, Community Hospital seemed a place for the desperate and despairing. As one emergency room doctor put it, "I don't know the numbers, but it's a rarity to see someone who has even has a job, actually." As a part of the health care access agreement that Sutter Health had signed with the county, Community Hospital was still responsible for medical clearances for the county jail (for which the hospital was to be reimbursed at approximately 80% of billed charges), as well as several other county services like screenings for victims of sexual assault and blood alcohol tests for drunk drivers.[36] A nurse in the ER explained, "The emergency room can be 90% medical clearances for jail drunks and fifty-one fifties… We may not have one sick or normal person in our ER." An emergency room doctor also acknowledged that Community was responsible for "a lot of fifty-one fifty clearances." Stories abounded within the ER about the travails of the psychiatric patients. In the past, for example, one of the examination rooms had had a lock in order to give patients gynecological exams with some privacy. The lock had been removed, however, when a nurse had accidentally put a psychiatric patient in the room, who had locked the door and hung herself. Another woman had tried to stab herself with a syringe, so none of the evaluation rooms had syringes any longer.

Given the hospital's close relationship with those living on the margins, one ER doctor had taken it upon herself to stay up to date with street slang: "[I] try to get the latest jargon with the drugs and the verbiage, because I can't keep up with it. They come in and tell me these things and I don't know what they're talking about. I'm trying to keep myself educated. Keep trying to stay street wise. Because we interface a lot with the cops." It was sometimes difficult even for the medical practitioners to know whether a case was medical or more suited for the mental health or criminal justice systems. On one occasion a patient was wheeled into the ER having been found passed out in a Laundromat, only to become combative in the ambulance en route to the hospital. Finding the patient only partially conscious and in restraints in the psychiatric room, the doctor did not know whether to send him to psychiatry for evaluation or to send him to jail.

The tension between care and control within the ER was illustrated even more forcefully one afternoon when the patient started yelling from his room, "I'm fucking cold!" One nurse said, "I'll get him a blanket." Paying no attention to the nurse, a doctor said, "Get him some Ativan," a popular anti-anxiety medication. And the charge nurse, disregarding both of the others, rushed into the man's room saying, "Would you like to go to jail? One more outburst from you and that's where you're going!" Among the nurse, doctor, and charge nurse the patient was understood, respectively, as in need of comfort, in need of medical treatment, and in need of discipline. On another occasion a woman had been brought to the ER because she had been loitering in a grocery store for over 24 hours. Her blood pressure was dangerously high but she was refusing to take her medications. The doctor was flustered because she felt she could not transfer the patient

to psychiatry before she got her blood pressure under control, but her refusal to take her blood pressure medication seemed to be a part of her psychiatric illness. "Should we go get the water board?" one of the technologists joked.

Because many patients at Community Hospital came from such difficult social situations, it was often a challenge for the hospital to discharge them. Insured patients not only had access to medical resources, but also—as a case manager said—were more likely to have "a stable home environment to go home to" and within which to receive follow-up care. As a charge nurse in the emergency room described, patients were often not sick enough to be admitted to the hospital, so she had to figure out "where are we going to go with this, socially." One unfunded patient had recently come to the ER in kidney failure and needed emergency dialysis. But since outpatient dialysis centers would not accept patients without funding, and since the hospital was not licensed as an outpatient dialysis center, the patient had to get treated in the hospital for six weeks while case management worked to secure insurance: "He was walking the halls, he was sitting in the patio. I mean, essentially we were room and board…"

On occasion, the hospital would also take in "social admissions," in which patients were admitted "until [it] can be sorted out how they can take care of themselves." A critical care doctor expressed frustration at the tremendous amount of resources the hospital spent dealing with social problems. One patient, who had been in the intensive care unit for a month, could have gone home if only the hospital could find the necessary equipment for her to take home with her. But since the patient had no insurance, and had "stiffed some of the [equipment] companies… nobody want[ed] to deal with her… So she sits in the ICU…. It's incredible." Another hospitalist was treating a man who had been hospitalized for seven months because no one else could be found to care for him. The hospitalist remarked to an ancillary worker that he sometimes felt he was directing traffic more than practicing medicine.

A Special Breed

Doctors throughout Santa Rosa had done their training at Community Hospital's prestigious family residency program, so many were familiar with the patients there. Remembering their residency, several oscillated between nostalgia and feelings of good riddance. One family practice doctor at Kaiser remembered how "a lot of patients were coming in for reasons that would be other than medical." And since "you're trained as a medical student and a resident to treat medical problems…. it drives you a little bit apoplectic." While this doctor "applaud[ed]" those who "had a stomach for" an environment like Community, he did not think he had the patience or skills for it himself: "I'm good at diagnosing disease, I'm good at coming up with treatments and working with people to impress upon them the importance, but I'm not good at that other stuff."

Those at Community agreed that there was something unique about those who chose to remain working there. One nurse at Community suggested that "Kaiser nurses pick Kaiser because they're not subject to" the social needs of patients. Another charge nurse, who had worked at both Community and Kaiser, said that there was "more impatience at Kaiser" with the indigent. She herself said she enjoyed the "variety of patients [at Community]… the people that have hard times from the community, as well as the private patients." This seemed connected to her own sense of egalitarianism: "That's a huge challenge to remember to treat everyone the same, respectfully, and I

think it's a really healthy environment to work in." Overall, she thought that practitioners at Community were united by a commitment to giving everyone—no matter what the background—the same quality of care: "You have an indigent patient on one hand and then you got little grandma from Oakmont on the other side with all her diamond rings.... Everybody is treated the same, and that's what makes this place so unique." This nurse also implied that caring for the indigent was particularly rewarding. The poor in particular "appreciated [the care] so much…" which made the work "very, very gratifying."

An ER doctor at Community also emphasized the importance of treating people equally, but for him this necessitated a certain abstraction from the person in order to focus instead on the illness: "One of my mentors told me, he said, 'Okay, here, we do just medicine here, just medicine.' And I got that finally. He said, 'Don't bring your social biases, your judgments, your picking and choosing, don't bring your opinions to this ER, just do medicine here and you'll get along fine.'" This doctor went on to acknowledge that "there were some docs who, for one reason or another, got really, really angry, and could not tolerate being in the Emergency Room with the kind of patients that we had, which were many times abusive, they were intoxicated so they were hard to deal with, they were manipulative, all of that kind of stress." Those were the physicians who were unable to let go of their judgments.

Several physicians and nurses at Community sought to displace their frustration with patients to the medical system more generally. According to one nurse in the ER,

> I think mentally you can work through it by understanding that a lot of time people have no choice. They have tried to go to the clinic, they can't get into the clinic for four or five, six weeks, they've tried to call their doctor and their doctor sent them to us…. It's not just the people not being responsible…. So you might as well get your head around that.

This nurse stressed the importance of not shaming those who came to the emergency room "because the implication of that is that they did the wrong thing, and then the next time they're not going to come to you…. Once we have somewhere for them to go, then we can tell them where to go, but we don't have that answer." An emergency room doctor felt frustrated "because for every step you try to take forward for the patient there's two steps back." She would write prescriptions and then realize that Medi-Cal did not cover them so the patients were not able to get them filled. The patients would then wind up back in the ER. Despite these frustrations, many staff-members seemed to take a certain pride in the Sisyphean work with which they were engaged. When I asked one social worker how she handled those patients who returned to the ER again and again—called "frequent fliers" in hospital parlance—she answered flatly:

> You start again. What are you going to do? You start from the beginning…. You cannot deny people medical supports…. If they're homeless and they've got pneumonia, we clear them up and they go right back out and sleep up under that same tree that they got pneumonia from the last time. We can't say, 'Oh, no you can't come in here, 'cause we told you to get a place to sleep,' when the reality is there is no place for you to sleep, and you're doing the best that you can…. We can't say no. We've gotta treat you.

Practitioners at Community often found themselves offering types of assistance that included a whole array of social services. As a doctor put it, "Okay, this person has nothing to eat and so why not give them a sandwich, you know? Or they have nowhere comfortable to sleep, so why not keep them a couple more hours?" One nurse administrator discussed how the emergency room would sometimes feed and board homeless people "if we're not too busy." The ER also had "a whole closet full of clothes and we give out… god knows how many socks and things like that." During the holidays the hospital would "give out toys to kids," and they always had a stash for children to use while their parents got treated. If they had run out of spare clothes, nurses would often give homeless people whatever they could find: "You know how many blankets we've sent out of this place for homeless people?" A nurse in the ER acknowledged that the needy had come to expect "this place to be… their shelter, their food source." The hospital would sometimes offer taxi vouchers to patients without a ride home, and would provide car seats for new mothers without the money to buy them. Nurses would bathe patients who had been unable to wash themselves. These sorts of services were almost unheard of at the other two facilities.

Moral Categories

For many who practiced at Community Hospital, health care was deeply tied to the provision of health care as a right to those in need. Yet alongside this commitment came a set of moral distinctions that practitioners used to differentiate the deserving poor from the undeserving.

First, several practitioners at Community recognized the hazard of providing *too much* support to patients. One nurse described how neighboring Memorial Hospital justified its own stinginess towards the indigent by saying, "This way they won't come back here…. If we give something for free, then they'll keep coming back wanting more." And while she asserted that "we don't think that way" at Community, she acknowledged that there had been pressure from administrators to cut back on such hand-outs: "We get in trouble all the time because of the budget." On one recent occasion the head of the linen department at the hospital was passing by the ER entrance as nurses were putting a blanket around a patient and discharging him: "I observed this one," the administrator said. "You're not going to be able to talk your way out of it." Another nurse in the ER also implied they were creating perverse incentives by offering resources too easily: "It's gotten to the point where people abuse taxi vouchers and every time they come here they take an ambulance and expect a taxi voucher home. And they're comin' in because they have a hang-nail."

Many practitioners at Community expressed a concern about the moral hazard of providing free care, a belief that care as a right conflicted with the market for care and undermined the sense of personal responsibility that the market helped to foster. Dr. Brittney Sampson was an emergency room doctor at Community. Now in her late fifties, Sampson had grown up and gone to school in Boston before doing her medical training in Washington State. And having come to Santa Rosa because it looked like a nice place to live, she had worked in almost all of the emergency rooms in the area before settling on Community, although she still worked the odd shift elsewhere. Like other physicians at Community, Sampson had a folksy air about her, though in her case it was moderated by some residual east coast grit.

Of the doctors I interviewed at Community, Sampson was the most forthright with her frustrations about the moral hazards in the medical system, particularly at Community. She recognized that Community Hospital had a "role and an obligation" to take care of the indigent, but was worried about the effects that the free provision of care had on the poor. As one example, she recounted the case of an eighteen-year-old with two children who lived in a shelter. Because she was obese and sleeping on a cot in the shelter, the woman was having back pain: "She called an ambulance because her pain was so bad to bring her to the emergency room to get her pain medication." Sampson asked whether the patient had tried ibuprofen, and the patient said she could not afford it. "I said, 'Do you know how much this ambulance just cost you to go from the shelter to Community? About fifteen hundred dollars.'" The patient responded, "Medi-Cal will cover my ambulance ride." The patient asked for pain medications, which Sampson prescribed, but the patient also asked for free ibuprofen. Sampson told the patient to "take your cigarette money and buy your ibuprofen." The patient then wanted a taxi voucher to get back to the shelter. "I said, 'No, you're going to have to figure out a ride.'" The patient then responded that she wanted an ambulance back. "I looked at her and I said, 'The state is bankrupt, there is no money…' They don't get that. She looked at me like I had three eyes."

Sampson felt that "there's so many people in society that we enable." Because of entitlements like Medi-Cal insurance and food stamps, she felt, "There's no reason for [people] to have to work." She was frustrated that people could receive disability insurance for bipolar disease "even if [it]… was induced by [their] methamphetamine abuse." She was frustrated that someone could get a lung transplant even though "he smoked all his life." She was frustrated that patients would "use their money for potato chips and cigarettes and ask me to write a script for them for ibuprofen so that the tax payers can pay for that." On one occasion a woman came into the ER needing an MRI. She said that she weighed 325 pounds, but a tech was afraid she might actually exceed the 350-pound limit on the hospital's MRI machine. Sampson said that the newer machines could handle patients of up to 450 pounds, but then remarked that it was sad that instead of getting people to lose weight we develop machines to accommodate heavier patients. "Where's the ownership?" she said. "These people, there's been so many handouts for so long they're so used to it… There is a sense of entitlement, and I hate that…. As an ER doc I cannot turn anybody away. They may owe fifty thousand dollars to the hospital and I cannot decline services to them." Alcoholics would wander into the ER and "you have to keep them there until they can walk and sober up…. And you kick them out of there, they're down at the bar and the local grocery store buying booze before you can blink an eye."

Sampson suggested that people's right to care should be contingent on them taking responsibility for themselves: "I'd be happy to give you health insurance, or provide your health care, but you gotta stop smoking. You gotta stop shooting heroin. You gotta stop snortin' the cocaine. You gotta lose weight." A doctor at Kaiser Health contrasted his experience at Kaiser with his residency at Community Hospital. At Kaiser he still saw some patients who were "not taking care of their health" and "wanting me to fix their health." He continued, "I'll take care of them, but we have some parameters how to do this…. You need to follow my plan, if you can't follow my plan, then you need to find somebody else to go see." At a place like Community, it was much more

difficult to hold patients accountable in this way. As an organization of last resort, there was nowhere else for patients to go.

And while Sampson was the most forward with me about the resources wasted on those she considered irresponsible, many others recognized that they sometimes felt their kindness was "abused." One nurse administrator discussed a patient who had a colostomy bag, "and every time it comes off, he will not try to learn how to put it back on. So he comes in incontinent of stool probably eight times a week for us just to clean him up… So that is terrible misuse." A critical care doctor at Community suggested that some patients in kidney failure would cross from Mexico to California emergency rooms to get treatment. Another emergency room doctor at Community worried that some were "taking advantage of the goodness of the system." When people receive Medi-Cal, she suggested, "you should give them a little talk… to feel their own responsibility in the system."

But the line between the deserving and undeserving poor was often murky. Sandra Lacks recognized that the "word was out on the street" that "all you have to do is go [to Community Hospital] and they'll give you food vouchers," and that some patients had come to take advantage of it. She acknowledged that it was a type of "game-playing," but asserted that it was "also survival. You do what you gotta do to survive out there." Was the Medi-Cal patient who came to the ER because there was a long wait at the clinic being manipulative? It was unclear to many. One ER doctor told a story of a woman who brought her daughter to juvenile hall saying they had been fighting, when in fact she did not have insurance and wanted her daughter's urinary tract infection to be treated while she was in custody. On the one hand, this doctor pointed out, it was "gaming the system." But on the other hand, could anyone blame her? Even Sampson herself was not uncaring. She volunteered in a local women's clinic, and in person seemed to treat almost all of her patients with respect. At the end of one shift, a homeless man was about to be discharged when the nurses brought him a hot meal from the kitchen. Sampson smiled the biggest smile I had seen on her the whole day and said, "Isn't that nice. This is the best meal this guy will probably have all week."

Practitioners in Community's ER thus spent much of their time trying to differentiate between the deserving and undeserving, serving as informal gatekeepers for the community's social welfare system. One doctor, reflecting on his training at Community, reflected on how it seemed that "the medical care system was one of the few areas where [the poor] could seek out some entitlement." Doctors were required to sign work-release forms for those insured on the job, for example. This doctor remembered "struggling with" patients who wanted two months off for a sprained wrist when a few days would likely have sufficed. Doctors were also wary of those seeking pain medications in order to sell them on the street. As one doctor who had trained at Community put it, "there's no teaching in medical school that tells you how to deal with the Vicodin addict that's going out and selling the prescriptions and coming out with incredibly ingenious and heart-felt stories of why they need more pain medications."

On several instances one ER doctor would walk out of a patient's room saying something like, "He's playing us." A second ER doctor discussed how patients would often only start groaning once she entered the room: "A huge amount of gaming goes on, a huge amount…. It can make you cynical, for sure." One homeless woman was brought to the ER having been hit by a car in the parking lot of the homeless shelter. The doctor

and charge nurse thought it was a case of "poor me, poor me," and that the woman might be trying to "turn it into something" like a lawsuit. A case manager at Community discussed a girl she had just seen who "didn't want to leave [the hospital] because she liked her IV pain meds… It was like I had to get a forklift and pry her out of that bed to get her out of here." She continued by discussing how patients like this young woman were "institutionalized," she "knows the drill, and she knows exactly what to say" to stay in the hospital. Some inmates from the prison would "fake seizures so they wouldn't have to go back to the jail." While I was observing, there was an inmate from the jail who had been admitted to Community for kidney problems. But it came out in a utilization meeting that the man was afraid of going back to jail, and had convinced one of the nephrologists (a "push over," according to the hospitalist) to let him to stay a few more days. The hospitalist said that someone was going to have to tell the man he was discharged and then walk out of the room without discussion; a case manager said the police would probably have to take him away "kicking and screaming."

Vocation and Disorganization

Many practitioners at Community discussed a need to be resourceful in the face of a lack of resources—a lack of resources that they faced as a hospital, and the lack of resources with which their patients arrived at the hospital. The implication, again, was that the hospital's mission—care as a right to all in need—was made more difficult by a market that systematically disadvantaged them and their patients. One nurse said that it was her and her colleagues' vocational commitment and creativity that kept the organization running: "There's great nurses here that can do more with nothing than I've ever seen people do." In place of missing doorstops, nurses would tape doors to walls; in place of pins to latch tubing together, nurses would use needles and tape.

Doctors, nurses, and social workers were also quite resourceful about finding treatments and placements for uninsured or underinsured patients. One case manager said with a smile, "We get pretty good and coming up with creative discharge plans." Sandra Lacks, the social worker, considered herself a "researcher of resources." If she had not been a social worker, she said, she would have been "an inspector over in Scotland somewhere… 'cause I like figuring stuff out." Given her wealth of knowledge, she saw herself as the "point guard of everything that happens within this county. Anybody who wants to know anything… regarding any resources, they'll start with me." But the way she spoke of her role was also indicative of the facility's overall lack of systemization or coordination. Whereas an organization like Kaiser had systems in place for different sorts of patients, each new case became, at Community, a Sherlock Holmes mystery.

Several practitioners discussed the relationships they would build and games that they would play in order to secure placement for their patients. When practitioners at Community interfaced with the broader medical community there seemed to be a sort of gift economy (Mauss 1967) in which ongoing relationships, implicit understandings and moral codes took the place of explicit exchanges. For example, one case manager described how she would send insured patients to particular nursing homes if those homes had also agreed to take the uninsured and underinsured. While I was observing her, she made at least two different "deals" to secure placement for those without good funding. With a worker from a local nursing facility she explained, "We'll joke around

and he'll be like, 'You're gonna help me out?' And I said, 'I'm gonna help you out….' It's kind of fun." Later on, she seemed to make a slightly more formal exchange: if the home would take a Medicaid patient, she promised she would send the same home her next Medicare patient (which reimbursed the home at a higher level). Laughing, she said, "It's a game." More generally, she explained her philosophy about placements: "We do the best that we can for the facilities that help us out." In turn, she tried to avoid some of the "fancier places" entirely:

> Not that I don't like them, I just know that they only want their cash cows. They want the fully funded, 75-year old with the hip replacement who's going to be there two weeks, so they'll get maximum benefits from Medicare and then they'll go home with a simple discharge plan. They don't want Joe Blow homeless guy who just had a BKA [below knee amputation], who…. needs IV antibiotics for six weeks, oh and by the way, I don't know where he's going after that.

Sandra and several others discussed how the resources to which she had access were oftentimes a product of the relationships she had established: "You do a favor for them, they do a favor for you… That's the way it works." Reciprocal obligations—"a favor for a favor for a favor"—meant that she was able to do a lot for patients without much in the way of financial incentives on her side: "It ain't got nothin' to do with resources. If it was resources, honey, all of us would be in the poor house, 'cause there's no resources." The difference between successful and unsuccessful social workers, she said, was that successful ones were "seasoned," had "been around for a while and they've learned the game." A case manager also referred to the relationships she had built over time "with facilities… and with certain people." She said that most people at Community Hospital had trouble with a particular equipment company but she knew "this one guy…. And he bends over backwards to help me." At an oxygen supply company, another man she knew would break protocol and bring a patient a tank before the funding came through. When other companies came to her, marketing their businesses, she would respond, "Well, you don't help me out."

At Community Hospital, then, individuals worked creatively on behalf of patients, but did so in place of any system. As one case manager recalled, where Community Hospital relied on informal relationships and favors in order to place patients, the other two hospitals each had a different system. Memorial Hospital would fax a patient request to all of the facilities in Santa Rosa and send the patient to the facility that made the best (or fastest) offer; Kaiser Hospital, in turn, had contracted with facilities in advance, "buying beds" that were reserved for their patients. If Memorial relied on a kind of impersonal market exchange, and Kaiser on bureaucratic arrangements, Community relied on the resourcefulness and relationships of its staff.

Among many practitioners at Community Hospital, it seemed that caring was understood as being opposed to efficiency—that pressures for efficient care threatened the mission of the hospital. One charge nurse said, "Community has the heart. [It has] a great heart, and the people that don't care about billing, they just want to take care of patients well. And they will do that. But they will not charge you for it. So it's a little crazy." Another nurse discussed how it would be "taboo" for her or her managers to ask her peers to conserve on costs because they would assume that management "just wanted to save a buck" and was sacrificing care because this was "a community hospital." The

same spirit that motivated practitioners to provide health care as a right, then, sometimes seemed to stand in the way of basic organizational efficiencies.

The level of disorganization throughout Community Hospital far exceeded anything at either of the other hospitals. On one morning I arrived in the hospitalist office just before Dr. Alex Polyakova was about to begin his rounds. The office fax machine was out of paper and seemed to have been for some time, because when Polyakova replaced it a stack of perhaps fifty faxes came spewing out. These faxes consisted mostly of lab reports on patients for which the hospitalist department was or had been responsible, but Polyakova seemed at a loss for what to do with them. Saying that under normal circumstances he would just recycle them, he decided to keep them in order to show them to an administrator as an example of organizational inefficiency. But these oversights abounded. Down in the ER, for example, the nursing board had been built in the early part of the 20th century with a lighting system. Nurses could turn on a red light beside a name if the doctor needed to take action on patient, and doctors could turn on a green light beside the name if the nurses needed to take action. But as far as I could tell only one doctor and none of the nurses used the lighting system at all.

Throughout the facility, Sutter Health was making a slow transition from paper records to electronic records. The hospitalists used at least two different computer programs—one for patient care and one for billing—in addition to the paper records, and charts were constantly being misplaced. According to one hospitalist, neither the electronic records nor the paper records were complete, meaning that practitioners had to refer to both in order to construct a comprehensive patient history. Inexplicably, results from blood sugar tests were not kept in patients' records but rather in a separate room behind a locked door. In the emergency room one doctor was particularly notorious for leaving charts in patients' rooms or in the wrong boxes, leaving various personnel scrambling to find them. The lack of reliable electronic records meant that tests were often duplicated unnecessarily, and some doctors jokingly discussed their biggest medical challenge as having to read other doctors' handwriting. On one occasion in the ER a patient looked closer to death than any patient I had previously seen—pale, dehydrated, and gaunt. For over two hours the doctor and nurses puzzled over his condition and tried to get his blood pressure to rise; it was only then that someone realized he had had a procedure in the hospital the previous day in which he had lost a lot of blood. With a more streamlined record system like they had at Kaiser there would not have been this confusion. At Kaiser, there was one comprehensive electronic records system on which all the staff had been trained. Each doctor interfaced constantly with the system or could be reached on a single cordless phone. At Community things were much more haphazard. One hospitalist whom I shadowed carried with him two cell phones (an iPhone that did not get reception and a cell-phone for calls), a cordless phone, a beeper, and an iPad that he used for emails and to look up medical information. Despite his dependence on these various devices, he joked, "To err is human, but to really screw up you need a computer."

Practitioners at Community Hospital seemed to eschew some of the specialization that has come to define modern American medicine, each focusing instead on the patient more holistically. Doctors would do procedures out of their specialties; and nurses at Community would "act more like doctors" than nurses elsewhere, according to a physician. Community Hospital was the only hospital in Los Lomas to hire family

practice doctors alongside board certified emergency physicians to staff its ER. These physicians would often spend more time with emergency patients, sitting down next to them where the ER doctor would stand. As one such doctor said of a hypothetical case, "This patient really could do those tests as an outpatient, but they may not get there, so I'm going to do them now." Another family practice doctor who worked in the ER said that she treated the "whole person, the whole family situation…. I mean, those are the things a family practitioner gets bogged down thinking about and ER doctors, are like, 'Stop using that [drug]—okay, next."

But this generality had its drawbacks. When ER physicians put on casts instead of orthopedists it took longer; when patients treated the ER like a family practice clinic, it could be argued, it wasted the ER's resources. Lines of communication between various practitioners often became tangled. And when everyone tried to do everything, some things got short shrift. For example, until recently the nurses at Community had been responsible for hospital billing. According to a charge nurse, "We used to be taking care of patients, running ragged… and before we turn in our chart, trying to click a few boxes for billing—well, you can imagine how much billing was missed."

The Mission Against the Market

At Community Hospital, then, the mission of healthcare—conceived of as the right to care for everyone—was widely understood to be at odds with the market for care. Practitioners would offer resources to needy patients—from free Tylenol to blankets to meals—that sapped the hospital of supplies. The very provision of health care as a right, according to many practitioners, risked creating moral hazards—the thousand-dollar ambulance ride for the two-dollar ibuprofen. And as explored above, the belief among practitioners that the mission of healthcare was inconsistent with the market seemed to become an ideology through which disorganization and haphazard care was understood. Practitioners, each of whom seemed deeply committed to patients' care on an individual basis, seemed to resist attempts to standardize or streamline the ways in which care was delivered as if rational organization was itself threatening to healthcare's public mission.

But the mission and market were even more starkly at odds with one another in terms of the hospital's desire to attract paying patients. The poor and underinsured at Community were a repellant for many of the wealthier patients. One ER doctor's wealthy neighbors had compared going to Community Hospital with "waiting in the Greyhound bus station [since] everyone's speaking Spanish." The doctor said that it was hard to get the fully insured patient to use Community, or even to get doctors in private practice to send their insured patients to the hospital: "It's prettier over there at Memorial. I mean the rooms are nicer, the nurses wear little caps…" He continued, "I don't see any real difference in the treatment, but you know as one medical marketer told me, 'Perception is everything.' I told him, 'Jeez, I hope not.'" Among the privately insured, the presence of the indigent suggested an inferior quality of care. One nurse said bluntly:

> If you had a choice to stay in a room that may or may not have heat or air conditioning, that might be within a foot of some homeless person, or to go stay at Memorial where everything's shiny and new and looks better, than as a paying customer, where are you going to go? Are you going to go to McDonald's or are you going to go to somewhere nice, you know?

A nurse administrator discussed one particular day in which a student from a nearby private high school was brought to the ER after having been hit in the face by a baseball. At the same time, right down the hall from this "very well-insured, wealthy family" was a prisoner who required four police officers with him. The mother was "sitting in the hall with her high school age son hearing this prisoner cuss, swear up and down…" The mother filed a "huge complaint" with the hospital.

Sutter Health sought to attract paying patients to Community Hospital by establishing a state-of-the-art cardiac care center; by investing millions in renovating the old facility; and by promoting the care that patients received at the hospital. Throughout my research there was a large banner perched outside the hospital entrance on which five gold stars symbolized the high rankings Community Hospital had been given by a quality-ranking agency (an online video featured practitioners and workers dancing around the hospital waving the stars). As one department manager put it,

> It's not known, because we don't as much as money to advertise as Kaiser or Memorial. We're a five-star hospital in cardiac services…. We also just won a quality award for not having ventilator-assisted pneumonias or central line infections for more than two years standing, which is really hard to do. So people don't perceive us as thus, they perceive us as the county hospital, and that's all we do. But actually we provide really good, quality care here and we're really good at the things we do, and not to say that Kaiser and Memorial don't, but we did get those awards, they didn't.

But it seemed that Sutter Health underestimated the extent to which the legacy of Community Hospital would linger in the minds of practitioners and patients within Santa Rosa. As a social worker put it, the people at the hospital came into new ownership "from the old mindset." The hospital "never changed; it's just the name got changed. The people were still the same. They're the same people that have been here for 30, 40, 50 years." As one case manager put it, "It still has that stereotype. I think it's the building, the location. I mean everything about it, it's still considered the county hospital." A nurse manager acknowledged that despite the good care it provided, it still had the feel of an old county facility: "There's still a lot of old prejudice… We are an old facility, it's not pretty." Sutter was unable to turn the old public hospital into a moneymaker. According to one ER doctor, "From the taxpayer's point of view, the county did well on that contract. From Sutter Health's point of view, um, luckily this was not their only hospital."

CHAPTER THREE: THE PROFESSIONAL ETHIC

….Tolling for the deaf an' blind, tolling for the mute
For the mistreated, mateless mother, the mistitled prostitute
For the misdemeanor outlaw, chased an' cheated by pursuit
An' we gazed upon the chimes of freedom….

- Bob Dylan, *Chimes of Freedom*

In an address to graduates of the prestigious family practice residency program at Community Hospital in 2000, Dr. Dan Brenner—the director of the program—quoted Dylan's ballad in order to make a broader point about the future of American medicine. With graduates facing large changes in the organization and financing of care, Brenner urged them to remember: "'to care' is derived from the same roots as caritas (meaning charity), carino (affection), caru (to love). In the largest sense." Access to care should be "everyone's right," Brenner argued. He bemoaned the influence of the market in modern medicine, suggesting that it corrupted the vocational calling of medical practitioners. By analogy, he encouraged the audience to imagine an HMO executive making cost-saving recommendations to a symphony orchestra after watching the orchestra play: "All 12 violins were playing identical notes at the same time. Such duplication could be eliminated with a cost savings of 92% in the string section alone." He suggested that if physicians allowed the market to "constrict our current concept of care to such qualified terms as 'managed' care, or merely care as 'commodity,' then we've really turned something once noble into something tacky, and made care just another… four letter word."

Similar themes were interwoven throughout many of Brenner's essays. In one piece, he emphasized that he preferred the word "patient" to the popular term "client" because its root, *pati*, means "one who suffers."[37] Several of his most meaningful experiences as a doctor—written down for residents to read and reflect upon[38]—had taken place when he ministered to dying patients at their homes. And in another piece he wrote even more explicitly about the market for health care: "Our medical heritage, passed on from the professors who taught us…. was that the practice of medicine, at its purest, is guided by science and driven by compassion. Money matters. But it has distorted the methodology of our science and has distracted us from the motive of our practice."[39] The market was something anathema to care, something the medical profession needed to counteract. He considered himself and his colleagues in the family residency program "medically counter-cultural; some are closet revolutionaries." Brenner wrote that today's residency students "remind us that the real measure of our work is not what we get paid for it, but what we become by doing it. We are, after all, privileged servants."[40]

In the minds of Brenner and many other physicians at Community Hospital, health care was deeply tied to serving the county's poor. Brenner understood care as a right that should not depend on one's access to financial resources; and doctoring as something that should be a vocational calling. In an interview, Brenner explained the orientation towards public service that he saw among his residents: "I thought when I got out of the Peace Corps that I would never again have the opportunity to work with a group of people as committed and as dedicated and hopeful for effecting change in the

world as I did in the Peace Corps. But I was wrong. The group of people that come through this program are equally committed." A family practice doctor who had been through the residency program and worked occasional shifts in Community's ER discussed how her medical work was connected to her commitment to social justice—albeit a commitment that was sometimes frustrated:

> It's very easy [to get frustrated] when you are doing stuff that feels kind of rinky-dink on a day-to-day level. It's like, you know, doing pap smears and checking people's cholesterol level is, you know, to feel so unimpressive…. I periodically get super pissed off, and I think I'm just going to go off and [work in] public housing and try to make the world a little bit better that way.

She was unconvinced that "medicine is the best place to actually address health disparities," and sometime believed that "bike lanes and more accessible healthy food would do a million times more difference than I do every day." But there was still something deeply satisfying about her work: "I have this person who's right in front of me and they are the one that I really want to help. And there is something magical about the relationship that, you know, you can actually make a difference." She thought she shared these commitments with other family practice doctors, particularly in Santa Rosa: "Most of primary care doctors that you meet [here] will have a fairly strong sense of trying to save the world." Another doctor said that he had come to Community Hospital because he was "already aligned with" working towards the public good.

In an interview, Brenner explained that he thought "we took a step in the wrong direction when we commercialized medicine, when we made it a commodity, and we corporatized it." While there "has to be enterprise in medicine," he went on, "we've lost sight of the real reason that we practice medicine…. I think physicians… [are] privileged servants." A hospitalist at Community Hospital expressed a similar sentiment about the ways he believed the mission of healthcare should be kept distinct from the market: "I wish we could weed out, in medical school, the guys that are entrepreneurs and are in it for the money." One way to attract the right people to medicine was to take the money out of it: "By not having it a lucrative field, you get rid of one group of people."

The vocational commitment expressed by many doctors in and around Community Hospital was evocative of a forgotten tradition in the sociology of professions—one in which professions were understood to be a bulwark against the spread of capitalism and a model of altruistic community towards which all workers might strive (Haskell 1984). From R.H. Tawney in England, to Emile Durkheim in France, to Beatrice and Sidney Webb and George Bernard Shaw in the United States, the professional community was thought to encourage work on behalf of "collective purposes that embrace and transcend all private interests" (Haskell 1984, p. 188). As Durkheim put the point in his Preface to the Second Edition of *The Division of Labor in Society* (1997[1933], p. xxxix), for instance, the professional group would be a "moral force capable of curbing individual egoism, nurturing among workers a more envigorated feeling of their common solidarity…"

A Vocational Ethic

In the middle of his rounds one morning, Dr. Polyakova paused for a moment to reflect on the tumultuous real-estate market. He and his wife had helped to buy their

son's house soon before the housing crash. But he did not seem too perturbed. He said that there were two ways to think about buying a house. One way was to treat the house as an economic investment. By this logic he and his wife had done miserably. But the other way to think about it was as an emotional investment, a place in which their son could build a life. He preferred to think about it in those terms. This was not so dissimilar from his understanding of the medical profession. He believed that "if it's not a calling, if it's not something that you really want to do, you shouldn't be in it…." He joked, "I always said I'd do it for nothing, so the government and insurance companies took me seriously."

For many of the doctors based at Community, the small family practice residency program—no longer run by Community Hospital but still centered there—helped to preserve what one hospitalist called the "ethic" of the organization. "No one ever got rich or famous by being a family doctor," said Brenner, "So they're not in it for that." He continued, "The choice of family medicine is an act of social commitment and probably political courage… And maybe financial insanity." At any one time there were over thirty residents who took rotations in the hospital and at a clinic across the street (although the residency program had recently branched out to include some rotations at Memorial and—to a lesser extent—Kaiser). Any patient admitted to Community from the ER without insurance or without a primary care provider would be assigned to the residents, who would follow up with them at the residency program's clinical offices across the street. Doctors and nurses in the ER would also sometime lean on the residents to follow up with outpatient cases. Many of the most beloved family practice doctors and healthcare leaders in the area had gone through the program and stayed in Santa Rosa afterwards. As one graduate of the program quipped, "When you finish residency, you are so exhausted, you can't even contemplate moving to a different city."

But doctors' vocational relationship to their work extended well beyond the residency program. This was particularly evident when doctors discussed why they remained at Community rather than pursue employment at either Memorial or Kaiser. One hospitalist discussed how, at Community, he was able to "really see the people a lot…. Half the time I'll just stop by the room, sit down and just talk to them in the afternoon." He had previously worked at Memorial Hospital, and admitted that he would "make more money" there. But there he would have as many as twenty patients to look after in a day, whereas at Community he had only between ten and twelve: "I can see everybody at least twice per day [here]."

Several doctors at Community had also had experiences working at Kaiser. Many echoed the sentiments of one ER doctor who said he "felt a little bit like a cog in the machine" there. A second ER doctor, who had done shifts at Kaiser, bemoaned the time that he had to spend at a computer there: "I'm just the kind of guy who, when someone finds out that they have cancer, I sit at the bedside and I put my arms around them, because they need that. There's no time for that at Kaiser, they're busy, you've got to go back to your computer." A third ER doctor said that Kaiser "really is cookie cutter in many respects." A fourth, who had practiced briefly in Kaiser's OB department, also discussed the standardization as a sacrifice: "Pretty much everybody gets an epidural, the midwife comes in, and you have your baby and you never see [the doctor] ever again." These doctors suggested that working at Kaiser meant sacrificing the professional discretion that they valued at Community. But the fourth doctor went even further by

describing her *political* opposition to working at Kaiser. Despite her belief in the efficiency of an integrated system, she said, "I went into this to address health disparities and make poor people's lives slightly better…. I think it would sort of go against my conscience to work for The Man."

Many of the doctors at Community had made sacrifices in their lifestyles in order to maintain professional independence. Don Clinton, an intensive care doctor, was at the time of our interview almost solely responsible for staffing the closed intensive care unit at Community, meaning that he was on call pretty much all the time. He had been unable to attract other intensive care doctors to Community because of the difficulty of the department's twenty-four hour shifts, which—ironically—meant that he had to work many more of them than he otherwise would have had to. The sleep deprivation was sometimes difficult (some doctors "get crazy" when they lose so much sleep, he said), and it was "difficult to have a family when you're tied up at the hospital all the time." But he liked the level of responsibility: "I see every patient and I manage every patient in the ICU." There was no single person responsible for the ICU at either Memorial Hospital or Kaiser. At Memorial, all of the intensivists had office practices as well. At Kaiser, the intensive care doctors only worked during daytime hours and handed off responsibility to the hospitalists at night.

Clinton was an employee of the Sutter Medical Foundation, and was paid a salary based on working at least 122 shifts of 24 hours a year (though Clinton worked significantly more than this). Hospitalists at Community were also employed by Sutter Medical Foundation and paid based on the number of shifts they worked, with some limited financial incentives offered for admissions and discharges. Within the ER, the arrangement was slightly different. The doctors there were part of a small, independent group that had secured the ER contract with the hospital. The contract was formally held by one of the old-time doctors, but eight of the full-time doctors were "partners" in the group, splitting proceeds from billing and paying several other doctors to cover occasional shifts. Unlike those working directly for the Sutter Medical Foundation, all of the ER doctors were compelled to buy health insurance on the individual market. Several of them had bought high-deductible plans, figuring they could take care of themselves or one another unless something serious came up. According to one part-timer, the group as a whole was "fiercely independent, willing to sacrifice benefits for, I don't know what, freedom and flexibility or something."

What was common to these doctors' financial arrangements was twofold: first, their pay did not vary significantly depending on how they practiced medicine (different from doctors at Memorial Hospital, who billed on an individual basis); and second, there was very little oversight over the ways that doctors practiced medicine (different from doctors at Kaiser Hospital, whose salaries were accompanied by detailed records of physician practice patterns). Doctors were oriented to their patients not through their pocketbooks, as they were at Memorial, and not through an extensive bureaucracy, as they were at Kaiser.

That Old Time Religion

But the vocational orientation of doctors at Community was not without its own complications. As Charles Rosenberg (1992, 1984) has well documented, there has long been an implicit exchange within teaching hospitals that the poor receive care while the

medical student receives "clinical material" on which to practice: "The objects of charity who filled a hospital's beds could hardly refuse to cooperate in clinical teaching; it was the principal way in which they could repay society for the gratuitous care they received" (p. 190). Wealthy paying patients were spared these indignities. This implicit exchange had not disappeared from Community. While insured patients would be admitted to the hospital by trained hospitalists, residents would admit the poor and uninsured. And when the county leased Community Hospital to Sutter Health, the maintenance of the residency program was of the utmost importance. One condition of the lease was that the corporation maintain the residency program and "continue to provide residents with the opportunity to develop technical proficiency in those gynecological surgical procedures that they may be called upon to perform…" Sutter would continue to provide the "material" on which this technical proficiency could be developed.

Rosenberg also recounts how, in the early public hospitals of the 19th century, professional paternalism was often coupled with disdain, as doctors regarded their patients as a "lower form of life" (p. 41). Among doctors at Community, compassion for the needs of the poor also would occasionally be coupled with a disregard for those considered undeserving. On one afternoon, for example, a patient showed up in the ER who had hurt his hand by cage fighting the night before. He had tattoos across his body. The doctor wondered aloud as we were leaving the examination room, "Sometimes you wonder what rock people have crawled out from under." A nurse administrator expressed her dismay with another ER doctor who would complain tirelessly about the number of drunks who showed up at the door. Even among those who did not express such disgust, doctors at Community seemed to feel less pressure because they were treating a population without power. One doctor said she was "afraid of the upper class patients" since the "more educated patients will challenge you more, they'll question you." She liked working at Community because she was insulated from the entitlement of upper class patients. The implication was that she preferred the deference of the poor to the more active role of the wealthy.

Furthermore, physician independence at Community sometimes seemed to come at the expense of patient care. On rounds one morning, Dr. Polyakova said that he was going to visit a "tragic case," a forty-year old who had been drinking almost constantly for the previous twenty-five years, had never sought medical attention, and was now in end-state liver failure. The man looked pale and incredibly skinny, except for a distended stomach out of which Dr. Polyakova said he had already removed three liters of fluid. Dr. Polyakova was pretty sure that the man was about to be given a "celestial discharge," but thought that there was some chance that with enough time he could stabilize and his liver cells just might start regenerating. A week later, I was back in the facility. The day before, the man was discharged to home hospice care, and word had just reached the hospital that the man had died. The news was delivered from person to person throughout the hospital with shakes of the head and sighs, and it became clear that this was a somewhat special case for Polyakova and others at Community. It turned out that Polyakova's wife used to live next door to the patient and his parents' family. A nurse had gone to school with him, and another nurse had known him as well. Reflecting on his care, Polyakova said that the odds against the patient were stacked high against him from the start, and that his family had been in favor of hospice care at the beginning of the man's hospitalization. But Polyakova had gotten "too emotionally invested," he said.

"First I thought we'd give him three days" of treatment, he continued, "Then five, then seven." Ultimately the patient stayed over a week, a costly and ultimately ineffective stay.

One part-timer said she felt that clinical freedom was "taken to an extreme" at Memorial. At other hospitals, she said, a doctor who ordered an antibiotic for a viral infection would be told it was inconsistent. Not at Community. She was "quite surprised" at how little physician oversight there seemed to be. Doctors at Community Hospital were nominally accountable to a utilization board made up of a nurse manager and several physician representatives. In theory, a doctor who was deviating sharply from clinical criteria would be referred to a physician from this utilization committee and brought into alignment. In practice, though, the board did not seem to exert much authority over the everyday decisions of physicians, at least in part because it consisted of department chairs who themselves seemed suspicious of efforts to curtail physician independence. One case manager said, "I think our length of stays are greater than they should be, and I don't think that certain physicians are being held accountable for that." A nurse manager said that the facility needed to "look at outcomes better than we ever have," and ask whether they were doing the "right thing" for people "because we drag some old people along forever."

And while the hospital could exercise some limited control over its regular physician staff, it was even more difficult to control the specialists who practiced there. A nurse manager discussed a ninety-three year old patient who had left Kaiser Health after they had rejected his request for a heart valve replacement since he did not meet the organization's criteria for such a procedure. He found a cardiac surgeon to do the procedure at Community Hospital, but spent the next four months in the intensive care unit, developed bed sores, and went into dialysis after entering renal failure. The episode was costing "enormous amounts" of money to Community, and likely should not have happened in the first place. While Medicare guidelines said that a total knee replacement warranted three days in the hospital, some of the orthopedic surgeons who practiced at Community would "sit on the patients until they feel that they're ready." Patients would "sit on the third floor for weeks pre-operatively, waiting for the surgery… [and] we're not getting paid for that." The hospital would invariably lose money on the supplies that certain specialists demanded—like the heart surgeon who demanded drug-eluting stents, or the orthopedist who liked to use customized knee joints. The physician discretion at Community contrasted sharply with an organization like Kaiser. A case manager at Community said with a laugh that at Kaiser a patient needing knee replacement surgery would get the standard "Kaiser knee."

Clinical freedom was of increasing concern to many at Community Hospital given new mandates from government and private insurers. During the period of time I observed, for example, Medicare had begun to implement its recovery audit contractor (RAC) program, which investigated patient records in order to recuperate Medicare overpayments to hospitals and other facilities. Case managers at Community were increasingly required to have difficult conversation with doctors, setting limits as to what sorts of services could be provided. In the hospitalist department there were daily utilization meetings during which case managers and doctors came together to discuss individual patients. Despite the collegiality among the staff, the meetings often had the

feeling of a negotiation, with doctors advocating for patients based on perceived medical needs and the case managers pushing back with financial realities and clinical criteria.

But physician freedom at Community extended beyond clinical decision-making and into physicians' daily interactions. One nurse in the ER described how each ER doctor had his or her own different style. Some would see a patient and then order a blood draw without telling the patient, assuming that it was the "nurse's job to tell them." Others would make diagnoses and discharge patients without communicating with the patients either. She had to ask each patient, "'What did the doctor tell you?' And then you have to make sure you don't say it in a way that make you look like you don't even know what's going on." A nurse administrator in the ER said that the doctors were "still trying to operate in the old ways, and they are not getting up to what we need to do for 2010 and to move forward progressively." She continued,

> They're not writing down orders, they're letting the nurses practice without a license. And even though we can start the IVs… we need the physician to still write those orders on that blue sheet. A lot of them aren't doin' it. 'Cause you didn't have to in the old days. But this is not the old days any more. As much as I love our physicians, at the same time, they're hindering us big-time here.

Physicians at Community seemed committed to doing things as they had always been done. According to one nurse administrator, who had left Community Hospital to work at Kaiser, "compliance wasn't… really part of what they talked about at Community."

This disorganization seemed a product of old loyalties and old habits. The medical director of the ER had been around for decades; according to one administrator, it was "time for him to retire." Another of the old-time ER doctors had recently had a heart attack and been told by his own doctor that he could only work for four hours at time. Rather than retiring, or taking time off, the doctor negotiated with the others that he would work four hours in the morning, go home for seven hours, and come back to work another four: what the rest of the medical staff referred to as the "princess shift." On one morning, a doctor called from home to tell the doctors on shift that he was feeling sick and could not come in that afternoon. For the next forty-five minutes, it seemed, one of the two ER doctors on shift stopped seeing patients in order to call around to find a replacement.

Unlike at Memorial or Kaiser, at Community Hospital there seemed to be an *absence* of incentives with which to motivate physician behavior. Instead, physician practice was based on loyalty and tradition, legitimated by a vocational belief that they were looking out for patients' best interests. According to an ER doctor at Memorial Hospital, those at Community had been there so long and were so comfortable with their jobs that they had not kept up with modern medical training. He said that he had not seen a Community doctor at the countywide emergency service meetings in years. And while doctors valued their independence at Community, some also recognized the need for physician accountability and change. Polyakova said,

> If you don't change what you do every year then it's no good. You tried something and it didn't work, or it did work, and you do something else. I mean, that's what you have to do, no matter what field you're in…. My father was in the restaurant business and I worked in all his restaurants—you try something on

> the menu, it works, people like it, then something gets old and tired and you're just having it around, you've got to change it. Everything is like that.

Nevertheless, Polyakova recognized that in the absence of financial incentives an organization needed to "find a way to weed… out" the poor performers. Community Hospital did not yet have such mechanisms.

Keeping the Market At Bay

If ER doctors, hospitalists, intensive care doctors, residents, and attendings at Community all seemed to embody a vocational (if disorganized) approach to medical practice, they were often forced to interact with specialists in private practice who did not share these same vocational beliefs. As Community Hospital had sought to bring in more revenue, for example, it had invested heavily in its cardiology department. The cardiologists there—most of who were from one prominent cardiology group in town—were known as being a clever and entrepreneurial bunch. After discussing the generosity and collegiality of working at Community, one social worker cited an exception:

> Except for your cardiologists, 'cause they're just a bunch of idiots…. They [have] the greater-than-thou attitude, you know, what I mean? "I'm better than everybody else," you know. And they're the moneymakers, so we have to treat them really nice.

Several of these specialists admitted patients at both Community and Memorial Hospitals, and seemed interested in making money more than in anything else. As an open facility, surgeons and other specialists would schedule procedures at Community without any input from other doctors. As one example, during rounds one morning, Polyakova visited a ninety-three year old with dementia who had just gone through hip surgery. When he told her that she had just woken up from surgery she said, "Oh no, that was years ago." She had no memory of the procedure ever having been scheduled. The hospitalist thought that such a surgery was a terrible waste of resources, but if the family had wanted the surgery he knew that orthopedic surgeon would not have objected. The most Polyakova could do to limit unnecessary utilization was to avoid calling specialists too frequently.

Among the regular doctors at Community there were many stories of the specialists' avarice. A hospitalist recalled a patient who had had surgery because of peripheral vascular disease in a leg. While he was recovering in the hospital, the hospitalist called a cardiologist for a consultation, but the cardiologist refused to see the patient: "He said, 'Well, you've already done the procedure that I would do on his leg, and now you're asking me to clean up?'" According to the hospitalist, the cardiologist refused because the procedure had already been done and "that's where he make his money," not by doing a consultation. On other occasions, this hospitalist would call specialists for consultations and they would answer, "There's nothing I'm going to do for him in the hospital, send him to my office after you discharge him"—another strategy for maximizing revenue. "That's totally unacceptable to me." A second hospitalist discussed the tricks by which a consultant would get out of doing consultations he did not want to do: either the specialist would say the patient was not sick enough for the consultant to feel justified in coming, or the patient would be *too* sick and need to be seen

by specialists at a more advanced facility. A case manager discussed how she was cornered by certain surgeons and podiatrists on call who wanted her to find emergency insurance for their uninsured patients just so that they could get reimbursed.

In the case of urgent medical emergencies, though, doctors at Community were usually able to convince the consultants on call to step in. The trick, then, was to avoid having to call the specialists that one despised. Polyakova said there was one gastroenterologist he always avoided, and one cardiologist who—during our time together—had seemed to make it onto the same do-not-call list. More of a problem was finding specialists that were not on call and finding specialists to follow up with patients for non-emergency conditions.

When faced with emergencies for which there were not specialists on call, and for which they could not find specialists willing to accept Medi-Cal insurance, doctors at Community would sometimes do procedures themselves. During one shift in the emergency room, the doctors exchanged stories about doing plastic surgeries on those needing face repair surgery when the plastic surgeons were—according to one of the doctors—"too busy doing breasts."

Doctors at Community would also work to find and sustain relationships with the rare specialist who was willing to treat the uninsured or Medi-Cal patient. At one point during a shift in the emergency room, a patient had told one of the doctors about a gastroenterologist in town who accepted Medi-Cal. The doctor was impressed, and—returning to the nurses' station—told another doctor he was "willing to trade this information" with her in exchange for a direct phone number at the local clinic. Laughing, the other doctor said that the number at the clinic would be no use, since one had to know the people at the clinic in order for them to help.

Like the social workers who agreed to send insured patients in exchange for accepting the uninsured or underinsured, physicians would sometimes implicitly promise to send insured patients to particular specialists if they would agree to see the occasional uninsured or Medi-Cal patient. Without these sorts of arrangements, specialists in town might be punished for their own kindness. One doctor in the ER at Community discussed how there had been a young orthopedic surgeon who was "extremely generous" with Medi-Cal patients. But he quickly got "overwhelmed, because if no one else is taking Medi-Cal, then everyone goes to you and your practice is bogged down with people who aren't paying."

CHAPTER FOUR: FEELS LIKE HOME

My first morning of observation at Community Hospital I entered the Emergency Room a few minutes before the 7am shift change. I told the clerk at the front desk that I was supposed to shadow Dr. David Harper, and she guided me through a secured doorway and left me by the nursing station. There was no doctor to be found. I took a seat and waited until a nurse approached. Since Harper was running late, she told me, I should feel free to start seeing patients myself. She seemed to assume that I was a medical resident. Needless to say, the offer was rescinded when I told her I was a sociologist.

Alvin Gouldner began his *Patterns of Industrial Bureaucracy* (1954) by describing bureaucracy's absence: what he called the "indulgency pattern." This form of organization was characterized by its leniency—rules were loosely enforced, people were given second chances, and workers had a great deal of discretion in their daily activities. In sum, "supervisors temper[ed] the performance of their managerial role by taking into account obligations that would be relevant in other relationships" (p. 55). Managers and workers treated one another like friends, like family. The indulgency pattern was undoubtedly inefficient in some respects, but inspired trust and generated loyalty to the company among workers. At Community Hospital, where care was considered a right and its provision considered a vocation, the relationships among different constituencies within the hospital were characterized by this same collegiality. Top administrators from Sutter Health, which took over the hospital in 1996, seemed regarded by many as outsiders.

Feels Like Home

Adriana Martinelli was the director of the Emergency Department at Community Hospital, born and raised in a large urban area near Santa Rosa. While she was still in high school, her older brother, and confidante, was killed in a car accident. She became a "lost soul" until her parents encouraged her to go to nursing school. "The way I look at it now, it [was]… divine intervention." She found her calling in the oncology ward where she would hold patients' hands at night, "letting them talk and hear things and letting them express things." She would celebrate recoveries and grieve losses with patients' families. Years later she still kept all the letters of gratitude she had received. But she was still young at the time, still grieving her brother, and got "too attached," as she stopped being able to separate her own life from those of her patients. She transitioned into emergency medicine and realized that, as something of an "adrenaline junkie," it was a good fit. While her training had been in a Catholic hospital, she came to Community Hospital in 1985 attracted by the poor patients it served: "They were really sick, and at the same time, they appreciated so much—it wasn't an expectation to be professional to them. They appreciated it." In 1996, when Sutter Health took over the hospital, her boss began asking her to work shifts that made it difficult to take care of her two kids at home. She left the facility and began working as a nurse manager in a variety of capacities at other facilities in Santa Rosa, but Community Hospital was always in the back of her mind as the place to which she wanted to return. When the nursing director called her in 2009 to become the director of Community's ER, "I just started crying, 'cause it felt like I was going home. That's all it was. It was coming back home to this place."

Since she began working as the department director, Martinelli had been feeling pressure to increase the department's patient satisfaction scores. She wished that the scores could reflect the staff's commitment to the place:

> We don't have the money, but we have the heart…. We don't have what other people have, we don't have new facilities, we don't have new equipment. You know, getting our floors waxed here is a challenge. But they have the heart. And I wish I could put that on my frickin' patient satisfactions scores. That would be a really good thing for me!

Many nurses and ancillary staff throughout the hospital felt like their ties to one another helped the hospital stand out. According to one social worker, staff-members at Community were "so much nicer and kinder" than those at the neighboring hospitals, where she also worked: "And when we say we're a family, there's nothing on one floor that ain't happenin' on all floors, you know? When a party is happening here, everybody comes to it." A department manager who had worked at all three hospitals said that Community was unique because "everybody thinks of each other as family. We have a lot of really long-term employees…. People know each other, whole families work here." A nurse in the ER said that when a colleague was going through something difficult, "the whole ER will show up at your house." Another nurse had lost a son, she remembered, and "everybody showed up." At Memorial Hospital, where this nurse also worked, "you might have some of your coworkers show up, but that would be it." When Sutter Health began a round of layoffs, a social worker recalled, some staff-members who were close to retirement "gave up their jobs… so other people [could] stay…. It really follows the model of 'I am my brother's keeper."

Those who worked at Community Hospital had different explanations for the sense of camaraderie they felt there. Some thought that it was because so many workers had been there so long. A charge nurse said that since many workers had been there "twenty years or more," they "have a history together." The sense of "teamwork, autonomy and respect" was what "keeps a lot of us here at Community." Martinelli thought that it might be because "all of us grew up together… We're watching our kids all graduate together and things like that." A case manager said that "people don't really leave this place when they work here." As a result, "we have a really good, tight-knit family and we consider everybody's job equally important here."

Others connected the spirit of the hospital to the kind of patients that they saw. One doctor said that he thought nurses liked it at Community because "they feel they are doing something good here. They're not just putting in their hours, clocking in, filling in the computer, you know, they're actually doing something that no one else will do." Another doctor said, "If you talk to respiratory therapists, specialty nurses, they can go work anywhere they want and some of them do. But you talk to people who have done it, and a lot of them say, 'Well I always return here because there's something else I get working here. I feel like I'm not just a cog in the corporate machine.'" A charge nurse thought that work at Community "takes a different breed, maybe a little lower key… to have the patience to deal with a lot of the indigents or whatever." This sentiment was echoed by another nurse who had been "burnt out" from working on a trauma unit: "I came back here, within working three months my blood pressure went back down, my nightmares stopped, and everything like that." Dealing with the mundane problems of

the poor—"people who come in the middle of the night who don't know how to treat fevers"—felt like something of a break compared to the cases she had been seeing.

Still others suggested that the camaraderie people felt had something to do with Community Hospital being a teaching hospital. According to one nurse manager, the residency program provided for a consistent stream of intelligent, creative young people who were able to keep relationships "collegial" instead of "patriarchal." The head of the residency program thought that it gave "a certain lifeblood to an institution that's beyond just employment…. People are here to take care of patients and all, but I think that the fact that we're an educational institution, that we have young people learning and teaching, that gives credence to it." Moreover, many of the medical residents depended upon the wisdom of the nursing staff as they gained their footing in the hospital. The institution's commitment to education sometimes meant that people went far beyond their job descriptions in the spirit of training others. For example, on the floor one day a nurse discussed with a nurse practitioner her role as a preceptor, training new paramedics when they arrived at the hospital. The nurse practitioner asked with disbelief, "You do that for free?" According to the nurse practitioner, paramedics got paid approximately $1,000 for each student they taught. She scoffed and said, "Nurses are stupid." The nurse agreed: "I was doing it out of the goodness of my heart! We *are* stupid." She added later, "We're too good-hearted."

Even if they sometimes felt their generosity abused, nurses and ancillary staff at Community were willing to work for lower wages than people in similar positions at either Memorial or Community. As one doctor said, "Most of the nurses will tell you that they work here for less money here, but they wouldn't work anywhere else." One nurse at Community joked that when people called her asking for donations to charity she would say, "Well, first of all, I don't have any money, but second of all, my work is my donation to life." Another nurse went further and implied that the lower pay actually attracted nicer people: "It seems to me that [the] people [who] are willing to make a lot less than Kaiser and a little bit less than Memorial are the same people who just are generally nicer people."

Several workers at Community had also spent time working at Memorial or Kaiser. At Kaiser, one charge nurse said, employees were "really well paid" and had a "very strong union." But there was something missing there: "They do their job and they just leave." At Community, on the other hand, "The nurses don't just leave 'cause your shift's over," but supported one another above and beyond the requirements of the workday. There was more interdependence at Community. Compared to management at Community, many nurses suggested, managers at Memorial were unsupportive. One nurse felt that Memorial was "management centered," whereas Community was "employee centered." Part of the difference, it seemed, was that many of the managers at Community had begun by working on the floors. As one nurse said, "Regular nurses became management and they still were real people, and helped you out as much as possible, and you were all in it together."

Shared Responsibility

Relationships between doctors, nurses, and managers seemed characterized by an informal egalitarianism at Community. This was in evidence in the Emergency Room, where nurses seemed nonplussed by the presence of their physician counterparts—they

would bounce rubber balls against the wall or make collages out of construction paper while doctors worked nearby. One nurse manager said it was "much more collaborative and respectful" between doctors and nurses at Community than elsewhere. A case manager said that it was "just a vibe or a feeling when you're here, you just kind of know right away that it's not tiered; everybody's on the same level." As one doctor explained, "You're kinda all in this pullin' up your boot straps and rollin' up your sleeves and jumpin' in the muck. You're in it together and there's a camaraderie [at Community]." According to another nurse, doctors and nurses looked out for one another but also held one another accountable. She recalled an incident in which an ER doctor, who had only spent two months at Community, was fired after he got into a fight with a nurse. She continued,

> You do not talk to the nurses that way, but do you know what? We have the ultimate respect for our physicians. We don't let the patients abuse our doctors, we don't let other people abuse our doctors, we don't let people take advantage or our doctors. We support our physicians just as much as they support us, and we kind of think of each other as a family and a team…"

The casual relationship between doctors and nurses was somewhat surprising for those unaccustomed to it. One nurse manager in the intensive care unit, who worked at Community after working at Memorial and before moving to Kaiser, said, "It was kind of interesting for me to come into this environment where it was much more—I mean the nurses would sit at the nurse's station and laugh at the physicians, talk about things that I was like, 'Oh! Ugh! What?!'"

The camaraderie between doctors and other employees was evident throughout the facility. During one morning, several nurses stood around joking with one of the ER doctors. Dan, one of the nurses, had borrowed the doctor's truck for a weekend and had taken it on Route 1, a highway that winds along the California coast. Several days later, after the nurse had returned the truck, its steering shaft had broken. Had this happened on the highway, everyone agreed, it would have seriously jeopardized Dan's life. The doctor looked sheepish: "It was a close call," he mumbled. I was struck not only by the casual way in which the nurses and doctors teased one another, but also by how fluidly the relationships in the ER seemed to extend beyond the facility. "We kibitz around here," said a case manager. "Everybody jokes around with each other."

The informal social relationship between doctors and nurses was mirrored in clinical practice. As one doctor put it, nurses liked it at Community because they could "act like doctors here." At both Memorial and at Kaiser, doctors and nurses were careful to abide by legal restrictions on nurse autonomy. At Community, however, nurses would do a wide range of treatments on patients before doctors had entered the room. A nurse manager in the emergency department said, "I know all of us here are really comfortable going ahead and doing everything, and we know our physicians will back us up." Nurses would do a lot of the ordering—setting up the IV, administering doses of morphine, etc.—and let the doctors know post-facto. The "trusting relationship" between doctors and nurses meant that they could disregard some of the legal restrictions on nursing practice. A charge nurse discussed how her interactions with the physician staff felt unique in that "we are really, really a team." She said that she valued having to "stretch

herself" at Community, she liked the autonomy and responsibility that came along with her role: "I don't mind doing more than I technically could, as long as it's safe."

Informal Influence

Both Memorial Hospital and Kaiser Hospitals had clear systems of stratification and centralized decision-making. At Community, however, power felt more nebulous. Nurses and ancillary workers were each represented by labor unions, but in each case the unions were relatively weak. Even lead administrators from Sutter Health seemed remarkably absent from daily decision-making. According to one nurse, Community Hospital had been losing money for so long that it was something of a pariah: "It's like [Sutter] could care less. They hate us; we are the money pit." As a result, she suggested, the administration had adopted a practice of benign neglect. It did not micromanage the facility, but nor did it make necessary investments in things like heating systems, meaning that "one year we didn't have heat in the middle of winter, and we had space heaters and it was forty-two degrees in the ER."

There seemed a vacuum of power at Community that no one seemed eager to fill. Most doctors I interviewed there seemed not to feel invested in making changes in hospital policy, nor did they feel they had mechanisms through which to do it. For example, the ER group would hold monthly meetings at which only the eight partners (and none of the part-timers) were invited. This ensured that many members of the department medical staff were left out of conversations about practice protocols or changes in department or hospital policy entirely. But even those who *were* partners did not seem to have much at stake in changing things. While the medical staff would sometimes make requests for pieces of equipment, they would rarely voice more controversial demands: "There's a lot of things we'd like to change, but we've been here long enough to... ask ourselves this question: What's the most important thing? And we always come down to patient care." A part-time ER doctor suggested that he was "not brave enough to go spouting off about" hospital policy. A second part-timer explained her own powerlessness by saying that since she was hired by the group that had been given the hospital contract, she was a contractee of a contractee: one of the "scabs of the scabs, you know, in a certain way."

Hypothetically, major department decisions could be made by physician department chairs in coordination with department directors. But these decisions often got mired in old habits and old loyalties. On one occasion, a department manager in the ED had gone to the physician chair (a "stick-in-the-mud") to complain that doctors were not following protocol. He responded that he could not "ask [his doctors] to do another thing." She responded, "This is the law. You have to ask 'em." But as of our interview she was still being stonewalled. Each department at Community Hospital was something of a silo, she suggested: "A lot of times what happens within these walls stays within these walls." But she had begun sending reports to peer review—something previously unheard of—and had even suggested that she might recommend that the ER contract not be renewed. While the physician director of the ER would "never admit it," she continued, he was technically subordinate to Sutter administration.

Making change within any department at Community seemed a steep climb. During a meeting between the ER and the Polyakova, who was chief of the hospitalist department, several ER doctors complained about one of the hospitalists who would

refuse to see patients in the ER and would often ignore or antagonize the ER doctors who called him. Polyakova told the group that he would take care of it, but said to me privately that it was a difficult situation, since the offending doctor had actually hired Polyakova many years before and so Polyakova felt some loyalty to him. These loyalties may have helped to sustain a certain kind of communitarian feel among doctors at Community, but they came at the expense of a coordinated system.

Even the labor unions many nurses and ancillary workers seemed to regard with mixed feelings. Some of the old-timers at the hospital remembered that during the heyday of public sector unionism in the 1970s, the union at Community hospital—which at the time represented both nurses and ancillary workers—had been a model of activism and solidarity. According to one labor organizer at Community, there would often be sixty to a hundred workers attending union meetings, filling up the meeting room to capacity. But since then the union's power had diminished. The nurses had broken off to join the California Nurses Association (CNA), and the ancillary workers had been shuffled among different Service Employee International Union (SEIU) locals. While some people suggested that the union legacy lived on in the camaraderie that worker felt at the facility, this solidarity now seemed more closely connected to the hospital as a whole than to any type of labor organization or class identity.

Many seemed to take the benefits of unionization for granted. One nurse admitted that the union might help explain why nurses were treated so much better at Community Hospital than at Memorial (whose nurses were part of a weak independent association), but seemed not to have spent much time thinking about it before I asked. A case manager appreciated the security that the union gave her but said, "We know it's there, but it doesn't, you know—I don't really think about it." When I asked a social worker about the union, she said, "My union is a great union." But she quickly shifted emphasis: "Let's leave the union out of this, simply for the fact that is who do you work for? I work for some of the greatest managers in the world, who really do everything they can to make us happy. So when you got managers like that, you don't need a union." Others valued the union but seemed to think that it threatened to interfere with the informal relationships among staff at the facility. One nurse said that there had been some resistance to joining the CNA because things have to "go down by chain of command of who has authority…. There's more restrictions." She liked the current system better, where people more informally tried to "cover each other's shifts," and said that the nurses in the ER were "holding our ground" with the union to keep it informal.

There seemed a similar ambivalence towards the union among many ancillary workers. According to a union representative, many employees seemed to feel that—given the hospital's financial difficulties—they would undermine the health of the community by advocating on their own behalf. Moreover, at Community, a number of managers had previously been ancillary workers themselves, and many workers seemed to feel more loyal to these managers than to the union. One respiratory therapist had become a human resources director. As the union representative remembered, "[Workers all] know him, and he's just a great guy… They always believed him over me, and I would get kicked out, and have the door slammed on me." Another nurse became a nursing director after having served as a leader in the nurses' union, again suggesting a fluidity between union and management that made labor solidarity difficult to achieve.

Enter the Entrepreneurs

Among many practitioners at Community, then, informal authority and collegiality defined social relationships. Yet these relationships—forged over decades—were in many ways incompatible with Sutter Health's desire to turn Community into a profitable acute-care facility. And as Sutter sought to bring Community into the black, it turned to a different set of entrepreneurial physicians who saw in Community opportunities for private profit.

Northern California Medical Associates (NCMA) was a multi-speciality physicians' group in Santa Rosa that consisted of family practice doctors, cardiologists, and small numbers of several other specialists. Historically, this group had done most of its business with Memorial— the only local hospital with an advanced cardiac center. Yet the group's dependence on Memorial had created a strategic disadvantage for the group, since Memorial could dictate the terms of its relationship with the foundation. This issue came to a head in the mid-1990s, when NCMA sought to bring onto its staff a cardiac surgeon—which would have greatly enhanced the organization's revenue, according to one cardiologist on staff of NCMA. Yet Memorial had already contracted its cardiac surgery to an independent local surgeon, and refused to grant privileges to a second on the staff of the NCMA. As a second cardiologist from NCMA remembered it, "it was a pretty hard line business stance."

Rather than sue Memorial, which would have been financially risky, NCMA decided to reach out to the Sutter Health, which had recently leased Community and was looking to make the hospital profitable. As one cardiologist put it, "We decided to bleed [Memorial] a different way. We're assholes!" Beginning in the late 1990s, several cardiologists from NCMA—working closely with the Sutter Health—began building the heart center at Community, which opened its doors in 2001. Community constructed a new wing of the hospital in order to house the center. The center had its own entrance, its own plush furnishings, and boasted—at the time of its opening—a coronary angiography machine that could take images of the heart unlike any other machine in the county.

While the move "infuriated Memorial," according to one cardiologist from NCMA, it was of great financial benefit to Community and a wise move for NCMA. According to one cardiologist from NCMA, the heart center "legitimized Community as a hospital," helping it to shed some of its image as the indigent facility. According to another NCMA cardiologist, the program had become "a big boon to the hospital" and played a role in "changing the general tilt in the future of hospitals" in the area. It also benefited NCMA, in at least two ways. First, since Community was so financially dependent on NCMA, doctors from NCMA had tremendous authority in the organization. One NCMA cardiologist said, "Community has a history right now of being more physician-friendly [than Memorial], simply because they needed to be, because they needed any support they could get." As of 2010, one NCMA cardiologist directed Community's heart catheterization lab, and several other cardiologists from NCMA played leadership roles within the hospital. And since NCMA doctors built the heart center at Community, it was organized in exactly the ways these doctors preferred. As one cardiologist put it, "I built that cath lab, it has all the things that I want, I know exactly what balloons, what stents, what wires—I mean, I know all that. It's not the same at Memorial."

Second, NCMA now occupied positions of authority in both Community and Memorial, and so was able to exert leverage with both. As one NCMA leader put it diplomatically, "All along we felt like… it's better for [us] to be somewhat independent and if you put all your eggs in one basket, it makes you vulnerable to the unpredictable changes in medicine." Both Community and Memorial had sought to make NCMA a part of their respective medical foundations, but NCMA had been enjoying the power that their independence brought. Another NCMA leader suggested that there power in being able to "play one hospital off the other, just like in any business."

While the informal, collegial culture of Community remained remarkably resilient throughout most of the hospital, Community's cardiac center suggested the ways in which lead administrators at the hospital sought organizational transformation—not by forcing old actors to practice in new ways, but rather by bringing in new actors who were more oriented towards profit. This effort at transformation was made even more apparent as Community administrators tried to convince NCMA to join Sutter's medical foundation. Community had promised that NCMA physicians could remain distinct from the other doctors affiliated with Community. NCMA doctors seemed to feel that the doctors who were currently part of the Sutter Medical Foundation at Community were somewhat lazy. One NCMA cardiologist said, "You can't decide you're going to work four days a week and [think] you're gonna make a million bucks. It's not that easy. And so you need people who are willing to work, take call, be available, do the hard parts of medicine in order to make things work." The only way they would consider a formal affiliation with Sutter was if they could retain a sense of distinction from the doctors who had traditionally practiced there.

Mission Against the Market

In early January of 2007, Sutter Health announced that it was closing Community Hospital altogether, having been losing money on the hospital since it first leased the facility in 1996. As an ER doctor at Community explained, Sutter had hoped they could "change [the hospital] around… without losing the ability to take care of patients and leaving people out in the street." But this had proven more difficult than the organization had expected. Around the same time that Sutter announced Community's closure, however, it was revealed in the local press that Sutter had bought a new plot of land on which it planned to build a new specialist facility. The cardiologists would be safe. An ER doctor at Memorial suspected that Sutter would "build [the specialists] a catheterization laboratory, build them an orthopedic center, and become this specialty hospital." Meanwhile, Community planned to transfer to Memorial the "Health Access Agreement" it had signed with the county, ridding itself of its obligation to the poor and underserved. Memorial, in turn, pledged that it would expand its inpatient capacity by eighty beds, expand its urgent care services and double the size of its emergency department in order to accommodate the new traffic.

Those who worked at Community—from ancillary workers to physicians—found out about the closure in the local paper. Many felt abandoned by higher-ups within the Sutter Health. As one ancillary worker put it, "It felt like it was upper Sutter management, probably the CEO saying… 'This hospital isn't making money, isn't making enough money, so we're gonna close you.'" For her, this felt like abandonment: "You've got an agreement with the County, you knew what you were getting into, you

knew how bad it was. You should have seen this if you really looked." Practitioners and patients were united in their outrage. An ancillary worker remembered the feeling of solidarity she had with patients who were similarly outraged by the news: "We had two ladies that were 87 and 89 and they were knee patients, and they probably knew everybody in the county, because of the phone calls they were making that day."

But workers and community members did not take the news sitting down. During one memorable Board of Supervisors meeting in February of 2007, a large meeting hall was packed with hundreds of concerned community members, almost all of whom were opposed to Community's closure. Many were concerned that Memorial did not have the capacity to handle the increased patient volume that would result from the closure. Others worried that Community's closure would signal the end of the facility's prestigious Family Residency Program, on which the county depended for a supply of local family practice doctors. Women's health advocates were concerned about Memorial's lack of women's reproductive services, services for which many depended on Community. Labor unions were concerned about layoffs, and Memorial's historical resistance to unionization. Some of those who lived close to Memorial were worried about increases in helicopter and ambulance traffic.

Over the summer of 2007, various coalitions of health care advocates took part in organizing drives to put a halt to what became known as the Sutter-Memorial transaction. The local healthcare workers' union—United Healthcare Workers-West (SEIU-UHW)—issued a "Healthcare Justice Platform" that became the basis of a summer-long petition drive. The platform demonstrated the union's effort to weave together a concern for healthcare in the county with a concern for healthcare *workers*. The first plank of the platform demanded a revised "Healthcare Access Agreement" to assure the indigent services be preserved in the county, and argued Community should remain open until Memorial was able fully to replace the services that would be lost; it also advocated for an expansion of primary health clinics in the county, and additional funding for several small district hospitals in the county. The second plank, "Be Fair to Those Who Care," advocated on behalf of healthcare workers as well as doctors. It encouraged that there be a plan to ensure smooth job transitions for those being moved from Community to Memorial, and made the transaction between Community and Memorial contingent on Memorial adopting "fair election" ground rules for its workers interested in unionizing (see Reich 2012). It also discussed the importance of a vibrant family medicine residency program. Finally, the third plank, "A Community Voice for Healthcare," asked the county to convene a "Citizens healthcare committee" to oversee the planned changes. During the spring and summer, the union spearheaded an effort to gather more than 5,000 signatures to the petition. Health care workers and community advocates collected signatures at grocery stores and farmers' markets. The union also hired a canvassing company to complement the volunteer effort.

In a campaign over the next twelve months, a coalition of community groups—led by SEIU-UHW, convinced the county Board of Supervisors to block the planned transaction and uphold the contract that Sutter had signed with the county. In the face of this public outrage and opposition, Sutter relented, and in recent years had been working instead to fulfill its contractual obligations by opening a new general facility alongside its planned specialist facility. A skeptical ER doctor at Memorial said, "So there will be two hospitals: one for the 'have-nots,' and one for the 'haves.'" One nurse administrator

thought that this strategy might be effective in changing private patients' perceptions of Sutter Health in the county: "Having the brand new facilities and be clean, with pretty floors and stuff will really help that part a lot in bringing the insured back." But it did not seem lost on anyone that a new facility in a new location might also give hesitation to the poor and underinsured who had traditionally relied on Community Hospital. One hospitalist said explicitly that if Sutter was truly committed to maintaining services to the indigent it would have renovated a building in downtown Santa Rosa that had been abandoned by a telephone company in recent years. But they would rather move far away from downtown, drill a new well and build a new building in order to get far away.

Meanwhile, as of 2010, Sutter still had not broken ground on the new facilities. Nevertheless, those at Community seemed somewhat despondent about the hospital's future. The announcement of Community's closure had "ruined a lot of people's faith in this company," according to one nurse. Moreover, Sutter seemed to have been divesting from Community in anticipation of its transition to a new location. One nurse described how many departments that were vibrant before the planned closure—orthopedics, pediatrics, and transitional care, for example—had been cut back or closed since then. While practitioners and the public had managed to preserve some degree of right to care at Community, the future of the organization—and of the public's right to care—seemed dim.

MEMORIAL HOSPITAL

CHAPTER FIVE: SACRED ENCOUNTERS

Amanda Roberts was a chaplain at Memorial Hospital. A heavy-set woman in her early forties with wide eyes and an expressive face, Amanda had been a graduate student in chemistry before she decided to begin a divinity program: "I decided that instead of being in a lab, what I really wanted to do was to be out working with people… to make the matter of spirit, and how we are really alive and awake in this life, part of the focus of my life." During a hospital residency she quickly came to appreciate both "how much someone coming from a spiritual perspective was needed in the hospital," and "how small my own God had been." Within the hospital she could "really feel the presence of the spirit." There, she was able to help people "to live, and live after they have experienced some of the most horrifying and difficult times in their lives." She continued, "I don't make it happen. The resilience, the amazing ability of the human self to come back from the pit is not my doing, but I accompany in amazement and encouragement."

For Amanda, delving into the depths of human suffering and redemption seemed to come naturally, but she acknowledged that this was not always what her patients needed: "Because we do not know what any interaction might bring, the ability to be flexible in how we approach is the sign of a skillful chaplain… If the patient wants me to be light and positive, I can do that." In the ICU, she found, many patients and families had gone into emotional shock. In those situations, "for someone then to bring you a cup of water, for someone to come in and be able to pray, when you as a patient or family member feel that you can't… [That] is grace."

The emotional flexibility that Amanda's job required was understandably exhausting: "The emotional demands, the size, the amount of flexibility required to go from situation to situation, from anguish to lightheartedness, from death to birth, is such a stretching thing." She had not been sure she would make it as a chaplain, especially at the beginning, when other people's suffering had made her see "how easily it could have been myself, my family." Over the years, though, she had learned to separate patients' suffering from her own fears, and realized that "it's not helpful for the patient or the family or for me to feel horrified, or for me to even try to imagine what they're feeling." Her role, instead, was "to be open-hearted and to serve and to be kind, to help them remember the presence of the divine however they name it." The trick was to strike an emotional middle ground between excessive emotional identification and burnout. After all, she laughed, "It would be hard… to be moved by a burnt out chaplain." In her daily interactions with physicians, nurses, and ancillary staff, she tried to help them find this balance as well.

Amanda was one of six chaplains who worked at Memorial Hospital. By comparison, Kaiser had only one chaplain on staff and Community had none. The size of the chaplaincy program at Memorial made it possible for each patient to be visited by a chaplain within three days of the patient's arrival. Joanne Logan, the supervisor of the chaplains, who also managed the hospital's Department of Spiritual Care and Mission Integration, had sought to place each chaplain in a department within which patients' experiences seemed to match that chaplain's emotional disposition. The oncology ward, for example, had a chaplain who was especially skilled at creating and sustaining long-term relationships. The emergency room had a charismatic chaplain who was a bit more of a "glad-hander." Joanne admitted that there were still some chaplains who were better

than others. And accountability was awkward, as Amanda observed, since much of what made a good chaplain was "self-awareness, our ability to be intuitive, our ability to understand what a good word might be…. That's so interior." The kind of emotional intimacy and authenticity that made a chaplain effective was difficult to measure, and difficult to produce in a predictable way. Given these factors, chaplains seemed to have much more independence than the rest of the medical staff.

Nevertheless, Joanne had recently decided to have the chaplains shadow one another and give one another feedback on the quality of the interactions they were having. In recent months she had also been asking the chaplains to take on more weekend hours. As market pressures squeezed the hospital as a whole, Joanne did not think the chaplains could be insulated completely: "You want spiritual care to be special and different, at the same time you wouldn't want to be sitting around and not be busy…. We're all being asked to do more with less."

The chaplains were only one component of Memorial's department of Spiritual Care and Mission Integration. The department, with an annual budget of slightly over $500,000, was responsible for looking after the "emotional and spiritual well-being" of patients as well as for elevating and maintaining the spiritual dimensions of the hospital as a whole. Historically, the Sisters of St. Joseph of Orange had done this work themselves, yet in 2007 the last two Sisters had retired and moved away from Santa Rosa. Joanne discussed how one of these Sisters, during her last years of work in the facility, had taken it upon herself to walk the halls giving "unconditional positive regard." According to Joanne, this Sister "was the visual cue of the mission and the values and she [made] people feel affirmed, and feel part of the legacy…" Since this Sister had left the hospital, it was Joanne's and her department's responsibility to fill the void. In the face of market pressures, Amanda admitted, "it can feel as though the spirit or the heart of the place is getting dried out." The market jeopardized those parts of hospital care that were most important. But, she continued, "That is always an issue in being in an alive institution." The challenge was to "have heart in our work, even when it feels like there's more pressure from all sides."

Joanne, a perky Catholic in her late forties with short brown hair and glistening white teeth, occupied an office in the old convent that sat astride the hospital facility. She had begun her work at Memorial as a nutritionist, and in this role had been invited to participate in an employee program called "Mission and Mentoring," in which managers and other employees were trained by system leadership in the values and traditions of the Sisters. When the former director of Mission Integration and Spiritual Care was promoted, Joanne was approached about replacing her. And after taking the job, Joanne went back to school for her masters' degree in theology.

According to Joanne, the "extraordinary happens in the ordinary." In addition to supervising the chaplains, Joanne sought to find ways of highlighting the "spiritual aspects of people's needs" in the hospital. For example, Joanne sent out a daily email reflection to all staff "to remind people to get in touch with the sacred in them, so they can be there for patients and their families." She also sought to have all staff meetings in the hospital began with short reflections that "set the context for how you want to be." This was easy to implement within her own department (the chaplains "loved reflections" so much that she sometimes had to "cut back the time" they spent on them), and more difficult in other departments. But she was "fairly certain that a majority of departments"

in the hospital did it. She had also recently been given responsibility for supervising a team of community organizers hired by the hospital to "help people respond to needs in their neighborhoods."

If Community Hospital wrestled with the tension between hospital care as a commodity and hospital care as a right, Memorial Hospital wrestled with the relationship between the market for care and the *meaning* of care. Several hospital leaders suggested that the commodification of hospital care might erode the meaning of care, undermining its social and moral foundations. Catholic values, lived out in organizational practice, could help to preserve the meaning of care in the face of a market that eroded its essence. Yet conversely, the Catholic values at Memorial Hospital seemed to serve as an ideological edifice within which the most blatantly individualistic and economistic health care activity in Santa Rosa was took place. Seen in this light, Catholic values had economic *value* since they connoted an attention to emotional, personal aspects of care for which people were willing to pay.

State of the Art

Leaders at Memorial Hospital took pride in its reputation for being the most comprehensive, state-of-the-art medical center in Santa Rosa. In 2000, after months of intense competition between Memorial and Community Hospitals, the local health department gave Memorial designation as a Level II trauma center, meaning that the most critically injured patients in the area would be sent there. A commission comparing the two hospitals found that Memorial had "better trauma services, better operating rooms and facilities for receiving patients arriving by helicopter and ambulance." The decision only bolstered the hospital's already high reputation. An ER doctor at Community said of the designation, "It's not necessarily such a great thing from an administrative or even from a financial standpoint… but it's another badge they can wear and fluff their chest feathers." As Memorial's COO put it at the time, "There is a status that comes with working around a trauma center."[41] This reputation was still intact. According to a head medical administrator at Memorial,

> Our niche in this marketplace as I see it is the greatest depth and breadth of services… Our depth and breadth of what we offer in almost any specialty is quite large…. We have a large cardiac program, a large orthopedics program oncology program, internal medicine, inpatient hospitalist.

An ER doctor at Memorial remembered that when he arrived in the area Memorial was the "flagship, premier hospital of choice for people who had a choice in the region." And despite competition from both Community and Kaiser, it remained the "specialty and subspecialty hospital of choice" for the area: "The sickest of the sick are referred to Memorial," he added. This reputation was reaffirmed by those working at the other hospitals in Santa Rosa. According to a nurse director at Kaiser, Memorial was "seen as the aggressor in the community in terms of having state-of-the-art care." A charge nurse at Community Hospital admitted that Memorial was "a little more cutting-edge."

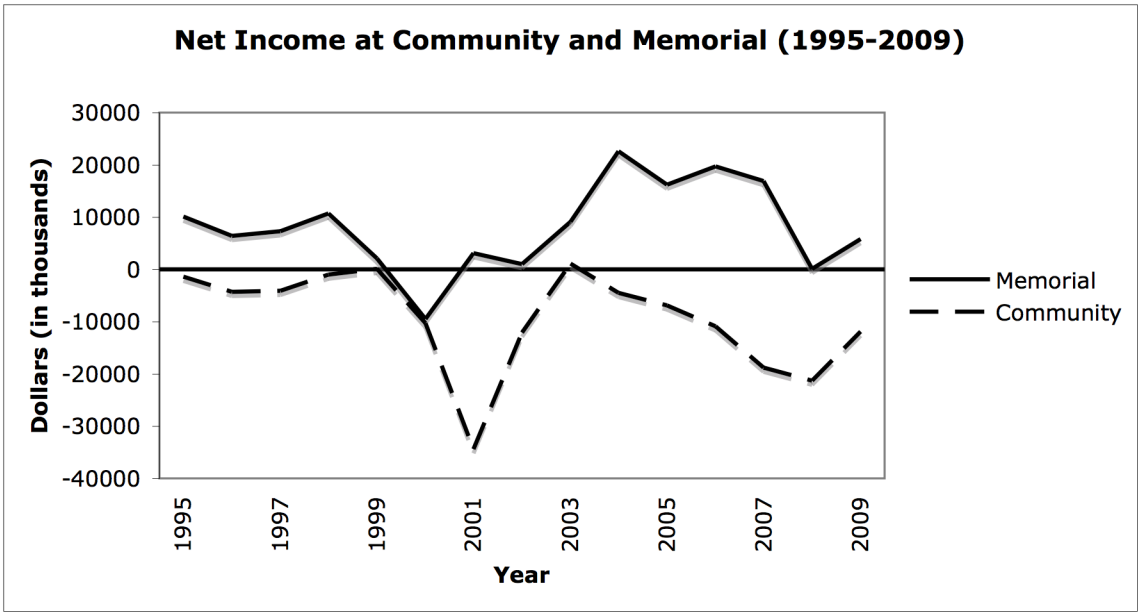
Its reputation for good medical care was likely both a cause and an effect of its image as the wealthy patients' facility. An ER doctor at Memorial said that there was a lot of "old money" in town loyal to Memorial. According to a doctor at Kaiser, "the richest of people tend to be at Memorial…" A doctor at Community Hospital said that

wealthy people liked to go to Memorial hospital because they "had music playing and artwork and nice sofas." A charge nurse at Community confirmed that the many of the "paying customers will ask to go to Memorial." And an independent family practice doctor in Santa Rosa said that while she used Community for herself, because "I know everybody and they're going to take care of me," most doctors in the area would rather be treated at Memorial "because it just looks nicer."

Wealthy patients (and doctors themselves!) responded to more than merely advanced medical technology. In order to attract the wealthy, administrators at Memorial had invested large amounts of money into giving Memorial Hospital a luxurious and personal feeling. A pianist sometimes played in the lobby. The chairs in the cafeteria were made of heavy oak, compared to the cheap plastic that graced the cafeterias of Community and Kaiser. According to one medical transporter, the administration had wanted Memorial to feel "like a hotel," and so had painted the walls brown and carpeted many of the floors. Ornate calligraphy welcomed patients entering the hospital through the lobby, and a chapel off the lobby swam with colorful light filtered from the outside through panes of stained glass. In the central courtyard of the hospital a "healing garden" had been established. Patients could walk along the curving pathway lined with therapeutic and medicinal herbs, meditate as they navigated a small stone labyrinth, or gaze at a beautiful mosaic wall. Every morning a prayer was played over the hospital intercom.

In this way, the hospital's marketing strategy merged seamlessly with its religious identity. One union leader argued that since patients "want to feel that they're more than just a number," there was an economic value to "having the religious brand on your hospital." The hospital sought explicitly to honor the spiritual side of patients' experiences, to make the experience of the hospital more personal and less sterile. And in so doing the hospital was able to attract those patients who could boost the facility's bottom line. Memorial Hospital attracted a higher percentage of insured patients than Community Hospital, and had been more profitable than Community Hospital during every year since Community had turned private in 1996 (see figure 7).

Figure 7.



California Office of Statewide Health Planning and Development

According to a physician administrator at the facility, however, this economic success was merely a means to fulfilling a broader mission: "We're a very robust hospital for a community hospital, and we do all that so that we can fund our mission." According to another system executive, "The question about finances is never a goal in itself. It's as a subjugated goal to help us fund our ministry." The mission of this ministry, according to a Sister also on the executive team, was "to extend the healing ministry of Jesus. And that's as old as Jesus and the gospel, and it's been a ministry of the Church throughout the history of the Church." A system executive suggested that each experience of interacting with Memorial Hospital and others within the system provided an opportunity for a "sacred encounter, sacred meaning."

Leaders at Memorial Hospital emphasized the tension between health care as a commodity and health care as a set of social interactions pregnant with meaning. One of the system's ethicists said he became involved in healthcare because it was the place where "many of the deepest human experiences" took place. He discussed David Rothman's (1991) *Strangers at the Bedside*, an historical and sociological account of patients' increasing alienation from the care they receive. The danger, the ethicist argued, was that certain "sociological forces… whether you want to call it market or technology or whatever" would "distance [practitioners] from the patient." The mission of Catholic health care was to "break into that" alienation—"really, really attending to the human person while… using the best of what we're continuing to develop." As one emergency room doctor at Memorial put it, "The Catholic health care system first and foremost places the patient's emotional, spiritual, physical welfare at the center of the process." The *Ethical and Religious Directives for Catholic Health Care Services*, published by the United States Conference of Catholic Bishops (USCCB), stated, "Since a Catholic health care institution is a community of healing and compassion, the care offered is not limited to the treatment of disease or bodily ailment but embraces the physical, psychological, social, and spiritual dimensions of the human person."

The Sisters of St. Joseph of Orange gave Memorial Hospital—and the St. Joseph Health System as a whole—a sense of common purpose. According to an internal report put together by a consulting firm for the St. Joseph Health System, leaders throughout the system—from physicians to managers to system executives—identified with the "mission of the Sisters" more than they did with their professional group, their local hospitals, or the health system. Yet the Sisters of St. Joseph of Orange had been retiring from active leadership roles across the system in recent years, a trend across the country. In response, the health system had sought to inculcate lay leaders with the Catholic values on which the hospital was founded. A Jewish medical administrator recalled going on a "pilgrimage" to the European village where the Sisters of St. Joseph of Orange were founded in order to "understand this heritage… understand what we're responsible for." He had also participated in four years of training within the system in order that he might learn the history of the order and might have a grounding in Catholic social teaching. "It has made me no less Jewish," he continued, "But I certainly understand what the responsibility is in a leadership role in this Catholic ministry."

Across all three hospitals, practitioners from doctors, to nurses, to orderlies and janitorial staff discussed the symbolic, ethical, and emotional dimensions to their work. But Memorial Hospital was unique in the extent to which it intentionally worked to foster an environment in which the symbolic and emotional dimensions to hospital care were taken into account. When I asked a local religious leader why it mattered whether or not a hospital was Catholic, he responded, "You ever been scared?... There isn't any time in the world when religion makes more sense than when you have a problem, especially a health problem, or confronting death…" An ER doctor discussed the religious icons around the facility. But more than any particular ornament, he suggested, was a "feeling" that everyone was working towards something greater than just service delivery.

The hospital was also invested in helping patients understand their experience in the facility as "sacred," an aspiration that was sometimes difficult to put into practice. As one leader put it, "We've really struggled with this area in terms of how do you measure it? Because we want to be certain that we're faithfully carrying that out. So we've struggled a lot with the measurement of something like that." Among employees, administrators were asking, "When did you feel respected, healed, whole by an interaction with a person? When do you think you've been able to be an agent of that for someone else?" This hospital leader continued, "I can say [to an employee], 'Have eye contact, be polite, be timely,' yes…. But it's really saying, 'How do I want to be all day long at work?'" Among patients, system leaders had been working to take "particular moments in the patient experience"—like the birth of a child—and make them more sacred. "We're taking that moment by moment and saying, 'Where are there opportunities?' And we're asking patients to tell us about [it], 'What does that feel like?'"

These initiatives sometimes seemed to put luxury ahead of practical or even medical concerns. The oak chairs in the cafeteria gave the room a homey feel, but were difficult for cafeteria workers to move. The carpets in the facility were quickly torn up with all the hospital traffic, and easily became stained with blood and urine. In order to keep the hospital quiet at night, the hospital had set up traffic lights that would signal to employees when they were being excessively noisy. But this made moving supplies during the evening hours quite difficult, according to one worker: "There's no easy way

to do it…" There had even been a recent initiative to get rid of overhead "code" pages, replacing them with "code beepers" that were given to doctors. According to an ER doctor, the administration justified the decision by saying, "Everybody knows what [Code Blue] is now, due to TV. If you call a Code Blue, other patients worry…" But the beepers did not work in some parts of the hospital, and physicians were sometimes unable to look at them when they were "in the midst of a procedure or something." The beepers had meant that fewer practitioners were responding to codes. In turn, this physician continued, the administration had decided "to play sweet musical tones every time a baby is born here," in order to highlight the positive things that were happening in the hospital. This doctor said he was "not opposed to baby tones" in theory, but that he had had patients in the hospital who were in mourning after losing their babies and for whom the tones served as a grim reminder of what they had lost: "It's not like it's all sweetness and light."

As part of another initiative, all employees of the hospital—from cafeteria workers to radiology technicians and phlebotomists—had been trained to respond to patient requests. As one technician put it, "You can respond and find out what it is they need and try to get their nurse or their aide, or whatever you can do to respond." As she put it, the initiative was intended to treat patient "like royalty as much as possible." A system ethicist had recently been treated in another hospital run by the Sisters of St. Joseph of Orange and discussed what distinguished it from other hospitals: "They made a real commitment to being friendly to everyone who walked in that door in every possible way, and you can just tell it when you go in there. It's like the difference between going into Nordstrom' and going…. You know, the staff is trained to be responsive." This ethicist was not the only one to compare Memorial to Nordstrom's. A family practice doctor who treated patients at both Memorial and Community compared the two by saying, "Memorial always reminds me of Nordstom's, 'cause… I walk in there and there's a piano guy in the lobby. Whereas I would think of Community as kind of like Target, the bargain everything."

As these examples indicate, the "sacred encounters" that hospital leaders emphasized seemed almost indistinguishable from the sorts of customer service practices to which all hospitals—and indeed all service industries—aspire (Hochschild 1983). Wall (2009, p. 5) makes a similar point when she observes that Catholic hospitals have in recent years been reasserting their values as a way of distinguishing the service they give from that of other hospitals.

When I made this point to hospital administrators at Memorial Health, however, they demurred. A system ethicist answered, "It's a bit unusual sometimes to think that way…. I don't want to speak for the congregation or for the sisters whose shoulders we stand upon, but they never thought about it as a business practice. It was just the way they work." The mission of the hospital had nothing to do with "good business practice," but rather emphasized "how we want to connect with [patients]." Another executive in the system said that "underlying assumption of [mission and market] being opposed to each other is a wrong assumption." She saw the hospital's financial health as a "subtext," and preferred to use the word "stewardship." She continued,

> Theologically, we've been given responsibility to steward the resources, so to me it's still part of the ministry…. We've been asked to be accountable for resources and how resources are bought and used and that, to me, is what financial

> management is, it's stewardship of our resources. And that's how we refer to it even in our goals. We have a set of goals that we're working on in a three year process, and it's a stewardship goal, it's not a finance goal. Because it's not about achieving a certain dollar amount, it's about financing the ministry.

A sister on the executive team discussed the importance of how they "framed" their discussion about the market for hospital care: "Framing it in the way we're framing it, finances are the supports to doing the ministry, finances and everything else…. We've been very disciplined [with] the use of the word 'stewardship.'" The market was understood through the lens of the mission.

Ethics and the Market

Tom Peterson, a physician in his early sixties, was a pioneer of palliative care practice in Santa Rosa. He had trained at Community Hospital during the 1970s and seen doctors "doing all sorts of things to patients with a sense that [they were] doing the right thing, when you could tell it was futile and the wrong thing." Soon after he began working as a private practice family medicine doctor he received a call from the first hospice in Santa Rosa asking if he would be on its advisory board. He quickly rose to become medical director of the hospice, and went on to become a founding member of the American Academy of Hospice and Palliative Medicine. He had also authored one of the field's most widely used handbooks.

Approximately twenty-five percent of Medicare spending occurs during the last year of life, a percentage that has remained consistent over the past twenty years (Hogan et al 2001). With that said, research has also shown that end-of-life costs are only slightly higher for those who die than for those sick patients who survive—meaning that these costs are likely attributable to the "substantial disease burden" (Hogan et al 2001, p. 191) of patients whether or not they are actually dying. Nevertheless, coordination of care for the frail and dying remains one of the primary drivers of healthcare costs in the country.

Palliative care professionals encourage those with serious medical conditions to consider hospice instead of expensive and intrusive medical intervention, and are one partial solution to high costs at the end of life. It costs significantly more money to die in a hospital than it does to die at home or in a hospice facility. When surveyed, approximately fifty percent of people say they would rather die at home than in a hospital. Yet over two thirds of people continue to die in hospitals (Fried et al 1999). Palliative care consultations can help people come to terms with their own approaching death so as to die in a way that feel comfortable to them, and in a way that is cost efficient as well.

Peterson spoke about the "collusion of silence" between doctors and patients surrounding death and dying. Specialists did not want to admit to their "potential for failure, if you define failure as death," while patients were often "unwilling to ask about it." Rather than delivering care in an open and honest way, doctors were too often constructing an "optimistic dream about things [being] okay." For Peterson, this mutual denial undermined patients' informed consent, since patients—whether complicit or not—were not in a position to choose based on full information. "We've got to get away from that model," he said.

Peterson did most of his hospital consultations at Memorial Hospital. While he said that his "loyalties were with" Community, he did not get called very often for patients there. He thought Memorial was more committed to "good end of life care" than was Community at least in part because of Memorial's "Catholic tradition." Of course, he continued, "It may be true that one of the phenomena that drove Memorial to be as strong as it is on the end of life care… is that they need an alternative to euthanasia, because they come out strongly against euthanasia." Peterson implied that the system's religious tradition was responsible *both* for the facility's progressive stance on certain issues and for the restrictions that the hospital put on physician practice; and indeed that these were two sides of the same coin. And while he thought the hospital's current policies regarding end of life care made sense, he expressed trepidation about conservative tendencies at the top of the Catholic Church. Memorial Hospital currently supported the withdrawal of feeding tubes when the patient or family requested it, but "the Vatican has looked at [that] more lately and there's risk of interpreting the Catholic tradition a little more conservatively right now." Thankfully, this had not yet become an issue: "So far, it's liberal enough that we really can follow the laws."

Peterson felt supported by the ethics department at system headquarters, which had in recent years been advocating for increased investments in palliative care programs at the system's hospitals. But this support was missing from Peterson's everyday work. This was at least in part because the palliative care program conflicted with the local hospital's bottom line. As Peterson explained, "At the moment this hospital's in big financial difficulty and so… my sense is there's a lower than appropriate impetus to support palliative care." Since the hospital was paid based on how much care it delivered, the more intensive care was done at Memorial, the more money the facility would make. And so while Peterson was aligned in principle with the ethics governing the organization as a whole, in practice he was left mostly on his own.

Of the three hospitals in Santa Rosa, Memorial put particular emphasis on the ethical dimensions of hospital care. According to one executive, St. Joseph Health System had been one of the earliest systems in the country to institute an ethics committee—an institution now commonplace in hospitals across the country, though varying widely in its practice (Fox 2007). A department head who served on this committee described the majority of the work of the committee as helping to determine what incapacitated people would want done "if they could speak for themselves." According to Peterson, the ethics committee at Community did not meet regularly and the number of ethics consultations was much lower than at Memorial.

As a Catholic facility, Memorial Hospital was guided by the USCCB's *Ethical and Religious Directives*, which gave answers to ethical questions concerning everything from patient-doctor interactions to organizational relationships to medical decision-making. According to Peterson, "We constantly have to deal with those in terms of what we offer patients." Many of the seventy-two directives were relatively abstract statements about the dignity of the person and the rights and duties that both individuals and providers had to the functional integrity of the body. But several were specific in the ways that they delineated the moral boundaries that economic and technological forces must respect. With regard to organ donations, the directives instructed that "economic advantages should not accrue to the donor" (#30). Surrogate motherhood was prohibited by a similar logic: "Because the dignity of the child and of marriage, and because of the

uniqueness of the mother-child relationship, participation in contracts or arrangements for surrogate motherhood is not permitted. Moreover, the commercialization of such surrogacy denigrates the dignity of women, especially the poor" (#42). In both of these instances, the Church suggested, contractual relationships risked undermining non-economic social values—from altruism, in the case of organ donation, to parental love, in the case of surrogacy.

In addition to the hospital's patient ethics committee, Memorial also had a committee responsible for issues of *organizational* ethics. Leaders up and down the health system described the sometimes-painstaking process by which the organization came to decisions that reconciled the market position of the hospital with the organization's ethical imperatives. One system leader distinguished St. Joseph Health System from other systems by the "way we do ethical decision-making… We gather community concern, really try to think through things and not do it in one particular way." Another system leader outlined a formalized process of "discernment" that leaders used when confronting big decisions. Explaining this process, she said, "Otherwise you do fall into the market factors of making decisions." She continued,

> We decide who needs to be in the dialogue, we have all the stakeholders, have we assembled the right people to have the dialogue. Then we have a process we go through within that dialogue that says, "Let's first recognize the biases that we come with, let's set those aside, let's try to explore all the facts and get all the information, let's generate possible solutions, let's see, let's identify where there may be conflicts, let's generate possible solutions, let's stop and reflect on that action, and then let's act."

Several executives discussed a recent decision to keep the system's founding hospital in Eureka, California, open despite its poor financial performance. Not only was the hospital symbolically important to the Sisters, but the hospital was also "the only major provider in the area." As one leader put it, "Anyone else looking at that on the financial side would have exited that market because it didn't make any sense." Summarizing the process he said, "We continually try to apply who we are and what we stand for to the realities of the marketplace and what's happening today to keep us consistent with who we are."

One of the hospital system's chief ethicists discussed the more quotidian concerns that the system faced in relationship to the market for care. For example, he discussed how the system was responding to the problem of drug companies spending advertising money in order to influence the prescribing habits of physicians. For St. Joseph Health System, he explained, the goal was to "help make [doctors] aware how [advertising] influences" them. Interestingly, it seemed, pharmaceutical company influence was understood as an ethical problem as opposed to a regulatory one. Kaiser, for example, prohibited all pharmaceutical spokespeople from meeting with its doctors in the first place. For Memorial, on the other hand, what was needed was the infrastructure that would enable doctors to make ethical choices on their own. When I asked a hospital director how ethical considerations constrained the hospital's business practices, she answered, "Well I'd like to think that we consider the people more." The committee sought to balance what was "good for the person," the individual, and the "value of the whole" organization. Yet she seemed unable to provide an example of an instance in

which the committee had chosen to prioritize the good of individuals over the financial health of the organization—a decision to outsource the hospital's medical transcriptionist services was a "really hard" one, but one that the hospital made nonetheless.

The Church's most well known ethical directives, of course, concerned women's access to reproductive services. Abortion and sterilization (not to mention any reproductive technology that substituted for procreation) were prohibited on the grounds that they were "medical practices that undermine the biological, psychological, and moral bonds on which the strength of marriage and the family depends." When Community Hospital threatened to close in 2007, many in Santa Rosa were concerned about losing access to women's reproductive health services. Practitioners at Community felt that Memorial's ethical restrictions violated the notion of health care as a right. According to one physician administrator at Community, Memorial's prohibition on doctors' prescribing the morning after pill was "denying someone a right to their care." He continued, "The conflict is in human rights, I think, being violated by a religious belief. It's a strong thing to say, but I believe that." Several regular doctors at Community Hospital who worked occasional shifts at Memorial admitted to violating hospital policy. According to one, "There were times when I did [prescribe it], actually, because I felt like they can't come and tell me not to." Another recalled being prohibited from referring patients to abortion providers, but said that he "did it all the time."

Another ER doctor at Community grew angry when he discussed Memorial's approach to abortion and other medical care. Memorial would only treat the needy, he argued, if they "fit into a pattern that [they] feel is appropriate and not sinful." Not only would they refuse reproductive health services, he recalled, but during the "crisis years" of the HIV/AIDS epidemic they would have "nothing to do with" the disease: "Every HIV patient who was picked up on the street by the paramedics came to [Community] hospital, *this hospital.*" People were "dying in the ER" at Community Hospital, he continued, his voice rising, "because, to them, homosexuality and IV drug use did not into their pattern of Catholic rights and morals." The doctor laughed: "Now it sounds like I'm angry. Maybe I am."

Preference for the Poor

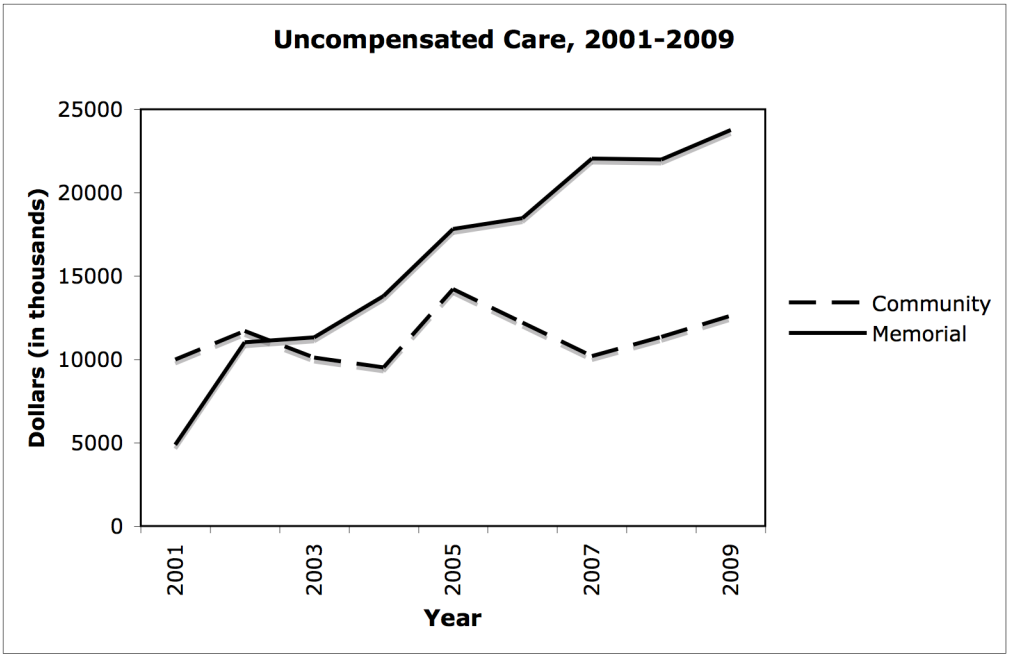
According to many hospital leaders at Memorial, the mission of Catholic healthcare extended beyond the "sacred encounter" to encompass what one hospital leader called "a special preference for the poor and the marginalized." This charitable mission was consistent with the USCCB ethical directives, which stated that "Catholic health care should distinguish itself by service to and advocacy for those people whose social condition puts them at the margins of our society…" One physician administrator said, "We do look at high-profit services because that's how we pay for low-profit services." An ER doctor said, "We've got a mission, we've got to take care of the less fortunate." When they were actively involved in hospital administration, the Sisters of St. Joseph of Orange had established a program to provide mobile medical vans and dental clinics to poor communities in Santa Rosa, and had founded a low-income primary care clinic. In recent years, Memorial had also set up at two urgent care centers for people whose conditions were serious but did not warrant emergency room visits; and had funded community programs that provided medical education to underserved populations in Santa Rosa. One administrator at Kaiser admitted, "I would tend to give

the Sisters of St. Joseph of Orange the benefit of the doubt that a lot more of their activities are driven by the belief that they really are supposed to minister to the poor with some of their resources, as opposed to Kaiser and Sutter Health which don't have that as a real central part to the way their leadership thinks."

The vast majority of any hospital's charitable endeavors consists of care that the hospital gives away to the uninsured or underinsured. Practitioners and administrators at Memorial said that while Community Hospital may have seen a higher percentage of uninsured or underinsured patients relative to its patient population, Memorial Hospital—as the premier hospital in the area—committed a greater amount of resources to care that was not reimbursed. Figure 2 demonstrates the uncompensated care provided by Community and Memorial hospitals between 2001 and 2009, and supports the proposition that Memorial had given more uncompensated care, especially in recent years.

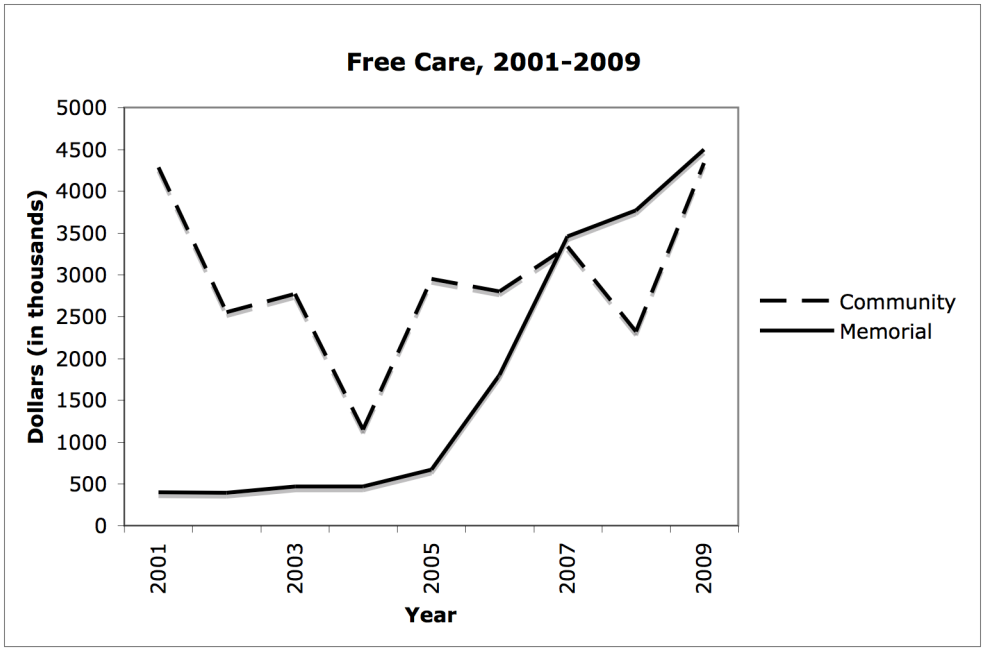
But the graph is also an indication of just how difficult it is to parse out reality from statistics when it comes to hospital care care. First, "uncompensated care" includes care that was given freely alongside bad debt (as well as an adjustment for participation in the county indigent program). Figure 3 compares the amount of free care given by the two hospitals, and suggests that Community had—in the recent past—regularly given much more care away than Memorial.

Figure 8.



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Figure 9.

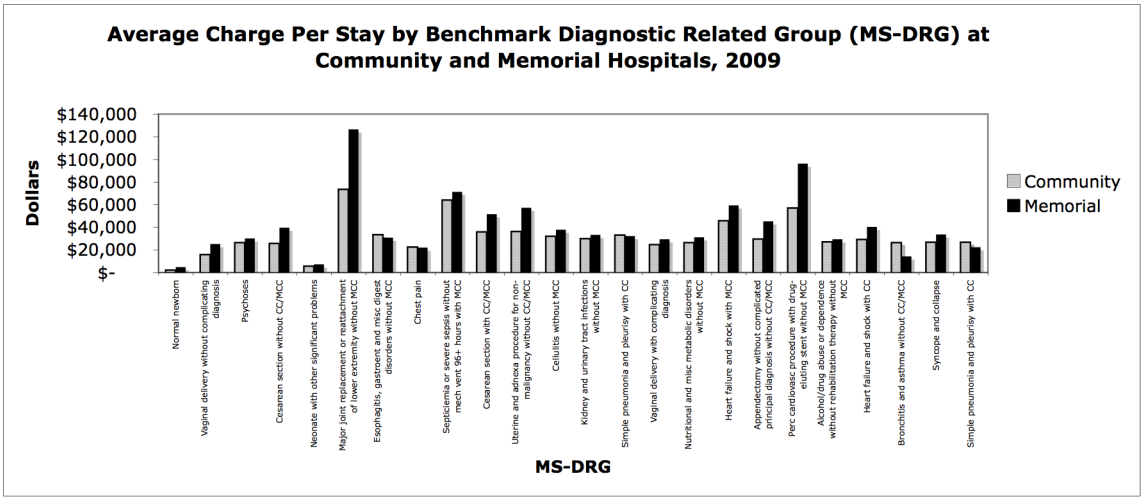


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Furthermore, calculations of both free care and uncompensated care are based on hospital *pricing* that varies widely between the two hospitals. Since Medicare and Medicaid pay standard amounts based on diagnostic and procedural groups, and insurers negotiate their own rates with hospitals, hospital prices are almost meaningless except as indications of

what hospitals charge the uninsured. Figure 10 compares average pricing for common diagnostic related groups at Community and Memorial Hospitals. It suggests that Memorial's pricing may also inflate the amount of uncompensated care the hospital provided.

Figure 10.



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Some surmised that Memorial's share of uncompensated care had risen unexpectedly in the years after winning the county trauma designation in 2000. An ER doctor at Community suggested that Memorial had miscalculated when it fought for the trauma designation, and that it was seeing a higher proportion of homeless and uninsured than it had expected: "It turns out… that lots of trauma [in Santa Rosa] is homeless people who fall down and hit their head." He laughed while he explained this as "karma" catching up to Memorial Hospital: "From those days of never wanting to see a bum or a homeless person or HIV person, when they became the trauma center" they began to be on more "equal footing" with Community.

Even the urgent care clinics run by Memorial Hospital had a mixed relationship to the poor and underserved. On the one hand, the clinics nominally were established as resources for those that did not have easy access to primary care doctors. One ER doctor at Memorial said, "You can go into those urgent care centers and you don't have to give them insurance, you don't have to tell them anything, they'll take care of you for free." But a physician administrator at Memorial acknowledged that the clinics had also been established in order to "take [a] load of patients off the ER, and put them into places with lower costs." In other words, the uninsured were becoming a burden on Memorial Hospital's ER, and the urgent care centers—staffed by family practice doctors in facilities with fewer medical technologies—would take care of this population more cheaply. Moreover, this administrator said, it soon became clear to the hospital's CFO that the urgent care centers were not paying for themselves as the plan had been. So the hospital started publicizing the clinics as places where insured patients could go, "advertising in very high-end publication and billboards in such a way that… they were likely to attract a patient population that had a higher insurance rate."

According to several physicians and nurses, the environment at Memorial hospital was actually *less* welcoming to the poor and vulnerable than the environment at Community. One doctor recalled that at Memorial "they don't give out meals, they're not as soft and fuzzy, they're a bit more like, 'Deal with it and move on…'" A nurse who worked at both facilities said that Memorial refused to perform many of the small kindnesses that were part of care at Community: "I haven't seen them give showers [at Memorial]," she said.

A physician administrator at Community suggested that while Memorial was seen by many as the "charitable, Catholic religious organization," he had seen its "seamy underbelly." A local priest and old friend of the Sisters of St. Joseph of Orange suggested that while the Sisters had previous used the hospitals to support their mission, they now used the mission to support their hospitals. They had "developed a language and a theology to protect themselves" and their economic interests, and had even modified their mission statement over the years to make it more consistent with their increasing immersion in the economics of care delivery. He saw Memorial's work on behalf of the poor and uninsured as little more than a way for the sisters to "solve their conscience," a kind of paternalistic philanthropy that helped them rationalize their deep ties to the market for medical care.

The Catholic Ethic

At Memorial Hospital, Catholicism seemed to provide the ideological framework within which hospital leaders and some physicians were able to understand their participation in the market for healthcare. The accumulation of money was not understood as an end in itself for those at Memorial Hospital, but rather as a means for living out Catholic values.

But at Memorial Hospital the relationship between means and ends was sometimes unclear. Did it participate in the market in order to forward its mission or was its mission part of its strategy for doing well in the market? Wall (2010, p. 175) suggests that since the first Catholic hospitals were established in the United States, "there has existed an inherent conflict between the Church's clearly enunciated spiritual values and the market realities with which they had to compete." And while this is certainly true, it is also true that Memorial Hospital's spiritual values had served as a productive ideological shell for a healthcare market in which economic success is rewarded to those who appeal to non-economic values.

Indeed, when the system's ethical commitments contrasted too sharply with its economic interests, the economic interests seemed to take precedence. For example, between 2002 and 2009, the St. Joseph Health System sponsored a Center for Healthcare Reform. A system ethicist who had helped to spearhead the center explained his involvement: "I would like for Catholic healthcare as a national body of shared ministry to be more aware of how much we are the captive of a large network of irrational, unjust, hodge-podge of cobbled together craziness." He continued by comparing Catholic healthcare to the "warden who really understands a different model of the criminal justice system but is living in the U.S. of A. in 2010 and both is trying to do whatever limited things are possible as well as somehow transform that larger world of misunderstanding." The goal of the Center was to envision and advocate for a "longer-term transformation of American healthcare" that would lead to healthcare to be treated "for what it is, and that

is a social good, and not a market good." The Center put forward a vision for the role that St. Joseph Health System might play in the health care world, and suggested that the system might be unable to live out its mission *without* a transformation in the organization of care in the U.S. A leader of the Center was cited as saying, "dysfunctional ethics on the societal level have cascaded down into our Catholic health care ministry in such a way that makes it almost impossible to carry out our ministry in any respectable manner" (Jones 2004). But these ideas seemed too radical for the system as a whole. The Center was closed in 2009.

Viviana Zelizer and her colleagues have long demonstrated the inseparability of culture from commodification. In *The Social Meaning of Money* (1997), for example, she argues that while money may alter social relationships, "values and social relations reciprocally transmute money by investing it with meaning and social patterns" (p. 18). Gift money, pin money, and welfare money—and the processes by which these marked monies have changed historically—provide strong evidence for how culture intersects with even those most abstract tokens on which market society is built. Zelizer would thus be unsurprised that Catholic values and understandings can flourish alongside the market for hospital care as they do at Memorial.

Yet the study of Memorial also raises important questions with Zelizer's analytic framework. For all of her insight into the ways in which morals and markets intersect, she rarely focuses on cultural meanings as a product of (or vehicle for) economic interests. For example, her path breaking work on the evolution of the life insurance industry demonstrated shifting patterns in people's understanding of the relationship between money and human life: "Sacrilegious because it equated cash with life, life insurance became on the other hand a legitimate vehicle for the symbolic use of money at the time of death" (Zelizer 1978, p. 601). Buried in her conclusion, however, is a materialist interpretation of the change: "Death yielded to the capitalist ethos—but not without compelling the latter to disguise its materialist mission in spiritual garb" (Ibid, p. 605). On the one hand, Zelizer wants to give autonomy to culture and demonstrate the resilience of meaning in the face of the market. Zelizer and her colleagues have demonstrated the ways in which "market exchange is saturated with moral meaning," and the tremendous variation in the ways that people understand the "moral valuation or appropriate classification of particular goods, or even of the market itself" over time and space (Fourcade and Healy 2007, p. 300-301). On the other hand, as Zelizer herself suggests but does not pursue, market actors themselves work to shape cultural values, or make use of these values in order to pursue economic ends.

In the case of Memorial, the Catholic values on which the hospital were founded had some autonomy from the market—in that they represented a realm not reducible to economic concerns—and yet simultaneously became a field of struggle in and through which multiple constituencies worked to advance their economic interests. The Sisters of St. Joseph of Orange were simultaneously committed nuns *and* owners of a corporation. Yet different constituencies in the hospital related to these values differently. As I explore in the next chapter, doctors at Memorial were the most entrepreneurial and individualistic in Santa Rosa. For them, Catholic values seemed to provide a spiritual framework that legitimized a pecuniary orientation to medicine. As I explore in the subsequent chapter, workers at the hospital were asked to martyr themselves in the name of the Catholic mission. While many did find personal resonance with these religious

values, over the course of a union organizing drive they rearticulated these values in a way that supported their efforts to win more power in the organization.

The case of Memorial Hospital illustrates the way in which the social meaning of hospital care became a set of beliefs through which market interests are expressed. There is a vocational dimension to the work that goes on in hospitals that cannot be understood purely in exchange terms—to the extent that matters of the heart are reduced to exchange relationships, they lose their value. Yet this does not mean that these vocational values and beliefs are a sphere entirely removed from or unrelated to market considerations and market interests. At the same time these beliefs and values retain a degree of autonomy from the market, they also become a terrain of struggle within which multiple actors assert their economic interests.

CHAPTER SIX: GOOD BUSINESS

During an early morning coffee break in the small cafeteria at Community, a senior emergency medicine doctor began describing the ER down the road at Memorial. In order to understand it, he said, I should read a book with a provocative title: *The Rape of Emergency Medicine*. Published in 1992 by James Keaney, a disillusioned ER doctor and the founder of an alternative professional association for emergency medicine physicians, the book documented how a few entrepreneurial ER doctors had, over the course of the 1980s, established large national corporations that contracted with hospitals to manage hospital emergency rooms. These contracts yielded large sums of money for the doctors-qua-administrators[42] and offered some stability to hospitals, which no longer had to worry about staffing themselves. But these contracts, according to Keaney and others, came at the expense of emergency room doctors themselves.

TeamHealth, one of the nation's largest contract management groups, held the contract for the emergency department at Memorial. The company managed the scheduling, billing, and workflow of the emergency medicine physicians, who were technically "independent contractors" with the company. It also provided them with medical malpractice insurance, and helped them minimize legal risk.[43] For a fee it even offered doctors personal "scribes" who, wearing polo shirts emblazoned with the TeamHealth logo, would follow doctors around to facilitate documentation for reimbursement.

In exchange, TeamHealth took (or "skimmed," according to some ER doctors) approximately thirty percent of physician billing revenue. For around ten percent more, the company also collected on late payments, since it ran its own collections agency. While no ER doctor in Santa Rosa knew exactly how much profit TeamHealth made from of its contract with Memorial, most estimated that it was tremendous. One ER doctor said, "They have fairly low administrative costs, and they have great economy of scale." Another said, "They've got this cash cow. They've got poor ER docs doing the stuff, and they're making a fortune, an aggregate fortune." This type of third-party management was strikingly different from the organization of the ER at either Community or Kaiser. At Community, a group of local physicians cooperatively owned the contract with the hospital. At Kaiser there was no hospital contract per se—all doctors in the ER and elsewhere were on staff of the same large Permanente Medical Group that was closely associated with the hospital.

Many of the ER doctors in Santa Rosa regarded TeamHealth with suspicion. One doctor at Kaiser had considered working at Memorial but worried that TeamHealth could "pull you out without any rhyme or reason." He was attracted to the money he imagined he could make there, but thought, "I don't really trust these guys." He and others told me that a longtime ER physician at Memorial recently had begun to question the way that TeamHealth was managing its finances and had "asked for more of an open book." He was fired. Another ER doctor, who had previously worked at Memorial before moving to Kaiser, said that the arrangement worked okay until "the interests of the ER doc and the hospital [were] divergent." In these cases, TeamHealth would "do whatever the hospital said," leaving physicians without any recourse.

As one example, according to a physician administrator, the hospital had begun to open up urgent care centers in low-income neighborhoods around Santa Rosa, an effort that was initially intended to reduce the number of uninsured patients visiting the ER and

so increase the hospital's (and physicians') revenues. TeamHealth was asked to manage these clinics, which were staffed by residents, nurses, and nurse practitioners, all of whom were paid at a significantly lower rate than ER doctors. Over time, however, as described in the previous chapter, the CFO of Memorial decided that the clinics were not making enough money, and decided that the hospital should advertise the clinics to attract more paying patients. As a result, Memorial's ER actually began to see a *reduction* in the number of insured patients, while TeamHealth was able to make a wider margin of income on insured patients who were seen in the urgent care clinics: "All of the sudden it wasn't the hospital doing things that were against TeamHealth and the physicians' best interests, it was the hospital and TeamHealth doing it against *our* best interests." Physicians had little option but to acquiesce, or leave—the latter of which they were doing in increasing numbers. According to those with whom I spoke, approximately half of the ER physician staff at Memorial recently had left or were preparing to leave.

But the insecurity that ER physicians felt at Memorial was—according to some doctors—precisely the appeal of such a contract for Memorial Hospital. As one ER doctor at Memorial put it, "The hospital [has] enough problems, they just want physicians who don't piss off the medical staff, don't piss off patients… Because the hospital has to staff with nurses and techs and supplies and the last thing they want is to be futzing with the docs." If a physician was performing poorly, a group like TeamHealth could simply "get rid of them." At a place like Community, this doctor implied, it was more difficult to discipline the ER physician staff: "If you've got a partnership of physicians and then one of them starts acting up, it's much more difficult to kick a partner out."

Matthew McEvoy, a local administrator of TeamHealth, came to the defense of his management company as the best solution to the organization of emergency care in an increasingly market-driven health care environment. McEvoy had practiced as an ER doctor at Memorial since the mid-1980s, and still worked the occasional shift. We met at his mansion in downtown Santa Rosa on the day before TeamHealth was planning to make its initial public offering. As he remembered it, Memorial doctors organized themselves into a corporation only as a defense against external market pressures. In the 1980s, according to McEvoy, Memorial told its ER doctors that due to financial constraints the hospital would no longer handle the doctors' billing, and that if the ER doctors did not figure out a way to organize billing themselves the hospital would look elsewhere to staff the department:

> It was kind of a wake-up call for us, because we were full-fledged members of the medical staff…. We were shocked that an administrator would take the position [that we were] expendable. So we [organized our own group], and actually it was good for us that we did it. It's a little microcosmic sort of picture of what was going on, on much broader terms throughout healthcare, which was it was becoming much more impersonal, much more business and economic driven.

McEvoy explained the company's expansion in defensive terms as well. After establishing themselves as a company, the founders recognized that they remained "vulnerable" if they had only one contract, since *other* contract management companies (and managed care organizations) might use their market share to pressure hospital chains into using their services across an entire hospital system: "Our worry was that, as those seemingly unstoppable juggernauts rolled across the country, that they would begin…

dominating emergency medicine." And so began a process of growth and consolidation: "We started slowly getting contracts at other hospitals in the area, and then ultimately throughout California. We turned our group into a much, much bigger group." It even briefly became a subsidiary of a large managed care organization—MedPartners. This merger fell apart when it came to light that the leaders of the managed care organization "were crooks" and the company went bankrupt.[44]

McEvoy acknowledged that he had become increasingly removed from the practice of emergency medicine as he learned the financial side of the organization:

> A lot of my focus is on making sure that we have good relationships everywhere, that we don't lose any of our relationships, we don't lose business, we don't lose market share. Because we're like any other organization, we have to grow…. And that's just a principle of business in a capitalistic society. So we do try to grow and get new business, get new contracts, and in emergency medicine, that usually means taking somebody else's business….

He saw the corporation's financial success as being closely related to the quality of care that the organization ultimately was able to provide. First, whereas the corporation had initially had been established as a kind of protection from the marketplace, McEvoy suggested that its size now made it possible for the company to offer resources with which smaller companies could never compete. From malpractice insurance, to risk-management tools, to programs to document patient outcomes and programs to enhance patient satisfaction, TeamHealth could help physicians and hospitals negotiate a "rapidly moving marketplace."

But in addition to the resources that TeamHealth was able to provide its doctors, McEvoy emphasized the ways in which he and other physician-managers could foster the right kind of "organizational culture," both in the sense that doctors had an incentive to work hard and in the sense that doctors felt they could get their work done easily and were recognized for doing a good job. Among the hospital contracts he managed, he thought that an incentive system based on relative value units (or RVUs) was most effective. In this system, after a management company took its proportion of patient reimbursement, the remainder was distributed to doctors according to the number of RVUs that the doctors produced. RVUs represent a way of rationalizing the unit of care delivered and documented by a physician in the ER—cases that demand more time or more expertise are assigned a higher number RVUs than simpler or quicker cases. An additional (and smaller) pool of revenue could be distributed according to measures of customer satisfaction or adherence to practice protocols. This sort of system, according to McEvoy, had several advantages for physicians and for the hospital managers. For individual physicians, the advantage was that the RVU system "separate[d] the payment aspect from the work aspect," so that physicians would be paid for the work they did regardless of the insurance status of the patients they saw. For hospitals and the physicians as a group, the advantage was that RVUs were assigned based on *documentation* of services delivered, since when third-parties are paying the bill, "If you don't do a good job of documentation, then you basically have lost that revenue." Doctors thus had an incentive both to work hard and to document their work well, maximizing reimbursements for the hospital, the management company, and the pool of doctors as a whole. The additional pool of money could be allocated according to

whatever the hospital's (or the management organization's) priorities were at any given time—whether that be customer service, adherence to practice protocols, or something else entirely.

An RVU system, designed to reward physician productivity and billing, used market incentives more than the systems in place in the EDs at either Community or Kaiser. At Community, the physicians who jointly owned the contract split profits based on the number of shifts they worked, and "subcontracted" shifts to other doctors for an hourly wage. At Kaiser, physicians were paid a yearly salary with minor financial incentives for meeting certain practice goals. But this RVU system was actually rejected as being *too communal* for many of the emergency doctors at Memorial. One explained his suspicion of the RVU model that TeamHealth had encouraged: "Their preferred model is to separate the physicians as far as possible from the actually money that's collected, because for every level that you're removed from the collection… [there are] more opportunities to take a percentage here for this or for that." Since TeamHealth had been founded at Memorial, the company had "a little bit of special connection" there, and allowed Memorial doctors to maintain a system of individual billing. Throughout Memorial Hospital, doctors were much freer to practice medicine as the individual craftspeople they had been in the golden age of professional autonomy.

Disintegration

Paradoxically, the most explicitly spiritual hospital in Santa Rosa was also the organization within which physicians were the most brazenly individualistic and entrepreneurial. But Catholic hospitals have always tended to have a hands-off approach to the physicians who use them. The majority of Catholic facilities were founded in the early part of the 20th century at a time when the medical profession had only recently established itself as a legitimate authority. Catholic hospitals could not thrive unless physicians decided to use them. And so the Sisters who founded these hospitals, entrepreneurs who had, through their tireless work, managed to win some autonomy from the men of the Church, now found themselves dependent for their hospitals' survival on the men of the medical profession. When the Sisters of St. Joseph of Orange founded their first hospital in Northern California, for example, they faced the skepticism of a local medical community "reluctant to bring their patients" to the hospital "for they believed the Sisters were untried and uneducated" (Geagley 1987, p. 112). It was only through three years of arduous work and training that the "rooms were filled and… ledger books indicated that the convent would be enjoying some financial security" (Geagley 1987, p. 113).

Among the three hospitals in Santa Rosa, doctors' relationship with Memorial continued to be the most financially autonomous. Every doctor who worked at Kaiser was part of the Permanente Medical Group. Since Sutter Health had taken over ownership of Community, it had also been working to expand the number of doctors there who were associated with the company's large Sutter Medical Foundation. In each of these cases, having a medical foundation associated with the hospital allowed the hospital to exercise some degree of accountability and control over the doctors practicing there. Moreover, to the extent that these medical foundations attracted primary care doctors, they guaranteed the hospitals a steady supply of patients. As one administrator associated with Memorial said, "Every healthcare organization in the country wants to

have a physician strategy. And the physician strategy is all about how do we retain our market share."

But Memorial had resisted the drive towards physician integration. As the hospital's chief medical officer explained, "Memorial for the most part is an open medical staff," meaning that doctors applied for credentials individually and then could practice at the hospital at their discretion. As a result, according to one emergency room doctor, the situation at Memorial was "very grim…. Memorial is years behind the organizational curve." Indeed, despite its reputation as the only high-end, state-of-the-art hospital in the area, several physicians with whom I spoke suggested that Memorial's very survival was uncertain.

The paradox was that Memorial's vulnerability seemed due in large part to way it sought to cater to the high-end specialty physicians. In the 1980s, in the midst of an expanding managed care industry, Memorial had—in association with the local HMO, Health Plan of the Redwoods (HPR)—contracted with a group of primary care physicians to manage the care of a large group of patients. HPR would pay the primary care doctors on a capitated basis, and the primary care doctors in turn would pay the specialists for referrals. This had roiled the specialists, who now depended on the primary care doctors for their pay. As an emergency room doctor at Memorial put it, the subspecialists were "used to being in control and getting paid a lot more." When HPR went bankrupt, moreover, the specialists did not get paid for work they had done. According to a physician administrator at Memorial, the specialists threatened to "blackball" Memorial. And the hospital learned its lesson. As the emergency room doctor put it, "Memorial pretty much made a commitment to its medical staff to move away from capitated programs and just focus on PPOs and fee-for-service"—on those programs that would pay doctors for the work they did individually.

For some leaders in the medical community, Memorial's financial difficulties were payback for the way that the organization had truckled to the interests of the highly-paid specialists. According to one physician administrator, who bridged several different healthcare organizations in Santa Rosa, Memorial had

> made a business decision to preserve a certain margin at the expense of a long-term view of what they really knew was the right thing to do. The right thing to do would have been to persist with developing an integrated delivery system…. Why was it the right thing to do? It would save lives, suffering would be assuaged, and in the end they would have been successful from a business perspective. I would guarantee it. I will also guarantee that they are now in the death throes…. They do not have a primary care base for referrals. And they will die.

Rather than organize large medical foundations in order to tie physicians (and their patients) to Memorial, Memorial appealed to doctors the same way they appealed to patients: as autonomous customers. As an ER doctor at Memorial put it, "Memorial historically has taken a, 'Come on why don't you work with us' [attitude]." And a physician administrator at Kaiser said, "Memorial doesn't make money unless doctors admit there, right? So doctors are… coddled." The physicians' lounge at Memorial was unlike anything one might find at the other two hospitals. Lunch and dinner were catered each day by the hospital's cafeteria staff, and a Starbucks coffee machine provided free

lattes and cappuccinos. While the hospital may not have offered the amenities typical of Silicon Valley, it certainly aimed to please more than the others.

A surgery scheduler at Memorial emphasized the ways in which the hospital aimed to woo surgeons. As she put it, "It's a symbiotic relationship, the physicians can't do surgery without the hospital, the hospital can't do surgery without the physicians." She described how the hospital had "sales reps that go to the doctors' offices and say, 'Hey, look at our new toy! Don't you want to play with this?'" According to her, the hospital had bought an expensive "heart laser" in order to attract cardiac surgeons. It was very rare that a doctor would use the machine, she continued, but it had great symbolic value among the cardiologists and cardiac patients. She saw her role as developing "rapport with the doctors' offices" and trying to "make it as easy as possible to schedule surgeries" so that they would use Memorial. And when a particular surgeon's monthly utilization was down, the scheduler would call the "gal in the [surgeon's]" to ask, "Hey, what's going on?" Indeed, administrators at Memorial seemed to encourage the nursing staff and ancillary workers to treat doctors as if the doctors were clients of the hospital—which, in a sense, they were. A hospitalist, who had practiced at Kaiser before recently joining Memorial, said, "I sat down the other day, the nurse went and got me a chart and brought it to me. I was like, 'What the heck is that?'… That would never happen at Kaiser." He continued, "At Memorial, they might be a little more old-fashioned in the way they treat the doctor with more respect."

But if this lack of integration gave doctors a degree of power within Memorial, it also made it very difficult for doctors to coordinate patient care or for the hospital to hold doctors accountable for their practice. Tom Peterson, the palliative care doctor at Memorial, expressed frustration that the hospital had not been able to develop a protocol for dealing with end-of-life care, despite the system's philosophical commitment to this sort of ethical question: "This is an open campus, open ICU, open everything. And so people aren't governed by a set of institutional rules on how to collectively go forward in the best way; everybody's operating in a silo." A critical care doctor at Community, who had previously worked at Memorial, described how "there are no dedicated ICU [intensive care unit] doctors at Memorial," meaning that each patient in the ICU was managed by a doctor who also maintained a private office practice. According to this doctor, the lack of coordination "makes it a little difficult to get protocols going and that's really important for care." A hospitalist at Community, who also had experience working at Memorial, said there was such lack of coordination at Memorial that each day of a patient's stay he or she would see a different hospitalist, who would do a separate history and physical, and bill separately: "Patients would routinely complain to me: 'I was in the hospital for a week, I got bills from six different hospitalists.' What's the sense of that?"

The lack of integration also meant that the hospital had a difficult time regulating physician practice. A physician administrator described how most doctors were subjected to only "soft and indirect" feedback from the hospital. Granted, if any doctor was practicing in a blatantly unethical manner the hospital could "kick them off our staff." But within the boundaries of acceptable conduct there was still wide variation. Individual practitioners were thus often left to decide on their own to which doctors they felt comfortable referring patients. One hospitalist described how he refused to refer patients to a particular cardiac surgeon because the surgeon seemed excessively

concerned with maximizing his profits: "I never use him for anything that he's going to make money on. Because I don't trust him."

You Eat What You Kill

The significance of trust (and its absence) at Memorial was heightened by the fact that doctors there billed on an individual basis, collecting money only for the patients that they saw. When an ER doctor from Kaiser had interviewed at Memorial, he had been told that doctors there "eat what they kill." This had several related effects on physicians' practice patterns, on the relationships among doctors, and on the relationships between doctors and their patients.

Given that doctors made money based on the number of patients they saw, doctors at Memorial had a clear incentive to see as many patients as possible. An emergency medicine doctor at Memorial said with evident pride that the average ER doctor at Memorial saw 2.4 patients an hour, compared with those at Kaiser who averaged 1.2. Moreover, he continued, "our admit [admission] rate is much higher, and our patients are more critical," making the faster rate even more remarkable.

Across several different departments at Memorial, doctors seemed to work harder and longer than they did at the other two hospitals. A hospitalist at Community, who had previously worked at Memorial, compared the pace of his practice at each: "At Memorial I would have maybe twenty patients that I had responsibility for a day. Here I have ten to twelve. I can see everybody at least twice here per day." At Community, this doctor could go home when his shift ended—usually around 5pm. At Memorial "finishing at eight or nine o'clock is routine." He described one doctor who worked the day shift but often stayed until midnight: "She can't get done because she's one of those methodical people who shouldn't be in that kind of practice."

Yet many doctors at Memorial actually resisted reducing their workloads. When the hospitalist above proposed hiring more staff he faced resistance from the rest of the hospitalists who felt that additional staff would be "cutting into [their] income." An emergency medicine doctor spoke about how adding another physician would mean "an immediate dilution of physician earnings." And while some doctors seemed to relish the pace and autonomy of work at Memorial, several others found it burdensome. A hospitalist who had left Memorial summarized his experience: "You're getting called constantly and you don't know what's going on, you're living on the edge, you're admitting multiple patients—it's brutal. I couldn't take it." The ER doctors agreed to hire additional doctor only after "we sort of saw… our lives were just sheer hell, all the patients were just yelling at us all the time, and you felt frustrated because nobody was checking things that needed to be checked."

Others felt more ambivalently about the tradeoffs. For example, Fred Lombardi—a hospitalist—had left Memorial for Kaiser when his wife had just given birth to their first child. At Memorial he felt like he could not refuse the requests of other doctors since his financial success depended at least in part on the informal relationships he had established with other doctors: "I help them out, it's better for the patient ultimately, and then not only that, I mean, to be honest with you, you do that, they're going to use you. And if they use me, it pays the bills." Yet he often found himself at work from 7 or 7:30 in the morning until "7, 8, 9, 10 o'clock at night." He would get home "and my daughter is asleep… So I'm like, 'What kind of life is this?'" At Kaiser

he had a more predictable schedule and more standardized salary. Yet having come from the fee-for-service world, Lombardi chafed at the slow pace and bureaucratic rules at Kaiser. He had recently returned to Memorial with a new appreciation for its flexibility: "I know I work harder during the day [at Memorial], I know there will be more likely to be late nights and there are definitely going to be late nights. But I can work for 6 less days a month, and actually have full days off [at the same pay]."

A system of individual billing meant that doctors were, in some sense, competing with one another for those patients likely to reimburse at a high rate, and—conversely—avoiding the uninsured. Within the Emergency Medicine and Hospitalist Departments, several physicians and nurses discussed the problem of "cherry-picking." A new hospitalist at Memorial, unfamiliar with the individual billing system, was once assigned twelve patients only two of whom had insurance. "Did that happen by accident?" he asked rhetorically. Over time, he said, he had to "learn how to defend [himself]" against other doctors' attempts to stack the deck. A second hospitalist, who had left Memorial to work at Community, described how his colleagues at Memorial would sometimes say, "Oh, I don't want to see that patient, I want to see this one." This hospitalist assumed that his colleagues had an aversion to treating a certain kind of condition: "It took me a long time to realize that they would routinely do that for patients who were uninsured. They would never see the uninsured. And I'm too stupid to realize it. I had no idea that that's what they were doing. They're better businessmen than I am."

A similar competition would sometimes arise in the Emergency Room. A charge-nurse recalled an incident in which one doctor signed up for a critical patient only to have another doctor steal the patient: "So the one doctor who signed up first took the other doctor to the patient's bedside—can you imagine? This is like two of my boys at home. And said, 'Okay, Mrs. Jones, which one of us did you see first?'" Occasionally, the charge nurse continued, she would have to serve as mediator, ensuring that the most lucrative patients (generally critical patients who had insurance) were evenly distributed across the physician staff: "I feel like I'm babysitting."

Matthew McEvoy, the Memorial ER doctor and administrator of TeamHealth, suggested that cherry-picking was not a significant problem in large part because "you don't know the patient's insurance status when you're taking care of them." But several other ER doctors and hospitalists described the strategies that their colleagues used to distinguish the paying customers from those likely to be uninsured. For example, those patients who had no primary care doctor listed—or whose primary care doctor was listed as being located at one of the community clinics—was likely either uninsured or on Medi-Cal. Latino last names were also red flags. Patients who came in for pancreatitis might be alcoholics, and so more likely to be uninsured. Those in the ER discussed how "blunt traumas" like the victims of car accidents and falls were more likely to be insured than "puncture traumas" like the victims of gun and stab wounds.

Among the ER doctors at Memorial there was one physician in particular whom others—both physicians and nursing staff—suspected of cherry-picking. A physician administrator confirmed that this doctor saw approximately twice as many critical care patients as the staff average. A second physician administrator discussed how, given suspicions within the department, he had analyzed the data and found that this doctor actually *had* seen significantly fewer uninsured patients than the others—more than two standard deviations below the mean. But when he brought the data to his superiors at

TeamHealth they did not think it merited an intervention. So when his colleagues asked him about it, "I lied to the members of my group."

Since doctors at Memorial did not get paid for caring for the uninsured, there seemed to emerge among several doctors a certain culture of disdain for the neediest patients—a disdain that contrasted sharply with the moral framework espoused by the Sisters who founded the hospital. One ER doctor complained about how he lost money when he treated the uninsured, since he had to pay for malpractice "in case the person for whom I'm providing the free care decides to sue me," and had to pay "to submit a bill that I know is going to be uncollectible." This doctor tried not to think about his earnings on a case-by-case basis "because if you try to dissect the patients that you see based on their payer class you'll go nuts, it'll start to eat at you." A charge nurse in the ER at Memorial described how two other ER doctors also got upset having to deal with the problems of the uninsured and underinsured. One doctor had several patient complaints against him because, according to the nurse, "He has a big issue with addiction. He feels that if you want to do that, that's fine, don't bother me with it." He would refuse to offer pain medication to people whom he suspected of drug-seeking, even when he had very little evidence to support his suspicion: "He gets himself in a lot of hot water." A second doctor "can't stand the homeless," and felt that they were "wasting his time." Even the department chief in the ER expressed frustration with the kinds of social problems with which the medical staff was forced to grapple: "We could probably employ, you know, four full-time social workers and six full-time case managers, if we sent everybody that needed some sort of help with their social situation, but we just can't get there from here. No money, no mission." Even those doctors who tried to think about caring for the poor in positive terms seemed to have to work at convincing themselves. As one hospitalist explained,

> The way I look at it is, "Hey, twenty-five percent of the people I see are uninsured, so be it. Who cares? Maybe that's a little bit of a contribution to the community and the homeless." Try to look at it with a positive spin to make yourself feel good about it, as opposed to, "Oh, my god, I have twenty-five percent that aren't insured, how am I going to make a living, this is bullshit."

Individual billing also exacerbated the facility's lack of integration. For example, in recent years TeamHealth had been trying to reduce the waiting times in the Emergency Room. In this vein, they had sought to introduce a system in which on designated physician who would see those less serious patients who could be discharged quickly and increase the number of beds available for the more serious patients. This sort of triage system had been implemented successfully at Kaiser. But at Memorial it was untenable. The less serious patients were often those uninsured patients who used the ER as a primary care clinic, and no physician wanted to work the triage shift. One doctor explained, "It broke down, essentially from probably passive aggressive behavior of the physicians." With individual billing, it was difficult to encourage physicians to act in the broader interests of the organization when these did not align precisely with physicians' narrow economic interests.

Medicine and the Marketplace

The effects of physicians' individualism on the quality of care at Memorial were somewhat ambiguous. Some seemed to think that market incentives encouraged physicians' best work. As one ER doctor put it, "It encourages you to do good work, document accurately so that you can be paid, and make patients feel happy so that they'll pay their bill, so that they feel like they've gotten value for what they've received." At the other facilities, he implied, the doctors had less incentive to work hard, document accurately, or please their patients. A hospitalist at Memorial suggested that market incentives also facilitated a degree of collegiality and cooperation among physicians, since physicians depended upon one another for business.

Physician individualism and lack of integration at Memorial almost certainly led to more treatment than took place at the other two hospitals, after controlling for the acuity and demographics of the patients each hospital saw. But the causes and consequences of this were not easy to disentangle. On the one hand, several practitioners at Memorial acknowledged that doctors there were incentivized to offer care even when it may not have been necessary. The chair of the Emergency Department admitted:

> If our billing is improved by ordering more tests on a patient and the complexity of the patient is higher, then it is an incentive at some level to order more tests. And the proof of that is that the physicians with the highest incomes are the ones that order the most tests. Now do they see a different subset of patients? No.

A charge nurse in the ER described how these incentives sometimes led to inarguably unethical behavior: "One of our doctors has been known to chase patients down the hall on the way to the OR, when he hasn't seen the patient to say, Can you open your mouth? Oh, okay, great. And charge for an airway assessment." Doctors at the other hospitals were also sometimes openly critical about physician practice at Memorial:

> Memorial practices bad medicine…. They just charge out the wing-wang all kinds of ridiculous tests, mostly radiologic tests. Oh, the radiologists are high on the hierarchy? Yes, they are. And so they do all kinds of over-treatment there that's financially lucrative.

Many others, while acknowledging that the care was more intensive at Memorial, had more complicated understandings of it. The department chief in the ER said, "We all see things with the glasses we've been handed." Without accusing those at Memorial of practicing unethically, he nevertheless believed that "where everybody's got an incentive to take the patient with a two-second twinge of chest pain to the cath lab, then you start to think that [you're] delivering high quality care by taking all these patients to the lab." At Kaiser, which did not have a cath lab, doctors had neither the incentives nor the resources to practice this style of medicine.

Others went further and suggested that higher levels of treatment were actually consistent with better care. A nurse who worked at both Kaiser and Memorial recognized that doctors at Memorial sometimes "over-order things." A patient who came to Memorial's ER with a bad headache would almost certainly get a CT scan to look for a stroke, whereas the attitude towards the same patient at Kaiser would likely be, "Oh, you have a headache? Big deal!" Yet this same nurse continued, "I think that most of the doctors at Memorial are slightly more competent or more aware of what's going on than some of the doctors [at Kaiser]…. If I drop dead or drop down in the parking lot [at

Kaiser], somebody's going to take me to Memorial Hospital." A hospitalist at Memorial argued that it was better to err on the side of too much care, particularly when patients might not reliably follow up as outpatients: "Overtreatment may come into play, but I think it's trumped by the bigger oath that we took of doing what's best for the patient. I don't think you see that everywhere." He continued, "Sometimes certain… institutions go above and beyond. It's nice to be associated with those institutions." Implicit in his account was the idea that Memorial doctors treated their patients more intensively because they were more committed to their patients.

CHAPTER SEVEN: THE MARTYRED HEART[45]

One's entry into a field of study often contains important lessons about the field itself. At Community, my entry was easy, if a little unstructured. Since I looked something like the medical residents who rotated in and out of Community's ER, the nurses there likely would have let me treat patients by myself had I not betrayed my total lack of medical training. In order to spend any time at Memorial, on the other hand, I had to submit to medical tests and a background check. I was also asked to attend a two-hour training about the history of the Sisters of St. Joseph of Orange, the expectations of the hospital volunteer, and the broader significance of the hospital's "auxiliary service." And when I had completed the training and spoke to the nurse manager of the ER about shadowing doctors, she said curtly that it was fine if I wanted just to be a "looky loo," but that I should only come talk to her if I was interested in being a *real* volunteer.

If at Community relationships were relatively egalitarian and informal, at Memorial they were more hierarchical and codified. This was true across many different strata of hospital staff-members. One physician administrator at Community suggested that there was a "lack of collegiality" at Memorial. When it seemed for a time that Community might close, certain rotations of Community's residency program had shifted to Memorial. Yet the interns had not felt welcome: "For the most part, [doctors] felt like [the residents] were an annoyance and an inconvenience: 'What am I getting out of this? And am I going to be liable for what the resident does?'" When this physician administrator had applied for staff privileges at Memorial he was struck by the amount of information they requested. Whereas the application at Community had been about eight pages long, at Memorial it was over sixty: "I felt like I was applying to the Department of Homeland Security, honest to God. The paranoia that exists in that—it's like the place is being run by lawyers, not doctors." Historically there had also been tremendous conflict over the allocation of resources between the primary care physicians and the specialists at Memorial, a conflict that—ten years later—still seemed to inflame passions.

Relationships between nurses and doctors were also more hierarchical at Memorial than they were at either Community or at Kaiser. As one nurse who worked at both Community and Memorial said, at Community "if a nurse is sitting there and the doctor comes up, [the nurse] is not going to leave their seat just because he showed up." On the other hand, at Memorial, "that's kind of expected." Another nurse who had worked at both Community and Memorial said that the doctors at Community "got our back" more than those at Memorial. A physician administrator at Kaiser admitted that one of his doctors, who had come from Memorial, had a "little bit tougher time getting along with some of the nurses, because he was a little bit more old-fashioned—'I'm the doctor, I'm right'—which just doesn't fly at Kaiser." A charge nurse who had worked at both Kaiser and Memorial said that there was "definitely more hostility between the doctors and nurses at Memorial."

Doctors and nurses at Memorial were united by their mutual suspicion of hospital management. Nurses and ancillary workers described the experience of working at Memorial as one defined by fear, insecurity, and unpredictability. Unlike Community or Kaiser, where nurses and ancillary workers were represented by national labor unions, ancillary workers at Memorial had no union representation and nurses at Memorial were represented by a small (and rather ineffectual) in-house nurses' union. An obstetrician technician said that workers at Memorial were "scared of their immediate supervisors."

An ancillary worker at Kaiser, who had spent time at Memorial, described the "authoritative structure" at Memorial that made workers "unhappy." Given the arbitrary power of management, workers were "scared of retaliation… scared to say anything." A charge nurse at Kaiser, who had also worked at Memorial, described a "top down" culture at Memorial: "The managers can make these decisions without any input from their staff and could care less…" He continued, "If you talk to any ER people, and if they're honest with you, they'll all tell you they hate management [at Memorial]."

Several with whom I spoke suggested that doctors had equally grim views of Memorial's administration. A nurse at Community suggested that "even the doctors are kind of intimidated by management [at Memorial]." One doctor who practiced at Memorial remembered how the administration had decided to close the hospital's unprofitable rehabilitation unit without telling the department's medical director: "They do what they want without much communication." A nurse leader said, "Nurses and physicians right now seem to share a lot of the same opinions about our administration."

Vocational Subordination

Despite their evident frustrations, doctors at Memorial were in positions structurally distinct from the positions of the nurses and ancillary staff. Doctors at Memorial tended to treat the hospital as a workshop within which to ply their wares individually. While specialists were paid by the hospital in order to on call, the vast majority of most doctors' salaries came not from the hospital directly but rather from insurance companies, from the state, or from patients themselves. When a doctor's affiliation with the hospital felt unsatisfying, it was relatively easy for him or her to work elsewhere. And while many doctors seemed to feel excluded from hospital decision-making processes, the hospital's dependence on them—particularly on the specialists—meant that Memorial spent significant time and resources working to secure their loyalty.

Among nurses and ancillary workers, however, the situation was different. These workers were the ones who were responsible for carrying on the work of the Sisters. The legacy of Sisters' sacrifice and dedication framed the ways in which power was justified and contested. Indeed, this legacy was used in order to elicit what I call elsewhere the "martyred heart" (Reich 2012), subordination through an appeal to vocational service. Many of the nurses and ancillary workers with whom I spoke suggested that the labor regime at Memorial was the most exploitative of the three hospitals in Santa Rosa, yet this exploitation was couched within a framework of religious values and vocational ethics. On the other hand, as a campaign to unionize Memorial Hospital revealed, the same values became a terrain of struggle on which workers were able to challenge their powerlessness.

I was exposed to this logic of vocational service during the volunteer training I was asked to attend. The director of the volunteer program, a broad-shouldered, middle-aged white woman with short-cropped hair, began Memorial's volunteer training with a short video about the history of the Sisters of St. Joseph of Orange that recounted their origins in Europe and their struggles as they made their way across the United States. "This is why we exist," she said to me and the assembled group—a high school student, a young Latina, and three elderly white women. Two other videos followed. The second trained us how to sneeze and cough in the correct way (into one's sleeve). The third, based on a book named *The Simple Truths of Service*, told the story of a grocery bagger

with Down Syndrome who begins putting "thoughts of the day" in customers' bags. These notes inspire customers so much that when they return to the supermarket they deliberately stand in his line. When the video ended, the trainer turned to us and said, "We want you all to be Johnny." According to the trainer, patient satisfaction scores had been on the decline in the hospital. As volunteers, we could make the difference by being particularly attentive to patients' needs. It seemed strange to me that in a hospital, a workplace so closely related to matters of life and death, to emotional vulnerability, we would look to a grocery store for our inspiration. A training that began with the sacrifices of the Sisters of St. Joseph of Orange ended with the inspirational grocery bagger.

Several ancillary workers at Memorial recalled the role that the Sisters of St. Joseph of Orange had played when they were an active presence at the hospital—models for a vocational commitment to hospital work. And while the Sisters had already begun to withdraw from daily practice at the hospital by the time most current employees arrived, several workers recounted fondly the administrative roles that the Sisters had continued to play. One licensed vocational nurse remembered how the sisters served as an emotional resource for patients: "I could always call them and say, you know, 'This person's having a really tough time, could you come over and just talk to them?'" The support the Sisters provided to the nurse herself was just as important. Recalling how difficult it had been when she had patients pass away as a young nurse, she said, "They would seek me out in the lounge and ask me, 'Are you doing okay? Do you want to talk to me? I know you had a relationship with that patient, and how are you doing?'" Sisters' concern for their employees went beyond the workplace as well. A worker in Central Supplies remembered that "people depended on them and they knew that they could go to them. They actually honestly listened to you and tried to help you."

While the Sisters were still actively administering the hospital, workers also felt that they had a means to discuss the difficulty of their jobs and come to collective solutions. One Sister would hold open meetings at which workers could talk about what was going on. A unit secretary recalled how "people would be crying about how they wanted [more time]" to care for the patients. And the Sister would follow up with everybody and try to see that the situation was rectified." These meetings would often stretch over several hours, giving space so that "everybody in the room who wanted to talk got to talk."

Under the leadership of the Sisters, a rigorous disciplinary regime was softened by a sense of maternal caring. A unit manager recalled how one of her first memories at Memorial was being "chewed out" by one of the Sisters on staff. "You haven't really and truly been scolded until you've been scolded by a nun." But she was not resentful. Rather, she continued, "To me the Sisters represented the conscience of the hospital," upholding standards and serving as a buffer against financial considerations. "Whenever the hospital administration would start getting greedy and start thinking about money versus people, the Sisters would kind of go, 'Wait a minute, that's not how you treat people.'" Even as the Sisters' presence in the hospital diminished, this unit manager seemed to think of them as guardian angels. Long after the Sisters had left active administration, there was a rumor going around the hospital that a Sister had played a part in getting a bad manager fired. This Sister, still involved in a local Catholic school, had seen the manager as a parent, "saw that her son was afraid of her," and then heard about

her employees being unhappy. "I think [she] put two and two together and said, 'Yeah, this is somebody we don't want around here.'"

For several employees, the Sisters' religious conviction resonated with their own values even more directly. This was especially true among some Latinos at the hospital who were also practicing Catholics. A Latina medical translator appreciated the chapel in the hospital and the visible presence of Catholic symbols and values. When her biological sister offered to help get her a better-compensated union position at a nearby facility, she declined. A kitchen worker also felt some resonance between the Catholic values of the hospital and his own values growing up: "Going to mass and church school, I mean, it really influenced me in the way I think and the way I carry myself." Soon after he began working at the hospital he realized that this work compelled him more than other kinds of service jobs he had worked before because of the way he was able to help out those in need, "nursing them with good food."

Since the last Sisters had left Santa Rosa in 2007, however, what remained of the Sisters' legacy seemed to many workers to have become little more than a language of sacrifice that belied managerial imperatives. Increasingly, the values that the hospital publicly espoused felt like a patina of religiosity over an increasingly businesslike core. An operating room technician said with more than a hint of irony, "Everything's push, push, push as far as making sure you charge the patient, making sure you're not stockpiling, making sure that you've got the minimum you need for the time. They always are watching you and pushing you about that, and they call it '*being a good steward.*' There's no spiritualism in it at all. It's just sterile." A kitchen worker and practicing Catholic suggested the "values that they're preaching go to garbage" in management's daily practices. A radiology technician assumed that the "suits are hiding behind these values. They're espousing them all the time and it strikes such a phony cord."

The values on which the hospital was founded had become, in managerial practice, rather blunt instruments through which to prod staff into obeisance. In order to promote the proper attitude among her staff, a nurse manager within the ER had required all nurses and ancillary workers to read a book titled *Eat That Cookie* (Jazwiec 2009), in which the author—a health care administrator—argued, "Focusing on service does not make the job more difficult. It makes it more rewarding…. It makes people feel proud about their work. It makes for a much more positive work environment. And that's what we need in healthcare" (p. 2). Put in the words of one nurse, the book's argument was "basically 'be glad you have a job and do your best every day.' And she repeats it for 125 pages."

The way in which the hospital's values had been distorted for managerial ends was perhaps most evident in the hospital's annual employee evaluations, during which workers were asked to discuss the ways they and their co-workers had lived out the values of the hospital. While the values publicly espoused by the hospital were "Dignity, Excellence, Service, and Justice," justice was excluded from the list in these evaluations. Each of the other values was interpreted in ways that consistent with managerial priorities:

Adaptability—Service

- Seeks to understand and responds to changing individual or team priorities.

- Accepts and deals with changes positively.
- Accepts direction willingly in order to adapt his/her role to organization or team change.
- Supports team and organizational leaders in change implementation.

Communication—Dignity

- Smiles and greets others. Communicates in a respectful manner.
- Listens attentively to others to understand what is being said.
- Initiatives difficult or uncomfortable conversations including requests for personal feedback.
- Discusses private matters in a private area.

Continuous Improvement—Excellence

- Champions/supports efforts that boost the organization's overall efficiency and quality.
- Seeks help in understanding and incorporating SJHS best practices and continuous improvement philosophy.
- Uses experience, knowledge, and data to make informed decisions.
- Adapts to changing needs by acquiring new skills, knowledge, and behaviors.

Customer/Patient Focus—Service

- Attends to individuals needing assistance by saying "I will help you find out," rather than "I don't know" or "That's not my job."
- Seeks to understand and exceed customers' service expectations by creating an environment characterized by hospitality, trust, and a spirit of community.
- Makes response to patients and others served a priority.
- Seeks to provide assistance that respects cultural health beliefs and practices.

Supervisors ranked employees on a scale from one (below expectations) to four (exceeds expectations) in relation to these values. Several employees discussed the ways that the process seemed designed to discourage them. A radiology technician referred to the evaluations as "intellectual purgatory," and suggested that his manager deliberately gave people low marks. If "everything's going smoothly," he observed, workers get a two out of four, "and you got to walk on water to get a four, so nobody generally gets fours." Since the evaluations were not tied to worker pay, he continued, "You'd think this would be used as a morale-building exercise." Instead, it seemed, the evaluations were used as a sort of annual repentance, a way for supervisors to demonstrate how workers might live out the hospital's values more observantly. A medical translator once overheard an administrator speaking with her supervisor about not giving high evaluations to employees because it might lead employees to ask for raises. Even a charge nurse admitted: "The joke is that you never hear of anything you do good, ever. And that is true."

Without labor contracts to set the terms of work, nurses and ancillary workers were also often asked to take on significantly more responsibilities than they had at the other two hospitals. According to one worker with experience at both Memorial and Kaiser, Memorial workers did not seem to have clear roles, and the hospital "cross-

train[ed] people that maybe shouldn't be cross-trained." At Kaiser, in contrast, there were more "skilled workers for appropriate classifications." A respiratory therapist at Memorial expressed frustration that while respiratory therapists had significantly more responsibility at Memorial than they did at Kaiser, Kaiser's therapists still made much more. An obstetrics technician who worked at both Memorial and Kaiser noted that while she was asked to work only in the labor and delivery department at Kaiser, she was often asked to "float" to different departments at Memorial when volume was low labor and delivery.

Yet some workers at Memorial appreciated the amount of responsibility they were given there. One nurse discussed how he had much more discretion at Memorial than he did at Kaiser: "I like Memorial a little bit better, just simply because I feel there's more autonomy there." He continued, "At Memorial, what happens is we get somebody comes in with chest pain, we start an IV, we order an X-ray, we order the labs, we do the EKG and all that stuff's done, usually before a doctor even comes in." This, he implied, would never happen at Kaiser, where only doctors could order such extensive testing. Similarly, a nurse who worked at both Community at Memorial observed how she was allowed to "order expensive tests [at Memorial] that we would not be allowed to do [at Community]… If we had a patient that we know could have a stroke, I could order in triage a CAT scan, which is a very expensive test. And it's part of their protocols—if someone has, you know, abdominal pain, and I'm suspecting appendicitis, I can order it." This nurse suggested that nurses had more discretion at Memorial than elsewhere because "they have paying customers." In contrast, Community saw many uninsured or underinsured patients, meaning that there was no guarantee of reimbursement for tests; and Kaiser, as a pre-paid group practice organization, also had financial incentives to limit such testing.

Some even suggested that the disciplinary regime at Memorial actually facilitated better care. A nurse administrator who had worked at all three hospitals in Santa Rosa noted that, at Memorial, there were "very high expectations around professionalism: how you behave, how you approach the physicians, how you present yourself." In comparison, at Community, it had been "laxadaisical." While she said she was able to give "pretty good care" to patients at Community, at Memorial "we were giving exceptional care." This exceptional care came "at a cost," she acknowledged:

> There was a lot of negativity, a lot of disciplinary stuff, people going through your charts, and if your 'i' wasn't dotted you'd get a conversation. I didn't have a lot of issue with that, in the sense that I've kind of always understood that there's gotta be a certain level of compliance. But a lot of my peers were pretty disgruntled with it, felt like Big Brother is watching, and felt like there was a lot of heavy discipline.

This sentiment was echoed by another nurse who had worked at both Community and Memorial. Explaining how "uptight" the administration was at Memorial, she said "they have such a higher standard that they hold you to, as far as your competence."

As one labor leader in Santa Rosa observed, the Catholic values at Memorial—"the dignity of the patient," "caring for others," etc.—were "more articulated in Catholic hospitals." While these values were often used to rationalize the poor treatment of employees, these same values *did* seem to inspire workers to strive for a particular kind

of care. One hypothetical situation discussed by several different workers, managers, and union staff involved a worker who was taking care of a critical patient when it was time for the worker's lunch break. A charge nurse at Memorial described how nurses from Kaiser, when they occasionally took shifts at Memorial, demanded that they be given a lunch breaks even when critical patients are in need:

> I don't want an hour lunch, what am I going to do for an hour? But the nurses who work at Kaiser full-time and work with us as a per-diem, kind of opposite of what I do, are very into their breaks. They want their breaks. They want their this, they're entitled to that, and it's like, you know, go down and get something to eat if your patient is set and someone can watch your patient, that's great.

As a result, she continued, "they're not committed to their patients the way we are."

When I used this example with the labor leader, however, he explained how workers at Kaiser—represented by a strong union—were given breaks by designated staff-people so they were able to care for their patients without giving up lunch. A worker at Kaiser who came to Memorial might just have different expectations:

> It's a union culture versus a non-union culture, and to some extent workers more empowered to get their breaks and some sense of entitlement around things like that because it's what they know is fair. To other workers they don't know that it's fair, they see it as almost arrogant. What are you doing? You leave a patient? Yeah! Let management take them. It's almost crass, but my point is… Let them figure it out.

This official suggested that the self-sacrifice of workers at Memorial undermined more fundamental change. He quoted a nurse who once told him, "We can't continually be the band-aid and then wonder why we keep on, these things keep on happening. We're always the people who stretch to make everything work. And that's kind of like, it's like setting ourselves up as opposed to demanding change or demanding a real fix." On the other hand, even this official admitted that "there are times when the management can't [take the patient] and the worker should stay." But when was self-sacrifice appropriate, and when did it only reproduce workers' subservience?

Values as a Terrain of Struggle

For workers to gain power within Memorial, then, they had to do so in relationship to the values that defined work there. This was important for two related reasons. First, despite the ways in which management had used the hospital's values to advance its own agenda, the values continued to have significance for workers. As one labor organizer put it, "Workers really believe in [the values espoused by the hospital], they really do, but they'll say all the time, 'We're the ones who make these values real, not management.'" The values of the hospital retained their importance among workers despite managers' misapplication of them. Second, the Sisters who continued to own Memorial were themselves immersed in a world of theology and values that was distinct from their market position. When I asked a second union leader whether he thought the Sisters were like other executives or whether they were susceptible to religious argument, he answered, "They're both." Unlike executives in other health systems, the Sisters who

govern Catholic hospitals are often deeply embedded in two overlapping yet distinct worlds—of business and of faith.

Given the hospital's strong financial position, workers' economic leverage against the hospital was limited. Moreover, given the Sisters values-orientation, it was unclear how effective economic leverage might be against them. A union leader explained that for-profit companies "have a clear objective, they want to make as much money as possible," and would capitulate if the union caused them to lose enough money. On the other hand, he continued, Catholic systems "have an ethic," and the Sisters who owned Memorial believed that they were "good advocates" for their workers. The Sisters might be ideologically opposed to unionization even if it made economic sense to settle, and using economic or political leverage against the system might only inspire the Sisters to dig in their heels.

Between the fall of 2004 and the spring of 2005, worker leaders had tried unsuccessfully to win a union election centered on workers' economic concerns. Within five weeks of going public, they had received the support of 68% of workers in the service and technical units of the facility. The union filed its petition in December of 2004, and a vote was scheduled by the National Labor Relations Board for early February. In response to the union drive, hospital management conducted a standard anti-union campaign: it hired an anti-union consultant; held one-on-one meetings between workers and supervisors; conducted mandatory group meetings in which anti-union literature was distributed; gave selective wage increases; and threatened union leaders.[46] These strategies have been shown to be quite effective in undermining union success (Bronfenbrenner and Juravich 1995; Bronfenbrenner 1994; Clawson 2003; Getman 2010; Jacoby 1991).

Yet the anti-union campaign also drew heavily on workers' emotional commitments to the hospital. Many workers felt uncomfortable with the conflict and tension that the drive had elicited. Those who had thought the union would be a way to improve the hospital now wondered if it might in fact be the adversarial force the hospital described. One oft-repeated story among union supporters was how a nun had approached a pro-union worker and told her she was "greedy" for wanting a union. While rarely so explicit, workers were consistently reminded of the vocational nature of their work and urged to mirror the sisters' own selflessness.

The rhetoric that the hospital used, one organizer explained, "made it very clear that supporting the union means you're against the hospital. Which is a big deal…. That resonates with people in a big way." This organizer recalled that people turned against the union faster than he had ever expected:

> There's this guy I met with who was like, "I'll do whatever it takes, we gotta win this union, I'm down, you can count on me." And then the week before the election he wouldn't even talk to me. Just 'cause the campaign management had run had scared the hell out of people. That stuff is surprising the first time you see it.

In the days leading up to the election the union came to the conclusion that it could not win. Support had dropped from 68% to less than 50% in a matter of a few weeks. The union withdrew the election petition and filed unfair labor practice lawsuits with the National Labor Relations Board. Four months later, in

June 2005, after the NLRB documented seven violations of federal labor law, Memorial settled with the labor board.

Union and worker leaders recognized that the union would not be able to win in the face of a concerted anti-union campaign. As a result, they regrouped and decided to wage a public campaign for what the union called a "fair election agreement": a set of ground rules and accountability mechanisms that would limit the hospital's anti-union campaign and create an environment in which workers could "freely" choose whether or not they wanted a union. As unions across the country have struggled against concerted management opposition and weak labor law, these sorts of longer-term campaigns—campaigns over the process leading up to the NRLB secret-ballot election—have become more common (see Getman 2010, pp. 101 ff.)

The union also recognized that it could not convince the Sisters to agree to such an agreement without engaging in a theological struggle over the meaning of Catholic teaching and the relationship between Catholic values and unionization. And so the union worked to highlight a pro-union theology. The Catholic Church's support for labor unions harkens back to Pope Leo XIII's Encyclicals on Labor and Capital, *Rerum Novarum* (or "of new things"), published in 1891. The document argued that the labor union was the best mechanism through which to ensure the dignity of working people while protecting the private property on which the foundations of society must be based. More recently, in 1981, Pope John Paul II argued in *Laborem Exercens* that workers have a right "to form associations for the purpose of defending the vital interests of those employed in the various professions." In 1986, the U.S. Catholic Bishops asserted in a pastoral letter on the economy, "No one may deny the right to organize without attacking human dignity itself."

Among union organizers, the challenge was to elevate this Catholic teaching in ways that would compel the Sisters to agree to negotiate election ground rules. Organizers argued that the Sisters remained at the helm of the organization, at least formally, and that these Sisters struggled with the tension between their values and the business of running a hospital. It was this tension that provided the union with the possibility of moral suasion. One organizer recognized that while the hospital was a business, "there are some sisters monitoring the mission, or aspiring to, who act out of that charism. And that has a softening impact, that has a pastoral dimension that is part of the culture, that is different from a for-profit hospital."

The union's challenge on the terrain of Catholic social teaching forced Memorial leaders to reconcile its anti-union practices with its ongoing moral commitments. Executives of the hospital system, both Sisters and lay leaders, rejected that they were anti-union, although they did ultimately acknowledge that managers' behavior in 2005 had been inappropriate. In addressing the question of fair election ground rules, however, system leadership disputed the idea they represented a "powerful organization" in opposition to a "voiceless worker." As one system ethicist put it, "I came to realize through study, through research, and through the discernment that that is not the landscape of this issue. The landscape is, there is a healthcare organization with power, there are unions with power. And there are two voices of employees, some employees who want [a union], and employees who don't want [it]. So for me, that's the landscape." Memorial leaders expressed concern that the voices of *anti*-union workers

might be silenced with fair election ground rules. According to one sister who was also an executive, when a group of workers file for a union election, "to that group and to that position come a whole range of resources—money, training… the shirts and the buttons and all of that. And those resources are not available to the people who have a different opinion." For her, the field was lopsided in *favor* of the union.

Despite their protestations, however, leaders in Memorial were affected by the theological debate, as well as by pressure from their colleagues in the religious arena. Beginning in 2007, several prominent Catholic organizations and intellectuals issued statements in support of workers' organizing efforts at Memorial. Over the summer of 2008, the union had staged a week-long vigil outside the Sisters' annual leadership retreat, garnering coverage in national religious and secular news outlets. By the fall of 2008, the system had agreed to negotiate fair election ground rules for the Memorial election.[47]

The theological debate did not only lessen the intensity of the hospital's anti-union campaign, however, but it also seemed to help workers feel that they could honor the values of the hospital while advocating for themselves and their patients through a union. Religious leaders had come to their rallies and had provided a framework within which workers could feel they were unionizing in order to *maintain* the Catholic values of the hospital. On one emblematic occasion, during a candlelight vigil in April of 2008, a locally beloved Latino priest spoke powerfully about workers' rights to collective representation. During the speech, several Latina cafeteria workers who had been "too scared to come to any events," according to one organizer, walked out of the hospital to hear him on their break. Importantly, then, while workers' symbolic role was significant to win power in the symbolic field, the union's struggle in the symbolic field also helped workers see their own symbolic investments in new light. In a secret-ballot election held in December of 2009, workers voted narrowly in favor of unionization.

KAISER

CHAPTER EIGHT: THRIVING

Ted Booth was a palliative care physician in his early 50s at Kaiser Hospital, thin with dark curly hair and thick-rimmed glasses. After attending medical school, Dr. Booth arrived in Santa Rosa to attend the family-practice residency program affiliated with Community Hospital. He finished his residency in 1985 and joined the family practice clinic at Kaiser. Booth began practicing medicine just as HIV/AIDS was starting to appear in the county. When Kaiser patients began developing symptoms, however, he saw how there was "no coordinated care at all, and very little support within the organization." So he and a few other family practice doctors "took on the issue of taking care of HIV patients." Since the mortality rate was one hundred percent, he "ended up taking care of a lot of young men who went on to die." He said, "It was a real formative experience."

Booth had worked off and on at Kaiser for the past twenty-five years, first in the family practice department and then taking care of Kaiser members who were living in local assisted-living facilities. In 2005, Kaiser started investing resources into a hospital-based palliative care service at the Santa Rosa facility, in which Booth served as the only physician, seeing patients every afternoon. In 2007 the organization formalized the service with a full-time nurse and full-time social worker. Booth also got the assistance of another physician.

On the first consultation of one particular afternoon, Ted and the palliative care nurse met with the two grown children of an eighty-seven year old woman who was only partially coherent. Before we even arrived at the small conference room where we were to meet, the son said to the nurse, "I've been through a lot of these things, but it's different when it's your own mother." Over the course of a short conference Ted explained how the hospice care program would let their mother "die with dignity." Whereas there was often "a lot of tension" within the hospital, the local hospice house was more peaceful. The two children seemed to have been crying, but also seemed resigned to their mother's death. Ted asked whether the mother had any religious beliefs or practices. And while both children answered "no," the son said that it would still be helpful to have a chaplain visit the hospice house and offer a prayer for the mother.

The second consultation of the afternoon was less straightforward. A middle-aged man had gone into acute liver failure, but had previously stated that he wanted to be resuscitated under any circumstances. Ted and the palliative care nurse met with the man's cousin as well as the man's thirty-year-old daughter, who had taken on primary responsibility for her father's health. Also in the room were a woman from the local hospice program and a second outside social worker. Ted began by asking the daughter to describe the father. She said that he was a party animal, that he did a lot of drugs, but that he was a "great father." Yet she soon revealed that he had left the family when the daughter was twelve or thirteen, and only reunited with her when she began to do drugs with him. She had come to realize, however, that she had to sober up, and over the last many months had taken him into the small apartment she shared with her boyfriend and child.

Outside of the conference room, out of the daughter's earshot, one of the support staffers remarked how hard the situation must be for the daughter. Ted agreed, but cautioned that they should not mention anything about making the daughter's life easier, and instead had to make the argument in terms of the father's best interests. They had to

consider how the daughter would feel six months from then about the father's death, he said, and they did not want her to feel guilty about having made the decision for her own sake. Nevertheless, Ted himself admitted that he felt the father was being abusive to the daughter just by forcing her to make the decision. Within the conference room, Ted explained their medical options. They could "still do things," he said, but it would involve tying the father down and administering laxatives in order to reduce his rising ammonia levels—which, left unaddressed, would lead to severe brain damage. Ted framed the choice as being one between comfort and prolonged suffering for limited gain. And by the end of the conversation, the palliative care nurse suggested that the daughter would "be compliant," meaning she would let the father die.

Booth and his colleagues got much more institutional support for palliative care at Kaiser than Peterson, the palliative care doctor at Memorial, got at that hospital. Nevertheless, the program was not always an easy pitch for Booth and his colleagues to make among the rest of the medical staff at the facility. Even among some of the hospital-based physicians with whom he worked closely, Booth observed, "They're very sensitive about me interfering with their primary-care patients." Despite being surrounded by illness and death, Booth said, many doctors and nurses do not like to think much about it. It is "not just a consumer culture of denial, you know, it's providers." On several occasions, different doctors at Kaiser had referred to him as an "Angel of Death." He remembered one time during which a surgeon was making fun of him. Booth asked how things were going for the surgeon and the surgeon had responded, "My practice is a little shop of horrors. Patients are dying left and right in the hospital." Booth continued, "He ended up talking very movingly about it, but it doesn't stop them from having this initial response that they don't want to go there around the death issues, even as they're surrounded by it."

Booth discussed how many of the physicians working in the hospital seemed "locked into a… more technical, curative mindset." On one recent occasion, he remembered asking a hospitalist about a dying patient's quality of life. The hospitalist had replied, "Well, to be honest with you, I was just really focused on her urinary tract infection." Booth suggested that this orientation among his colleagues was at least in part a product of the pace at which they worked: "They are running so quickly from morning till night, taking care of their group of patients." The palliative care team, on the other hand, often spent over an hour with a patient:

> We have this huge luxury that the three or four of us can sit in the room with a patient and a family for a whole hour or more, and they really see us going in there, turning our pagers off and just say, "What are the issues?" And many times, you know, there's a lot of venting, and we have a style that allows them to many times say the things that they need to say, and then are able to gently steer things back.

The palliative care team had the space and time for difficult, emotional conversations that were nearly impossible in other circumstances. In those sessions I observed, the conversations often felt intimate and open-ended. After working through the patient's medical history, Booth or one of his colleagues would step back and ask the patient or the patient's family something like, "So what do you think is going on?" Out of the uncomfortable silences that often followed would sometimes emerge a new clarity:

"Now they're freed up to begin to think, 'What do I want to do with my time?'" The crisis in a patient's life becomes an "opportunity" for the palliative care team to "talk more about what their options are alternatives are."

Other doctors' reluctance to talk about death and dying also seemed a psychological defense given the proximity of death in hospital work. Booth recalled how one of the social workers on his team, who had transferred from hospice care, was used to working with patients who "understood the trajectory of their illness." In the hospital, however, she would have to have conversations with people coming to terms "with the fact they were dying" almost every day, and found it exhausting. Booth explained, "You can watch the pain that we cause… It's part of the job description. So there is a certain sadistic, cruel quality to it." The palliative care team had begun to have conversations as a team about how to cope with the emotional difficulties of the work.

Because of doctors' resistance to thinking about death, Booth argued, if the palliative care program merely waited for referrals they would not see any patients. Instead, the program identified patients admitted for conditions like congestive heart failure, chronic lung disease, declining renal function, or cancer. The palliative care doctors then worked to "convince the hospitalists and [specialists] that we are not there to push the patients in one direction or another; we're simply trying to open a conversation." With patients, then, the work was often merely to "help people with planning," to create documents that would help name people to speak on their behalf and to get a sense of "what's important to [patients] in terms of cure versus the things that are most important to them in their lives." This often then led to discussions about "preferred intensity of care." Slowly but surely, Booth and his colleagues were working to "change the medical culture" around death and dying within the Kaiser system. As Booth explained, "If we can steer more of those patients to what they really want and provide the services, the resources and the infrastructure to make it be a good experience, then it's a win-win."

Booth and his colleagues in the palliative care team were supported not only by national literature but also by evidence from across the Kaiser System that investments in palliative care teams paid off. The team-model had been initiated at a facility in Denver, and the team there had shown correlations with increased patient satisfaction scores, shorter hospitalizations, more referrals to hospice centers, and fewer emergency room visits at the end of life—all of which suggested it was worth the investment. The Santa Rosa facility had also recently hired a clinical social worker to run clinics for new advanced cancer patients. Patients would have six sessions of interviews and consultations intended to "talk about disease trajectory, care planning choices… making legal and financial plans for the future, emotional support and things like that." Among Kaiser's oncologists, those in Northern California were said to have had a higher percentage of patients die in the hospital than those in Southern California. The clinical social work sessions were intended to help bring those numbers down.

At Community and Memorial Hospitals there was no financial incentive to invest in the development of these sorts of programs. During my research, Community Hospital had no formal palliative care program at all. Memorial Hospital had one palliative care specialist who relied on referrals from specialists and had little organizational support. Yet at Kaiser, a system based on pre-paid group practice, the system made more money the less it spent on the end-of-life. Ted Booth admitted that the "palliative care service at Kaiser wouldn't exist if we were not that interested in 'appropriate utilization'"—a

phrase that in this instance he seemed to use as a euphemism for cost control. With that said, Booth had to be careful lest he—or Kaiser as a whole—be perceived to be advocates for the "death panels" that haunted Obama's healthcare reform campaign.[48]

Booth's role at Kaiser embodied a paradox of this large, bureaucratic, health system. On the one hand, Booth and his colleagues created a space for intimacy, honesty, and personal connection that has become exceedingly rare in the U.S. medical system as financial pressures have risen for hospitals and practitioners around the country. On the other hand, Kaiser considered the palliative care program to be consistent with its goal of "appropriate utilization," and likely would not have invested such resources in the program had it not been seen as economically efficient. Booth's deep empathy for his patients made patients more willing to die. As explored throughout this chapter and the chapters following, those at Kaiser tended to believe that through rationalization and technical savvy it could make the mission of healthcare and the market for healthcare consistent with and supportive of one another.

The Kaiser System

Over ten years, Kaiser had invested approximately four billion dollars implementing an extensive electronic medical records infrastructure across its multi-state health system, generating what one system executive called "the largest electronic medical record in the world." The idea, according to this executive, was not only to make patient information more consistent and reliable, but also to develop a common language across heretofore disparate and disconnected practices. Because each site had previously been so different, "it was relatively difficult to transplant stuff from one site to another." He continued, "You can't re-engineer a system until you have a system to re-engineer. So you first have to engineer a system." The EMR system was not intended to standardize practice so much as it was to make *differences* in practice understandable, so that everyone would have "the same dataflow and the same process and starts from the same set of underlying interactions with the patient and database." This similar structure would allow the system to analyze and make use of existing variation: "We can take a variation that happens in Hawaii and move it to Baltimore, because when it lands in Baltimore, it lands into the same basic [framework]." Five years ago, the executive continued, "we had 125 [different] billing systems," making comparisons across the different facilities next to impossible. Now there was a standard system that allowed comparisons to be drawn. For this executive, and many at Kaiser, processes of bureaucratization were not necessarily inconsistent with innovation. The standardization of the organization's information infrastructure would allow good ideas to percolate upwards and spread from one facility to another. While the organization had always had "many very creative things going on," in previous years it had been "relatively hard to transplant stuff from one site to another."

If the EMR made possible a new level of standardization, it also allowed for a more thorough monitoring of and interaction with each individual member's individuality—both longitudinally, as it tracked each member's care over time, and horizontally, as it tracked each member's care in relationship to other members. When I would observe doctors at Community Hospital or Memorial Hospital, the doctor would often rely on the patient to provide an account of his or her medical history. At Kaiser,

doctors would spend more time studying the electronic record before joining a patient at the bedside.

Several practitioners discussed the usefulness of having patients' medical information easily on hand. Physicians and nurses could log into computers from anywhere in the hospital to access patient records, and could even use bedside computers to walk through x-rays with patients in their rooms. The electronic records helped physicians analyze patient records quickly, and helped prevent them from duplicating tests or treatments unnecessarily. One hospitalist described how, if he was considering ordering an echocardiogram on somebody, he could—with the click of a mouse—discover if they had recently had the test already. Another emergency room physician discussed how he could easily discover whether a patient had been coming to the ER regularly without seeing his or her primary care physician; or if a person had been asking for too many narcotics. An electronic trail of all of the patient's visits—from labs, to X-rays, to EKGs, to prescriptions—were all easily accessible. Since doctors prescribed medications on the system, the computer was also able to test for dangerous and unusual drug interactions; and the system could also draw doctors' attention to unusual test results that might otherwise go unnoticed.

The wealth of new information also allowed physicians and Kaiser researchers to compare patients with one another in new ways. According to one specialist, the system had "allowed every physician everywhere in the entire system to have every bit of information everybody else has." A physician administrator in family medicine explained how the new system allowed him to use the database and "take out one aspect of" care. For example, he continued, he could easily generate a list of his diabetics, analyze how well his doctors were managing their diabetic patients, and "find out whether or not we're accomplishing what we want in terms of goals." Moreover, the system would allow him to analyze, in real-time, whether a particular level of diabetes control resulted in an improved outcome—for example, whether there was a lower rate of heart attacks among these patients. Historically, medical research had taken place *separate* from everyday clinical practice. The advent of the EMR opened up the possibility of practice and research occurring concurrently. The same system also allowed each physician to see his or her own outcomes more clearly. According to one family medicine doctor, "The fact that I have ways of knowing how I'm doing in general, controlling my diabetes, controlling my hypertension, controlling other chronic medical problems, is valuable to me. And I then can use that data in a way that would be constructive to patients."

Over the last several years, Kaiser had also been using its technological infrastructure in new and innovative ways. For example, members increasingly were able to get in touch with their primary care physicians through e-mail; and were able to schedule appointments and check lab results online through member accounts. According to one family practice doctor, these technologies allowed patients not to "make a visit just to get a question answered, or get a medication that you know you need." The system had also been using a new consultation system in which primary care doctors could get in touch with specialists over the phone while they were seeing patients. As one family practice doctor explained, "For many of these referrals you can call up and get an answer right there." If a specialist did not think he or she needed to see a patient before scheduling a surgery, the surgery could be scheduled right there. The

rumor was that once physicians had mastered phone consults the system was going to introduce video consults. In some of the Kaiser facilities that had already implemented this consultation system fully, one executive said, there had been a fifteen percent reduction in referrals. These types of innovations had helped to shorten waiting lists so, according to one family practice doctor, "you have immediate access, which is what patients want."

Some physicians at Kaiser recognized that there were tradeoffs to this degree of standardization. One family practice doctor suggested that the "personal touch" was sometimes lost. But, he continued, "Here I have the ability to call up their x-ray [on the computer] and see the fractured ankle, call the podiatrist on the phone… he looks at the ankle x-ray too, on the computer, and talks to the patient, does the interview over the phone, says, 'You're gonna need a splint and I'll see you in a couple weeks for the fracture,' and it's all done. And you could never do that in private practice." Another family practice doctor recognized that while Kaiser was not a "boutique practice," he was able to offer many more resources to his patients: "I've got a health educator down the hall, I've got a behavioral therapist right next to me. I can get somebody on the phone and talk with a specialist. I had none of that in private practice."

More commonly, however, those working at Kaiser did not recognize these tradeoffs at all. One executive discussed how he disagreed with the characterization of "standardization as being cookie-cutter—we treat everybody exactly the same." Rather, he suggested, standardization actually gave doctors "more time to talk to the patients and be with the patients" since there was not uncertainty about a medical course of action. He continued that some might describe patient-doctor e-mails as "so impersonal." But, he countered, "Even if you have these really quick interchanges… you're really building a relationship, even if it's on e-mail." Overall, a physician-administrator suggested that these technologies were able to reconcile medical and financial concerns—were able to make the mission of healthcare consistent with the market:

> From a medical care model, it makes sense. It also aligns itself with the business. And so, as long as we can always keep in our heads, you know, 'Does this make sense medically?' Then, if the winds are changing and say, 'Okay, the winds are changing, how do we adapt to those changing winds but still keep us on that care path.' And I think that we'll be okay.

Thriving

Kaiser's motto, THRIVE, was ubiquitous around the Santa Rosa facility, and on advertisements for the system that proliferated on television and radio. Ads for most hospitals and health plans include doctors or patients singing the praises of the treatment they have received. When I began my research at Kaiser, in contrast, a highway billboard en route to the facility displayed only the silhouette of a young woman dancing beside the THRIVE. On my early visits to the facility, in the middle of an expansion of the main hospital, construction signs around the parking lot read, "We are growing to help you THRIVE. Thank you for your patience during our construction." While it may have become something of a mantra, the idea of thriving also embodied the organization's commitment to the wellbeing of its members in general—not merely on treating acute medical problems. This commitment also made sense from the perspective of the organization's bottom line. Given that the organization is based on a pre-paid group

practice model—in which members pay a set amount regardless of how much care they receive—the more that members are thriving, the more net revenue the system is able to bring in.

More than many other health systems, then, Kaiser invested resources in preventative health care—in keeping members out of the hospital in the first place. For example, the system tracked what percentage of members had their blood pressure and lipids checked during the year, and created incentives among doctors and staff to increase these numbers. Kaiser also had elaborate programs created to help people manage conditions like childhood asthma or diabetes, and programs to address the "social determinants of health" like mental health and diet. During the H1N1 scare of 2009-2010, Kaiser was one of the first health systems to acquire and distribute vaccines. According to one physician-administrator,

> When somebody joins Kaiser, we assume they're going to be members for life. So we want them to have all their preventative screening. We want them to have a good weight and low cholesterol and all those things that are going to make them healthy for the long run. Whereas the for-profits, you know, they knew that a lot of those members will have switched to somebody else next year.

In recent years the system had also been experimenting with ways of giving members incentives to manage their own health more rigorously. A Kaiser executive recalled how such steps "used to be illegal" because the state was "afraid you'd be discriminating against people who were genetically overweight or something." But Kaiser had gradually been introducing new programs: "If you fill in a health history and then do a couple healthy things… you can go to the Kaiser store and buy running shoes or something." Outside the Santa Rosa facility, Kaiser held a weekly farmer's market, one of thirty that the system had organized around the entire system.[49] The system was also offering discounts for members to sign up for weight-loss programs.

As another example, the system was putting energy into rethinking members' relationship to primary care providers. Consistent with a patient-centered medical home (PCMH) model endorsed by many health practitioners (see Rittenhouse and Shortell 2009), Kaiser emphasized the importance of primary care physicians who would manage the care provision of particular panels of patients—not as a gatekeeper so much as a "contractor," to use a metaphor of Atul Gawande's, responsible for understanding the patient's health in an integrated and holistic fashion.[50] Not only did this model of care prevent multiple specialists from doing needless procedures or working at cross-purposes, it was argued, but increasing the role of primary care providers (and increasing the ratio of primary care doctors to specialists) would reduce staffing costs as well. As one physician-administrator put it, "Very few physicians have a hint about this new model of care. When you really start asking them about it, they're still doing medicine the way they did in 1990. And who would go to a banker or any other professional person who's still doing the business they were 20 years ago?" This model also allowed family practice doctors to expand their own knowledge about some specialties. As one family practice physician put it, "It was to the advantage of the specialist to make sure that I as a generalist knew as much as possible and could treat the patients as well as possible."

According to many doctors and administrators within the Kaiser System, all of these programs were simultaneously good for patients and made good economic sense. There was "alignment" between the organization's economic incentives and patients' wellbeing. These physicians and system leaders drew a stark contrast between the incentives that existed at Kaiser and those that existed in the "real world." According to a Kaiser executive, healthcare "is just like every other business in that the people who sell whatever it is they're selling do whatever it is they need to do to get the money. And so, if you can make more money by doing lots of scans, lots of scans happen." He and others cited countless examples of overtreatment in the fee-for-service world. At Kaiser, the implication was, the incentives were aligned so as to maintain members' health without costly and ineffective treatments. An emergency room physician put the point more bluntly as he compared working in Kaiser to working elsewhere: "As an emergency physician, it's much easier to admit people… So, in some ways, I think their job is easier, because their incentives are aligned to utilize resources and to admit people to the hospital and then call in consultants. That's where their incentives are aligned." Another physician-administrator argued that only at Kaiser could members be assured that they were getting the "best care possible" because the "incentives are aligned."

Leaders at Kaiser spoke about a "culture of continuous improvement." Organizationally, however, continuous improvement was sometimes indistinguishable from processes of speed-up—doing more with the same amount of resources. One physician administrator discussed how, in anticipation of lower revenue after healthcare reform is implemented fully, the organization's goal was to increase productivity by twenty percent. He rattled off examples of how the organization was doing this—shortening the length of time between CT scans so that the radiology department could conduct more scans per day; increasing throughput in surgery so that orthopedics could now do four joint replacement surgeries per day instead of two; doing more cataract surgeries every day and more epidural steroid injections. Six months ago, he described, the blood infusion center "was in total chaos," scheduling people in what looked like a "hairdresser's appointment book." Now the department's scheduling had been computerized and made "more scientific," increasing throughput.

While some of these efficiencies came about through enhanced technology, many of them entailed increased pressure on staffers charged with implementing them. A charge nurse in the emergency department discussed one initiative to increase the speed with which patients were admitted to the hospital from the emergency room: the goal of the previous month was to admit fifty percent of patients within fifteen minutes of occupying a bed in the ER. He described how a supervisor would time him "with a stopwatch," calling him "constantly." The nursing director of the critical care department discussed how she was budgeted for "six patients per day," and that the system worked "like a checking account"—if she consistently treated seven or eight patients a day she would be harassed by the "finance people" about going over budget. For her, there seemed a disconnection between the financial side of the organization and the clinical side:

> Our finance person now understands that, but the first 20 times [they] came to me and said, "Why are you over your budget?" And I was, like, "Okay, so how about this? If your grandmother is going to-you want her to be admitted to the unit, and I say 'I'm sorry, but I can't afford to admit your grandmother to the unit….' How

would you feel?.... You'd feel that you're grandmother's getting terrible care, right? Right?"

At its worst, then, "continuous improvement" seemed little more than a euphemism for speed-ups and cutbacks.

Finally, Kaiser promoted some programming that—at first glance—seemed to treat patients as interchangeable parts. For example, a physician administrator discussed how the organization had been "implementing group appointments for teaching about chemotherapy," since an individual consultation "ties up the chair" that could be used for treatment. A specialist remembered being "aghast" when he learned that the system was conducting group therapy for depression in place of individual treatment. In each of these cases, however, practitioners suggested that the benefits of the programs were medical as well as financial. The specialist was surprised to learn that "the statistics… say that [the therapy] actually works pretty darn well… There are things that we didn't predict… I think there's something about the group process that helps people." The implication was that the system's constant search for more efficient ways of doing things could lead to some surprising and counterintuitive outcomes. The market, again, was consistent with the mission. Yet this specialist also recognized the limits of these sorts of efficiencies:

> We're already getting terrific pressure at our most efficient nursing facility to cut down length of stay, because it's so long. And we look at the patients who are driving length of stays—When patient gets admitted to a nursing facility for 6 weeks of intravenous therapy for their bone infection, very hard to change that length of stay.

While this specialist had been surprised at the positive effects of group therapy, he also seemed to suggest that Kaiser had already picked the low-hanging fruit, and seemed to worry that the drive for efficiency might eventually lead to erosion in the quality of care.

Navigating Between Rational Care and Rationing Care

John Scott was the chair of the emergency room department at Kaiser. A short and muscular Iron Man competitor, he had a no-nonsense affect with his patients and colleagues alike, and was widely respected as both a physician and as an administrator. Recently, Scott had seen an elderly woman in the emergency room with a high white blood cell count and had diagnosed her as having diverticulitis. He had been unsure about whether to admit the patient, and the patient was clear that she "did not want to be admitted to the hospital." So, in coordination with a gastroenterologist, Scott sent her home. Two days later, however, the laboratory found that her blood cultures were growing bacteria. The hospital called her back and she returned to the hospital, although she "still did not want to come in." Within a day or so she had gone into septic shock, and Scott did not know how she was doing at the moment. He said openly, "She may die."

In retrospect, he admitted, "If you're going to look at that, you might say, 'Well, did our incentives push us to get her home instead of bring her into the hospital?'" In a fee-for-service environment, Scott suggested, an emergency room doctor would likely have thought, "Oh yeah, little old lady, high white count, boom, bed, no problem." On

the other hand, the patient might have died of sepsis even if she had stayed in the hospital. And hospital admission brought with it all sorts of other risks. What might have been the wrong decision in this particular case may have been the right decision in aggregate. Scott believed that the "balance of evidence" pointed to the course of action he took:

> Our incentives are aligned the right way…. Certainly for controlling costs, which—we can't just spend money we don't have. I mean, if we get to a point where 50% of income is spent on health care, we're going to fail as a society. So sooner or later we're going to have to change the way we align things. And I believe strongly that we're on the right side, but still sometimes it makes my job harder.

But Scott's account was somewhat contradictory. In one breath, Scott suggested that his course of action was more medically sound than any other—that the risks of returning home were less than the risks of remaining in the hospital. In another, Scott suggested that this course of action *also* took into consideration the need to allocate scarce medical resources—that part of the process of "alignment" inevitably included "controlling costs." This was a tension throughout Kaiser—a commitment to "scientific medicine" that left unstated the ways in which efficient care inevitably involved the rationing of resources.

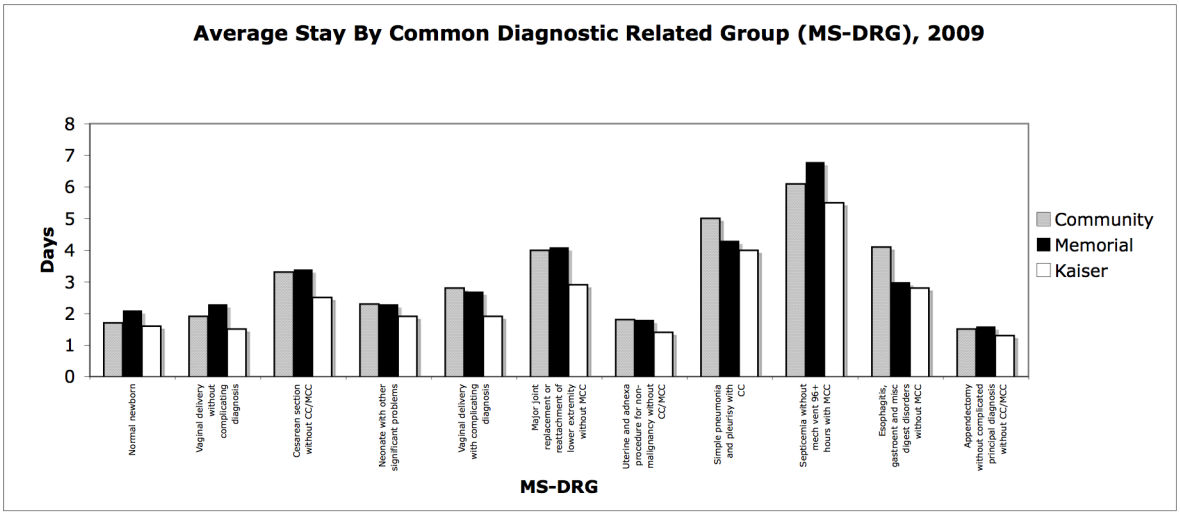
In terms of the organization of medical practice, several physicians and nurses alluded to the ways in which Kaiser weighed financial costs against medical benefits. For example, one emergency room physician discussed how the ER at the Santa Rosa facility did not have its own MRI machine: "When you really look at it carefully, there are very, very few indications for an emergency MRI, and it's extremely expensive." He and his colleagues agreed, "You… have to make some economic decisions." Given that there were "very few reasons that you would ever need it emergently" they decided to rely on the radiology department for the "one time a year" when it was necessary—which meant that they would not have access to the machine at night. "It's probably okay," he concluded. A family practice physician administrator discussed how the facility did not "quite have the capacity" for conducting the colonoscopies needed by its membership. But, he continued, comparing the colonoscopy with a sigmoidoscopy or stool sample, there was "no survival benefit" to doing a colonoscopy every ten years versus doing a stool test every year or a sigmoidoscopy every five years. He admitted, "the perception of the public is that we're withholding care because we emphasize the other two first…" But he countered that "any patient can ask for a colonoscopy… hear the discussion why the other ones might be just as good and less invasive or painful. And if they opt for a colonoscopy, we sign them up." The same physician administrator discussed how Kaiser used generic drugs instead of their brand-name equivalents. One patient had recently told him that he "only wanted Valtrex for his cold sores," and he had to argue with the patient that the generic would "do the same job for pennies on the dollar." The patient ultimately capitulated. In all of these ways, physicians reaffirmed that quality medical care was consistent with cost efficiency.

Kaiser also saved significant money by relying on a "tertiary care system," meaning that different Kaiser campuses specialized in different conditions—one city for neurosurgery, for example, another for critical pediatrics, another for complicated cardiac

patients and another for rehabilitation. According to one charge nurse, "Kaiser knows it can't give everything to everybody immediately." But while this was often more a matter of convenience than of care, it occasionally had serious consequences. Since the Kaiser facility in Santa Rosa did not have a catheterization laboratory for its heart attack patients, cardiologists give these patients thrombolytics instead of an angioplasty and then transfer them to San Francisco. One cardiologist estimated that this system probably led to one death per year, but implied that the cost savings made it justifiable.

There were other more subtle ways that the system saved money as well. For example, family practice doctors could not order certain MRIs or ultrasounds without the approval of a consultant. The cardiology department at Kaiser had begun to review every echocardiogram order as it was requested so that the doctors requesting the test would read the EKGs and look at blood tests before ordering the more expensive diagnostic. This red tape was justified as a way of ensuring that expensive diagnostic procedures were not being used as "handicaps." Kaiser also pushed to discharge patients from the hospital as soon as safely possible. For nearly every common diagnosis or procedure seen across the three hospitals in Santa Rosa, lengths of stay at Kaiser were the shortest (see figure 11).

Figure 11



California Office of Statewide Health Planning and Development

Among health practitioners in and around Kaiser, discussions about the "rationing" of care tended to be characterized by extremes. One group of practitioners—most of whom were not currently employed at Kaiser—tended to see undertreatment at Kaiser as a problem even more pernicious than the overtreatment in the fee-for-service world. If the Kaiser executive cited above was right, and "people who sell… do whatever it is they need to do to get the money," then Kaiser had a clear incentive to

withhold treatment even in cases in which it was necessary. One of the more disillusioned physicians at Kaiser, for example, was skeptical about whether Kaiser was "…designed with such a noble mission as to make sure that the patients… *flourish*." He suggested that economic calculations pushed the system to ration treatment in ways to make money: "I think if you don't do a bilateral shoulder MRI it will save us four or five hundred dollars that's going to go in somebody's pocket up the pyramid there…. No matter how you try to get away from the dollar, from the capitalistic side, you can't. I mean, it's a symptom of our society." An emergency room physician at Memorial, who had previously worked for Kaiser, began yelling at me when I praised Kaiser's pediatrics program: "They almost killed my son!" He said that the system was an "insurance company masquerading as a hospital system." He stopped working at Kaiser when he could no longer "put his head on his pillow," or could not live with himself for working there.

On the other extreme, several leaders in the Kaiser System denied any sort of tradeoffs occurred at all. One physician-administrator asserted, "Rational care is not rationing care." Another executive said that there was "no need for tradeoffs" given the amount of money currently in U.S. healthcare. Given the inefficiencies in the fee-for-service world, he implied, Kaiser was able to provide patients with all the care they needed while still managing to sustain high net revenues while keeping insurance prices lower than the competition. Kaiser had "more than enough money to do just about anything we need to do."

But the truth is likely in between these extremes. Without question there is rampant over-treatment in the fee-for-service medical world—treatments that drive medical bills upwards while doing nothing for patients or actually harming them. One department chief had even bought for all his physicians copies of Sharon Brownlee's (2007) *Overtreated: Why Too Much Medicine is Making Us Sicker and Poorer*, which argues—using powerful statistics and vignettes—that up to thirty percent of health spending in the United States is wasteful. But at Kaiser this belief tended to take on the quality of an ideology, masking decisions about resource allocation that must necessarily exist within such a system. While there is plenty of evidence to suggest that particular tests and procedures often do more harm than good, even this evidence is often ambiguous, as in the case of the recent controversy over PSA testing for prostate-cancer (Andriole et al 2009; Schroder et al 2009). Moreover, a rational weighing of costs and benefits to any test or procedure, which includes the opportunity costs of spending resources on the particular intervention as opposed to something else, necessarily leads to choices *not* to intervene in certain cases in which expensive intervention might lead to marginally better outcomes. Evidence-based medicine cannot answer ethical questions about those treatments that *are* marginally effective but are also very expensive or may lessen patients' quality of life (Jonsen 1973; Jonsen 2006). And there are certainly times in which individual patients' relationship to medicine is understandably *irrational*: sometimes a patient does not want those tests that seem reasonable given the symptoms, but wants *any* test that has *any* chance of yielding results; *wants* the expensive treatment that has an infinitesimal chance of curing a serious illness.

Lurking in the background of the Kaiser System, however, are monetary values on life itself—figures that implicitly motivate decisions about resource allocation within the organization. In the fee-for-service world these values are hidden and highly

variable, driven by differences in insurance coverage and differences in patients' capacity to pay. In a pre-paid system like Kaiser, however, they are structured into the organization more apparently. The systemization of patient data described above played an important role in this process—helping to transform the Kaiser member from a "case" or "consumer" to a set of *components* or variables that could be understood at different levels of analysis. The goal of the Kaiser System might be understood to be allocating its resources most efficiently across the system as a whole—in other words, working to maximize the value of every dollar it spends. To the extent that patients can be reduced to sets of independent variables (disease histories, demographic characteristics, patient preferences, courses of treatment, prescriptions) and dependent variables (outcomes of treatments or drugs), then models might be developed in order to predict the benefits of using resources in particular ways, and help prioritize spending over a population of patients. But judgments were sometimes made—usually implicitly—about what costs are too high to pay.

Given the extensive rules and regulations that dictated practice within Kaiser, members were better served when they learned to navigate the bureaucratic rules of the game—those who asked explicitly for particular procedures or particular drugs during primary-care visits, those who knew how to speak on the phone with the advice nurse in order that she or he might schedule a same-day appointment, those who knew which clinics and specialty departments needed a primary care referral and which members could call without a referral. One nurse with experience at all three hospitals in Santa Rosa suggested that at Community and Memorial Hospitals one needed to know the "players" whereas at Kaiser one needed to know "how the play works." While a patient at the other hospitals could advocate for him or herself by having personal connections to the staff, he continued, at Kaiser "it's kind of a system thing… Knowing where things are at and how it's played out." And whereas the scale and scope of the bureaucracy was "hard for customers a lot of times," there were "some customers who know the system really well and they know exactly what to ask for and where to go and how to get things."

Kaiser's Community

Unlike either Community Hospital or Memorial Hospital, Kaiser had a defined group of members who received their care within the system. This organizational structure was a legacy of the industrial insurance program out of which the modern-day Kaiser emerged, a history in which large industrial employers bought insurance for their employees through the Kaiser System. One hospitalist remembered how the system was developed for the "blue collar workers, the shipyard, the union guys." It was "affordable" and "no frills." When she started working at Kaiser, in the late 1970s, the doctors in the organization were still regarded as "Commie-Pinkos," and the system as providing "socialized medicine." A second family practice doctor, who began at Kaiser in the early 1980s, remembered being the "radical fringe" of the medical profession: "We were considered commies." This was not only because the system took care of working-class patients, but also because there was an egalitarian streak among medical practitioners within the system as well. As late as the 1980s and early 1990s, all Kaiser doctors in the Santa Rosa facility treated panels of primary-care patients; and all were paid nearly the same salaries.[51]

While Kaiser's membership has grown more affluent over the years, it is still widely regarded as the working-person's hospital system. As one specialist described, some current members have been so since the system's inception: "I have a number of patients who have told me that they'd been members since '48… since the shipyards." Comparing Kaiser with Community Hospital, one family practice doctor said, "There's more down and outs there than there are down and outs here." Yet the "richest of people tend to be at Memorial, patient-wise." He said that Kaiser used to be "more middle class," whereas now the "upper middle class would be here too."

Many doctors described how different it was at Kaiser Hospital than in other practice environments. One specialist, who had trained at Community Hospital before joining Kaiser, was used to taking care of "poor people, marginalized people" who treated the medical system as "one of the few areas where they could seek out some entitlement." He remembered at Community Hospital "struggling with patients about them wanting time off work," having to push back against patients when they wanted more time off than their medical conditions indicated. At Kaiser, in contrast, he would have to encourage patients to take any time off at all: "I'd say, 'I think you need to take the rest of the week off,' and they'd go, 'Oh, no, doc, I got a job. I gotta get back to work!'" This sentiment was echoed in the account of another family practice doctor who said that since most Kaiser members work, "they really would prefer to be working and so they aren't going to be coming in to see us all the time." An emergency room doctor put the point even more straightforwardly:

> This isn't what I would call the real world. It's not. I mean, basically, I'm taking care of people… they're motivated, they have prescription medical coverage, they have insurance, they have sort of a better place in life, because they have certain things…. So if you go through your career thinking that everybody's a Kaiser member and you just kind of bee-bop along, 'cause everyone has insurance, then you're really forgetting the reality of the world we live in.

The archetypal Kaiser member was understood to be different from patients in the fee-for-service world: hard working and motivated to take care of his or her own health. This was in stark contrast to the poor and marginalized, who depended on the medical system as a social safety net. One charge nurse at Community Hospital, who had worked at Kaiser as well, said that at Kaiser "the people you take care of are like your mom and pop. I mean, they're polite people, appreciative people, patient people."

Kaiser's integrated system has led some outside the system to accuse it of not doing its part within the broader community—particularly as Kaiser's market share had come to include the plurality of insured patients in the area. One physician-administrator said that when he began as a leader in the organization "we were clearly considered… the carpet-baggers… that were there to suck everything out of the community and not give anything back." A family practice doctor anticipated a similar criticism when he said, "It's not like we live somewhere else and just come in here and grab all your money and then go home. I see patients in the stores…" Nevertheless, many practitioners at Kaiser acknowledged that they did not see as many uninsured patients as those at the other hospitals. While Kaiser's emergency room—like all ERs in the U.S.—is open to anyone in need of help, many patients "think of Kaiser as members-only," according to an ER doctor, and so "go to other hospitals." Another ER doctor suggested that people think

"'Well, I don't have Kaiser, I'm not going to Kaiser,'" and that this "insulated" the system from most uninsured patients. He continued, "I think that is used against us." Granted, Kaiser did not go out of its way to advertise the fact that its emergency room was open to the public. At both Community Hospital and Memorial Hospital, the emergency rooms were easily visible and accessible from the adjacent streets. At Kaiser, it was at the back of the hospital, and not easily visible from the adjacent street. During one community meeting, in the spring of 2007, a leader from Memorial Hospital suggested—tongue in cheek—that some of the financial pressures on the community's hospitals could be alleviated if Kaiser put up a sign directing emergency patients to its doors.

But if Kaiser did not want a flood of uninsured patients at its doors, it *did* want to be seen as a "pillar of the community," as one physician administrator put it: "If we're not a community player, it's going to limit our future success. We can go so far, but if you're a community player, you can go up to the next level." Other Kaiser employees suggested that the organization had been under pressure from local politicians and advocacy groups to do more locally to warrant its tax-exempt status. A first step for the organization was to become more integrated into ongoing charitable endeavors. As one public relations specialist said,

> Everything's relationships—everything! So if you're not out there on the boards, if you're not active at dinners and events, and you're not working with the chamber, you're not working with different groups, they don't know who you are…. But if you're sitting across from this guy twice a month at a Board meeting and he says yeah, that doc's a pretty smart guy, he's pretty cool too, he's a bike rider just like I am. You start building relationships and credibility and trust and that's what we really started to do.

When one physician administrator took on a leadership role, he insisted that each medical department have a business plan that included being "involved in the community some way… Drives for this and drives for that and food drive and school supply drive…" The organization began to purchase tables at Chamber of Commerce events, Heart Association events, and other charitable fundraisers. Many system leaders also took on leadership roles in local nonprofits—a couple of physician administrators had become doctors for local high school teams; several doctors had begun to volunteer at some of the health clinics for indigent patients.

One specialist remembered how local institutions, from the local paper to the local medical association, had historically been hostile to Kaiser. This began to change, however, when these same institutions began to run into financial trouble—one of the main sponsors of an important charity event run by the newspaper went bankrupt, and a foundation withdrew funding from the local medical association. Kaiser "jumped at the chance" to step in. It began to contribute to the newspaper's annual charity; and it began to pay dues for each of its doctors to join the local medical association, meaning that Kaiser doctors came to make up the majority of dues-paying members. As one specialist put it, "That tends to shift the dialogue within the medical association pretty quickly."

In one sense, Kaiser might be understood to have found an efficient way of enhancing its reputation as a community asset—building goodwill without having to take care of the neediest and most expensive patients. But the organization also had a broader

vision for its public involvement. Just as leaders at Kaiser seemed to understand the market and mission of healthcare to be reconcilable through technological innovation and rational administration, it saw its role in the community as being a rationalizing force. The organization had shared its information technology infrastructure with a local network of indigent primary care clinics. As one leader put it, "Okay, so we're not providing a lot of direct care to a lot of the uninsured that the clinics see—that's their job and they do it well—but we provide infrastructure…. we provide for improving their electronic technology." Moreover, the organization shared the care protocols it was developing in order to help the clinics "do things more efficiently." As an emergency room doctor put it, "We've given literally millions of dollars to improve quality." As another less ambitious example of the same commitment, a leader at Kaiser had transformed the database for the local medical association in order to make it more streamlined: "They're still using the database that I wrote… They just hit a button and it faxes people their dues and all that stuff."

Several leaders felt that the organization's insular reputation was undeserved given the organization's participation in a variety of programs for low-income patients—from its program for indigent children, to its enrollment of some patients in various state insurance initiatives. Nevertheless, many recognized that Kaiser did not do as much direct care provision for low-income and uninsured patients as the other hospitals in the area. Indeed, many leaders and practitioners seemed to suggest that Kaiser's role in the community was to serve as a model for health care in the county and country—a model that would combine market efficiencies and healthcare quality. In coordination with Kaiser leaders, the local Medi-Cal program was beginning to restructure itself in line with Kaiser's pre-paid group practice model. Kaiser would not *care* for the indigent so much as it would provide the organizational and technological templates in order that others might take care of these patients more efficiently.

CHAPTER NINE: DISCIPLINED DOCTORS

The Chief Medical Officer (CMO) at Kaiser Permanente, Ron Schmidt, was a tall, loping man in his fifties. Before attending medical school, Dr. Schmidt had worked as an electrical engineer at a large defense firm, and then as a medical researcher. As he rose through the ranks at Kaiser, from physician to department chief to CMO, he began to apply his engineering background to the organization of care: "I started reading about Toyota, and the lean production methodology," he said. But he learned that other physicians were not responsive to the language of efficiency: "You say, 'Well, we're going to use these Toyota principles, and the response, especially from physicians, is, they make cars, they don't take care of patients." He came to appreciate that you "have to take the concepts and ideas and sort of repackage them in ways that are more palatable for medical professionals." His challenge was in some ways the challenge of Kaiser as a whole: how to convince salaried physicians that physicians' submission to disciplinary authority was in the interests of both patients and physicians themselves: that *efficient* care was synonymous with *quality* care.

Every doctor at Kaiser-Permanente was salaried. Kaiser Permanente justified physician salaries by pointing to the "mal-alignment of incentives" in the fee-for-service world, in which doctors were paid according to the number of tests they ordered or procedures they performed. Nearly every doctor I interviewed at Kaiser cited examples *outside* of Kaiser in which doctors did damage to patients by conducting needless tests or conducting unnecessary procedures. At Kaiser, the only incentives that did exist were unrelated to utilization. One department chief noted, "We pay people more for good outcomes. But we don't pay people more or less for utilization. We draw the line there." One medical executive remarked, "We draw a firewall between any personal financial gain and utilization. It's just not even on the table."

But if a salaried physician staff solved the problem of over-testing and over-treatment, it presented Kaiser Permanente with challenges familiar to other industrial employers: how to turn purchased labor time into labor power. The challenge was made even more difficult by the uncertainty inherent in medical work and the degree to which medical work necessitated doctors' emotional investments. As one anesthesiologist at Kaiser pointed out, how can the organization determine the "right amount of time" for an epidural or another procedure? How can the health system distinguish between when a doctor is being deliberate and when a doctor is a laggard? How can physicians be asked to speed up or administer less tests without risking patient safety and patient outcomes? And what inspires doctors to be kind to patients or collegial to one another?

This chapter begins by describing physicians' understandings of their work at Kaiser. It then analyzes two disciplinary technologies through which doctors were brought into line with the prerogatives of the organization as a whole: the Electronic Medical Record (EMR) and the Patient Satisfaction Survey (PSS).

Professional Autonomy is So Overrated

On large posters that hung throughout the Kaiser facility, doctors, administrators, nurses, and ancillary staff were pictured exercising in various ways. Some were standing with their tennis racquets, others riding their bikes, others taking part in triathalons. These pictures were part of the health system's ongoing THRIVE campaign, aimed at inspiring patients to partner with the system to take care of themselves. But the pictures

were not just propaganda. I was surprised one afternoon in the emergency room to find the doctors comparing ski stories from the previous weekend. It seemed that nearly all of them had gone to the mountains.

Kaiser Permanente was structured in such a way that doctors were able to balance work with other aspects of their life without feeling that they were neglecting their patients or their profession. According to one emergency room doctor, working at Kaiser was "like a job, like a normal job." At one point, she thought, other doctors might have "look[ed] down at Kaiser doctors, like, 'Oh, you just punch a clock.'" But she and others had realized that "we're all out there fulfilling our lives and having good lives and healthy lifestyles." She concluded, "There's nothing wrong with it and we're a model for our patients." These doctors not only told their patients to be healthy—they were able to be healthy themselves!

This reputation meant that doctors sometimes joined Kaiser in order to balance work and family more easily. According to one assistant department chief, doctors who "wanted a family" were inclined to join Kaiser—especially female doctors who wanted to "manage their schedules better."

Other doctors chose Kaiser for the stability of employment more than its limited hours. One hospitalist recounted that while Kaiser paid less than some of the other hospitals, "it was more secure." Moreover, Kaiser "had a better long-term retirement plan, healthcare benefits and my family was covered as well, so I didn't have to worry about that. It was just more secure." There were rumors that another emergency room doctor had moved from Memorial to Kaiser because of his own ongoing health condition—and Kaiser offered much better benefits than he was able to get through his work at Memorial.

Some doctors recognized that there were tradeoffs in working on salary in a large bureaucracy like Kaiser. For one family practice doctor who had arrived at Kaiser from out of state, "I think… the issue that most of the new docs have who start here is the complete lack of control. You don't really think about yourself as being a control freak until you have none. A hospitalist who had transferred from Memorial in order to balance work and family grew frustrated with the slower pace of work at Kaiser. He said, "I don't like having down time," yet doctors in his department were not allowed to take on additional patients "even if you wanted to. And if you did want to, you're not going to get paid for it. Because that would take an act of Congress or God or something." His wife started to call him a "county worker," and he came to feel like he was "in jail" at Kaiser. Eventually he left the organization in order to return to Memorial.

But these stories were exceptions. Indeed, many doctors at Kaiser rejected the idea that they were less autonomous than their counterparts in private practice, particularly in light of the turmoil within the broader healthcare environment. According to one family practice doctor, "You lose some of your control, but you have a lot more control in many ways, because you're less buffeted by the insurance companies and by the trade guilds and by what hospital is doing what, and by your lack of access to specialty care, by the uninsured patients, by just the social turmoil that's currently happening now throughout the country." An emergency room doctor remarked, "People talk about the good old days…. They're nostalgic. But medicine got much more complex, insurers… the government…. So even then [those in private practice] are *so* not in charge of their own lives anymore." More humorously, when I asked her whether

she felt she had autonomy at Kaiser, she answered, "Yes. To walk out at five o'clock and go take my run! Have a bike ride!"

For the well-known medical sociologist Eliot Freidson, doctors' formal positions inside or outside of organizational hierarchies were less important than "the characteristics of the employment position itself" (1986, p. 130). When doctors are employees they may not have the "power to allocate the total resources of the organization" (p. 154), but they maintain at least some discretion over "the work they do and [they] decide how to do it" (p. 154). Along these lines, many doctors at Kaiser seemed to feel like they had the best of both worlds—medical discretion without financial responsibilities or long hours.

But the same factors that allowed for doctors' freedom also changed doctors' relationship to their work in profound if subtle ways. Their relationship to the product of their labor, their patients, was increasingly mediated by the organization for which they worked. Doctors' labor power and specialized knowledge became something the organization could put to use at its discretion. The chair of the emergency department discussed how the Kaiser structure allowed the organization to allocate physicians' time in the most efficient ways without doctors worrying about compensation. For example, Kaiser was easily able to set up a Physician-In-Triage room (or "pit") within the ER, so that those patients without serious problems were able to get cared for and turned around quickly. No matter what physicians were doing in the ER, there was "no mal-alignment of incentives there," whereas fee-for-service environments trying to implement similar structures struggled with resistance from doctors who were worried they would not get compensated in the pit. Similarly, at the end of a shift in the emergency room, "when my shift is over, if I have a patient who's still waiting for a CT scan, then I can just sign him out to my colleague." In the fee-for-service environment, "When you pick up a patient, you see them through to the end, and that may mean staying two, three, four hours beyond the end of your shift, because why would a colleague take that patient when they're not going to get paid for it?"

Kaiser also had a more rigid division of labor among its physicians than one would find at Community or Memorial. Again, this made doctors' lives easier in many ways. For example, the facility staffed "laborists," or obstetricians who were at the facility 24/7 in order to deliver babies, meaning that obstetricians did not have to be on call to come to the hospital at night. Likewise, family practice doctors, who in private practice might have done everything from conducting circumcisions to casting fractures to doing sigmoidoscopies, at Kaiser had a more specific scope of practice and almost never visited their patients in the hospital. For family practice doctors transitioning to Kaiser, this could be something of a challenge. One said, "I want to keep kids in my practice. When the mom has an abnormal pap smear, I want to do the diagnostic testing. When the grandfather needs a sigmoidoscopy, I want to do it. I want to deliver babies-you know, I want to do that stuff." When he confronted his department chief about treating a wider range of conditions among his own patients, the chief responded, "Well, I'll put you in a different suite where they do colposcopies…. But there'll be colposcopies on people you've never met. You'd be like a referral guy." This doctor, however, wanted to see his own patients, not "line up these women, have them drop [their] pants so you do the test on them."

Each of Kaiser's organizational structures had its benefits—the pit, at least theoretically, would provide more efficient care for patients; doctors' capacity to sign over patients would prevent them from becoming overworked; narrow scopes of treatment would allow for specialization and efficiencies of scale. But each of these structures also made doctors' contributions less clear to doctors themselves by limiting the extent to which doctors were able to identify patients as their own. Specialization is nothing new to medicine, but at Kaiser doctors' labor is even more abstracted from its product than elsewhere in American medicine.

This process of abstraction seemed closely connected—at Kaiser—to processes of organizational change. To the extent that physician labor was disconnected from particular patients and treated as something to be applied at the discretion of the organization as a whole, *changing* the organization of this work became easier. Younger doctors at Kaiser seemed to accept this ongoing change as part of the nature of medical work. According to one young emergency room doctor, "Medical knowledge itself is changing all the time. So [Kaiser] is more evidence-based now, so as soon as the evidence comes you have to put it into practice." This doctor suggested that older doctors would say, "Well, I've been doing this forever and it's always worked, right?" And so he suggested that at Kaiser "There's a lot of pretty bitter fifty-something year old doctors…. I don't know what to do about that."

Disciplining the Doctor

At Kaiser, administrators elicited consent from the medical staff through disciplinary technologies like the Electronic Medical Record and the Patient Satisfaction Survey. Both the Electronic Medical Record and the Patient Satisfaction Survey are widely regarded as technologies that improve the quality of healthcare in the United States. Among the many components of recent healthcare reform legislation, perhaps none has received as much positive attention and bipartisan support as the institutionalization of EMR.[52] Health policy research has demonstrated the positive effects of such technology on patient health outcomes (Hunt et al 1998; Institute of Medicine 2001), and shown the ways in which EMR can limit unnecessary healthcare spending (Wang et al 2003). The PSS is also widely accepted as important to contemporary medical practice, which puts a premium on the idea of patients as allies in the provision of care (Armstrong 1984). Not only have patients increasingly come to assert their right to make informed medical decisions as consumers (Reeder 1972; Timmermans and Oh 2010), but practitioners have come to appreciate the importance of this involvement for patient compliance with treatment plans and for subsequent health outcomes (Reiser 1993; Hibbard 2003). Over the last thirty years there has been an exponential increase in the number of medical journal articles addressing patient satisfaction with medical treatment (Sitzia and Wood 1997, p. 1832).

Yet each technology came to shape physician thought and practice in less obvious ways. Not only did the EMR require that doctors spend more time behind consoles, but the computer language with which they interacted helped structure the way they thought about the cases they saw. When the computer language was connected to diagnosis-specific protocols, physicians either had to comply with the protocols or develop mechanisms to resist or override them. The PSS meant that doctors had to pay more attention to the non-medical dimension of their interactions with patients, and seek to

reconcile the paternalism of the professional role with the subservience of customer service. Perhaps most importantly, both technologies allowed for the aggregation of data and the analysis of variation. Data generated from the EMR allowed physician-administrators to analyze variation in practice across physician, as well as the relationships between physician practices and patient outcome. Data generated from the PSS allowed administrators to evaluate the relative popularity of different physicians.

As new knowledge was reflected back to physicians, they came to think of *themselves*—at least to a certain extent—in the same statistical manner they increasingly came to regard their patients. As doctors interacted with the "language" of EMR—shaping the system, entering information, and being measured and compared on the basis of this data—they came to think more statistically and systematically about the work that they do. They came to focus not only on particular cases, but on the universe of cases. Almost invisibly, then, they came to take on responsibility for the allocation of scarce resources across their patient population, *becoming* the administrators whom, in the previous generation of health maintenance organizations, they had fought against. As doctors became invested in their patient satisfaction scores, they came to regard themselves—at least in part—as service workers instead of as medical professionals.

Through their disciplinary effects, each technology also served the economic interests of the managed care organization as a whole. At Kaiser, the EMR system was closely to the development of practice protocols and "evidence-based medicine" that together obscure the rationing of resources which take place in any health system (Orentlicher 2003). By allowing detailed comparisons among physicians of utilization rates and patient outcomes, the system encouraged conformity to the mean—which, in practice, meant that those who did more tests and more procedures felt pressure to do less. The PSS encouraged physicians to think of themselves as service-providers and privilege customer service, occasionally at the expense of good medicine. Moreover, like consumer reports throughout the service sector, the PSS functioned as a strategy for managerial control (Fuller and Smith 1991), helping to address the problem of workplace motivation at an organization in which physicians have little financial incentive to keep patients coming back.

In their relationship to technologies like EMR and PSS, doctors saw their professional interests as more or less consistent with the interests of a market-oriented administrative elite. The medical standards against which physicians are measured through EMR were widely regarded as legitimate among Kaiser's medical staff. Their efforts at self-discipline in relationship to the EMR felt consistent with their professional values. In contrast, many physicians were skeptical of the medical value of the PSS. Yet despite these suspicions, the PSS has effects on physician practice through the competition that it set up among the medical staff. Moreover, in different contexts across the organization, these disciplinary technologies differed in their intensity and legitimacy.

Through different technologies and with different degrees of success in different departments, physicians' interests at Kaiser were coordinated so as to be in the financial interests of the organization as a whole. Doctors were not proletarianized so much as have were *incorporated* into the interests of a large corporate enterprise out of their control.

The Electronic Medical Record

As explored in the previous chapter, technologies like the EMR have helped to create a coherent information system across the disparate Kaiser facilities and regions. At the same time these technologies allow the system to monitor its members more easily and more seamlessly, they also create an organizational language through which practitioners and administrators can compare practices and results across facilities and across regions.

The implementation of the electronic system was not without its rough edges, as physicians adjusted to the new infrastructure and new expectations. Several doctors expressed that the system had made them into "secretaries," and were frustrated by the length of time the data entry was taking. One emergency room doctor complained, "You can see a patient in thirty seconds for something simple… and then ten minutes charting—you're sitting in front of the computer charting a lot." But in almost the same breath, many of these same physicians argued that the benefits were worth the costs. After suggesting that he's "a secretary now," the same emergency room doctor said, "But I find [the EMR system] to be actually a lot bigger benefit than a detriment." An older hospitalist explained that while on the one hand the EMR system was "intrusive," on the other, "if you're not getting any feedback, you're not going to know how you're doing." And an anesthesiologist said that while there was always the danger of imposing "technology between personal relationships," nevertheless the EMR meant that doctors had "access to information, instantaneously and in an organized fashion. So… it really encourages better care." Not to mention that less paper charts got lost.

That most physicians found the system more helpful than obstructive was a testament not only to the value of the product but to the *process* by which it was introduced. From its inception, physicians had been a part of the system's development. They had been given leadership roles in pilot studies and had been participants in those meetings during administrators and practitioners evaluated the system's progress. In part, this degree of physician involvement was a strategic move on behalf of the health system's administration. Not only were physicians essential to designing a good product, but—according to one system executive—their involvement ensured that "when the system got there, there were already pre-sold, pre-educated, pre-prepared folks." This same executive juxtaposed the success of the Kaiser system with the relative failure of a similar system within the National Heath System of Great Britain: "Their system doesn't work yet, in part, because they didn't do any of the upfront collaborative stuff… The doctors [there] are refusing to input data." Doctors have felt a part of the design of the EMR at Kaiser, and so have been willing and sometimes enthusiastic participants.

Changing Practice by Measuring It

The implementation of the EMR system was intended initially to create a common language across physicians and across facilities, yet the elaboration of this language had effects on physicians' thinking as well. One hospitalist discussed at length the extent to which her use of the EMR technology began to change her mental process for diagnosis. Before the advent of the EMR technology, she remembered, she wrote down a patient's "set of symptoms and [her own] impression," ordered tests, and then used the results of these tests to begin to narrow down the universe of possible diagnoses. The EMR, on the other hand, made her arrive at a "diagnosis first" and then gave her "some order sets based on that." As a result, she felt, patients were being given the

wrong diagnosis more often. For example, when a patient arrives at the emergency room with shortness of breath, "they usually get diagnosed with pneumonia or heart attack—some definite diagnosis…. But of the thirty things that can cause you to be short of breath, they pick the wrong diagnosis." Because the EMR forced doctors to be "exact" early in their clinical evaluations, she felt, it "gets people thinking wrong." It worked well for "the person who comes in with a broken foot," she concluded, but not for the "complicated, hard-to-figure-out cases."

More obviously, the EMR allowed doctors to observe one another's patterns of practice more closely. One hospitalist said, "because of the electronics… they're much more connected and know more what each other is doing, but also it's become much more one big group, held to the same sorts of standards." As a result of the new technology, Kaiser had sought new ways to ascertain "best practice" and to encourage doctors to follow it. An underlying assumption, of course, was that doctors—left to their own devices—would not practice in accordance with the best science, and that—once this scientific knowledge was communicated—doctors would change their practice accordingly. According to one department chief, the "outliers" in the department—who tended to over or under-utilize certain resources—"do it out of lack of information." Either they were "just out of residency and they really don't know," or they have been in practice a long time and do things because "it was always how they did it." An emergency room doctor agreed, saying, "In medicine, people have done foolish things enough for eons just because that's the way they were trained."

The challenge among doctors at Kaiser, then, was to create a culture in which best practices are found, circulated, and encouraged—helping new doctors learn appropriate patterns of practice, and helping old doctors break their traditional habits. I outline three related processes by which physicians at Kaiser were brought into alignment, or disciplined, through the EMR system: *protocols*, *peer review*, *and peer pressure.*

Protocols

Most practice protocols at Kaiser were developed at a regional—or multi-site—level. According to one physician who had run the hospital's efforts to improve quality, practitioners were drawn "collectively from all the medical centers and they centrally come up with what's the best care plan for this particular issue." Each protocol was circulated among all physicians, "so people can critique it," and then it "becomes part of order sets that are electronically part of our medical record now." Another hospitalist described how these regional committees "weigh the studies" out there and "give them a value" as they go about recommending protocol.

Sometimes, of course, the committees get it wrong. The same hospitalist described a time when a committee decided that patients on IV in the intensive care unit should be given a particular amount of insulin in order to control patients' sugars. The decision was made on majority, although "a lot of people disagreed with it." A few months later, however, "some articles came out that said controlling the sugar too much is really bad." As a result, the people that had disagreed said, 'Nye nye, told you so!' And so then they ha[d] to change it."

The development of protocols assumes that it is possible to define best practices despite high degrees of medical uncertainty (see Fox 1990). According to some doctors,

medical knowledge changes so quickly that evidence-based medicine is something of a lost cause. One family medicine doctor suggested:

> I believe that there is no right answer. And I believe that somewhere between a P-value of .01 and a .99 lies the truth. And we'll never know what that truth is…. And that's always been the drawback of evidence-based medicine. You get someone who does a study, and they do all the rigorous statistical analyses, they have controls and doubles blinds and all that stuff and come up with a result. And they publish it. And it becomes gospel for a short amount of time. Then about four or five other studies come out and some of them are a little bit different…. You know, I mean, it is a moving target.

Most protocols, he implied, were based on questionable science—science that would likely be changed over time. An emergency room doctor with a more positive take on evidence-based medicine also acknowledged the lack of good data about many aspects of his own practice:

> There can be many times where… you've got just as much saying do it and just as much saying don't do it, and then you do have to just say, "Well, I know what the science is, I'm going to decide"…. But I think that you accept that there's a lot of grey and very rarely just one way to do it.

Given this inevitable grey area, several physicians recognized that non-medical concerns might seep into the development of practice standards. A family medicine doctor asserted that "you can always find a research study to prove what you want to prove," implying that political or financial concerns often entered into the way that science was deployed within Kaiser. He continued, "After a while, you just kind of get jaded about pretty much any study. There are certainly some that have been huge. But there's a lot of crap out there too." This sentiment was echoed by a hospitalist, who described the often-invisible influence of drug companies on medical journal articles. While this politicized research is often in the name of *more* treatment rather than less (Angell 2000; Krimsky 2003), these physicians demonstrate a certain skepticism towards any standardized set of practices.

This is not to say that existing protocols at Kaiser privileged economic considerations over medical ones, but rather that the inevitable gray areas of medical science leave open the possibility for economic considerations to infringe on the development of these protocols. Through the development of practice protocols, the structure of medical knowledge becomes more susceptible to outside intervention. Nevertheless, despite the fact that there were—according to one hospitalist—"group decisions about things for which there may not be good data," and despite the fact that these protocols removed some physician discretion at the bedside, most physicians saw them as useful, especially since the protocols were generally framed as recommendations rather than mandates.

Peer-Review

Compliance with Kaiser's protocols were encouraged through a process of peer-review. According to one hospitalist, protocols did not "stop you from doing what you want, but you have to go through extra hurdles to do it." This sentiment was echoed by

family medicine doctor, who said, "I get to practice medicine the way I think is right, but I don't just make it up, because if I were to make up something weird and goofy, I have other colleagues around me that would be saying, 'Hm, what made you think this would be a good idea?'" Two doctors from different departments discussed being called by a radiologist after ordering a CT scan, who wanted to know the rationale for ordering a CT instead of the cheaper, and safer, MRI. But neither felt imposed upon. One felt thankful that he had to justify his position to another doctor rather than an insurance administrator. And the other felt it reasonable that a radiologist would make sure the ordering doctor was not "doing it flippantly." He continued, "So yeah, you're never ever told no, as long as you've got a good rationale, as long as you can talk to the person who's in charge of that resource and say, 'Here's my rationale.'"

For one family medicine doctor with experience in fee-for-service practice, however, these sorts of conversations amounted to interference: "Then they start laying the statistics at you. And that's when it just starts to get frustrating, because this is one of your colleagues in there fuckin' with the talent." Another family medicine doctor suggested that it was the older doctors in the department who were most resistant to this kind of accountability, because contemporary medical schools and residencies were "turning out graduates that are more [accustomed to] going into medical groups… and following guidelines." Given the fast pace at which some protocols changed at Kaiser, one emergency room doctor suggested, "I think the old-time family doc would say, 'Well, I've been doing this forever and it's always worked, right?...' There's a lot of pretty bitter fifty-something year-old doctors [at Kaiser]." For younger doctors, and those familiar with the Kaiser system, peer accountability is a normal part of everyday practice.

Peer-Pressure

The most common mechanism by which doctors at Kaiser were disciplined with regard to utilization was also the most subtle. Physicians were shown where they stand on various metrics in relation to other doctors. As one department director explained:

> We're very successful here with standardizing the care…. And we do it not so much by forcing people, but by bombarding people with the evidence—with their own practices, with where they fit on a curve. Are you ordering 50 carotid ultrasounds when your colleague next to you is ordering 2, and their outcomes are identical, how good is that? Why are you doing that?

One specialist recalled, "Every month now I get a listing in the family medicine service about which doctor are the most successful in seeing their heart disease patients are on the four key drugs, for example." And while originally the physician-administrator only listed the top ten percent of doctors, they gradually listed everyone "including the outliers at the bottom." According to this specialist, these public forms of accountability "created tremendous pressure" among those that were measured.

Several doctors in the family medicine and emergency departments discussed how the public exhibition of physician statistics changed physician behavior because of doctors' own inherent competitiveness. One emergency room physician described how doctors "get feedback on utilization," and continued, "You don't want to be on either end of the scale." One of her colleagues "was ordering way more tests than anyone else" and "made this really big effort to cut back on the latest" interval. Another emergency room

doctor recounted a time, soon after arriving at Kaiser from residency, when he was the outlier, having ordered more CT scans than anyone else in the department. As he remembered it, he was a new doctor and "didn't want to miss anything." But by being made aware of his own practices, he became "more conscientious," and began ordering less tests.

While there were some financial incentives tied to doctors' metrics, these incentives were "much more symbolic," according to one emergency room doctor. Another suggested that the bonus "really doesn't matter, except for psychologically." Within the emergency department, the amount of doctors' salaries that depended on these quality metrics was less than $1,000, a number which was slightly less in the hospital-based medicine department, and slightly more in the family medicine department. But in any event, it made up a small fraction of doctors' salaries. Nevertheless, the process of measurement was itself quite effective at standardizing practice. According to the chief of the family medicine department, there was always variation in practice, but while "you still get the bell-shaped curve… it gets smaller and smaller." Over time, doctors' practices were getting more and more alike.

The line between accountability and public embarrassment was sometimes a thin one. As a result, the hospital-based medicine department had yet to institute any sort of public demonstration of outcomes. The chief of the department recognized, "You want to keep some degree of privacy, but on the other hand, you know, you want transparency too and privacy and transparency are inherently contradictory concepts." For this chief, going over statistics with doctors individually was—at least at the time of the interview—transparent enough. And there were certainly some doctors within the other two departments who grumbled about the public disclosure. Around the emergency room, doctors jokingly called the presentations the "wall of shame."

Nevertheless, across the Kaiser system, the observation and documentation of variation in physician performance inevitably raised questions about the extent to which variation was acceptable. One specialist discussed how some ophthalmologists at Kaiser could "very comfortably" conduct twelve cataract surgeries in a day, whereas others in the same department were only able to do four. Would it not be more cost efficient to hire only those who could do surgeries more quickly? "I think it's something that eventually will need to be looked at in a model like Kaiser," this specialist continued, "But I don't know if they're ever going to be able to 'poke that skunk' because… you don't want to incentivize a sloppy practice either." A similar question might be asked of those who ordered more diagnostic tests without better medical outcomes; of those emergency room doctors who saw less patients per shift; or of those family practice doctors were unable to help their patients manage their chronic conditions. During my research, measurements seemed intended to make variation more visible and to implicitly encourage doctors to move towards the mean. But these measurements certainly could also be used to isolate and exclude outliers. A hospitalist at Kaiser said that he had had colleagues who had been fired from Kaiser for ordering too many tests.

A Culture of Constraint

Through their protocols, peer-reviews, and peer-pressure, physicians at Kaiser are encouraged to think about healthcare delivery systemically: weighing costs and benefits of different courses of action in order to maximize the health of the system's membership

in the aggregate. One high-level physician administrator explicitly discussed this as a tension between the needs of the system's members in the aggregate and the needs of each individual member. Among most physicians interviewed, however, resource allocation (or rationing) is acknowledged only obliquely. One department chief said,

> Now, if you're a boutique doctor that sees three patients a day and can look up everything and spend an hour and a half with each patient, fine—you might give better care to those three patients you see. But if you've got 3 million members across [the state], you need to be able to do things in a systematic way that guarantees that you're doing things the right way.

This chief implied that a highly individualized approach to care might lead to better outcomes, but that the size of the system necessitated standardized procedures.

A hospitalist admitted that "we're conscious of costs" because "it's our patients' dollars we're spending." But he asserted that no decision is ever "just about the time and the money." He described a hypothetical situation in which a physician has to make a decision about whether to undertake an expensive procedure that will likely only lead to a marginally longer life. For him, the particular situation made all the difference: "Is it a young patient, who's 24 years old and could really use an extra month or six months of life? Or is it an 85 year old person who's demented and in a nursing home who doesn't really need an extra three weeks?" Yet what initially sounded like an acknowledgement of resource allocation quickly transitioned to a suggestion that the 85 year old would not *want* a marginally longer life: "Or, if you sit down with a patient and the family, and they say it's not worth it to us to do this, I want comfort rather than three more weeks of this kind of suffering."

Among the doctors I interviewed, there was never a time in which scientific-medicine was discussed as something leading to *more* care; it was always brought up in the context of *reducing* utilization. This suggests that evidence-based medicine, at least in the context of Kaiser, is in part an indirect way for talking about reducing healthcare utilization. Rationing care—understood as allocating scarce resources across populations—must take place within any healthcare system. In the fee-for-service world, this rationing is masked underneath a rhetoric of individual preferences: those financially unable to pay for care "choose" not to. The rationing that takes place at Kaiser is masked by the language of scientific medicine and quality care.

The Patient Satisfaction Survey

The patient satisfaction survey is a simpler technology than the electronic medical record, and in some ways is more transparent in its effects. Each year, Integrated Health mails to a sample of its patients a survey about either an experience with their family medicine doctor or an experience they have had within the hospital. The results of these surveys are aggregated and shown to practitioners, and are factored into end-of-the-year bonuses. In many ways these surveys resemble the consumer reports that Fuller and Smith (1991) observed proliferating throughout the service-sector. They observed, "Quality service requires that workers rely on inner arsenals of affective and interpersonal skills, capabilities which cannot be successfully codified, standardized, or dissected into discrete components and set forth in a company handbook" (p. 3). The consumer report allows for a sort of hands-off management, a strategy that "intefere[s] as

little as possible with employees' ability to exercise the amount of self-direction necessary to deliver quality service" (p. 4).

But PSS is also resonant with doctors' evolving understanding of their professional role, at least in part. While EMR measures medical inputs and patient health outcomes, the PSS is meant to measure patients' affective experience of care. And just as EMR is legitimated through an appeal to "evidence-based medicine," the PSS is legitimated through an appeal to "patient-centered medicine." Since the 1960s, medical attention has shifted from the body of the patient to the wider social and psychological context within which he or she lives; and the profession has come to appreciate the importance of patient care *over time*. The doctor, therefore, is no longer merely the carrier of an abstract body of medical knowledge, but also an interpreter of the social and psychological dimensions of the patient; the doctor's intervention is also conceived of as occurring over time: patient compliance, patient satisfaction, and the doctor-patient *relationship* are understood to have medical importance (Armstrong 1984; Armstrong 2002). Patients are understood as "coproducers" of health, who can act "as effective partners with providers in the care process" (Hibbard 2003, p. 61). One hospitalist discussed the PSS in the context of patient-centered medicine: "It's that whole push in America that it's not the doctor saying, 'Here's what you do.' That there's some discussion. And all of us have been slow to say that how the patient feels about it counts for something."

In this patient-centered model, the doctor—who previously had been the detached observer—becomes the patient's partner: "Doctor and patient were now two personalities circling around each other engaged in a process of mutual constitution" (Armstrong 2002, p. 168). One public relations specialist at Kaiser put the point more bluntly:

> Quality very often in healthcare is the perception of service. The perception of quality is what kind of service you get…. If you operate on my knee, [I don't know] how good a job you did, as long as it works. And even if it doesn't work, you got a million excuses for the reason it didn't…. So you don't really know much about that, you just know how people treat you, and how they listen and if they understand what you're telling them. If they treat you for what you *think* you need, as well as what you need, or explain it to you…. Part of health is perception.

Given patients' lack of medical knowledge, this professional suggested, the quality of service they receive is often their only metric for evaluating the quality of care they have been given.

As a result, the doctor's interpersonal skills—his or her capacity to understand the patient's broader social context, to put a patient at ease, to earn the patient's trust, to win the patient's compliance—is increasingly subject to analysis and improvement. The doctor's own pathologies may manifest themselves in the doctor-patient interaction, and have to be diagnosed and remedied (Armstrong 2002, p. 171). One emergency room doctor had recently been going through a divorce, and had noticed a downward trend in his PSS scores: "…Those scores go up and down with things happening in your personal life…. Whenever people go through problems, their scores go down. It's easy to see." For those who score consistently poorly on the PSS, Kaiser offers training in bedside manner. An emergency room doctor said, "If [the scores are] really low, there's all these

classes that people can take. [These classes teach doctors to] empathize and smile, and greet people and look them in the eye. Which are all important skills."

A focus on patients' emotional well-being sometimes risks reducing the doctor-patient relationship to one of customer service. One department chief had been making changes in his department based on experiences he had had as a waiter:

> I thought it was really important to greet people when they sit down, get them their drinks, try and get their orders in to get them some food. And then they're happy and they're eating and they've had their dessert, and I don't have to worry about dropping the check, because they're happy and eating, and I'm just going to worry about these other people coming in. Suddenly I have people who are waiting 45 minutes to go. Those are unhappy people. So, I never close the deal and I kill my tip. So I've learned that over time.

His department had been focusing on the beginning of patients' visits, on having patients registered, tested, and seen by doctors quickly, only to make them wait forty-five minutes for their discharge paperwork. This made sense from a medical perspective, but "screwed up the whole experience" from the patient's perspective. Another specialist said that entire EMR system, for which Kaiser spent billions of dollars, was "*probably* going to lead to better patient care, but [would] *certainly* lead to higher satisfaction." He continued that the new system contained "bells and whistles," "things that are impressive to patients, like, you'll send them off to get a chest X-ray and you'll bring them back to the room, and you'll literally be able to show them their chest X-ray on the [screen]—you know, because it's all digital now, you know?" In this case, the doctor implied, the purpose of the technology was as much for the satisfaction of the patient as it was for the quality of care the health system could provide.

Patient satisfaction was itself seen as a legitimate medical goal among many of the medical administrators I interviewed. One department chief suggested that doctors had historically "ignored the customer service aspect of medicine." He explained, "It's not just ass-kissing…. We forget that patients walk out of here and they're going to choose to do what we ask them to do or not." Patient satisfaction, he suggested, was related to health outcomes because patients were more likely to comply with doctors' orders if they had positive experiences with them: "If we don't engage them as people and as customers, then they're not going to believe in us when we tell them, 'You've got to take your baby-aspirin every day, or you need to stop smoking…'" This was becoming *more* true as a result of patients' changing attitudes towards doctors, he suggested. Previously, there had been a "very paternalistic relationship between doctor and patient," but now "they've been reading about their problem on the internet and they probably know more about it than you do…. Or certainly they have a list of the possibilities…. They need to believe that you're engaged in the whole process before they'll engage in it." A nurse administrator echoed the sentiments of the department chair, yet emphasized that one's "mental health… contributes to your health." She continued, "So, if I'm in the hospital and I'm particularly disenchanted and I hate the food, and I'm upset about my diet and I think the people are rude, all of that feeds into my ability to get well quicker." Finally, an emergency room doctor put the point somewhat more coarsely: "Medicine's a service job, right? It is. It took me a long time to realize that. It is. You come in with a demand, I'm providing you a service, and I

have to make you happy." Despite himself, this doctor seemed to acknowledge the legitimacy of satisfaction as a medical goal.

Ambiguous Acceptance

If physicians almost universally recognized the value of EMR to their own professional goals, their feelings about the PSS were more ambivalent. Their criticisms of the PSS fell along three lines: first, that sample size and sample error in the administration of the PSS made it unreliable; second, that the PSS was invalid, since it was not a good measure of the quality of the doctor; third, that that the PSS actually skewed care towards practices that would enhance "satisfaction" at the expense of quality care.

Several physicians suggested that the PSS was unreliable. An emergency room doctor said that several physicians wondered, "How good is that data when you measure only six or twelve surveys?" Another observed that "on any given quarter your numbers can drastically be different for some reason—sample size more than anything else." Nevertheless, several doctors also acknowledged that there were consistent patterns over time. One emergency room doctor said, "Consistently some people's are high." Another recognized, "People do complain about them, that they're biased, and they're not perfect. But the flip side of that is there are definitely trends. There are people who have consistently low [scores]—they have a little more trouble getting along people." Overall, while there were some grumblings among doctors about the unreliability of the PSS, most acknowledged that the surveys did capture something about a doctor's interactions with patients.

A more damning critique was that the PSS was invalid. A family medicine doctor decried, "They give lip-service to wanting to connect with patients, but [satisfaction] scores are popularity contests. You know, it depends on how jovial you are and, you know, if you sit and hold their hand…" An emergency doctor confirmed that the PSS was not related to a doctor's clinical judgment: "If you're brilliant and you make the right diagnosis, doesn't mean people are going to like you and think you're a good doctor. I mean, they don't. It doesn't have much of a correlation—it has a little correlation but not much." He continued that the scores have "nothing to do with how good a doctor you are—it's a personality test." A second emergency room doctor was even more scathing: "I think this whole membership satisfaction thing is a bunch of nonsense. So if the patient likes what I had to offer, fine. If not, I'll usually try and figure out if it's somebody who I think is, you know, a solid citizen, I'll try and figure it out. If it's just a drug addict, then I really don't care." This doctor distinguished between patients whose opinion he might respect and those who he felt were unreliable. In general, he continued, "The average Joe… doesn't recognize when they're getting good or bad quality. They just know whether they like their doctor. It's unbelievable the number of times I look at some and go, I don't know what that guy was thinking-that's just the worst medicine, but the patient loves them, because they're nice to 'em and they listen, or whatever it is that the patient needs to have to feel good." These doctors tended to downplay the extent to which patients' regard for the physician affected the care given.

Moreover, several physicians expressed worry that a focus on the PSS encouraged doctors to *compromise* healthcare quality for the sake of high scores. Several suggested that pain medications were over-prescribed because of doctors' concerns about their

scores. According to an emergency room doctor, "Probably more Vicodin prescriptions get written because of [the PSS], you know?" According to a family medicine doctor, "As long as you give them their Vicodin, they're happy and they'll rank you high." A second emergency room doctor suggested that, because of the PSS, Kaiser has "a massive, massive proportion of people that are addicted to meds." Using the example of a thirty-year-old woman with a hurt back, he continued, "Now she's addicted to drugs, because every time she comes in, the doctor says, 'Oh, here you go…. You'll feel better,' instead of doing the right thing, which is either figure out what's causing it, or if there's no answer, get her into the chronic pain people…. It's like Burger King." Of course, this same doctor acknowledged that the same rules apply in the fee-for-service world, where "the [patient] wanted more, you wanted them to want more, 'cause you can bill more." But at Kaiser, he said, "You want to do what's right medically." And the PSS scores "get in the way of doing the right thing. Because most of the time, people are complaining and dropping your scores because they didn't get something they wanted."

With that said, other doctors suggested that PSS scores were not related to doctors' utilization rates, calling into question concerns about over-prescription. One hospitalist said, "Our highest scoring doctor is a pediatrician, and I've shared some patients with her, and I don't see her over-ordering. So I don't think you can—'cause we would have pretty good data about that—that to get a good score you need to order lots of tests. So I don't think that happens." In fact, one family medicine doctor suggested that high patient satisfaction might allow him to convince patients *not* to over-utilize resources: "When you establish you relationship with a patient—you know, after I've known somebody after a year or so, they know I take good care of them." This level of trust, he implied, would allow him to push back on a patient's desire for care he did not think was necessary.

The Game

Just as doctors were compared to one another regarding utilization rates, so they were compared regarding their PSS scores. PSS scores would factor into physicians' bonus at the end of the year, but—like the incentives surrounding utilization rates—the amount of money was less important than its symbolism. According to one department chief, "It's symbolic, and everyone has this desire to get as much of the incentive payment as possible. If there's a very human feeling there. You know, you don't want that payment, however small it is, to be cut."

But where discussions about practitioners' utilization rates were couched within the context of scientific medicine, and variation was examined as a puzzle as much as was a problem, the display of PSS scores was more obviously competitive. And so despite the different degrees to which doctors view the PSS as legitimate, most felt inspired to work on increasing their scores in relationship to one another. One emergency room doctor said, "Everyone going into medicine…[is] very competitive," so they do not like to be below the curve. Another emergency room doctor acknowledged he tried "to maximize [the PSS score], and it's just purely because of the number, because we're competitive people." A department chief echoed this sentiment, saying, "By nature, physicians are competitive people, and so we can put up people's statistics and say, 'Hey, congratulations Dr. A, you're at the top of the list and… Hey, Dr. J., how come you're… behind?'" Even those doctors who did not feel invested in their own PSS

scores tried to avoid having scores that were too low. One emergency room doctor said, "You don't want to be the guy at the bottom." Another emergency room doctor said that while he did not personally care about his scores, "In the last few months, the gal that's at the bottom feels bad about it. So I think it does have a little bit of a shame effect."

PSS scores were widely shared, both across departments in the same facility and across facilities in the same department. The chief of the emergency department bragged, "I have… five doctors in the top ten percent of the region in terms of patient satisfaction…. So, you know, we're doing something right here." But this transparency also led to some hurt feelings and confusion. One emergency room doctor recalled how the administration had recently "released a lot of data about all the docs in the medical center—like a mass e-mail… about [PSS] scores, and docs were, like, 'What are you doing? Why are you doing this? Within your department, okay, but all the docs?'" He implied that this degree of transparency felt like an invasion of privacy. A specialist, who was not ranked himself, suggested that among those doctors who were ranked it "creates tremendous pressure." One family medicine doctor confirmed, "They publish the [PSS] scores and they publish unblended, so your name is there, your rank or where you are on this list of the [PSS] score." He felt that the decision to publish PSS scores was evidence that physicians "don't know how to manage people." He felt the medical administrators within Kaiser used the PSS comparisons to "just kind of pit [doctors] against each other." He continued, "We're not going to actually sit down and chastise you, we're just going to embarrass the living shit out of you, you know?"

The Market Motive

Several doctors suggested that the PSS was especially important given that doctors were on salary within Kaiser System. While insulation from the market allowed doctors to practice without paying attention to utilization rates, according to one department chief, the same insulation meant that "it is a little bit harder to get people motivated" than in the fee-for-service world. Several others echoed this idea, suggesting that doctors in the fee-for-service world were more motivated to keep their patients happy. According to one family medicine doctor, "In the private practice setting it's the consummate capitalistic environment, where patients vote with their feet. They like you they stay, if they don't like you there's a guy next door, who'd be more than happy to take your insurance." When one emergency room doctor moved to Kaiser from the fee-for-service environment, she remembered, "It was shocking to me when I had the first kind of experiences with the doctors who didn't want to do their job."

Variation and the Limits of Discipline

There was some variation by department in terms of the types of information that the EMR system and PSS surveys were able to capture. Among different departments, these technologies had different degrees of intensity, in that they could capture more or less detailed information; and different degrees legitimacy among the medical staff. Different departments, moreover, had different social arrangements within which these technologies were understood. In some departments, doctors were isolated from one another, while in other departments they worked alongside one another. As a result, different departments had different sorts of disciplinary regimes, and physicians within each had different strategies for negotiating them.

Within the family medicine department, doctors were linked to a particular panel of patients, so each doctor could be evaluated in terms of their patients' health. The department chief easily collected data by physician on patients' "blood pressure, cholesterol, lipids, cervical cancer screening, mammography," among other indicators. Similarly, since family medicine doctors had particular patients for whom they were responsible over time, their PSS scores were assumed to reflect something about the ongoing relationships they have managed to establish. Compared to other departments, then, the family medicine department was subject to scrutiny that was seen as both more intense and more valid. Moreover, physicians in the family medicine department typically worked in relative isolation from one another, returning to private offices (or shared with one other doctor) after seeing patients.

Within the family medicine department, doctors were under close surveillance, but do not interact closely with one another on a daily basis. While this combination does not bother many family medicine doctors (especially the high-performing ones), it has the potential to lead to a sense of deep estrangement. One family medicine doctor said, "Definitely there's some isolation, there are some people that get belligerent…. This system has gobbled up and spit out some very good people." There was even a group of family medicine doctors who were going to group therapy together in order to deal with the pressure of working under such scrutiny: "We actually have a group that meets every other week with a psychologist sitting at the end of the table down there, and it's like a group therapy thing. And we're all reasonably tight, because we're sharing heartfelt things."

Within the emergency department, indicators were less intense and seen as less legitimate. The chief of the emergency department admitted that family medicine's utilization metrics are "much more robust" than his own department's. He went on to describe some quality-related measures, like whether doctors were following protocol for pneumonia patients; or whether heart-attack patients were given aspirin and nitroglycerine within thirty minutes. But he also described more *process*-related metrics, like whether doctors "follow up on patients either by phone or by email," and whether they "do some training." Likewise, the PSS surveys were based on single emergency room visits, and so were not treated with the same seriousness as the same measures were in the family medicine department. As one emergency room doctor put it, "There definitely are a lot of unhappy people" in the emergency room. Not only are they often very sick, but they often have to wait for a long time to get treated and discharged. Emergency room doctors thus take their PSS scores with large grains of salt.

As important as the difference in the intensity and legitimacy of the measurements in the ER was the social organization of work there. Emergency doctors worked closely with one another all the time. While family-practice doctors often see patients without coming into contact with one another, the emergency room doctors were constantly working with and seeking advice from each other. One emergency room doctor described the group meetings by saying, "People squawk about [the metrics] and say funny comments—we're a pretty silly, funny group." Describing how he chose to work at Kaiser in the first place, the chief suggested that Kaiser's emergency room has always been especially collegial when compared with other emergency rooms: "It's really nice to have someone to bounce ideas off of and say, 'What would you do with this person?

What do you think of this x-ray?... It seemed like a relatively comfortable, safe environment to practice in."

Within the ER, then, the results of the technology depend on the groups' collective interpretation of it. Oftentimes the doctors in the emergency department seemed to hold one another accountable for hard work and good results, intensifying the competition among doctors in some ways but also providing a social framework in which this competition did not feel alienating. Occasionally, however, doctors seemed collectively to challenge the technologies. For example, one doctor had scored especially high PSS scores and was teased by his colleagues: "It has garnished me the reputation among a couple of the docs within my group as being a hugger-a warm and fuzzy hugger—that's why he's got such good patient care scores—'cause he hugs everybody. Well, no, I'm just not old and crusty like you. I don't say that…" A group with high social cohesion seems likely to support one another in striving for good marks, but this cohesion also opens up opportunities for the delegitimation of these marks.

Of the three departments in this study, hospital-based medicine had the most difficulty tying particular metrics to particular doctors, since most patients see multiple doctors while they are admitted in the hospital. That being said, there are some metrics that are "either attached to the admitting doctor or they're attached to the discharge doctor." For example, the aspirin beta-blocker on admission is attached to the admitting doctor, and the discharge orders are attributed to the discharge doctor. But within the hospital-based medicine department it is harder to hold one doctor accountable for the patient's health as a whole. According to one hospitalist, "if you're measuring something about that patient, like how long they were in the hospital… it may involve five of us, so we can't pin it to a doctor…" As a result, there are some benchmarks that the whole department is held accountable to, but "we can't peel out each individual person, so we just take a conglomerate of the department."

Likewise, since many doctors were often responsible for the same patient, patient satisfaction scores were generated regarding the doctor who took responsibility for the patient the longest. The chief of the department admitted, "The attribution is very spotty still." As a result, he continued, "You're not looking for minute differences." Rather, the PSS scores are a way of finding the doctor "that's consistently… in the lower end."

Within the hospital-based medicine department, then, clinical measurement was relatively lax. Doctors also worked independently of one another. Therefore, those that were dissatisfied with the organization could shirk without being noticed. One doctor discussed how another doctor finished seeing his patients quickly and used to "go lay in the call room and watch TV and lock the door" when he was done seeing his patients. The doctor himself would often be done seeing his patients a few hours after he had arrived and "just sit around." Perhaps because of the lack of monitoring mechanisms, there were no ways to prevent—or even observe—this obvious inefficiency within the department.

Constructing Collegiality

Of great concern to many of the doctors I interviewed was not physicians' relationship to patients so much as doctors' relationships to specialists. Just as some doctors suggested that the fee-for-service market provided incentives for doctors to treat patients well, they also believed that the market had a civilizing impact on specialists'

collegiality with referring doctors. According to one hospitalist, specialists who depended on doctor referrals often bent over backwards for the referring doctors. But at Kaiser, "It almost allows you, once you're a partner to treat certain people in a negative way." Indeed, many of the doctors interviewed in this study mentioned how difficult it was to motivate specialists to go out of their way for patients given the lack of market incentives *and* their autonomy from PSS scores. One hospitalist observed:

> So, yeah, the willingness of a GI doctor to come into the emergency room in the middle of the night and endoscope somebody, to risk stratify them, do they need to be in the hospital, or they don't, there's one of them on call for any given week, and they're pretty well extended out, and they're not willing to do that sort of thing, which would help us immensely and help the patients too. But, in terms of this culture here, they're not willing to do that.

An emergency medicine doctor expressed a similar sentiment:

> And particularly in the middle of the night, when human nature says I want to stay in my bed, if they stay in their bed, they're going to get paid the same, whether they get up or not. It's a lot harder, as an emergency physician, to get [specialists] to do things that need to be done.

A second hospital-based medicine doctor recounted how one of his colleagues was driven to tears when she had called for a surgical consultation on a patient and been told by the surgeon, "Why are you calling me?"

In response, over the course of this study, Kaiser began to implement peer-review surveys among physicians in an effort to monitor those practitioners whom patients were less able to assess. Under this new system, according to a hospitalist, doctors would be able to evaluate any other doctor in the facility about whether the person "go[es] the extra mile," whether the person was "civil, responsive, easy to deal with, available." Since the implementation of the new peer surveys, the hospitalist observed, one of the more notoriously rude orthopedic surgeons "doesn't argue quite as strenuously any more, you know, and so it's kind of nice." And a physician-administrator in a specialty department suggested that while these evaluations not particularly useful for identifying difficult colleagues, since "if you ask the department who is the problem… people would know," they did help to document bad behavior so "something can be done" about it.

CHAPTER TEN: THE PARTNERSHIP

Andrew Quan was a 30-something emergency room physician at Kaiser. He had begun his undergraduate years as an engineering major. But when he volunteered in an emergency room, he got a taste for the excitement of emergency medicine and never looked back. He switched his major, went to medical school, and joined Kaiser Health directly after finishing his residency. Yet he soon grew frustrated by how little Kaiser seemed to "cater to doctors." At other hospitals in the area, doctors could park their cars right by the hospital entrance: "That's important to [doctors]… to get to their jobs and get things done." At Kaiser, they had to use the same garage as the other staff. Other hospitals had luxurious doctors' lounges, "stocked with food for breakfast, lunch and sometimes dinner," whereas Kaiser doctors had to use the cafeteria along with everyone else. In Dr. Quan's account, the hair that "broke the camel's back" came on a Christmas. The nurses were having a holiday party, and one of them came up to Dr. Quan to ask whether he wanted to contribute some money for the potluck. Then she interrupted herself and joked, "Well, actually, don't worry about it. I'm getting paid more than you are anyway." The nurses and ancillary staff at Kaiser are paid significantly more than at the other hospitals. Quan left the hospital soon after this exchange, although he would return a few years later.

Kaiser Health's vision of healthcare—one that combines efficiency and quality, commoditization and care—is embodied not only in the way that it manages its doctors but also in the egalitarian relationships it works to establish among different constituencies within the organization. Throughout the organization the language of partnership abounds—patients partner with the organization, doctors partner with one another, and nurses and ancillary workers partner with doctors and managers. In some ways there was a sense of equality among different players at Kaiser that was absent from the other two facilities. The logic—at least as discussed by administrators—was that the mitigation of status distinctions allowed the organization to evolve into a "culture of continuous improvement." By harnessing the creativity, energy and empathy of everyone in the organization it could deliver the highest quality care at a competitive price. According to one charge nurse, Kaiser administrators "want employee participation and new ideas, they're really into that. They're really into evidence-based medicine and putting it into—you know, making it happen. They'll try anything that's progressive."

Yet there are tensions inherent in this vision. On the one hand the organization rewards and fosters voice, participation and creativity among employees with the idea that these qualities will lead to gains in efficiency and healthcare quality. On the other hand, in order to conduct experiments successfully, and in order to institutionalize successful experiments across multiple departments, Kaiser Health requires an extensive bureaucracy. The same vision of inclusiveness and partnership thus meant that *all constituencies*, from doctors to managers to workers, were subordinate to bureaucratic authority. And it meant that as "efficient" solutions were institutionalized there became less room to innovate—bureaucratic rules supplanting charismatic creativity.

Second, the existence of an extensive bureaucracy meant that bureaucratic elites were able to represent their own interests as being in the interests of the organization as a whole. And third, while bureaucratic rules and chains of command were more formalized here than elsewhere, these rules and staff structures were supported by bureaucratic shortcuts and informal networks of authority. Practical knowledge—

knowledge of how to navigate Kaiser's bureaucracy—seemed as important as formal position or technical skill.

Doctors as Partners

The headquarters of Kaiser Health Foundation, one of the largest physicians' groups in the country, is situated in a skyscraper not more than an hour's drive from Santa Rosa. In order to make it to the executive offices one needs security clearance. The executive with whom I met, Roger Gleeson, had a spacious corner office and a supply of Diet Coke, a can of which he was still nursing in the late afternoon. While he had been a dermatologist for approximately thirty years, since he became an executive he only participated in the occasional surgery. Since he led a twenty billion dollar organization and taught classes at a prestigious business school, he said, he did not have time for being a doctor. It was one of the big sacrifices he made going into management.

The Kaiser Health Foundation is the physicians' branch of Kaiser Health, a for-profit organization that is legally distinct though practically inseparable from Kaiser as a whole. After trial periods of approximately three years, doctors are offered "partner" status by their departments. Formally, partner status means that doctors are able to vote on admitting other doctors to partnership status, and to vote on the group's CEO and local facility's physician-in-chief; it also means that doctors receive a financial stake in the corporation. Beyond the elections, however, "The rest of the process, the administrative process, is not so open," according to one hospitalist. Even the leadership elections were "much more like a politburo," according to another specialist. Nevertheless, partnership status did help doctors feel invested in the well-being of the organization. It also served as a kind of tenure—according to one young emergency room doctor, "Once you're partner, you can fall back and do the minimum." Discussing doctors with partner status, an older hospitalist (and partner herself) agreed: "You just can't get rid of them, you know. They can screw up royally after that." A third hospitalist agreed, saying that getting rid of a negligent partner was a "long, arduous process" involving several stages of documentation, meetings with administrators, and arbitration—and could take as long as two years. A final emergency room doctor, discussing his decision to come to Kaiser, acknowledged, "Nobody's asking me about big decisions with the hospital, but nobody's gonna can me without cause."

Finally, the partner model at Kaiser is designed so that nearly all physician administrators also maintain clinical practices. According to one physician administrator, this means that administrators "have the credibility of seeing patients… and suffering under the same [procedures]" that they impose. This is resonant with the observation made by Eliot Friedson (1984, p. 12) that professions on salary—in contrast with most workers—are controlled by a "superordinate colleague." For him, this meant that while bureaucratization might diminish the autonomy of "*individual* rank and file professional workers" (p. 12) (emphasis in original), it did not diminish the autonomy of the profession as a whole. Of course, among some physicians, a physician administrator is little more than an administrator with a cloak of medical legitimacy. Once people become concerned with "the system in general… and optimiz[ing] the system… they become not a physician anymore. They're an administrator, which is almost like swearing, you know."

If most doctors at the organization were partners, there was still a wide range informal authority among doctors in the organization. Informal authority was loosely correlated with administrative responsibilities, but also distinct from formal position. Referring to one of his colleagues, a family practice doctor acknowledged, "You can collect titles, put them on the shelf… Titles don't mean much. He's actually got sway." Explaining how power worked within the organization as a whole, he continued, "There [is] a sub-group of people who—I guess the analogy would be [they] ran for student council… That's just what they want to do; they want to be at the microphone during assemblies… and they want to be popular. And those people, when they get an idea, they can make changes." While some people were "in," this family doctor did not consider himself "in that inner circle." He had recently written an email to Dr. Gleeson about what he considered unnecessary roadblocks to ordering certain tests; when Gleeson responded, he had copied the CMO of the local facility, the department chief, and others; and he had gotten a call from a colleague asking what he was doing writing to Gleeson in the first place. The implication from this family practice doctor was that only certain doctors were supposed to have access to Gleeson.

Others also acknowledged the unstated differences in power held by different members of the physician staff. One older hospitalist explained that despite the rhetoric of partnership, "the process is driven by a handful of people, and major decisions are made by a handful of people and then presented to the group, and the group generally ratifies those decisions. But do you have input in terms of the way the decision was made? No, you don't." Given the informal hierarchies among the medical staff, a younger hospitalist who had left Kaiser observed that "you have to walk on eggshells a lot more" at Kaiser than at Memorial. "You find out who has power, and you kiss their butt." There was one decision in particular that had rankled this hospitalist. The critical care department at Kaiser—or ICU—was typically "closed," meaning that internal medicine doctors were not permitted to practice within it. Yet one physician administrator in the critical care department with "a lot of power" had advocated for a system in which hospitalists would staff the critical care department between 5pm and 7am. For the hospitalist, it seemed as though the critical care doctor had used her power in order to advance the interests of her department—not the interests of patients. The hospitalist was frustrated that the "more power you have, the more you could change things or direct things so your quality of life is better." In this case, the head of the hospitalist department himself was "afraid of her, he does anything he can to make her happy, because she has too much power. And you want to be on her 'good' side. If you're not on her good side, then you're done with." Even though the department chief was a well-respected partner, "if he rocked the boat with her, she could make their lives more miserable."

Several nurse administrators echoed these sentiments. One suggested that there were "people in positions of power [at Kaiser] that utilize that power in a way that degrades the system." She thought that there were boundaries between work and private life that were systematically violated within the organization: "Nurses have these relationships with physicians, physicians have those relationships with each other, nurses have those relationships with each other." She had been surprised to learn that one of the head doctors at the facility had gone traveling with the director of the quality department—what she considered a potential conflict of interest. "The director of quality

shouldn't have a goddamn thing to do with the head physician." For her, the "incestuous" nature of the organization undermined people's ability to "take care of the things you need to take care of, because there's friendship involved."

But if these informal allegiances and hierarchies made the Kaiser bureaucracy an imperfectly efficient one, in some respects, they also seemed to have developed as a necessary complement to the impersonal and rationalistic elements of the organizational structure. One longstanding hospitalist explained that because doctors were on salary at Kaiser, their "responsiveness and willingess to participate is more personal than it is professional." He himself relied on these informal relationships as he advocated for his patients: "For instance, there are certain surgeons that I know I can get to see a patient right away and do what needs to be done. And some that aren't quite so responsive. And you have to play your cards right in terms of who's on call at any given time." This, he argued, was a "part of practicing medicine in an integrated system." Somewhat paradoxically, this same hospitalist implied that the increasing standardization and rationalization actually *generated* a type of inefficiency, since he no longer "had time to establish a relationship over a long period of time" with each new doctors. The "small group camaraderie" that helped to lubricate the wheels of the bureaucracy was wearing thin.

Organizational theory has long suggested that those within an organization able to solve its "central problem" are able to exert influence over the organization's direction (March 1962; Pfeffer and Salancik 1978). At Kaiser, power tended to be held by those who were central to the processes of rationalization and systemization deemed critical to Kaiser's success. For example, the charge nurse in Kaiser's Emergency Room was given more authority than his or her counterparts at the other two hospitals. John Hoddess, a charge nurse at Kaiser, said proudly, "Whoever's in charge is the most critical position in the whole department. You're telling the doctors what to do because it's all about the flow." He liked the job because he was able "to make thousands of decisions every shift," and was able to intervene in crisis situations and "be the hero." He also felt "responsible for everything that goes on in the shift." Yet despite this pressure, John felt as though the organization backed up his authority. For example, in most emergency rooms, the charge nurse is the "only person that's thinking about who's in the waiting room, and [whether there is] someone dying in the waiting room." But Kaiser administrators had recently been "all about flow," and had begun an initiative to get patients admitted to the hospital (and out of the emergency room) within sixty minutes. On the one hand, this meant that John's supervisor was recording admission times on a stopwatch and calling John constantly. On the other hand, this pressure—and other quality improvement initiatives like this one—had "really helped out" by giving him the power to do his job well. While his job had always involved managing the department as a whole, the administration's prioritization of these processes gave him organizational backing.

On occasion, however, these organizational priorities meant that there were mismatches between people's status in medical hierarchies and their power within the department. One emergency room doctor remarked that "when nurses get promoted to charge nurse position… the relationships get more difficult." People whom she "got along with well when they were regular floor nurses" she now found "really annoying." According to her, it was "a hard position to pull off without alienating people." Yet it

seemed that this doctor was also frustrated with the authority that the charge nurse wielded over her and other doctors at Kaiser: doctors were not used to taking commands from nurses.

The Limits to Rationalization

As explored in the previous two chapters, doctors and administrators at Kaiser were committed to the belief that, through evidence-based medicine and the right financial incentives, high quality care and cost-efficient care were identical. But several doctors and nurse administrators suggested that standardization had seemed to become an end in itself. One hospitalist argued that standardization had begun "for stuff… which there is science" to support. Yet, she continued, the administration of the hospital "seems to have… been riding on that success… to push for more things that involve micromanaging." For example, Gleeson had recently mandated that hospitalists work seven days in a row. Yet this hospitalists' group had "some people that like working five days in a row" and she herself "like[d] working ten days in a row." Her response was, "What study shows that seven days is better than six days, is better than ten?"

In the emergency room, several physicians complained that administrators had made it impossible for emergency room doctors to send less serious cases to the outpatient clinics—a practice that many relied upon in order to open up beds for more serious patients. According to one physician-administrator, Gleeson was "not an emergency physician, he doesn't work up here, he doesn't know our situation. He's a good CEO… but he's jamming something down our throat that's pretty far down the line for him." A second emergency room physician suggested that the policy decision may have been made in response to an adverse event at a separate facility, in which someone had been triaged to the outpatient clinics and then died. But if this was the case, it was not made public to the emergency room doctors at Kaiser, who were unable to change a policy that felt far removed from scientific medicine *or* efficient care.

One nurse-administrator thought that these sorts of decisions were evidence of bureaucratic corruption: "It doesn't matter how much evidence-based practice you have, if the people who oversee that and ensure that it's handled appropriately are corrupt." But more likely, it seems, was that processes of centralization, first made in the name of organizational efficiency and quality, had led to standardization beyond the point that many physicians thought was positively related to outcomes.

Partnering with Labor

As physicians at Kaiser are partners with one another, so labor at Kaiser is partnered with management. At Kaiser Health, the union is part of the infrastructure—figuratively and literally. In the middle of the facility's sprawling campus, off a hallway between primary care clinics, the labor management partnership has a small office space. Inside, I met Julia, labor contract specialist for the union. Julia was a short, stocky, charismatic Filipina in her late 30s. In the late 1990s, Julia was working as a phone operator for a cable company, a job she hated. When the company sold itself off to a bigger company, she took the severance package and started her own cleaning business. The business was going well, but Julia was still working long days. So when two clients encouraged her to apply for a job at Kaiser Health, she said she'd consider it—despite her desire to "be my own boss." As a phone operator at Kaiser Health, Julia started "making

the most money I've ever made." In the seventeen years she had been with her husband, it was the first time she was making more than him, a point of some pride. And while she began as a non-contractual employee, working part-time, she gradually increased her hours and joined Kaiser Health's full-time staff: "When I got that first check from Kaiser Health, I ripped up my resume. I knew that they were not taking me away unless they were dragging me out by security, kicking and screaming…" Kaiser Health is well known to pay its employees—from nurses on down—well above the rates of the two other hospitals in town.

Julia had grown up in a union family—she remembered riding her bicycle on the picket line with her father outside his manufacturing plant while her mother and some of the other wives made sandwiches for the strikers. And as she began working at Kaiser Health she became increasingly involved in the union, first as a union steward, then as chief steward at the hospital, and then as contract specialist—a full-time position paid by Kaiser Health with responsibility for handling workers' grievances with supervisors as well as supervisors' problems with workers. By the time I met her, Julia represented roughly 1,200 union members at Kaiser facilities all over the county. She loved it: "I like to talk a lot… and I think that I'm a people person, so when I walk down the hallway everybody knows me… I make time to talk to each of the members, because they're important to me."

The labor management partnership at Kaiser Health is unique in the healthcare industry. Since Kaiser was founded as a health plan for a largely unionized workforce in the 1940s, the organization has always been sympathetic to labor unions. Not only did union pressure help inspire the *creation* of the health system (Kochan et al 2009, p. 26), but the health system has always counted a large number of union members as patients (Hendricks 1993, p. 66). According to one union leader, Kaiser "was more accepting of unions from its inception." A physician administrator agreed, saying, "We're committed to unions. We came from a union environment." And even those who were less enthusiastic about the partnership acknowledged the union's lasting influence in the facility. According to one hospital-based physician, "We will never split up from the unions because that's how it started." One worker-leader recalled how John Sweeney, then the head of the AFL-CIO, threatened to withdraw union members from the Kaiser system if a deal was not reached. According to her, Sweeney said, "Don't forget where you came from, where your roots are, who supports you—it's the unions."

In addition to Kaiser's working-class heritage, two other factors help make the union at Kaiser Health especially strong. First, unlike the other two hospitals in town, Kaiser Health is an integrated health system consisting of several primary and specialty clinics in addition to its hospital. While ancillary workers make up less than half of employees in most hospitals, they make up the majority of employees in the Kaiser Health clinics. As a whole, then, Kaiser Health is much more reliant on its ancillary workers than other hospitals. Second, Kaiser Health's integrated, pre-paid group model made it hugely profitable compared with other health care providers in California. According to one physician director, despite the high wages that Kaiser provides, it could easily pay more.

The labor-management contract at Kaiser covered nearly every aspect of workers' lives at the organization, from worker evaluations to processes of interest-based conflict resolution. In keeping with her role, Julia seemed always to keep a physical copy of it

close at hand. Julia had thumbed through the thick purple book so thoroughly it looked like it had been through the wash, although by the time I met her she seemed to have committed most of it to memory. In meetings she often told her stewards to read the contract carefully enough so that it looked as worn as hers. And at the end of our first meeting, with an air of gravitas, she gave me a copy of the contract that had been owned by one of her favorite union representatives. She had been saving it as a sort of keepsake.

In some ways the contract was like union contracts in any other industry. In contrast with the vague and value-laden evaluations at Memorial Hospital, the contract required that worker evaluations at Kaiser be broken down into detailed elements tailored to specific job positions. Within each category (i.e. "Job Knowledge," "Patient Interaction," "Communication and Documentation," "Emergency Response") were a set of particular practices on which a manager evaluated a particular employee (i.e. "Effectively communicates with co-workers and members," "Clearly writes/edits, documents, and transcribes information," "Completes documentation on time," "Uses correct terminology, style, and format.") Unlike the horizontal surveillance at Memorial Hospital, workers were not expected to evaluate one another at Kaiser. And perhaps most importantly, there an elaborate process of demerits and warnings that managers must abide by in order to discipline or fire employees. One worker leader who had previously worked at a hospital owned by the same Sisters who owned Memorial felt that he had been "brainwashed" into not wanting the union there. When he came to Kaiser Health it was a revelation: "Because you actually have some representation. They couldn't just kick you out the door just because they didn't like you or whatever. They actually had to have grounds to do it and everything."

If job security, wages, and due process are the bread and butter of union representation, in other ways the Kaiser contract is much more expansive—a contract that creates space for dimensions of work-life irreducible to contracts. For example, the cornerstone of the labor-management partnership is the "unit-based team," or UBT, defined by Kaiser Health as "how frontline employees, managers, and physicians work in partnership to lead organizational performance at Kaiser Health." These teams, made up of representatives from all partnering members of the work unit (physicians, managers, and those workers part of the partnership), were responsible for making decisions about "core operational and environmental issues" using a core set of labor-management partnership principles and practices like interest based problem solving and consensus decision-making. An Implementation Resource Team (IRT) was installed at each facility to provide coaching for the members of these teams and facilitation to assist teams with group process.[53] As one of several color fliers put out by the labor-management partnership explained, the UBTs were intended "to increase involvement and result in improved performance…" One labor leader believed that the UBT "empowers workers a lot… It's not just following directives; it's really thinking critically about what they can do to help and be more productive. And I shouldn't even say productive; they think creatively about what they can do to help the department."

The premise of the partnership is that productivity and involvement, efficiency and vocation, went hand in hand. The partnership thus embodies the idea—widespread throughout the organization—that market forces and a healthcare mission can be reconciled through the right kind of organizational structure. As one department head put it, the labor management partnership was "brilliant strategy." He explained that after a

"horrible strike" in 1986, managers of the system and union leaders realized, "We all want the same thing." He continued, "The labor unions can get the malcontents to work better than we can… [They can] get their own in line." Moreover, he said, "It also works a lot better to do things in partnership and to… work out problems on the front lines together." The partnership ensured that workers did not feel like "the man's telling them what to do all the time. You know, they're the man. They're making a difference in their own workplace, and they're valued and listened to." Since labor shared responsibility for the functioning of the department, "if they have someone who's not doing their job, it impacts all of their members, too. And it's frustrating to them." For this department chief, the partnership seemed a strategy for managing labor relations: "In terms of discipline it's better, in terms of functioning on a module it's better." One emergency room doctor, who was less impressed with the partnership overall, nevertheless recognized that while the nurses at Memorial and Community Hospitals consistently went on strike, "We don't have that." So, he concluded, "the [partnership] obviously has its benefits."

Many worker leaders and union staff also understood that Kaiser's commitment to the partnership is at least in part a managerial strategy—as was "labor peace" for industrial manufacturing in the post-World War II era (Fantasia and Voss 2004; Brody 1993). A union leader admitted that there was only labor peace at Kaiser Health "to the extent that they can make money." Yet many of the executives at Kaiser Health, he suggested, also had "an appreciation…that there's value to the workers having a union and there's value to the political power that the union may bring to help Kaiser Health in other areas… that there's value to workers having a voice."

A Kaiser executive who had been intimately involved in the development and implementation of the UBT program expanded on the idea that the partnership was more than merely a managerial strategy. Indeed, he argued that it would not work as a managerial strategy if it was understood by either labor or management as being "an artificial setting… where we sit around and push jargon at each other." At those sites in which the partnership "was politically correct ideology, the process sort of failed. And the places where the supervisors weren't good at listening, the process failed." But in many settings, he continued, the process had been able to work: "When the first unit based teams were done, many of them had real successes and care was better, service was better, work through was better. And that was celebrated, shared, publicized."

One key to a successful UBT, this executive suggested, was building a sense of teamwork and group identity to bridge different employees' formal positions in the organization's hierarchy. In many cases the idea of "patient care" was able to be this unifying ideology. Since all constituencies had a common interest in the patient, he explained, "if you focus on the patient and then the team sits down and talks about how do we collectively work on making the patient fare better, you get a level of buy-in." Of course, this "sense of [group] identity" also relied on savvy leaders. The organization thus committed significant resources to "training the supervisors to be good team leaders." The partnership did not mean that supervisors "stopped [being] accountable," but rather they had "accountability for managing [workers] differently than they would have otherwise. And all the team members have an accountability to provide input and make the team better."

When the UBT process was successful, this executive asserted, it led to both better outcomes for patients and higher satisfaction for workers. This was particularly noticeable, he suggested, when a team could measure their improvements quantitatively over time. "People love to be on teams," he said. "When you do it well, it's really fun… You get to watch the scores go up and you get to see things get better. And people like to win and people like to get better." Over time, teams would come to compete not only with themselves but also with other departments in the facility or in other facilities around the state and country. Organization-wide, the aspiration was to create a "fabric of teams" that would begin to cooperate and compete along the same indicators of success. If one department, for example, was able to bring the "infection rate from fifteen down to ten down to five, all the places at ten want to know how the people at five got there." Not only would teams help to bridge the interests of labor and management in the organization, but they would also invest employees at all levels in games related to patient care. One department chief at Kaiser Health, who had recently taken over as the head of the regional chiefs, discussed the excitement of "the metrics that [these departments] should be following." Since there were now twenty departments within the same region, "if one facility has really good metrics on door-to-doctor or lab turnaround… we can share that practice."

April, a worker leader in the family medicine department, discussed how the labor-management partnership led to the installation of floor mats around the department to reduce musculoskeletal injuries. Julia described an initiative to "turn off all the lights" when not in use: "Labor's going to help turn off all the lights, that's going to help save Kaiser Health money…. And we work that out and we track that, and then at the end it becomes a monetary value. That's the partnership, right? Because really ultimately it's saving that money, saves me, saves the employer, benefits the patient."

As important as these organizational initiatives were the daily adjustments that the hospital staff makes in response to the unexpected. The labor-management partnership tried to make sure that these adjustments were made as inclusively as possible: "You know, Susie called out sick today, so how are we going to get through the day? How are we going to serve those patients, and how is that going to work?... You're constantly working out those little problems." Julia went on to describe how much of her work involved "teaching the members to have those conversations with the manager," helping them to *feel* like partners. The day before our interview, a group of staff discussed with Julia and their manager how they felt like the manager was "intimidating" and "bullying" them into making changes in their schedule. Julia told the manager that she could "go contract on him" and make him negotiate the changes since they involved changes in working conditions. But she coached him to "use some of the tools that we know: interest-based problem-solving, consensus decision-making, and let's get them to buy into it and let them decide."

Common Interests and Their Limits

On one occasion I was able to attend a department meeting to observe the labor-management partnership in action. Almost twenty doctors, managers, and workers were involved in the meeting, which began with a discussion about an ongoing training to improve the relationship between medical assistants and physicians. According to one doctor, the assistants did not yet see empathy as part of their role, did not see themselves

as part of the "healing arts." Another doctor commented that assistants would sometimes knock on patients' rooms after fifteen minutes, and were not sensitive to the patients' needs. A manager explained that one medical assistant had been uncomfortable with managers being a part of the training.

The conversation then shifted to a question of how to handle doctors who, having not been on the day's schedule, want to "open" his or her schedule. Several doctors expressed that doctors should be able to work when they want to. A few nurse managers responded that managers should be able to say no, especially if they did not have adequate staff to open up a doctor's schedule. At this point a female doctor, who had been knitting for the duration of the meeting, looked up and said that the staff needed to "suck it up and do it." Another doctor opined that the group should approach the problem "from a positive aspect," having an attitude that is "yes, let's do it." One manager responded that the staff "can only suck up so much," while another argued that the staff would be more willing to go along with scheduling changes if they felt "a part of the process." At this point the physician director of the department intervened, saying, "I'm glad to see where this is going," and that the department should be focused on "putting patients first."

As the conversation continued, it became clear that the group would be unable to make it through the ambitious agenda that the director had planned. While the group began a lengthy discussion about how to handle appointments for members who call at night and want to be seen the next day, the director intervened: "[The physician in chief] wants us to be more action oriented and less consensus building." The meeting ended with acknowledgements. A doctor began to acknowledge a medical assistant for "never saying no," then stopped himself and reframed: "For being empathetic." The department director added, "For kindness and generosity." The meeting them came to a close.

This meeting, while a somewhat arbitrary snapshot of Kaiser Health's organizational life, illustrated both the possibilities and constraints of the partnership model. On the one hand, the fact that so many different constituencies could come together and discuss the work of the department was itself remarkable. At times there seemed to be room for creative problem-solving and a productive back-and-forth of experiences and perspectives. Yet it also was a stark reminder of how power does not disappear from processes of "consensus building." The few workers at the meeting remained quiet throughout, while doctors tended to dominate the conversation. Moreover, the need for "action" seemed to assure that those who had positional power in the department—the physician director and his staff—ultimately would make the tough decisions.

Indeed, despite the common interests to which the labor management partnership appealed, labor and management simultaneously recognized the limits of this commonality. Julia did not mince words in the way she described workers' motivation for becoming involved in the union: either "you've been wronged [by management] and you're pissed off" about it, she explained, or "you're advocating for someone else who you've seen done wrong." After seeing her manager intimidating workers and "pitting employees against each other," she decided to get involved in order to "advocate[] for the weak in the department." She also felt personally targeted when she had plans to go on vacation and "was told I had to come in." Her involvement in the union, at least initially, was motivated by a desire for more control over her work.

One union representative made a similar point more generally: "There's absolutely a class difference between those who own the means of production and those who don't." Yet he saw the partnership as an opportunity to "question the sovereignty of capital." For him, the partnership was an example of "taking over the shop, not in real economic terms… but just in terms of there's no real reason why me as a person who's producing the wealth shouldn't be able to really take part in the… decisions that are going to affect my life." Interestingly, this leader framed participation in the labor-management partnership as an instantiation of radical politics, rather than as a concession made by hospital administrators.

One worker leader expressed a tension in the partnership that many seemed to feel when she explained how Kaiser Health executives approached her, "talking about, 'What if we could just sit down at the table and talk about things.' And we're going, 'Yeah, that would be good. But a lot of the problems are your managers. Are you going to talk about that?'" If the partnership was part of Kaiser Health's economic strategy, several workers wondered, was power sharing merely a strategy for making exploitation more palatable?

According to the workers I interviewed, the partnership worked best for those aspects of work that did not involve a zero-sum game. Kochan et al (2009) found something similar when they studied the interest-based bargaining process behind the 2005 Kaiser contract. In their study, a partnership model worked more easily on the non-economic aspects of the contract (p. 107), and less well on the economic aspects of it. For those technical problems that could be solved by bringing people's experiences and perspectives together, an investment in partnership made good sense. Yet for "power problems," or problems that had to do with the allocation of resources among staff, the partnership worked less well. Kochan et al (2009, p. 235) quoted one top executive at Kaiser Health who asserted that "partnership is about a business strategy and trying to change a culture. But it does not excuse us from our management responsibility." Julia herself admitted, "We don't hire, we don't fire. So at that point, that's where that line is drawn, and we say, Managers manage, I don't have the ability to tell you how to manage." And Jake remembered feeling "slightly frustrated" on occasion because "sometimes management would use the labor-management partnership to blow smoke up our ass." Susanna, a worker leader and a mentor of Julia's, was worried about the partnership for this reason when she first heard about it, and did not mince words: "I thought it was a bunch of bullshit. In bed with management? What kind of crap is this?"

Of course, the idea of partnership was even more difficult to swallow for many members of the physician staff and hospital administration. According to one physician administrator, the "lack of autonomy" with regard to hiring and firing was an adjustment for many physicians. An emergency room physician suggested that workers' power in the organization meant that workers were "a little bit more sensitive in terms of physicians' demands on them." And a family practice doctor acknowledged wryly, "The only people here that aren't union are the physicians." He explained, "When you're in private practice, the women there work for you… You can chastise them, you can fire, you can hire, you can reassign..." In contrast, he continued, "Here, you don't have any of that. And as a matter of fact, you're told up front, 'Hands off the staff because they're union'…. If you have a gripe, then it has to go through certain channels." He noticed great variation in the staff from different departments. While the staff in his office were

"consummate professionals," those at the other end of the hall were "young, they're cliquish… they're shopping online, they're twittering about make-up." That being said, this same doctor recognized that "after you work with these folks long enough, they either respect you or they don't. And if they respect you, they will bend over backwards for you, whether they're union or not, whether you fire them or not." As a result, he said, he understood "which side of the bread my butter is on and I try and treat'em well."

Several physicians and administrators also expressed concerns that the unions' power within the organization meant that good care was sacrificed in the name of organizational predictability. A Kaiser Health administrator expressed her frustrations with union regulations. She explained, "We have an obligation to follow the contract, and so in some ways it gives us less flexibility." When she put together committees to address patient care, for example, "I need the union to tell me who [will be on it]. I don't get to pick, I don't get to say, 'You would be great on this committee. Would you like to do it?' They tell me who is going to be on it." Furthermore, the contract meant people do not work past their shifts because managers would have to pay them time and a half for any extra work they did; and meant that people who were "tired of nursing" waited longer to retire in order to hold out for increases in benefits. This administrator recognized the benefits of the union contract, in that rules and lines of accountability were clear: "It's very clear if it's in the contract that you have to call in and let us know that you're going to be sick two hours before the start of the shift and that's what you have to do. And that's what I can hold you accountable for." Yet she worried that employees became "so oriented to the contract that they become less professional," that working at Kaiser becomes just "a job for them," whereas she felt that the work should be "more important than just a paycheck."

A hospital-based physician supported this sentiment when she complained that "mediocre employees" were able to "hide behind the union skirts." Moreover, she suggested, it was sometimes "hard to pull the union into having the same goals" as the organization as a whole. For example, while Kaiser Health had begun an initiative to "improve how patients perceive the service they receive in the hospital," the nurses' union had refused to participate because "you can't use the word 'service' around them." In this doctor's account, the union was so bent on seeing themselves as professionals that they rejected the implication that they work within a service industry.

Partnership and Struggle

Several worker and union leaders came to understand that the labor-management partnership was not a substitute for struggle against management but a *part* of that struggle. The very *idea* of partnership gave the union leverage. Susanna, who was initially skeptical of the partnership, came to see, "They're saying we have true equality, and we don't have true equality. Not true equality. But we have way more than we would have if we didn't have the partnership…" Phil, a chief steward, described partnership meetings by saying, "You're an equal to management when you go in there. Whether they think so or not." The partnership did not actually put labor and management on equal footing, but gave the union an advantageous context within which to struggle. Jake described how the union "could put pressure on managers" through the labor-management partnership process: "We didn't have any qualms going to their boss and saying, 'This person's not partnering.'" Not only was there a high cultural premium

placed on the idea of the partnership, but managers were evaluated in part based on how well they worked with the union. Susanna recalled, early in the partnership, how hospital leaders would often ask her to be a "token labor representative" at meetings. She had to work, with both herself and with Kaiser Health's leadership, to have a real voice. She remembered saying,

> "You're asking me to sit here and rubber-stamp something and be token labor, and I have to say, I don't agree with what this decision is." That is hard to say to a bunch of leadership, you know, when you're just… a path assistant…. When you're… in the workforce and you're working for them, [you think there is] going to be retaliation…. You know, you have to say what you think and your feelings. And they responded to it, and they started responding to labor. They started asking us. They would call: "What do you think about this, Susanna?"

Through advocating for herself and for labor within such leadership meetings, Susanna felt she was able to achieve a real say for the union. For Julia, one of the most important pieces of the labor-management partnership contract was also the most abstract—respect. She described her relationship with a difficult manager: "I actually believe we've had this conversation about respect. It isn't about you—me earning your respect. Because I don't need to earn it. You have to give it to me. It's actually page four of our contract."

Workers' power seemed to reside in their capacity to use the idea of partnership to their own advantage. Susanna explained that many of those who had the hardest time with the partnership were the "mid-managers—people who just cannot let go of their control…. That's what they do—they control. It's in their blood! You know, they can't help themselves." Left uncontested, then, the partnership existed in name only—rhetoric from Kaiser Health leadership that did not influence departments' daily practice. Will, a steward at the hospital, admitted that in these instances "some of it's labor's fault, because… there are some stewards that are just weak… I think there's quite a few stewards that are just there to have the day off—the one day off during the month that we have steward council." Yet because the leadership "really believes in this partnership," and because the partnership is "in our literature," workers had leverage against managers in order to make the partnership a reality. April said that she will "get slapped on the hand once in a while" for being outspoken within her department, but that "nothing's gonna change until you start voicing something…. That's why change has happened in the clinic." Far from a *substitute* for struggle, the partnership provides a context within which workers can struggle successfully.

Jake explained how Kaiser Health's history, and the labor-management partnership contract, established "rhetoric… to be able to have better labor-management relationships than in other places." Still, he acknowledged, the union had to use the rhetoric "along with real power" in order for it to be effective. Behind the collaborative nature of the partnership, then, was the threat of workplace action. Among those in the union this kind of direct action was described as "going traditional," or "going contract." During one memorable instance, the janitorial staff had been asking their manager for new mops to no avail for three months. Julia called a meeting of the janitors outside the building, in plain view of administrators, where together they planned a "sticker day," on which workers would wear stickers and sing jingles demanding that they be heard. By taking action together, the janitors learned that they could make their manager mad "and

there's nothing she can do about it." Within three days the manager gave her staff six hundred new mops. Julia thus teaches workers to advocate for themselves while also coaching managers on how to listen. Disagreements that cannot be resolved through the partnership do not always escalate to this kind of direct action. More often, Julia explained, when labor and management cannot reach consensus they are able to fall back on the contract: "But when it comes down to it, we always have the contract. And so it's black and white. So at some point, when we don't agree, we go through the process. And so I think that there are defined, distinct lines, and I think that that's what helps us—is that the partnership lets us engage into those conversations, but we can also say: It's time to agree to disagree."

Oligarchy, Though Not Iron-Clad

But if the labor-management partnership did offer the possibility of more power for workers, this possibility seemed to hinge on the quality of the worker leaders in and around the facility. With the wrong kind of leadership, the partnership also had the potential to slip into oligarchy. As the partnership began, the union appointed what was then called a "union liaison" who worked between the union and management at the facility. Susanna recalled that the liaison "came in and started making deals, violating the contract with management," which "really pissed us off about the partnership." For Susanna, the partnership worked well if it did not impinge at all on the contract, but "we cannot compromise the contract" without "screwing with our members."

Even at the departmental level, Jake described how there was variation among worker leaders in terms of their capacity to advocate for workers. Given the partnership, he explained, "there were a number of forums where the stewards and the managers would be taken outside of the shop and be forced into conversation… about how to make things better." Some stewards treated this role "as a way to get on the up and up," a "really nice job on their way to something else." According to Jake, this tendency was most common among younger stewards, and among those from lower-paid departments. The younger stewards would see the role as one that might lead them into management; while the stewards from the lower-paid departments "came from a blue collar background and so they would get into this job and then they'd see all these various opportunities open up before their eyes and sort of lose touch with what I would see as a responsibility to be a steward." As a result they were more likely to "buddy up" to their managers and be less "accountable" to the workers they were supposed to represent. Given the intimacy with which labor and management would work together within the unit-based team, Jake saw this structure as "one of the places with the greatest potential. But it's also one of the places where, you know, people began to start to gang up on their coworkers."

Still, the line between oligarchy and representation was not quite so clean cut. During one conversation in the union office at Kaiser Health, Susanna and Julia described their different approaches to negotiations with managers. At one point in the conversation, Susanna chided Julia for her adversarial relationship with the human resources manager: "The two of them are like oil and vinegar…. Julia just calls her on her stuff, gets in her face." Susanna herself, though, had "learned that if you bend a little bit, and kinda play ball with them at their level, the way they do things, when you need a favor or you need something, they're going to be more willing to say, 'Okay.'" As

Susanna mentored Julia she had tried to teach her "to play the game." Occasionally, Susanna admitted, they'll even change the contract slightly: "When we want to do something that's a little gray, which is what we just did, it's better to have HR on your side, so that you can work out deals that help our members, even if it's a little bit not strict by the book, but it's where you can manipulate it." Certainly, Susanna's intentions seemed to be in the right place, her commitments to the workers she represents undiluted. Yet it did seem that her friendship with those in human resources, her understanding of "the game," might leave her more disconnected from her constituency than she was when she started.

CONCLUSION

Through detailed case studies of three hospitals within the same California community, this dissertation has demonstrated the ways in which different organizations contest the commodification of hospital care. Each organization confronts the market both with a set of ideas about the mission of hospital care and with a set of organizational structures and practices. At Community Hospital, care is regarded by many physicians and nursing staff as a right, and these practitioners work haphazardly against a market that continuously threatens their capacity to provide care for all. At Memorial Hospital, leaders and some segments of the nursing staff understand hospital care as an emotional and spiritual good, yet these understandings frame an approach to care that in many ways is the most market driven, and the hospital comes to resemble a luxury hotel. At Kaiser, care is regarded by many different constituencies as a technical undertaking made possible by organizational integration, information technology, evidence-based medicine, and the "right" kind of incentives.

This dissertation also makes broader contributions to economic sociology, medical sociology, and the sociology of work. Throughout the dissertation, I have sought to bring Polanyi's critical edge back to the cultural sociology of the market. Like Polanyi, this study suggests that in any society certain commodities are contested. They are treated as commodities to large extent, bought and sold on a market, but in other ways their commodification is understood as problematic. Consistent with sociologists in the "moralized markets" school, however, I observe wide variation in the ways that the market is criticized and acted upon in different organizational contexts. More generally, we can observe societies with different understandings of social rights. We can imagine societies in which the meaning we ascribe to market exchanges is consistent with the non-economic things (like friendship) we now feel would be defiled by the introduction of pure monetary exchange. And the things we do not feel capable of measuring today we might feel able to measure tomorrow.

For Zelizer and others in the moralized markets school, processes of commodification—by which formerly noneconomic goods come to be bought and sold on the market—may change those goods but do not destroy them. For Zelizer (2005, pp. 32 ff.), economic activity takes place across a wide variety of social relationships, and we "mark differences between ties with distinctive names, symbols, practices, and media of exchange." Commodification and exchange do not threaten society but rather help to constitute our "connected lives," and remain embedded within social relationships and social values. Thus, for example, sociological critiques of monetization are unfounded because "[c]ultural and social structures set inevitable limits to the monetization process by introducing profound controls and restrictions on the flow and liquidity of monies" (Zelizer 1997[1994], p. 18).

But Zelizer's theoretical framework does not allow us to distinguish between limits like the mental sorting that people use to earmark their own money (Zelizer 1997[1994], pp. 71 ff.) and limits like state regulations around welfare payments (Zelizer 1997[1994], pp. 119 ff.). Furthermore, as the case of Memorial Hospital suggests, some cultural and symbolic "limits" are perhaps better understood as *masks* for economic domination. For example, based on her own analysis, different conceptions of "domestic money" (Zelizer 1997[1994], pp. 64 ff.) may have helped to sustain intimate relations

between couples, but these conceptions also seem to have helped mask men's ongoing economic domination of women in the household.

Furthermore, by discussing the "inevitability" of limits to commodification, Zelizer's approach preempts an examination of the different sorts of struggles against commodification and their different effects. This dissertation highlights how people understand commodification as problematic in different ways, and so challenge (and enable!) market society in different ways. And while the dissertation focuses on hospital care, one can easily expand the analysis to other sorts of things. For example, one might imagine an environmental group's campaign against the commodification of a rain forest. The group might argue that its sale violates the right of the people and animals that depend on it, and that it should be kept distinct from market mechanisms entirely. On the other hand, they might argue that its commodification threatens to erode something about its essential nature. The proposed solution in this case might be to couch market activity within an institutional framework in keeping with these threatened essential values: an ecotourism business, for example, that works to sustain the forest's spiritual aura. Finally, they might argue that the price of the forest must adequately reflect its worth to the people and animals that depend on it—externalities that would likely not enter into a standard real-estate calculation. In this case the problem is a technical problem, and the solution might be to adjust the price so as to more accurately measure what the forest is worth.

The dissertation also brings a new perspective to an old debate within the sociology of the profession about the relationship between professional work and the market. Different organizational logics and structures make possible very different relationships between physicians' economic interests and their professional commitments (see Stark 2009). At Community Hospital, where care is protected as a right, doctors struggle to uphold an ideal of the profession as an altruistic and cooperative community that mitigates the influence of capitalism. In this way, doctors at Community seem to embody a model of professionalism predominant among thinkers of the early 20th century (Durkheim 1984[1933]; Haskell 1984; Tawney 1921). At Memorial, in contrast, care is commodified at the same time its non-economic, spiritual character is emphasized. Likewise, here, doctors' professional identities seem to serve as a cloak of legitimacy for their own entrepreneurship. In this way doctors at Memorial seem to provide evidence for a critique leveraged against professionals since the 1970s: that professionals have come to constitute a new dominant class or serve as a new source of legitimacy for an older bourgeoisie (Bell 1973; Konrad and Szelenyi 1979; Larson 1977). At Kaiser, finally, care is regarded as a set of discrete and measurable inputs that can be allocated efficiently across the system through scientific medicine and standardization. Here, doctors' work seems to have been disciplined through an extensive bureaucracy (Reich 2012), providing some support for scholars of the deprofessionalization or proletarianization of the profession (Aronowitz 1973; Huag 1973; McKinlay and Marceau 2002; Navarro 1976).

What is unclear in my analysis, of course, is to what extent these organizations *shape* the understandings of their respective physician staffs, versus the extent to which physicians select into the organizations that foster understandings of care most resonant with them. While this may be a fruitful avenue for future research, what my dissertation

demonstrates is the ongoing relevance of alternative visions of the profession, and the ways in which different organizational forms support these alternatives.

Finally, this dissertation demonstrates the critical roles that organizational culture and structure play in the possibilities for worker power and organization. At Community Hospital, the lack of role differentiation and the general level of disorganization fostered a collegial and familial atmosphere that seemed in some ways to sap the potential for a powerful workers' organization. Practitioners' commitments to providing care as a right seemed also to weaken workers' motivations to make claims on their own behalf. Simultaneously, however, the hospital's history as a public institution created possibilities for workers (and other practitioners) to build coalitions with the local community, tying workers' interests to the public interest. At Memorial Hospital, in contrast, leaders and administrators had historically used Catholic values to maintain a rigid hierarchy among staff. The Sisters who founded the hospital were consistently invoked as exemplars of obedience and martyrdom in whose footsteps workers were encouraged to follow. When workers successfully challenged their own subordination, as they did in their campaign to unionize, they did so by appealing to Catholic ethics and Catholic values. At Kaiser, finally, workers were strictly differentiated but fully incorporated into the bureaucracy. Through workers' participation in a strong union and an innovative labor-management partnership they were able to have a voice in their workplace, while the organization was able to secure a predictable and reliable supply of labor.

When workplace culture is analyzed in relation to worker power, it is often treated as a tool that managers use in order to generate customer service and organizational subordination (Hochschild 1983) or conversely as an invariant "culture of solidarity" (Fantasia 1988) that workers generate to challenge managerial authority. This dissertation highlights how different social economies at the three hospitals differently shape both the opportunities that actors have to win power and the ways that they think about claiming power in the first place.

Despite increasing market pressures in the American hospital, then, non-economic ideas and practices continue to influence the delivery of hospital care, but do so differently in different organizational contexts. As is suggested throughout this dissertation, hospital care remains between mission and market.

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[42] Keaney called these administrators "kitchen schedulers," suggesting that they did little more than sit at home and schedule other doctors' work.
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[46] See Memorial Hospital's settlement with National Labor Relations Board: Case 20-CA-32414-1 (2005). See also "A Report on Workers' Right to Organize at Santa Rosa Memorial Hospital, St. Joseph Health System," by the Fair Election Commission Sonoma County, California (August 2005). This commission, made up of several community leaders and organized by the union, documented the hospital's anti-union campaign in great detail.
[47] Given internal union politics outside the scope of this study, the system never actually negotiated such ground rules before the election took place.
[48] See Jim Rutenberg and Jackie Calmes, "False 'Death Panel' Rumor Has Some Familiar Roots," *The New York Times* (August 13, 2009), p. A1.

[49] Mary MacVean, "Kaiser Farmers Markets Put Nutrition Within Reach," *The Los Angeles Times* (May 20, 2009).

[50] Gawande, Atul. "The Cost Conundrum: What A Texas Town Can Teach Us About Health Care," *The New Yorker* (June 1, 2009).

[51] According to one specialist, income inequality within the physician staff grew as the system began to have trouble hiring sub-specialists in the early 1990s.

[52] "The American Recovery and Reinvestment Act of 2009" allocated nearly $19 billion towards the implementation of electronic medical records systems.

[53] Northern California Office of the Kaiser Permanente Labor Management Partnership, "Unit Based Teams: Frequently Asked Questions."