WALLFLOWERS TO GLOWING BELLES:

THE SOCIAL TRANSFORMATION OF PHYSICIANS

IN PRACTICE

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CHAPTER ONE

INTRODUCTION

The purpose of this research is to examine the social consequences to physicians resulting from the structural consolidation and system integration of the healthcare industry in the United States from 1980 to 2000. These twenty years saw some of the greatest changes in the history of American healthcare. The economic demands of those paying for healthcare translated into major revisions of the social structure, business organizational relationships and financing mechanisms of physicians, hospitals, and health insurance plans.

The current structure of the healthcare industry in 2000 is characterized by large, integrated healthcare systems composed of general and specialty hospitals, primary care and specialist physicians, and multi-structured health insurance plans. These systems encompass metropolitan and contiguous rural areas, various distributions of primary and specialty physicians, and a plethora of payment mechanisms for healthcare services, including prepaid components. These organizations, some not-for-profit and some investor-owned for-profit entities, developed in response to the need for common financial incentives among components of the health system, and the search for economies of large scale operation, with reduced operating expenses from consolidation.

By contrast, in 1980 the industry's dynamic of hospitals, doctors, and insurance companies operated differently. At that time the industry was

composed of independent, stand-alone hospitals, mostly organized as not-for-profit community service operations; physicians in solo practice or small groups of the same specialty; and indemnity health insurance programs offered by nearly every company in the life, or property and casualty insurance industry.

Over the last 20 years, the dynamic interaction of these three groups changed the medical care equation considerably. In fact an historical comparison reveals the changing nature of this dynamic. The research question is simply stated, but more complex to understand and analyze. It is this: what social forces propelled these changes and what has been their impact? Before examining the details of this research project, readers can appreciate the importance of change by noting the magnitude of often unanticipated consequences. The dynamics of interaction lead to a new mix of healthcare operational realities.

These dramatic changes have come not only at the expense of physician autonomy, but also at the operational autonomy of the hospital and health insurance industries as well. The insurance companies have consolidated to the point that three or four national health insurers are all that remain from the more than fifteen in 1980. Hospitals have been bought, sold, traded and merged in record numbers over the last twenty years, keeping the Federal Trade Commission and state antitrust regulators busy. The mergers in both of these industries have been the result of attempts to consolidate market share, eliminate competition, reduce overhead, or secure additional revenue streams. In addition, hospitals and insurance plans have been involved in a variety of attempts at

vertical integration, in which complementary businesses are consolidated in the same entity at successive positions in the normal course of operation.

The environmental issues that drove the integration of physicians, hospitals, and health plans into consolidated organizations also resulted in the formation of an entirely new industry—physician practice management companies. This new industry development was driven both by doctors trying to escape the control of integrated systems, hospitals, or managed care companies and was fed by public ownership and the stock market's quest for growth. In the same way, a new profession of doctors as administrators also developed as a way to ease the loss of autonomy and incorporate a broader range of business management expertise into the practice of medicine.

In looking at the totality of change that took place in the healthcare environment, a presupposition might be that the greater social consequence was experienced by the hospital industry or the health insurance industry. However, their experiences were not that different from those experienced by other organizations in the banking or airline industries in their recent mergers and acquisitions. You might also suppose that the physician practice management company alternative or the physician administrative job opportunity would offset the negative effects on physicians from this integration.

But the working hypothesis is that, by far, the most radical changes in healthcare over the last twenty years happened to physicians. Their traditional autonomy—they are among the most independent classes of people in the American economy—has been assaulted from many different sides. They have,

by choice or pressure, consolidated into larger practices with peers in their own specialty, merged with physicians of other specialties into multi-specialty group practices, and/or have become employees of hospitals or insurance companies in record numbers. Since most physician practices were part of a cottage industry until very recently, nearly every doctor in practice 10 to 15 years ago was employed in a relatively small organization of which he or she was an owner. The consolidations, mergers and acquisitions of these small organizations produced significant consequences to patients, employees, the families of physicians and the new employers. At the center of this mix stood the physicians who adjusted to their new and less powerful work responsibilities. Once physicians' roles were associated with autonomy, independence and total control. They exchanged those for security and money by joining a corporate group practice. It is the effects of transition from being the outright owner of a small company to becoming an employee of an integrated healthcare delivery system, corporate group practice, or hospital that is the research topic.

Part of the impact on physicians is the result of their choice to be associated more closely with other physicians for social and business reasons, and part is the result of the healthcare system reacting to changing demands of those paying for healthcare. On the one hand, social integration involves an examination of the relationships between people in the industry, and on the other hand system integration looks at the relationship between parts of the system. The social context in which these changes took place can be divided into three parts, which will be explored in order to understand the causes of social change:

A. The economic reconfiguration of the healthcare industry with its changing payment plans and move to vertical integration.

B. The changing occupational structure as primary care physicians assume a central place in the physician culture. One advisor to a medical school practice plan said they transformed "from wallflowers to glowing belles of the ball" (Mangan, 1994:24).

C. Individual physicians who described the reasons for their decision to change employment structure or keep the preexisting structure.

These issues involving the consolidation of the American healthcare industry will be examined in light of a theory developed by a British sociologist, David Lockwood, in 1964, that compares social integration and system integration as explanations for changing social structures.

Theoretical Framework

The British sociologist, David Lockwood (1964:244), examined the similarities and differences between social and system integration and their effect, if any, on social change and reported on them in an article published in 1964 in *Explorations of Social Change,* edited by George K. Zollschan and Walter Hirsch. Lockwood's stated purpose was "to discuss some of the implications of recent criticisms of functionalism, especially those which have a bearing on how social change is internally generated in a society". His thesis was that critics of functionalism had become over-focused on social aspects,

tending to ignore the system integration aspects of social change. He distinguished between the two in this way, "social integration focuses attention upon the orderly or conflictual relationships between the *actors*", while "system integration focuses on the orderly or conflictual relationships between the *parts* of a social system" (1964:245).

Lockwood used compelling components of conflict theory in analyzing Ralf Dahrendorf's and John Rex's criticisms of normative functionalism. Lockwood said "the major criticism of normative functionalism is that it treats institutions primarily as moral entities, without rigorously exploring the interplay between norms and power that is universally present in major institutional contexts" (1964:246). In this way, Rex recognized the role of power as an element of social systems and social change.

> We have also to recognize that some of the ends which the actors in our system pursue may be random ends from the point of view of the system or actually in conflict with it. If there is an actual conflict of ends, the behavior of actors towards one another may not be determined by shared norms but by the success which each has in compelling the other to act in accordance with his interests. Power then becomes a crucial variable in the study of social systems (Rex, 1961:112).

Various sociologists have commented upon Lockwood's original article, most notably Jurgen Habermas, Anthony Giddens, Margaret Archer, and Nicos Mouzelis. While their comments mainly focused on the purity of the functionalist interpretation of social and system integration undertaken by Lockwood, they

also had some thoughts useful in the application of Lockwood's theoretical distinction to the healthcare marketplace. Mouzelis, for example, contrasted social and system integration in a way that has particular relevance for physician integration. "From a social integration perspective the focus is on concrete actors and their relations/interactions in time and space" (Mouzelis, 1997:113). This aspect of social integration is the focus of physicians and administrators as they struggle to find a different way to interact because of the changing dynamic of the healthcare system.

> The much more complex issues of relative power arrangements and conflicts between institutions in the healthcare system is described as "the system integration perspective (in which) the focus shifts to institutional complexes as a virtual order of rules/norms which, in Giddens' terminology, are instantiated only when actors draw upon them in order to act or interact in specific situations" (1997:113).

In other words, the norms demanded of physicians as employees of large health systems are dramatically different from the norms expected of them as owners of their own small businesses. And the demands imposed by hospital administrators may or may not improve with integration.

> You're in the unusual situation where you're a CEO and yet the huge majority of what you deal with is not under your control. The medical staff controls your environment. Not to mention lawmakers manipulating

> Medicare reimbursement and HMO utilization reviewers second-guessing every decision (Greene, 1997b:28).

The conflict between health administrators and physicians, that has existed as long as doctors admitted patients to hospitals in a free market economy, is altered again when physician practices are integrated into the same corporate entity with the hospital. Habermas' writings are perhaps even more to the point.

> From the point of view of social integration, action co-ordination is based on 'a normatively secured or communicatively achieved consensus'; whereas on the level of system integration, co-ordination is based on the systemic steering media of money and power that regulate actions more or less 'automatically.' In this latter case, action co-ordination is assured by systemic mechanisms operating behind the actors' backs so to speak, i.e. by mechanisms necessitating neither normatively reached agreements nor mutual understanding (Habermas, 1987:117).

There is no question that the systemic steering media of money and power regulated the actions of physicians causing them to become employees. This happened even when the normatively achieved consensus of doctors would be for them to remain independent and autonomous from hospitals.

Giddens, like Lockwood, phrased a similar dichotomy as Lockwood that seems clearer in addressing social and system integration as it applies to healthcare integration. His analogy to system integration is institutional analysis,

and for social integration it is strategic conduct (Mouzelis, 1997). Doctors have had to conduct their relationships with administrators, insurance executives, and even other physicians, strategically in order to secure their long-term access to patients in the managed care economic order. The system integration drives their new roles.

For purposes of this study, the relationship between physicians and complex organizations is a perfect laboratory to study how conflict impacts social change. In the last two decades of the twentieth century, the societal upheaval in the American healthcare industry has totally changed the cottage industry in which physicians have practiced medicine for two hundred years. One of the results of this change process is the integration of physicians into new business organizations with hospitals and health plans, collectively referred to as health systems. While the impetus for this change in business organization emerges from changing economic incentives of physicians, the impact on physicians results in a totally new relationship among physicians, hospitals, and health insurers.

Observing two decades of the American healthcare marketplace, one could intuitively accept the assertion by both Dahrendorf and Rex that "social change is a result of the shifting balance of power between conflict groups" (Lockwood, 1964:249), especially if you define physicians, hospitals, and insurers as conflict groups. In the past physicians exercised incredible independence from hospitals and health insurers because of their primary relationship with patients. Along with their patients doctors made decisions as to

which hospitals the patients utilized. The insurer's relationship to patients and doctors was secondary to the patient's relationship with the doctor because the doctor's ethical and economic contract was with their patients. The insurer's contract with patients was typically an indemnity arrangement in which patients were reimbursed for physician and hospital services selected by the patient within certain broad limits.

In the 1970s the economic consequences of these fee-for-service arrangements were seriously questioned by third party payors, including the government. An early development (1983) that changed the healthcare social sector centered on the implementation of a new payment methodology for hospitalized Medicare patients. That methodology resulted in hospital payments being determined prospectively, by the diagnoses recorded by the admitting physician for each patient admitted to the hospital, rather than simply being the accumulation of charges for services ordered by the doctor during the hospital stay. This was a significant change since, until then, physicians had almost total control over the services provided to patients in hospitals, and a considerable amount of control over the cost of those services. By itself, this change in hospital payments produced a new set of conflicts between doctors and hospitals since it represented a significant shift in the balance of power. In the change to prospective payments based on diagnoses, the doctor's pen became a source of cost, not revenue, to the hospital.

The change in hospital payments alone didn't sufficiently change the slumping economics of healthcare. Therefore, the next targets of third party

payors were the physicians themselves. Several control methods were attempted including pre-admission or pre-procedure certification. Here physicians needed to seek permission from the payor before a compensable service could be provided. Further limitations on payment saw payors capitate groups of physicians. They did this by prospectively providing a certain amount of money each month to a group of physicians for the care of a certain group of patients. The effect of these capitation limitations, regardless of the cost of the medical care rendered, changed the balance of power between doctors and third party payors. It also exacerbated the growing conflicts between hospitals and physicians. Hospitals were the repositories of considerable amounts of capital; physicians were not. American hospitals reacted to the power shift in their favor by boldly seeking to capture the revenue streams previously managed by doctors. So hospitals used their accumulated capital reserves aggressively. Physicians were losing most power conflicts to the complex organizations. Power and control of not only access to the patient but autonomy in prescribing treatment, and reimbursement for such, was slipping away from the physicians.

The works of Karl Marx and Max Weber are integral to a study of conflict and complex organizations. Lockwood (1964:249-250) recognized that it is precisely Marx who clearly differentiates social and system integration. The propensity to class antagonism (social integration aspect) is generally a function of the character of production relationships (e.g., possibilities of intra-class identification and communication). But the dynamics of class antagonisms are

clearly related to the progressively growing 'contradictions' of the economic system (system integration).

Physicians have traditionally focused on "intra-class identification and communication." This way they maintained their professional autonomy, and a strong "propensity to class antagonism" against hospital administrators and third party payor managers. The growing contradictions in the economic system provided considerable impetus to doctors, hospitals, and health plans to change the nature of class relations through integration.

Lockwood (1964:253) looked at Weber's views of patrimonial bureaucracy as "the core institutional order of the society and as a major point of reference for societal change". Weber's theories are more relevant to the integration of physicians, moving from their small business entities of the past into much larger bureaucratic structures. Weber (1948:205) stated that "a certain measure of a developed money economy is the normal precondition for the unchanged and continued existence, if not for the establishment, of pure bureaucratic administration". The interests of the integrated system comprise cross-subsidies and shortfalls of individual units. These are also necessary for survival of the integrated entity. Lockwood believed "the centralizing goal of bureaucratic institutions is constantly liable to sabotage by the potential social relationship structure of the subsistence economy which favors the decentralization and 'feudalization' of power relationships" (1964:254). Weber (1948:205) continued "a stable system of taxation is the precondition for the permanent existence of bureaucratic administration". It is cross subsidization of individual components

through systems of taxation of moneymaking system components that supports the administration and remains essential for the health system's success.

The results of these changes are shifting power dynamics: payors sought to limit the decision-making authority of physicians in order to save money; hospitals sought to control the economic decisions of physicians for inpatients; both hospitals and third party payors sought to hire physicians as employees in order to more effectively control them. Moreover, physicians sought to counter these limitations on their autonomy in a variety of ways, including consolidating their practices into larger economic units for bargaining purposes. They also established their own health plans and purchased or built their own hospitals.

Significant conflict resulted from these power struggles, and a play on words of Lockwood's views of system integration is particularly relevant to conflict theory (1964:252). Substituting *physician* for material and *hospital* for institutional results in this summary:

1. One generally conceivable source of tension and possible change in a social system is that which arises from a 'lack of fit' between its core *hospital* order and its *physician* substructure.
2. The *physician* substructure in such a case facilitates the development of social relationships which, if actualized, would directly threaten the existing *hospital* order.
3. The system will be characterized by a typical form of 'strain' arising from the functional incompatibility between its *hospital* order and *physician* base.

4. The actualization of the latent social relationships of the system will depend on the success with which groups having vested interests in the maintenance of the *hospital* order are able to cope with the dysfunctional tendency of the system in the face of particular exigencies.

5. If these exigencies lead to an intensification of the functional incompatibility of the system, and if compensating measures by vested interest groups lead (unintentionally) to a further actualization of the potential social relationships of the system, a vicious circle of social disintegration and change of the *hospital* order is under way. If, on the other hand, compensating measures are effective, the *hospital* order will remain intact, but the focal point of strain will continue to be evident so long as the functional incompatibility of the system persists" (Lockwood, 1964:252).

There is no question that the healthcare social system has undergone substantial change and, some would say, disintegration, as a result of the changing power relationships between hospitals, health plans, and physicians over the past twenty years. Of particular concern is the ability of physicians to maintain their historical autonomy and power position in the face of a changing economic and social order. Combining Lockwood's theory with my pre-existing involvement in the integration of the healthcare industry results in the following research questions.

Research Questions

The purpose of this research is to develop a more rigorous, systematic study of the conflict theory components of system integration of physician practices with hospitals and health plans. Through these efforts I hope to assess the validity of Lockwood's theory, described earlier. Specifically, the research questions are these:

1. How much of the integration is driven by the changing power relationships between physicians, hospitals, and insurance companies, and how much is simply the result of the converging economic interests of those three groups?

2. Similarly, how responsive are the resulting integrated organizations to the power conflicts that are inherent in such combinations?

3. Do the governance structures of the new entities reflect a mix of the new economic realities and an accommodation of prior existing conflicts of power?

The history of physician-hospital relationships led many physicians to question whether a corporate practice model, involving a hospital-related entity as their employer, could satisfy their professional needs. Physicians generally see

hospital administrators as the enemy. They are intent on frustrating doctors' attempts to get what they want. In addition, hospital bureaucracies are unintelligible and unnecessarily complex compared to the simplicity of the doctor's office. The reality of the healthcare environment, however, is that the government and managed care entities have already made the simplicity of the past disappear, never to return.

Significance Of The Study

This study examines emerging phenomena in the healthcare marketplace—the transformation of a significant segment of the provider market from solo independence to corporate practice—both as a social transformation and as a study in complex organizations. A theoretical linkage exists between recent changes in healthcare systems for physicians and Lockwood's (1964: 244-256) analysis of social change. He described social change as part social integration, "the orderly or conflictual relationships between the actors," and part system integration, "contradictory relationships between the parts of the social system."

The transformation of the medical practice industry from independent, solo or small group practices, to large groups, vertically integrated with hospitals and insurance companies occurred as a result of a variety of social factors. From the system integration perspective, it could be argued that the explosion of healthcare costs over the 1970s and 1980s provided unfortunate incentives that propelled both the fee-for-service payment system for physicians and the cost

based, fee-for-service reimbursement mechanism for hospitals. The act of containing that explosion of costs through prepaid, risk-oriented payment methodologies for hospitals and doctors resulted in a completely different dynamic among employers, doctors, hospitals, and third party payors, and resulted in social change of mass proportions for the entire healthcare industry.

In the same way, the relationship among individual physicians, hospital administrators, insurance company executives, and employer representatives changed as a result of the explosion of costs. Norms, roles, and status issues for each of those groups changed dramatically as employers told insurance company representatives they were no longer writing blank checks to pay whatever healthcare costs were incurred. Insurance company executives started questioning what doctors did in exam rooms and operatories. Hospital administrators started telling doctors "NO," and doctors started banding together in larger groups to combat their loss of power.

This study examines some of those issues from several sources. Given the paucity of scholarly reviews of the social transformation's impact on physicians, I studied integration activity reported in trade journals. Reported incidents served as a proxy for the relative interest of these issues to physicians and healthcare executives. The contents of those journals also served as historical archives from which to gather contemporary, relevant data on the social transformation. And finally, I interviewed individual physicians from two groups—one having joined a complex health system as employees, and one having rejected the employment opportunity to remain independent. My goal was

twofold: to get a quantitative measure of the integration issues of importance to those in the industry and to contrast the data reported in the national healthcare press with the actual lived experience of individual physicians.

CHAPTER TWO

REVIEW OF THE LITERATURE

This study examines vertical integration in the healthcare industry as a reaction to one primary stimulus—healthcare cost reduction pressures. This driving force resulted from the changing structure of the political economy where physicians, hospitals, and insurance companies operate. As a former senior healthcare executive, this research effort allowed me to unravel and come to a more complete understanding of my professional experiences, in light of this driving force. During the period under study, my experiences ranged from developing and managing networks of hospitals, to creating and purchasing physician practices (hiring and firing physicians), to creating an HMO from start-up. Having lived through the changes described in this research means that mine is a unique perspective. My roles in observing and making these changes happen were complex and varied, at least for one healthcare marketplace. But my recent mid-career shift (sociology graduate student), provided time for interpretive reflections of the changes and experiences. Musing over and filtering though my former profession, allowed me to bring administrator decisions to library shelves. I shifted from being a manager of change to an observer and analyst of the social reasons behind the change. This literature survey naturally reflects some of both sides of my managing change and analyzing change.

The survey begins with a review of vertical integration in the healthcare industry (consolidation in the healthcare industry). Issues surrounding integration emerged as my career as a healthcare executive progressed. Since vertical integration issues centered around three groups, my decisions were influenced by the perspective of hospitals, the perspective of physicians, and the interests of the HMO industry. While models of integration vary, each one culminates in vertically integrated organizations that combine all three elements.

This research evaluated the social implications for professionals in complex organizations. Review of the literature of organizations, including organizational improvement and development in industrial organizations and healthcare entities, as well as labor market analysis and the dynamics of power in organizations was conducted. Classical sociological writings on bureaucracy and social psychology of organizations are important as they relate to discussions of professionals and collegiality.

Finally, the reader finds other sociological implications for vertical integration, issues such as the history of development of the political economy and the study of social movements. The study of these last issues brought me back academically, as it were, to the reason for my beginning this graduate study. Some relevant questions here are these: What are the social implications of vertical integration? What is behind the movement of significant numbers of physicians from private practice to employment in complex organizational structures? What were the effects of the drastic change in the manner in which society chose to compensate providers for their services?

While this study is about medicine and sociology, except for understanding the medical mindset, it is not much about medical sociology. Medical sociology examines things like the patient-physician relationship, the nature of the medical mind, the medicalization of deviance, and the social construction of illness. Reviewing social science literature indicates that books and articles in medical sociology cover social issues of specific disease processes (AIDS or breast cancer). These topics, while very interesting, are not really related to the subject matter of this dissertation. One key piece of research that preceded this study was done by Paul Starr (1982). His book chronicled the growth of medicine as an autonomous profession and the most powerful force in the modern healthcare industry. He looked at the history of medicine from 1760 through 1980, but was able to report only the beginnings of the trend toward corporatization as a response to the shifting payment arrangements. In many ways, this study picks up where his left off. One key section of his book points out this unusual time for the medical profession, coming as it does at the beginning of the Reagan revolution:

> the medical profession, in protesting against government regulation, wants a return to the traditional liberties and privileges of private practice. But at least in medical care, the reliance on the private sector is not likely to return America to the status quo, but rather to accelerate the movement toward an entirely new system of corporate medical enterprise (Starr, 1982:419).

Consolidation in the Healthcare Industry

The reorganization process occurring in many healthcare delivery systems today, tries to provide the following: all the components of the delivery system with appropriate incentives to guide activities designed to provide quality care at relatively low cost to enrolled patients (members). Some of the first attempts at addressing healthcare cost reduction were focused on horizontal integration. Hospitals, especially, believed that larger aggregations of hospitals could save money through economies of scale by purchasing, as a group, supplies and equipment from common vendors. The entire for-profit hospital management company industry grew as a result of that proposition, as well as the additional notion that management could be improved through increased standardization of management practices across a variety of hospitals. Insurance companies experienced more traditional business cycles of consolidation and formation, influenced by the financial industry with its corporate roots and publicly traded mentality. Some medical groups tried similar strategies, although the transition away from solo practice or small single-specialty groups was a huge step before the transition to capitated payment methodologies.

But the truly radical transformation of the healthcare business began with the introduction of capitated payment mechanisms as a solution to the explosive increases in medical costs. The diversity of ownership of the key parts of the system was an impediment to risk sharing. Primary care doctors were placed in a much more strategic role as "gatekeepers" under capitated systems. The

strategy of capitation is to provide appropriate healthcare service in the part of the health system with the lowest cost. Primary care physicians assist that by taking care of increasingly more medical problems, rather than referring them to more expensive subspecialists. They also attempt to keep people out of the hospital, the highest cost component of the system.

> One of the lessons learned is that hospitals and specialists are taking a significant risk if they continue to rely on a traditional system where primary care physicians, usually operating independently in solo practices or small groups, refer patients to specialists who are major users of the hospital. The end result is that primary care physicians will soon lose the last vestiges of their freedom to refer patients to the specialist of their choice (Coddington, Moore, and Fischer, 1994:72).

But there was a legal downside to that commonsense statement. Antitrust regulators generally viewed vertical integration, that is, multiple steps in the food chain combined in one economic entity, as reducing competition. However, the addition of managed care plans into a market, with the ability to use any of a number of integrated systems, changes that prohibition.

> Because they direct patients to lower cost health care providers, managed care plans have reduced the physician's role as the patient's agent in selecting other medical providers. By reducing the importance of the physician's role as the patient's agent in selecting other providers such as a hospital, managed care eliminates one of the major reasons

> for keeping physicians and hospitals independent. Physician-hospital integration can take several forms. A hospital that employs primary care physicians would be one example of vertical integration. Another example would be a physician-hospital organization (PHO), a separate legal entity through which hospitals and physicians market their services collectively. In the current health care environment, these types of integration between a hospital and physicians may offer several advantages over the more traditional marketplace or contractual relationship between a hospital and physicians (Simpson and Cooke, 1998:376-7).

Even aside from the substantial legal issues involved in consolidation, this has proved to be much more difficult than it might appear philosophically. As Jeff Goldsmith said, "there is a certain dynamic tension that is lost when hospitals, physicians, and health plans are combined in the same organization" (Goldsmith, 1995a:55). Physicians traditionally had the closest relationship with their patients compared to health plans and hospitals. That is, once a doctor-patient relationships were established, patients bought health insurance that permitted them to see their doctor, and went to the specialist physician or hospital chosen by their doctor. The doctor was responsible to his patient.

> Managed care both modifies the traditional relationship and introduces a second relationship into the equation, that of the physician and the

> managed care organization to which the physician is also accountable. Under capitation and related forms of managed care, physicians are asked to consider the incremental benefit of a treatment to their specific, identified patient (the one with whom they have established a physician-patient relationship), not some abstract member of a population or group. They are expected to weigh that benefit against the incremental cost of that treatment to the patient and the managed care organization when making decisions (Shortell et al. 1998:1102).

The process of putting just two of those elements, physicians and hospitals, together is difficult enough, especially if the hospitals are not-for-profit. Not-for-profit hospitals are organized around, and driven by, a mission; physician organizations are typically driven by the small business motive of profit. As Peter Drucker put it, "non-profit institutions generally find it almost impossible to abandon anything. Everything they do is 'the Lord's work' or 'a good cause.' In an economic cause, one asks: Is this the best application of our scarce resources? There is so much work to be done. Let's put our resources where the results are" (Drucker, 1992:111).

Physician organizations have become very proficient at putting their resources where the results are, and in the process taking over revenue streams that have traditionally belonged to the hospital. Large, independent, physician organizations are typically a hospital's biggest competitor for most ancillary services. Combining such organizations into one forces conflict over revenue

streams that, if managed properly, can be the salvation of the combination and its demise, if not. The process of independent specialty physicians working collaboratively with a health system sponsored, primary care group to accomplish a cost effective, high quality, fully capitated managed care plan is about as complicated a scenario as one can find. The primary care doctors have traditionally been seen as second class citizens among the medical staff members of tertiary, sub-specialty hospitals. If you add the fact that some health systems have purchased the primary care doctors' practices, and not the specialists' practices, in order to establish their sponsored medical groups, you get an idea of the complexity of the integration process. Physicians have a tendency to believe that those physicians who integrate their practices with hospitals or health systems have "sold out" to them and are inappropriately beholden to them, as result. It creates a division in the medical staff that wasn't present before, and it spills over into other business issues between referring doctors (Coddington et al. 1994:48).

When a health plan is added into the same organization as hospitals and physicians, a truly new component is introduced to the system. Hospitals and physicians have, in the past, each made their money by seeing patients; health plans, on the other hand, have made their money by collecting premiums from members they hope will never require medical services. While health plans have for a long time operated physician practices or even hospitals, it is only recently that providers have gotten into the business of taking the financial risk for the health care of given populations. The assumption of risk is based on the premise

that any other arrangement will not succeed in meeting the needs of all parties to the union, and will result in failure to maximize the potential opportunity (Nash and Parks,1996:81).

It is now viewed as essential to have this health plan component in a truly integrated health system. One of the executives involved in the subject matter of this research project said that if the physicians and health plans were going to share the stream of insurance payments, and reduce the numbers of patients in her hospital, she better make sure the hospital shares in that revenue stream. Consultants could be found who would argue that hospitals should remain hospitals and not make a transition to an integrated health care system, but that number dwindled in the 1990s. The opportunity to combine organizations and align financial incentives between payors, primary care physicians, specialists, and hospitals was just too great a dream, even though everyone acknowledged implementation would be very difficult (Coddington et al. 1994:90).

The leadership of primary care groups must spend considerable political capital in building the group, and making it effective. Large medical groups and health systems have spent considerable resources developing primary care capacity for the eventuality managed care would require it. But some experts think it requires more than the threat of managed care. "Hospitals need to make sure that buying physicians' practices in exchange for giving physicians a measure of management and policy making authority is compatible with their operative goals such as reducing costs and delivering specialized services in addition to primary care" (Kane and Duke, 1996:51). Specialists have invested a

lot of time and energy in remaining independent of hospitals, and in some cases, diverting the hospital's revenue stream to themselves.

The key, however, to securing the collective future of the primary care doctors, the specialists, and the hospital, is to focus on a common future, whether through collaboration against a common enemy or joint development of a substantial enterprise. That requires trust and a willingness to look out for the interests of the collective before the professional's personal interests. Each step of the process is accomplished with a significant amount of communication, disagreement, and compromise. Especially with regard to physicians, this communication needs to be focused on conflict resolution.

> A central issue involves power and control. The consensus is that the struggle for power and control reflects tension between clinicians and managers over loyalty to the two masters they must serve: patients and the organization. This tension manifests itself in issues of leadership, vision and mission, culture, decision-making skills, managing conflict, and the alignment of compensation and incentives (Shortell, et al, 1998:1102).

In a lot of these integration scenarios, the players were interested in gaining experience with a capitation payment methodology, while securing their revenue stream and patient base. The key element in devising a program beneficial to all parties was trust. Trust does not come easily in the beginning stages of integration. There is a whole generation of physicians who were

trained not to trust hospital administrators, and hospital administrators view their work as supporting the community, as opposed to physicians who are looking out for themselves. While both of those viewpoints are unfortunate, they must be put aside for integration efforts to be successful. One study of health care mergers, both successful and not, found several key elements essential to successful integration efforts, including a willingness to cooperate, a preference for open communication, an attempt to respect all viewpoints and to seek common ground, and a willingness to give up control and share risk (Lowery, 1997:122).

Only recently has the movement of doctors from private practice into more complex practice structures in America received much academic attention. Stephen Shortell, formerly a professor at Northwestern, is a well-known and widely publicized lecturer to physicians and health care administrators. He, and others, published an article in 1998 on attitudes and behaviors of physicians in integrated systems (Shortell, et al, 1998). This research used a mail questionnaire to survey physicians as to their attitudes and behaviors as a result of having integrated their practices with hospitals in Arizona. While these were mostly hospital-based specialty physicians that have relatively minor, if any, practice outside the hospital, some of the findings were useful for this study. For example, they found that salaried physicians sense less autonomy than independent physicians. They also found more of a sense of trust and commitment between salaried physicians and the hospital administrators than that which existed between independent doctors and hospital administrators.

The salaried doctors also felt a stronger sense of voice in that relationship (p. 105).

Professionals in Organizations

Hospitals are among the most classic forms of bureaucracy in the modern economy. They are typically hierarchically structured with very well documented rules governing performance. People in key roles are accorded a high level of respect by virtue of their position, regardless of their ability or knowledge. Budgets control much of the activity that transpires between departments, so that each department acts based on predetermined estimates of what is expected of them, controlled by a higher authority. One recent observer of American business, Robert Jackall, wrote about the contrast between the classic bureaucracy of Weber's Prussia and that which developed in American business and government. His view was that some elements of the big city boss system in politics made their way into the unique form of American bureaucracy so that personal loyalties, rather than predetermined qualifications and performance often put people in various roles. Once in the role, however, they acted much like Weber's description (Jackall, 1988). He also found the work ethic and devotion to position of Weber's Protestant Ethic and the Spirit of Capitalism (Weber, 1992) missing in the American form of bureaucracy. He argues Americans have wrung the spirit and devotion of the Protestant entrepreneurs out of modern bureaucrats, much as Weber's iron cage comments predicted.

Kunda looked at American bureaucracy from the standpoint of symbolic interactionism, rather than structure. His focus was on the merger of ideology and self in analyzing one high-tech company. They had the ability to inculcate the values of the founder throughout the organization because of the organizational reaction down through the layers (Kunda, 1992). Using the language of dramaturgical analysis he described how managers act dependent upon framework. In the front stage, they carried on the necessary upbeat, entrepreneurial dialogue, while in the backstage they were control freaks, in lockstep with their supervisor's commands. His year as a participant-observer surfaced the dominant views of people in the ranks—they were not fooled. In the early stages of the company, people made it to the top as rebels and innovators. Once they got there, however, they maintained their positions by forcing compliance with the culture of normative control.

Morris also wrote that managers should, and must, rely on manipulation to keep workers motivated (Morris, 1975). He believes positive benefits of worker productivity improvement programs are short-term. In the long run they are worthless at maintaining high levels of enthusiasm unless followed by a succession of improvement programs. The resulting spikes in enthusiasm for each program raises productivity and alternates favor among the champions of each new program. Morris cynically views the people's willingness to settle for mundane, tedious, boring jobs in exchange for money. Yet at the same time he criticizes consultants who try to enliven the workplace with creativity and

freedom. Why? Because as he says plenty of people, including those in upper management prefer the stability and security of settled jobs.

Reengineering the American workplace emerges as the solution for an ever increasing need to reduce costs and improve productivity. Some scholars believe these efforts respond to the short term demands of the stock market (Bennis, 1990, Lee,1980, Micklethwait and Wooldridge, 1998, Hammer and Champy, 1993, McGill, 1988). They also detail negative effects bureaucratization has on professionals in organizations. Shapiro describes actual experiences of most reengineering efforts in large corporations this way: most junior consultants from large firms come into complex businesses carrying their calculators and computers full of pre-designed solutions to every business issue they might come across. Their job is to crunch numbers and come up with the combination of templates that will make the numbers look best. Often this is done with little or no regard for the people in the organization, and with little or none of their input. She says "the heavy emphasis on the learned knowledge of the outsiders about the process of reengineering can overwhelm the earned knowledge of the insiders about the substance of their business" (Shapiro, 1997). The thick, messy aspects of organizations define actual experiences of the companies more than the thin, pre-packaged, for public-consumption-only charts, diagrams, and regulations of the bureaucracy.

O'Toole specified three main motivations and methods usually used to effect change: command, manipulate, or paternalize (O'Toole, 1995). While he shows examples of different types of organizations, he prefers an approach that

is spelled out in terms of the attributes of the four United States Presidents enshrined on Mount Rushmore. He is honest about their strengths as well as their shortcomings, making a distinction between personal failure and public betrayal. The key point relevant to professionals is his notion that these four men were known for having hired very strong subordinates who challenged their own statements and actions, rather than yes-people. The commitment to higher purpose and doing the right thing was the main factor that separated these "Rushmorean" leaders, and O'Toole's gallery of Rushmorean leaders in contemporary American business reflects those traits, among others.

Physicians, with or without justification, consider themselves Rushmorean based on the sanctity of their relationship with patients. Physicians' feelings may, however, translate into organizational problems because of their being held to professional standards they consider above the organization. Abrahamsson expanded the concept of bureaucracy as described by Weber, Marx, and Michels. His own theory, based on a combination of rationalism, the structural-functionalist view, and the systems perspective (Abrahamsson, 1993) focused on the process by which goals are established in and for the organization. According to his view of the systems perspective, all goals of stakeholders of the organization are created equal. He rejects this as failing to provide direction; physicians would also reject this since their goals are clearly superior to those of other stakeholders. He also believes it is the administrator's challenge to sort through the competing goals to select those that will guide the organization at any particular time. That notion sets physicians and administrators up as

adversaries, but explains some of the difficulties in maintaining physicians in organizations.

Power issues such as those are present in every organization, although maybe disproportionately so where physicians are involved. With specific emphasis on worker participation rights Bachrach and Botwinick (1992) discuss power issues in the economy. For physicians and hospitals, these power issues are complicated. On the one hand, hospitals are hierarchical and the vast majority of the caregivers in them are in the lower echelons, with low pay and low power. On the other hand, physicians control most of the revenue and costs generated yet they have no official position. Bachrach and Botwinick argue worker organizations can counteract the concentration of power in the hands of corporate owners. Some physicians have formed unions in an attempt to maintain the same participation rights that underclass worker unions are attempting to secure.

Bureaucracy and Collegiality

The Enlightenment changed how people view reality. Rather than a mystical, spiritual focus, the predominant viewpoint shifted to science, rationality, and reason. At the same time, the economic structure became more complicated with an increasing specialization of labor to accommodate an explosion of urban industrialization. The concentration of the labor force brought heightened awareness of common life issues and provided an opportunity for a

unified way of addressing issues. The result was modernity, a new view of the world in which people no longer passively accepted society, but rather they wanted to perfect it through reason and scientific tools. Rather than a "world of wonder", people faced a world to be dissected and analyzed.

Issues of modernity challenged Weber. He analyzed it from several angles, including religion, politics, art, and social structure. His analysis of the best way to manage the business and public affairs of modern society resulted in the development of an ideal type for bureaucracy, a management system described by Weber as the most efficient way to get people in an organization to do what the organization wants them to do. He also thought bureaucracy would eventually make people feel hopeless, as if they had no chance of escape, and no reasonable alternative (Gerth and Mills, 1958).

The result is a rationalization of society that leaves people more in touch with how things work, and less able to select how they should live. The society is disenchanted as a result of the elimination of mystery and the spiritual element in favor of the increasing prominence of science. The increasing self-awareness eventually leaves men less fulfilled, and feeling less completed at the end of life.

Weber's view of human nature seems more complex than other writers. For example, he doesn't express, in these writings, the notion of Hobbes that men need to be protected from themselves through the intervention of an oppressive governmental force. He does seem to view men as pursuing life, liberty, happiness, and property, as they see those things. And the bargain that men make with others in society is really not license for liberty, or the combined

protection of others in the social contract, since he thinks liberty will be gradually reduced with the increasing use of science to perfect society. His expressions are combinations of all those things and more.

His writings on religion indicate that he thinks men in their natural condition are creative and self-driven, in need of structure and a higher authority, but not too much structure. The lengths to which he goes to link the mindset of Protestants in their rebellion from the runaway popes of pre-Enlightenment Catholicism with the same characteristics required of capitalists in the developing economy shows the complexity of understanding he was able to discern. In the same way, his development of the bureaucracy ideal type is still the primer for developing bureaucrats. Many professional training courses in the health care industry begin with Weber to help budding administrators understand the world they have entered. Making allowances for the fact it was an ideal type, there is still a fair amount to be learned that is as relevant today as when it was written.

The use of his own profession to look at the creeping disenchantment and rationalization was useful from a different viewpoint. He could describe artists, physicists, and social scientists—a wide variety of people—using the same analytical tool. In the same way, the combination of looking at professors in two completely different societies of the late nineteenth Century, Germany and the United States provided a more general understanding of the nature of science in society. The result is almost an advance warning of the impact on individuals in a society that is drifting into a modern world from which a headlong pursuit of

advancement will surely cause a step backward in ultimate personal satisfaction and contentment (Gerth and Mills, 1958).

The sociological literature describes the relationship between professionals and bureaucracy from such diverse theoretical viewpoints as symbolic interactionism and structural functionalism. One of the most difficult and interesting groups to encounter as part of a bureaucracy is a group of professionals. There is always a struggle to maintain loyalty to professional standards while also being loyal to the organization, and for many professionals there really is no choice. The entire training program for physicians, for example, is competitive and designed to instill independence, since most of their important tasks demand that ability. Such a spirit is rarely conducive to system integration, however, and the scenario of physicians joining complex organizations like HMO's and health systems as employees, while maintaining their freedom to treat patients as they determine, is now being tested nationally with mixed results. Structural functionalists like Parsons have described organizations of professionals, including physicians as collegiate organizations, in which members "do not carry out their work under the terms of a contract of employment,...but rather in terms of a set of vocational commitments to suprapersonal norms" (Waters, 1989:959)

Blau contrasts Weber's classic statements on bureaucracy with an analysis of collegiality, especially with respect to the contrast between professional knowledge and bureaucratic authority. He describes the difference in very clear terms:

> Professional authority rests on the certified superior competence of the expert, which prompts others voluntarily to follow his directives because they consider doing so to be in their own interest. Bureaucratic authority, in contrast, rests on the legitimate power of command vested in an official position, which obligates subordinates to follow directives under the threat of sanctions. Superior knowledge is not required for bureaucratic authority (Blau, 1974:246).

The conflict of professional knowledge vs. bureaucratic authority does not end with the analysis of physicians and their relationship to patients, however. The conflict continues in the analysis of the business of physician practices and the business of health systems. Physicians have traditionally organized their business affairs as owners of small, simple proprietorships, partnerships, or corporations. Many physicians have also traditionally been bad business people, mainly for the same reasons they make problematic employees; they are simply not trained in a manner conducive to development of the appropriate skills. As physicians become employees of complex health systems in increasing numbers, Blau's recognition of differences between Weber's ideal type bureaucracy that required to deal with professionals seems on point, and a matter to be taken into consideration by health system executives and governing bodies. Since the professional may be part of a complex organization, but no less a professional because of it, a natural conflict is inevitable. The

professional's orientation to service does not work well with the bureaucratic approach that insists on compliance with procedures. And most importantly, the relationship of the professional with an external source complicates loyalty to the organization (1974:247).

Other professionals are impacted, and described in the literature, in a similar way. Hummel described the changeover to bureaucratic control of the New York State supreme courts in the mid-1970's.

> What we see is a conflict between personal gratification and the changing value-concerns of bureaucracy—efficiency, formal rationality, discipline, and calculability of results. In terms of the conflict between bureaucracy and society, the crucial (issues) are those that expose the changing situation of the judges as a clear-cut example of bureaucratization" (Hummel, 1982:61).

This changing value-concern has significant implications for physicians.

> In the past, physicians had a controlling voice in the U. S. health care delivery system. Many analysts, however, argue that the dominance of the medical profession is weakening, and many of the factors associated with the declining dominance of medicine are linked to the observed changes in physicians' practice arrangements. If current trends persist, a majority of physicians will be employees in the very near future. In comparison to physicians of the past, these physicians are likely to have

> relatively low levels of clinical autonomy, the hallmark of medical professionalism. Many of these physicians will be in the employ of what has been called the 'new medical-industrial complex,' with their practices subject to an increasing degree of bureaucratic rationalization. Physicians in these settings are likely to face intense pressure to pay closer attention to their institutions' financial concerns (Kletke, Emmons, and Gillis, 1996:561).

To some extent Weber, and more specifically Talcott Parsons, looked at collegiality among professionals as an alternative to bureaucracy for their associations. Collegiality enhances autonomy by allowing everyone to have his or her say. The result is a consensus process in which decisions are not delegated, and processes are not structured to exclude professionals as they are in bureaucracies. But the most interesting part of the collegial process is the moral mandate that comes when all decisions are open and above board, and become binding on the entire collective (Waters, 1989:961). The idea is that both collegiality and bureaucracy may be rational decision processes, just not for the same type of individuals. They may even coexist in some types of structures in which organizations of professionals also have non-professional components, or the one might succeed the other as the structure of choice. But the moral directive is really only present when the professionals are allowed their say. Once given their say, professionals accept decisions that don't go their way, at least for a while. With integration, the need to involve people other than those in

the same professional category in a similar, open decision process becomes more important.

> The workforce of the post-bureaucratic organization would consist of temporary teams of specialists with diverse skills; each specialist would have divided loyalties, much as members of academic staffs do now. On the one hand, the specialist would pursue his professional goals, and on the other hand, he would pursue those of the organization (Kamenka and Krygier, 1979:150).

These structures will be studied more closely through an examination of Parsons' structural functionalist views on collegiality. Parsons made the same type of ideal-typical analysis of collegiality as Weber did for bureaucracy, and based his analysis on the graduate school component of universities. The analysis starts, however, with an understanding of authority as it relates to collegiality. Weber made the point that rulers sometimes relied on bodies of experts to advise them on rule making. Whether the result was a command issued by the ruler or the group of experts, the effect was the same, and therefore the exercise of authority on the sole basis of expertise is the first and most important component of collegiality. (Waters, 1989:955)

A second theme that runs throughout analyses of collegiality is that of equality. If expertise is paramount, then each member's area of competence may not be subordinated to other forms of authority. In other areas of Parsons'

work, there is the added concept of specialization. This allows for the understanding that consensus derives from people who are equal, but not similar, such as full professors in different parts of the university. With no clear definition from Weber, and with a synthesis of the points made above mostly by Parsons, Waters makes the following statement of collegial principle. "Collegial structures are those in which there is dominant orientation to a consensus achieved between the members of a body of experts who are theoretically equal in their levels of expertise but who are specialized by area of expertise" (1989). This is the emerging ideal behind vertical integration in the healthcare business. Physicians are not above everyone else in the decision process, but rather a part of a group of specialists who can come together to work for the good of a collective that is bigger than any of the parts. The biggest adjustment must be made by physicians in order to make this structure work, however, since they must abandon the most power to make it work.

Finally, as pointed out earlier, there are various ways that collegial and bureaucratic organizations co-exist. Waters categorizes collegiate organizations "in terms of their proximity to the ideal-type" (1989). Exclusively collegiate organizations are those in which the authority of a group of professional colleagues is undivided by bureaucracy. In predominately collegial organizations, the internal authority of the college over members is undivided, but its external authority is mediated by bureaucracy; and in intermediate collegial organizations, the powers of the collegial body, both internally and externally, are severely circumscribed by bureaucratic systems. It is also useful to point out the

differences between the placement of organizations in Water's classification scheme at the time he wrote it versus now.

Hospitals have almost certainly moved from predominately to intermediate collegiate organizations as a result of their growing complexity and the declining influence of the medical staff on their revenue stream. This reduction of influence has occurred due to the growth of influence of managed care plans and other insurance arrangements on physicians' ability to direct patient referrals to hospitals. Administration's ability to make necessary arrangements with these third party payors is the controlling element, rather than solely administration's ability to please the medical staff.

Physicians, for their part, have moved out of exclusively collegiate organizations into one of the other types in increasing numbers over the past ten years. Most of the physicians have moved into predominately collegiate organizations, although many have become employees of a differentiated collegial unit of an intermediate collegiate organization. The key part of the analysis for this research in the health care market is the interdependence of hospitals and physicians in the developing organizational structures.

> Most physicians do not have the capital or the managerial and organizational expertise to remain independent in the current and emerging market. Hospitals and other health care organizations, on the other hand, do not and cannot practice medicine. Thus there is necessarily interdependence. (Shortell, et al. 1998:1102)

And that increasing interdependence has led to the vertically integrated organizations that are the subject of this research.

> The large organizational scale that brings better health plan contracts and more advantageous capital financing may threaten the sense of participation and control at the grass roots level. As they grow and consolidate, medical groups face the imperative to forge a culture that combines managerial efficiency and professional dedication (Robinson, 1998:150).

The Development of the Political Economy

Thinking about how society came to be formed and the nature of the social brought a revelation to me in terms of my career spent building organizations. I had read Plato (translated by Lee, 1987) and Machiavelli (Machiavelli in Bronowski and Mazlish, 1960), and used gems of wisdom from them in presentations to managers and physicians. But I had not considered the question of legitimacy of authority in terms that would indicate the depth of their contribution to modern organizations. Aristotle also contributed to my understanding as I attempted to understand his description of the place and source of reason in society (Aristotle, 1992).

Hobbes, Locke, and Jefferson were also very enlightening with respect to their insights on developing the political economy. From the belief of Hobbes that government was an oppressive beast intent on controlling men and putting

them in their place, (Hobbes, 1988) he moves to the notion that men, by right of nature, have the liberty to use their power to maintain their existing power. Locke at least added the notion that liberty is not license, that one man's liberty ends where it intersects another man (Locke, 1988). Much of the United States Constitution is based on Locke's writings.

Jefferson takes the position that each generation should decide how it will govern itself, how it will manage its economic resources, and how its society will function. He goes back to an earlier study of the American Indians to make the observation that man at his best needs no structured government. The freedom to pursue life, liberty, and happiness are key for him, and the self-contained existence of the small farmer is the best example of the free life. He believes that is possible because all men are created with a moral sense that gives them the basics for living socially with others (Matthews on Jefferson, 1986).

Rousseau's version of democracy calls for an exchange in which a person's freedom in the state of nature is given up in order to receive an equal share in the liberties found from an association with others as citizens. His promise is that men can only be truly free by such an action, and that the rewards of the commune, such as rightful ownership of property whose ownership is defended by the society, outweigh the freedom to act without regard to others in the state of nature. Democracy is obtained when the citizens, acting as the sovereign power of the society, enact a moral code for the governance of the society, and thereby grant themselves freedom by establishing the rules

under which they live. This moral code is, by Roussean definition, accepted by all who enter into the social contract (Rousseau, 1968).

This is one of the two-sided points of Rousseau's writing. From the true law standpoint, in the ideal, the result of the collection of social contracts in a society is a nearly unanimous agreement of the rules and regulations of society. He does say that unanimous agreement is not always required, but that everyone must have a vote that is counted. Anyone who subsequently departs from those rules is confronted by other society members who hold a mirror up to the norm violator so he can see the error in his ways and return to normal status. From the actual law standpoint, the unanimous consent of the governed is impossible to obtain and therefor some interpretation of the collective viewpoint by less than all the society members is required. This is the notion of the general will. The general will is that which supports the common interest, and not the collection of opinions that support individual interests. Everyone in the society agrees to be bound by the same rules that are used to bind others; all in the society thus have the same rights and are bound by the same rules. Everyone is also obligated to police one another and enforce the general will in this arrangement. Someone is responsible, no matter what the system of government in a particular society, to interpret the general will as the society develops. Someone must overcome the fact expressed by Rousseau that "the general will is always rightful, but the judgement which guides it is not always enlightened" (Rousseau, 1968). Physician governance structures rely heavily on issues such as those expressed by these thinkers, as does the construction of all types of organizations.

Social Movements

My study of social movements also caused an epiphany of sorts as I dissected the sociological characterization of collective behavior. The dramatic change in the social order caused by outrage over escalating costs of healthcare resulted in the restructuring of three entire industries—medical groups, hospitals, and insurance companies. While the point of social movement analysis is typically something else, its application to my field of interest is not totally misplaced. Three perspectives from social movement literature—resource mobilization, frame analysis, and new social movement theory—serve to draw the parallels with the results of integration in the healthcare industry.

Resource Mobilization

My study of the literature of collective behavior and social movements starts with the resource mobilization perspective. This perspective was developed after review of existing methods of describing collective behavior failed to account for the social movements of the 1960's in the United States. Resource refers to money and time, while mobilization refers to the process of securing resources for the cause.

Earlier conceptions of collective action focused on the reasons collections of individuals took action, based on grievances, seeking changes in social

structure to redress their situation. These changes were usually sought as a result of a spike in the level of individual grievances as a result of some strain in the social structure brought about by accelerated social change.

The numbers of these events that occurred in the 60's provided a rich vein of material for analysis in the tradition of collective behavior and social movements; from that analysis came the resource mobilization perspective. Resource mobilization parallels political process sociology (McAdam, 1982) in many ways, while taking more account of structure and institutions. It emphasizes the rationality of actions that seek social change, the interplay between those who stand to gain from the change, and those who provide the resources necessary to accomplish the change. One key assumption is that there is always enough strain in the social structure to go around, so that earlier conceptions of the necessity for high emotion, based on some strain in society as the catalyst to right a wrong, is misplaced. Rather, in the resource mobilization perspective, what is necessary is an organized approach based on charity alone or in concert with someone's rational assessment of his or her relative deprivation in order to start and sustain a movement.

McCarthy and Zald (1977) were among the first to describe resource mobilization, and their focus has been labeled an entrepreneurial approach that first looks at the organizers of the movement. They describe movement leaders in different terms if the leaders are among those who stand to benefit directly from the accomplishment of movement goals, than if the leaders are merely interested observers who have organizational skills and access to resources

needed by the movement. They generally find that successful movements are launched from pre-existing organizations that are reorganized, re-energized, or refocused on the new target.

Traditional analysis of collective behavior and social movements looked at these situations along a matrix, consisting on one axis of the energy needed to get the movement up and running as a separate matter from the energy needed to sustain the movement over time. The other axis divides the analysis between the microprocesses operating in the movement versus the macroprocesses operating on the movement. McCarthy and Zald's conception of resource mobilization fits this analytical model very well. From a macro standpoint, the organization that provides centrality to the movement is typically already existing in the political landscape when the movement forms. They even assess the odds of success of a movement based on whether or not some organization is present when something happens to trigger a movement. The political situation is also typically arrayed against the deprived individuals, so that all that is needed is a catalyst in order to have a movement.

From a micro standpoint, there must be awareness among similarly situated individuals of their collective relative deprivation. While it is certainly possible for those in the deprived group to provide their own resources to attack their shared problem, it is seen by McCarthy and Zald as more likely that the majority of resources needed to affect change will come from outside the disaffected group. By definition, those seeking the change for themselves are outside the political control process, and, except for the most egregious

examples of discrimination (such as the civil rights movement), will need help from someone more politically in tune. For those with resources to use in helping fund such causes, the choice of the cause is all-important. The political power of the sponsor must be conserved for future personal causes, so the movement must not be too violent or otherwise radical for the typically conservative institutions that maintain the resources. The long-term sustenance of the movement must also take such micro and macro issues into consideration.

In the McCarthy and Zald model, the emergence and sustenance of movements are also affected by their structure. That is, movements that are driven and funded by outsiders are more dependent on the message being acceptable to the outsider than those movements funded from the grassroots. They are also more independently sustainable. They describe ways in which movements must appeal to multiple individual interests through "selective incentives" (McCarthy and Zald, 1977). These incentives act to diversify, and potentially de-focus, the movement organization, the trade-off being the necessity to raise funds and other resources to support the movement.

McAdam (1982), on the other hand, argues that the deprived groups have within their own power and control the ability to create and sustain a movement aimed at correcting existing structural inequalities. He views the support from outside "elite" groups as coming only when it serves the interests of the outside group, and never solely for charitable reasons. But more than monetary resources, which he acknowledges must come, in no small part, from outside the disaffected community, the ability to create, organize, and sustain the movement

is entirely present inside the group that stands to benefit from the movement. The motivation behind the movement is the essential quality from this perspective, and some level of internal commitment as shown by organizational ability is very important. The motives of outsiders must always be questioned lest the control, and therefor focus, shift to less committed individuals.

Morris (1981) uses the black community and the civil rights movement as a prime example of the ability of resource-poor groups to organize themselves effectively, create appropriate strategy and tactics to accomplish their ends, and solicit resources necessary for those same ends. The argument is even made that movements are not possible if conceived and directed solely by people other than those who stand to gain.

Tilly (1975 and 1978) focuses on interactions between the polity and those speaking on behalf of a deprived group over time, in which demands for change and public demonstrations of support for that position are made. He saw this process revealing less actual organization than is at first apparent within the movement, and viewed one job of the analyst as looking at the internal workings of a disaffected group for such things as strategy, ability to attract participants, and the actual unity among those participants. In addition, he focused on the response of the polity and power brokers in maintaining control of the status quo, in order to accurately assess social change.

One of the key issues in the political process model is the social control aspect of the polity and the outsiders--the elite, in McAdam's (1982) terms. When the political mechanism is stacked against a movement, as it typically is

(McAdam says it always is), any involvement of outsiders must be suspect. While liberal groups are often tapped as sources of funds and organization for social causes, much of the funds available for charitable purposes are held by conservative foundations. Those foundations are typically highly intertwined with the political establishment, certainly more so than liberal groups, and will tend to vary their support based on the reaction of the polity. They are also more in tune with the social control goals of the polity, and could be accused of supporting some social movements in order to control the beneficiaries of the movement. Observers of this issue disagree strongly about the motivations of funding sources, and seem to believe ultimately that each funding source must be examined separately in order to accurately determine its impact on the movement.

The resource mobilization perspective departs from earlier conceptions of collective behavior by focusing more on the organizational aspects of social change than on the social psychology of participants in change. It characterizes the functionality of those seeking to change some aspect of society in terms of their ability to attract resources and recruit members who will support the effort. There is some disagreement among theorists about the role of outsiders, especially elites, in the creation of a movement and the mobilization of resources to support the movement, which is the primary point that distinguishes the professional organizer model from the political process model (Pichardo, 1988). Both models, however, focus on the attempts of insurgents to gain power and change the existing social order, the methods and resources they use to do so,

and the methods the existing power brokers use to maintain the existing social control relationship. Both models also spend some time explaining the micro and macro issues as they relate to the creation and sustenance of the movement. This paper is written to describe the frame alignment perspective of social movements. This perspective was derived during the 1970's as were other new perspectives on collective behavior, as a result of the wealth of social movements of the 1960's and the rich research and analysis that was made possible by those movements.

Frame Analysis

Frame analysis is based on the symbolic interactionist branch of sociology, with its emphasis on an actor's experience of his environment through the development of symbolic meanings attached to happenings in the world (Snow, et al. 1986). The work of Erving Goffman, in particular, provided the original description of framing: "schemata of interpretation that enable individuals to locate, perceive, identify, and label occurrences within their life space and the world at large" (Goffman, 1974).

The application of these principles to social movements was made because of the necessity to merge the micro, social psychological aspects with the macro, structural aspects of collective behavior and social movements. The notion that shared perceptions of a common enemy to be fought, or a common good that should be sought by a group of people seems to fit very well with the

frame alignment process that seeks commonality of individual preferences and those of a collective. The analysis holds true for the initial mobilization of a cause, for recruitment of additional adherents to the cause, and for the fund raising aspects of a cause as it develops and seeks victory through goal attainment. Snow, et al (1986) sought to apply and extend Goffman's frame analysis perspective to the perceived shortcomings and weaknesses of Turner and Killian (1987), Tilly (1978), and McCarthy and Zald (1977), by elaborating four processes they observed in three movements: the Nichiren Shoshu Buddhist movement, the peace movement, and the urban neighborhood movements. (Snow, et al. 1986) The four processes they described, frame bridging, frame amplification, frame extension, and frame transformation, are the initial formulation of this perspective, which was developed considerably over the next decade, since this perspective has dominated much of the recent research in social movements over that time frame.

In addition to the defining work done by Snow, et al (1986), Hunt, et al (1994) looked at some of the same movements, and others, in order to enhance the frame alignment perspective. Specifically, they added descriptions of three identity fields to explain more fully the reasons for social movements than the classical perspectives had done. They used the terms protagonist, antagonist, and audience to explain the actions of constituents, opponents, and bystanders in framing the movement from those various perspectives. Taylor (1989) was also helpful in clarifying the necessity for accurately defining frame boundaries as the identities shift in the amplification, extension, and transformation processes.

Snow and Benford (1992) made the theoretical connection between master frames and cycles of protest in order to apply the principles of frame alignment to the study the relationship between movements in the same cycle. Others have more recently applied the frame analysis perspective to the study of actual movements. Benford (1993), for example, looked at the importance of social construction of vocabularies of motive in the nuclear disarmament movement. Valocchi (1996) reported on the construction of the rights frame used by civil rights movements of the 1930s. And Haydu (1999) applied counter action frames to U. S. employers as they sought to counter union organizers in the late nineteenth century. A significant number of other recent researchers have applied the frame alignment perspective to traditional issues in social movements analysis in order to more fully explain structural views in the rich language of frames. The frame alignment analytical process provides an insightful look at movement mobilization, structure, and success, because of its focus on shared meaning created by movement creators, mobilizers, and recruits.

New Social Movement Theory

New social movement theory is actually a collection of theories that seek to improve on the dominant perspective in social movements analysis for the last 30 years—the resource mobilization perspective. Unlike traditional collective behavior theorists who believed people acted because of a spike of grievances in the community, and resource mobilization theorists who believed that enough

grievances were ever-present in society so that organization and resources were all that was required for a social movement, new social movement theorists believe that the existing societal structure issues at any particular time, such as postmodernity, create the environment for social movements (Buechler, 1995). Most of the work in conceptualizing new social movement theory has been done by European political sociologists, perhaps first by an Italian, Alberto Melucci (Calhoun, 1993).

Melucci addresses new social movements in terms of the search for personal identity amid the confusion and chaos of postmodern society (Melucci, 1988). He thinks movements are somehow ordinary reactions to the instrumental rationality of bureaucracy in modern society. He makes it clear that people construct society around and in-between the traditional social control apparatus put in place by others in society. It is the ability to construct and maintain a collective identity that gives life to social movements, not the pre-existence of an organization that can be used to address a grievance. Melucci also makes it clear that, like most other things in postmodern society, the mobilization of collective identity behind new social movements is temporary, almost fleeting. Successful movements build on networks of related reference groups, accomplish their task (or not), and then move on to the next cause (Melucci, 1988).

Another European thinker in this tradition is the Spaniard, Manuel Castella. Castella focused on urban social movements and the conflicts between capitalist focus on profits and the state's interest in securing the goods and

services necessary to support the population (Castella, 1978). One of the areas he focuses on, interestingly, is the necessity for autonomy and decentralized government. It is somewhat of a paradox, given the limitations on capitalist autonomy he seems to suggest are necessary. It is this dialectical approach that caused Buechler (1995) to argue that Castella is more similar to Marx, in his conception of new social movements, than the others.

Alain Touraine of France used the term historicity to reflect the growing ability of people in a society to provide for themselves. He views the central conflict of postindustrial society to be between consumer/clients and manager/technocrats. The battleground is social control of the society's ability to self-govern and self-manage. Since the state is the logical unit to control the manager/technocrat group, the state is the principal target of new social movements. The argument is similar to that of Castella—the state on one hand seeking to expand production and power, among other things, and the movement seeking to maintain and expand individuality (Touraine, 1988). Touraine is somewhat Marxist in his view that one central conflict dominates each era, although he believes that postindustrial conflicts center on cultural issues and not solely economic ones.

Finally, Jurgen Habermas argues that economic realities of modern existence invade the space of personal interaction, where society is actually established and maintained. Again, the distinction between political bureaucratic power and money exerting social control over and above the ability of individuals seeking to define control over themselves and their "lifeworld" is the grounds for

conflict. Power is centralized by the political and economic necessities, and the bureaucracy obscures the need to defend the social control implications of such a system in free and open debate. New social movements, with their focus on quality of life issues and self-actualization, are a reaction to such limitations (Habermas, 1984-87).

Observers of the development of new social movement theories point to some common elements that seem to bind the variety of theorists writing in this area together. New social movement theory seems to address the more mundane specific aspects of everyday life, rather than seeking an overall explanation of the society's political and economic system (Calhoun, 1993). Calhoun distinguishes the new social movements from the old in this way. The new movements are not political parties seeking to capture all of the issues relevant to the state and prioritize them in terms of their likelihood of being accomplished. They are rather single issue oriented, allowing a social actor the freedom to accomplish his personal aims by networks of associations.

New social movements also shift the class struggle focus away from the working class focus of Marxist industrial movements to the quality of life and lifestyle concerns of the middle class (Pichardo, 1997). These movements call into question the materialistic goals of industrial societies, and the limitations on input that representative democracies provide, favoring instead the personal intercourse that allows direct construction of social norms by those most affected and involved. Pichardo also notes that new social movements are structured in much the same way they would have society evolve. They encourage active

participation by rotating leadership, requiring open debate and votes on substantive issues (Pichardo, 1997).

Finally, Buechler lists several common threads that run through the work of the new social movement theorists cited here, and others: the importance of the symbolic construction of collective action, focus on autonomy and self-determination, postmaterialist values, a de-emphasis of structure in favor of collective construction of identity and grievances, and the presence of networks that are often mobilized for various causes (Buechler, 1995). He believes these themes document significant departures from classical Marxism and resource mobilization theory, although they are present in widely varying degrees in the new social movement theories, when taken individually.

Summary

For a person with an undergraduate degree in accounting and a master's degree in health administration, the foregoing journey through the literature of sociology, healthcare, and classical political economy is indicative of the circuitous nature of my studies. I would not have predicted 28 years ago that this route was the one I would follow, but looking back, it is not totally without merit. Being an accountant for a short time, a career (and mindset) I despise, made me a better healthcare administrator, especially one whose interest developed into organizational development in the healthcare industry. And being an administrator who put together networks and developed organizations from

scratch certainly made me a better student of complex organizations and social psychology.

The breadth of the study of sociology has made progress through this literature considerably more interesting than anything else I have studied, and the variety of professors who exposed an accountant/administrator to such interesting and relevant topics as those addressed here are certainly appreciated. It is a twenty-year business career that brings these subjects to life. It is the combination of that career and this accumulation of knowledge that makes the anticipation of the next stage of life so compelling.

CHAPTER THREE

METHOD AND PROCEDURE

This chapter describes certain data collection and data analysis strategies. My attempt was to find those strategies that best suited the research needs. Participant observation and triangulation seemed basic. Because of the subjective nature of qualitative data, I used triangulation: demographic (quantitative) analysis, document analysis (content), and in-depth interviews of physicians. Thus I combined qualitative field research with quantitative statistical approaches. Since the data came from several sources they would either support or refute each other's validity. Since my participant observations established much of the methods and procedures, readers should understand what these activities mean. While participant observation refers to a method of research, in this dissertation it incorporates a range of approaches for data collection and the major method for this study. It was through direct personal observations and experiences that I drew a parallel between healthcare administration and participant observation research.

Both activities take place in a natural setting in which people apply meaning to their professional lives and explanations evolve from life contexts. Thus both are context-laden situations resulting from dynamic interactions. Just as participant observation features a form of theorizing, stressing interpretations and understanding human experiences, so too does healthcare administration.

The professional interactions provoke concepts and generalizations formulated as interpretive theory. Because of my selection of participant observation as a technique of shared, subjective data collection, I reentered the healthcare arena once again to observe physicians' actions and interactions. Doing that allowed me to understand their decisions and how they make sense of their everyday lived professional experiences. This chapter covers the subjects and design of the study, the procedure used to accomplish each method, and the ethical issues contemplated in this study.

Subjects and Design

I approached this study in order to better understand a phenomenon that was relatively new, the migration of physicians from their role as owners of private practices to that of employees of complex health systems. I began with a substantial personal knowledge of the subject, having spent 20 years in the healthcare industry. With that knowledge, I looked at the relevant literature to frame the issues, and discover what research had been published. That literature survey highlighted the dearth of scholarly information on the social implications of vertical integration of physicians, hospitals, and health insurance plans into the same organizations. However, a substantial amount of trade news had been generated over the past 15 years.

By examining the healthcare periodical literature systematically and performing a content analysis, trends were highlighted through a quantitative

analysis of the proportions of several journals that were devoted to integration topics. While gathering the data on proportions of the journals devoted to integration issues, I also reviewed the articles written about physician mergers and acquisitions in order to prepare an historical analysis of those archival records.

In addition, I decided to examine the changes in numbers of physicians in a geographic region over the decade of the 1990s. I also compared those changes to the changes in general population and HMO enrollment. All of the data comes from the same area over the same period in order to gauge the impact those things had on physician population and composition by specialty.

Finally, I interviewed 30 physicians from two different groups in order to compare their experiences with the information gained from a review of the national healthcare trade literature. One group of doctors had joined a health system sponsored group, while the other group had remained independent.

Procedure

Demographic Analysis

I gathered data on the numbers and distribution of physicians by specialty for a small metropolitan market and the ten county secondary market that surrounds it, for 1990 and 1997. This data was the most recent for this time, and was public information, available from the state licensure board and the

professional associations for Medical Doctors (MDs) and Doctors of Osteopathy (DOs) for that state. I also gathered data on the population of those same counties in that same time frame, including data on gender and age. Finally, I secured the enrollments by HMO by county for 1990 and 1997, as reported to the State Department of Health. I compiled all of this data into tables that allow comparison and calculations of the relevant factors. I then used industry-wide standards to calculate numbers of physicians required to take care of the numbers of new residents by age category, and compared that to the actual numbers of new physicians. Finally, I compared the changes in HMO enrollment to the changes in physician composition to see if the shift from specialists to primary care physicians could be documented.

Content Analysis

National experience of physician integration was analyzed by reviewing the content of five healthcare trade journals from 1985 through the present. The proportion of each of those journals devoted to integration issues was compared as well as the types of issues covered. The five journals are *Modern Healthcare*, *Medical Economics*, *Hospitals and Health Systems*, *Health Care Management Review,* and the *Journal of Health Care Management.* These magazines come from dramatically different historical viewpoints. They represent hospital administration trade journals, doctor oriented trade journals, healthcare research journals and one general healthcare journal.

The point of the quantitative portion of the content analysis was to establish relevant categories of interest to the study, and divide the articles into the categories. The pages found in each category each year were totaled, and a three-way analysis of variance performed on the results. The dependent variable was the proportions found in the journals, and independent variables were categories, years, and journals.

The categories were chosen to highlight the possible integration themes that are reported in the healthcare literature. While the special focus of this study is the impact on physicians, an understanding of the hospital and insurance company integration activity was relevant to understanding all aspects of vertical integration. The categories chosen were the following:

- Hospital-hospital mergers
- Doctor-doctor mergers
- Insurance company mergers
- Hospital-doctor mergers
- Hospital-insurance company mergers
- Doctor-insurance company mergers
- Health system formation issues
- Hospital-physician joint ventures
- Physician integration issues

The necessary journals were readily available in the OSU library, the OSU College of Osteopathic Medicine and Surgery, and the medical libraries of major hospitals. These journals have been published variously one, two, or four times

monthly over the period 1985 through 1999. I randomly selected one issue per month over that 15-year period for each journal, and reviewed its contents using the table of contents and a page by page review of each article and news report. For each article that fit in one of the nine categories, I recorded the number of pages or parts of pages of the article, and its title and category.

At the completion of the study, I computed the proportions each category represents for each journal each year. I grouped the proportions data into five three-year units of analysis, 1985-1987, 1988-1990, 1991-1993, 1994-1996, and 1997-1999 by journal by category. This data was then entered into the SPSS statistical analysis software package in order to perform a three-way analysis of variance with proportions as the dependent variable, and years, journal, and categories as the independent variables. I calculated each single AOV, each two way AOV, and the three way. In addition, I computed the table of means for each of these analyses.

The second part of the content analysis paints a picture of the progress of integration in the healthcare system from 1985 through the end of the century. In order to paint that picture, I recorded the data relevant to physician integration issues or photocopied the articles as I categorized the data. I then compiled the data by journal by topic, in order to focus on the themes and patterns of social issues impacting the physicians, and recorded those themes and patterns in the findings section of this paper.

Structured In-depth Interviews

I selected a sample of physicians from the two groups for a series of structured, in-depth interviews. In one case the doctors have made the transition from private practice to an integrated system, and in the other, the doctors have remained independent of an integrated system, but have considered a variety of joint ventures. Hospital-physician joint ventures, in which both parties remain independent but share some limited economic interests, are sometimes seen as a first step toward integration. The two medical groups are very diverse, one consisting of ten doctors of three different specialties all involved in the treatment of one category of disease. The other group is composed of more than 150 doctors of a variety of specialties, with multiple practice locations throughout half of a southern state.

These structured, in-depth interviews focused on the social impact on the physicians, their patients, and their employees of their decision to integrate their practices with a hospital or other physicians. The interviews covered a representative group of doctors, across all the specialties, ages and gender of physicians. Because of my current or former business relationship with most of the doctors to be interviewed, access was not a problem. The doctors were approached with a brief explanation of the goals of the research project, a description of the research methodology, an estimate of the time involved, and a request for their assistance. The doctors were asked to meet with me at a comfortable place and convenient time. Most of the interviews took

approximately one hour; several of them required follow-up sessions for clarification of certain issues, or because of schedule constraints.

The two integrated health systems that are involved with the medical groups are very similar. They are based around regional, tertiary hospitals that are involved in competitive markets with aggressive competitors who began buying physician practices before the two systems described herein. In an effort to respond to the practices of their competitors, these two systems established organizations under their control to purchase physician practices and employ physicians. Each of the systems also has a strong managed care component, one having started its own combined HMO/PPO managed care plan, while the other system joined with a competitor health system to start an HMO/PPO managed care company.

This triangulation of methods, the qualitative structured in-depth interviews, the content analysis that has both quantitative and qualitative components, and the demographic analysis provided a rich understanding of the relationship between physicians and complex organizations. In addition, these methods should also provide a thorough evaluation of Lockwood's theory, as it has been adapted to the particular economic system defined by this research project.

Ethical Issues

Perhaps the largest single ethical issue involved in this study was the guarantee of confidentiality and anonymity given to protect the interview subjects. The results of the interviews were reported in the narrative style to protect confidentiality, while the important distinctions of age, gender, or specialty were made as appropriate. The geographic areas used in the demographic analysis were changed to pseudonyms in order to preserve the confidentiality of the interviewees. Although some of the issues that were discussed could be seen as sensitive, the physicians did not give any indication they were troubled in any way by the questions. Each of them was provided a description of the research plan in advance, and consented in writing to participate in the study. Each physician knew they were free to withdraw their participation at any time during the study. The Institutional Review Board of the University gave its initial approval for this research on November 19, 1998, (IRB #AS-99-018) and extended the approval through October 5, 2000 on October 5, 1999.

Validity

One of the problems in studying a macro-level theory such as system integration is the definition of the society. While Lockwood's (1964:250) article made it clear that multiple levels of analyses are possible, the task here, in part, is to prove the construct validity of the measuring tools as proxies for the society.

In order to study the changes in the American healthcare industry during the 1980s and 1990s, a variety of methods was required. A macro study of the movement of physicians in the industry, for a particular region, is a valid way to observe the impact of environmental changes in that region, although absolute conclusions about the reasons for the changes would not be valid with that data alone.

An analysis of the content of relevant health industry trade journals enhanced the content validity of the study in two ways: first, by reflecting the issues of concern to the participants in the change; and second, by reflecting the prevalence of related issues as a proportion of the total issues being reported to members of the relevant society (healthcare industry executives and physicians). To the extent that the selected trade journals represented the thinking of participants in the social system, valid conclusions about the focus of, and impact on, those participants were made.

The structured in-depth interviews also enhanced validity by confirming the accuracy of the reported information, if only for the markets being studied. This data will provide the most valid interpretation possible, of events in each market and the participants' conclusions about those events.

Reliability

The reliability of the conclusions reached in this study will be high for the markets being studied, and especially so for the particular medical groups who

participate. The information contained in the report should also be instructive to people in similar markets going through similar social dynamics. Obviously, the results will not be easily generalizable to everyone in the American healthcare industry. That is, while the entire American healthcare industry has undergone substantial upheaval over the last twenty years, healthcare is primarily a local phenomenon. Particular structures of one market are unique to that market, as are the political, economic, philanthropic, and other relevant forces acting on that market. The presence of nationwide structural elements of the healthcare industry, such as the Medicare and Medicaid programs and third party payors who are national in scope, is helpful in defining a particular market, but it is the local application of rules for those national programs that defines the structural response in the end. For example, a national HMO company might have standard rules for pre-admission certification of its members, but it is the doctor or nurse interpreting those rules who has the greater impact on the local healthcare market. Those personal interventions in each local market become the warning sign to readers of this research report, who must interpret the application of its conclusions with caution as to their own local circumstances. Overall, I believe that readers of this report who work in the industry will find much of it familiar and helpful, and to that extent reliable and applicable.

Bias

With respect to bias, a study of this particular industry is somewhat unique in social research. The most important ethical considerations in this research are access to and confidentiality of the participants. My familiarity with these group practices facilitated an invaluable amount of access, and otherwise difficult to obtain background from which to draw conclusions. The high level of trust the doctors have in me from prior business dealings was very helpful in fighting through the "lab coat bias." This bias would have been present for these groups with another researcher or for me in approaching another physician organization. In order to maintain strict individual confidentiality, the specific answers of the doctors will not be shared with anyone. However, since there is so little research on this topic, my familiarity with the doctors facilitated a stronger research project than would have been obtained with other groups of doctors or another researcher.

Because of my past or current association with the physicians who were interviewed for this study, the appearance of bias is certainly present. But alternative methods for gathering reliable, valid interview data are very limited. The questions are these: Were conclusions drawn based on a different agenda than expressed in the research questions? Was there a way to interpret the data that would cast a positive light on my involvement at the expense of someone else? Was there motivation for me to do that? Did the doctors not answer the questions truthfully because of their relationship with me? The answer to each of

these questions is negative, the results obtained are valid and reasonable, and the accuracy of conclusions that could have been made by anyone not similarly associated with the doctors would be less valid and reliable.

CHAPTER FOUR

FINDINGS

The findings from this research project represent widely diverse sources of data and method. As more data were gathered, more information about the social aspects of vertical integration was derived. The findings are accordingly presented in this chapter along a continuum from the general to the specific. First, the quantitative review of the content of periodical healthcare industry literature is presented. Then, the demographic analysis of total population and physician population and composition in one of the markets analyzed for this study is presented. Next, the archival research describing integration topics found in the healthcare periodicals is discussed, followed by the findings from the interviews from the two physician groups.

Content Analysis

The healthcare industry has seen merger and acquisition activity for years, typically intra-category, horizontal integration in which hospitals buy other hospitals, or medical groups expand through purchases of other practices. But the fifteen years between 1985 and 2000 saw a tremendous increase in merger and acquisition activity as physicians, hospitals, and insurance companies scrambled to deal with the changing system-wide payment structure. As employers refused to pay the steadily increasing costs of health insurance for their employees, various methodologies that shifted the economic risk of health

services provision away from those who pay for it to those who provide it were attempted. One of the most popular methods was capitation—the payment of a fixed amount of money per capita for each enrollee covered by a health plan per unit of time (per member per month). A group of physicians, for example, might have been paid $30-50 per member per month to provide all physician services for a group of commercial insurance patients under age 65. The consequences of that payment style were cataclysmic for care providers and third party payors alike.

Physicians, for the first time, had an economic incentive to provide the least amount of care possible consistent with quality practices. Information was developed showing that more care is not always better care, weaning physicians from their training to some degree. When they are in medical school, internship, and residency, physicians are encouraged to perform as many tests as necessary in order to be educated on their impact. Teaching hospitals are notoriously expense, and invasive, as a result of these additional interventions.

So the new rules made it imperative that physicians reverse their training and consider a more economical approach to patient care management. The impact on the hospital was similar, except that the locus of control for hospital costs is basically external to the hospital. That is, the factors of production in a hospital, such as laboratory tests, radiology procedures, and surgical operations, happen as a result of a physician's order—only as a result of a physician's order. They cannot happen any other way. So, if a hospital is being paid a fixed amount for each patient, determined in advance, their incentive is to help

physicians find the most economically efficient way to provide quality care to patients. They spent millions of dollars on this effort in the 1980s and 1990s.

Finally, insurance companies come into play in this discussion because they are temporally the first in line to have a contractual arrangement with patients. Employers typically strike a bargain with an insurance company to provide payment for medical services for their employees. As those payments became too expensive, insurance companies were forced to respond by seeking discounts from hospitals and physicians in exchange for volume guarantees, for example, or by negotiating prepaid arrangements with them. In addition, they built vast databases on hospitals and physicians in order to make decisions about those who were efficient, high quality providers.

This is the environment that fostered vertical integration in the healthcare industry. As a result of the three way dynamic just described, the periodical literature of the healthcare industry reported a considerable amount of integration activity during the period as all the players scrambled to address the new environment. This study looked at those reports as a way to determine which issues were uppermost in the minds of physicians, insurance company executives, and hospital administrators, by assigning articles on integration to categories whose relative proportions were measured and analyzed statistically. My goal in undertaking this analysis was to highlight, from a quantitative perspective, those integration issues that were most important for hospital administrators and for physicians. I wondered about several issues as I began this analysis, including the following:

- was different information reported in business journals that cater to those two groups, both in terms of news items, and educational/marketing pieces;
- did statistically significant variations in timing of that information flow make any difference to the preparedness of the two groups for integration;
- did two of the popular research journals catering to physicians and hospital administrators report any results from vertical integration attempts over the time period covered by the study; and
- did saturation occur: did the numbers of available partners decline so much that integration activity declined over the relevant time period.

The results of that analysis showed statistically significant variation among the calculated proportions of articles by each of nine categories in five different journals over fifteen years. One note about the statistical findings is important. I entered the data into SPSS as proportions of each category found in each journal each month. In many cases, there were no articles found in a particular category for an issue. In some cases, there were no articles found in a particular category for a journal in all of the 15 years. For example, *Medical Economics* did not report a single article on hospital mergers. Zero was entered for every month in which no articles were found. In addition, very small news reports were all that was found in some cases, as little as one-eighth or one-tenth of a page, and these proportions were entered.

The calculations involved in three-way analysis of variance start with the computation of means across all categories by journal by year. The computation of means of proportions results in averaging averages, and thereby the assignment of equal weight to each of the items in the calculation. This averaging of proportions gives different results than the average proportion, which would be the sum of all pages devoted to each category divided by the sum of all pages in the corresponding journals. Both are valid, just not to be confused. Calculating the arithmetic mean of the proportions has the impact of assigning equal weight to cells with zero or very small proportions and to those with large proportions, resulting in a smaller calculated proportion than is actually found in the journals. While the general relationship between the variables is maintained, the comparability of descriptive and inferential statistics is complicated. The impact gets larger as more averages are calculated, making the results of interaction calculations especially complicated. As a result of this mathematical reality, I have separated the statistics into two parts: a simple calculation of average proportions by journal by year, and the inferential statistics that result from three-way analysis of variance calculations.

Descriptive Statistics

In total, I found 1,740 articles that fit into one of the nine categories described earlier. The journals had a total of 80,672 pages in them, of which articles in the nine categories accounted for 3,734 pages of text, or 4.63 percent

of the total content of the journals over the fifteen years (Table 16). The proportions of all five journals in total for 15 years devoted to these integration topics range from 1.34 percent in 1987 to 9.38 percent in 1996. The range of proportions of each journal devoted to these topics in total for the 15 years was 3.34 percent for *Medical Economics* to 7.62 percent for the *Journal of Hospitals and Health Services Administration*.

These proportions are also impacted by the fact that some of the journals are supported by advertising. For example, a random sample of 12 issues of the journals over the 15 years indicated that *Modern Healthcare* and *Hospitals* included approximately 55 percent of their pages devoted to advertising. Incorporating that statistic in the analysis, these general interest journals devoted approximately ten percent, on average, of their total pages to integration topics (4.63%/ 45%), and as much as 20 percent in 1996 (9.38%/45%). Given the variety of management, marketing, legal, and regulatory topics, among other topics, that are included in these journals each issue, 20 percent represents a significant portion devoted to integration activity.

Inferential Statistics

One would possibly have expected the journals to report increasing amounts of integration activity over time, since the largest part of the phenomenon, vertical integration, was relatively new to the industry in 1985. Table 12 shows that expectation to be true, as the means by year climb steadily

throughout the period when examined in three-year blocks, and with minor exceptions when viewed in single years, until the reported activity fell off precipitously in 1999. One would also reasonably expect to see all categories of cross-discipline merger activity and the general integration discussion categories increase over time, which is certainly indicated in Table 12. It might also be reasonable to expect merger activity to decline at some point in time, since industry consolidation brings with it decreasing opportunities for integration. That is not found across all categories of integration activity (Table 12).

Another reasonable expectation might be that the physician journal, *Medical Economics*, would report only mergers involving physicians, in addition to general interest topics on integration. In the same way the hospital journals might focus on mergers involving hospitals. *Medical Economics* did not report a single article on hospital mergers, insurance company mergers, or mergers between the two. *Hospitals* magazine did, however, report on physician mergers, although in substantially less amounts than *Medical Economics* (Table 13). The two research journals, *Health Care Management Review* and the *Journal of Healthcare Management* reported no insurance merger activity, and considerably less physician merger activity than the other journals. The formation of health systems was reported much less in *Medical Economics* than in the other journals (Table 14).

The categories that were selected for this study resulted in different proportions across all years and journals, and the journals did report different proportions of integration activity across all years. Most were very close to the

mean, except *Medical Economics*, which reported slightly more than half the proportion the others did (Table 13). There were statistically significant interactions between category and journal, category and time, and category, journal, and time (Table 15). This means that the differences in the means of category and journal across all periods of time are not what one would expect based on the observed effects of category and journal by themselves.

Physician Population and Composition Changes 1990-1997

Overview

The purpose of this section is to look for the impact of capitated managed care plans (or other gatekeeper model health plans) on the census and specialty composition of physicians in a developing managed care market in a southwestern state. The primary market is a metropolitan area (Metro 1 on all charts) and the secondary market includes the surrounding ten rural counties. Most healthcare observers believe that health insurance plans requiring enrollees to access all healthcare services through one primary care physician (the gatekeeper) will result in higher demand for primary care doctors, and a corresponding decrease in demand for specialist physicians (references). Several things are expected to occur as a result of this shift, including the following:

- a redistribution of physicians in areas with higher managed care concentration;
- a reduction in the ratio of specialists to total doctors in the area;
- higher relative compensation of primary care doctors;
- development of primary care groups by health systems and managed care plans; and
- eventually a shift in the numbers of generalists and specialists being trained in medical residency programs.

Proving the impact of managed care on physician census and specialty composition using a demographic analysis was the initial goal of this study, although it quickly became clear that the impact of changing population demographics would also be required. The following is an environmental assessment of some of the conditions and factors that were present in the healthcare communities of the target market over the past twenty years. The source of much of this background is my actual experience, together with a reference from a major healthcare journal that is omitted in order to protect the anonymity of those interviewed for this study.

Managed Care Environmental Background

Metropolitan

From a purely historical perspective, managed care came to the market in 1982 with the start-up of an HMO by the owner of a large, underutilized hospital and clinic. While this venture was never very successful, it did cause other healthcare facilities and payors in the market to react and form their own health insurance programs. Within two years time, hospitals and insurance companies had established eleven HMOs and risk-bearing preferred provider organizations (PPO's) in the area, none of them approaching the kinds of enrollment necessary for long-term survivability. Consolidation of these abortive attempts to corner the market took place over the decade of the 1980's, until only three HMOs remained in 1990 (Table 1). There were, however, several gatekeeper model PPO plans in existence in the area during that time period. These plans can have a similar effect as the HMOs on the demographics of the physician population, although the effects are somewhat muted because patients are permitted to bypass their gatekeeper in some PPO plans with the payment of substantial, additional fees out of their own pockets. HMOs typically do not allow such desertions under any circumstances, which results in a slightly higher ratio of primary care doctors in HMOs than in PPOs.

During the 1990's, however, enrollment in the market's HMOs grew substantially (Table 2). A fair amount of the gains in enrollment were due to

increases in commercial enrollees, but there were also additions of senior citizens as a result of Medicare HMOs coming into existence (Table 3). Also, since 1990, the State government encouraged substantial growth in HMOs in two ways. First, the state employee's health plan was opened to allow HMOs to market directly to state employees and teachers, and secondly, the Medicaid program enrolled some of the people it was responsible for in HMO programs. The Medicare and Medicaid programs, in particular, have a dramatic effect on physician distribution since one primary care doctor can feasibly provide services to about 800 Medicare or Medicaid enrollees instead of 2,000 to 2,500 commercial enrollees. Each time a Medicare HMO enrolls 8,000 members, then, 10 full-time primary care doctors are required. Those same patients typically have well established relationships with specialists already, and may or may not see much of a primary care doctor before enrolling in an HMO. The result is a shift of patient visits from specialists to primary care doctors and a corresponding shift in the necessary composition of the physician population.

The hospital environment in the pre-1985 market consisted of four major tertiary hospitals, with medical staffs composed mostly of specialists who provided the majority of admissions directly from their private practices, and five smaller facilities providing primary care or specialty psychiatric services. The ratio of specialists to total physicians in the three large tertiary allopathic hospitals was quite high, and even higher if one considered the ratio of patients admitted by specialists to patients admitted by primary care doctors. Many of the specialists held the belief that their practices were self-perpetuating, depending

on referrals from former patients or other specialists with whom they shared responsibility for care, and depending very little on primary care doctors for referrals. During this time the hospitals were content to leave physician recruitment to the doctors, and were not in the business of employing physicians. As a result, specialists recruited consistently over time into their own practices, and primary care physicians were hardly ever recruited; at one major hospital, only one group of primary care doctors had added new associates over the time period of 1985-1990. Also, specialists in the pre-gatekeeper era had considerably more cash flow with which to fund the start-up of new associates. Gradually, however, the gatekeeper plans enrolled more people and the dynamic changed--perhaps forever.

With the advent of the gatekeeper era, hospitals were not able to passively sit back and watch the existing economic structure determine the mix of primary care physicians to specialists. Each of the four major hospitals in the area became involved in strategic planning for primary care physician recruitment and retention. They each decided to become more directly involved in implementing those plans, and each of the hospitals eventually evolved into integrated health systems which included the employment of primary care doctors and some attempt to integrate care processes across the continuum of healthcare services. These system-owned clinics were formed in the late 1980s and early 1990s, and came to have a dramatic impact on the primary care to specialist ratio later in the 1990s. These health system-owned clinics were set up for long-term survival of the system. The goal was to merge the practices of

the existing loyalist, primary care doctors with new doctors recruited to the system, without having to compete with the concerns of the loyalists. A secondary purpose was to provide a forum for enhanced relationships between the system and independent specialty physicians.

The one major exception to the physician practice pattern described earlier in this section was the existence of multi-specialty clinics in the market. During this time frame there were two such clinics that consisted of more than twenty doctors. A multi-specialty clinic is generally distinguished from the health system-based medical groups in three principal ways. First, the clinic is owned by the doctors (assets and practice). Second, the group competes with the health system by operating ancillary services for the profit of the group's owners, usually without the best interests of the larger community taken into consideration. That is, adequate demand for a service is demonstrated based on the doctors' ability to profit from their operation and not from a community-wide assessment of the necessity for competing operations. Third, multi-specialty groups are known for their mix of primary care and specialty doctors who cross-subsidize one another as the need arises. In that way, aggressive multi-specialty groups, when faced with the gatekeeper phenomenon, responded by subsidizing the earnings of primary care doctors they were recruiting by lowering the incomes of their specialists. In a way, the income reductions were considerably less than the specialists would have faced if they had lost market share by not recruiting adequate numbers of primary care gatekeepers. The specialists in multi-specialty groups also looked upon the income reductions as small payment

for a guaranteed stream of referrals. In any case, the aggressive multi-specialty groups also helped change the mix of primary care to specialists in the physician population, although the composition changes in these groups were almost completed by 1990.

Rural

Because managed care is a numbers game—the sharing of risk for the healthcare of a population requires a minimum of five to seven thousand lives for any chance of financial success—rural residents were slower to be offered capitated managed care programs. Even as late as 1997, there were relatively few such plans offered in the area defined as rural in this market. But other factors in the rural healthcare environment provided some impetus for change in physician composition in this area in the 1990s.

The development of primary care-inspired clinics in the metropolitan area rapidly spread into the surrounding rural area during the 1990s. Perhaps it was inevitable that the stories of amounts being paid to metropolitan primary care doctors for their practices would spread to their friends in the rural areas, creating a dynamic in which those rural doctors would bid the potential buyers against one another. Or maybe the specialists saw a less financially threatening way to secure their future referral streams and pressed metropolitan hospital administrators to move into the rural area. Whatever the case, each of the health system-sponsored groups acquired physician practices in the rural area. This

resulted in the recruitment of additional primary care physicians in these markets, but also in the recruitment of specialists to support the growing practices in some cases.

Another dynamic that is harder to quantify is the extension of specialists from the metropolitan hospitals into the rural areas on a part-time basis, and the resulting recruitment of specialists into those rural communities which clamored for full-time specialists, once having had the experience of part-time specialist services available locally. This permanent introduction of the specialists into the rural community caused the part-timers to discontinue their rural practices or to add these new specialists in their own practices.

Finally, the multi-specialty effect described earlier was also present in some rural areas, and it begat a more complicated reaction from the hospitals in those areas. When a "big city" clinic made inroads in a rural area, the local hospital administrator often found it necessary to build up or build from scratch a competitive multi-specialty group in order to maintain control over the health services provided in "his" community. The monopoly effect--controlled by any one of the local hospitals, a physician owned medical group, or an out-of-town based health system—and the determination of the local hospital administrator to remain independent provided the setting for a duplication of services and a negative effect on patient care in a community.

The Basic Changes in Population: Increases, Gender, and Age

As discussed in the overview, the impact of managed care on physician census and specialty composition cannot be fully evaluated without an analysis of the more basic impact of changing population demographics. The basic analysis looks at the pure effect of population changes with all other variables held constant. This is based on the application of health industry ratios of numbers of patients assigned per doctor to the numbers of net population increase. A refinement of the calculated numbers can be made when the effect of gender composition and its changes over the decade are considered, as well as the changing age mix of the population in the subject area.

Total Population Increases

The data show that population in the metropolitan area increased by 31,346 from 1990 to 1997, an increase of 6 percent over the 1990 population of 507,061 (Table 4). During the same time frame, the population increased 25,274 in the designated rural area, an increase of 5 percent over the 1990 population of 484,853. Two counties actually experienced declines in population over that time period, K and W counties. These declines were undoubtedly related to the declining fortunes of major employers in the principal city in each county. Another company town in Ot County showed essentially no population growth

over the period, which can be largely attributed to the loss of a major manufacturing plant in the late 1980s.

The largest increase in population for any county in the area was R County, with an increase of 10,295 or 18.5 percent. R County benefited from being in the highest growth corridor in the metropolitan area. Many of the new employers in the metropolitan area are clustered around the World Airport, which is just across the county line from R county, and accordingly many of the workers at those new employers live there. R and T counties account for 70 percent of the total growth in this eleven county area.

Population Composition by Gender

Since women consume more healthcare services per capita than men, the change in the rural and urban populations by gender by county is shown in Table 5. In this case, however, there are no significant differences in the population changes for any county, except P County. The male population there increased 250 percent more (7.9%/3.0%) than the female population. The impact of the presence of a major state facility is one possible explanation, but the definitive impact was not available. Overall, males accounted for just fewer than 60 percent (13,973/25,274) of the total increase in the rural areas, 52 percent (16,114/31,346) in the metropolitan area, and 55 percent of the total growth for the area (30,087/56,620).

Population Composition by Age

Age also accounts for some variations in demand for healthcare services, not only in the very old, but also the very young. Table 6 calculates the population age change in the period studied. Medicare populations account for the use of as much as 300 percent more healthcare services than under age 65 populations. As described in the overview, while one primary care doctor can handle 2,500 active commercial patients he can reasonably handle only 800 active Medicare patients. As for the use of hospital services, Medicare patients are hospitalized at the rate of 1,200 inpatient days per thousand people in unmanaged populations, compared to 400 days per thousand for commercial patients. In the under 20 population, capitation rates for children under one year old are the highest of any age group, while capitation rates for ages 1 through 20 are among the lowest. Pediatricians can also handle the highest number of patients of all primary care physicians, usually caring for up to 3,000 children. Thus, average healthcare services indicate the need for physicians would be lower for the population under 20 years, and significantly higher than average for the over 65 population. In this case, with a total population increase of 56,620 (Table 4) the under 20 population accounts for 21 percent of the increase (11,974), the 20-65 group accounts for 67 percent of the increase (37,677), and the over 65 group 12 percent (6,969) (Table 6).

The Impact on Doctor Requirements

From the standpoint of raw numbers, a rough analysis would indicate the need for an additional 28 doctors in the subject area—4 pediatricians, 15 family practitioners or obstetrician/gynecologists, and 9 internists. This is based on 11,974 new under-20 year olds, divided by 3,000 patients per doctor means 4 pediatricians; 37,677 new people between 20 and 65 divided by 2,500 per doctor equals 15 new family practice, internal medicine, or ob-gyn doctors, and 6,969 new people over 65 divided by 800 patients per doctor equals 9 family practice or internal medicine doctors. Performing the same calculations, and holding all other factors constant, shows the rural population needing 13 new doctors and 15 new doctors would be required in the metropolitan area.

However, Table 7 shows there were 298 new doctors in the subject area, 252 metropolitan, and 46 rural—over ten times the number that could reasonably be explained by the measure of population change taken by itself. One other measure of doctors in the population, useful in comparing populations, is the ratio of physicians to total population. In this case, the metropolitan area had 1,237 doctors in 1990 (Table 8), and total population of 507,061 (Table 4) at that time, for a ratio of 1 doctor for every 410 people. The rural population in 1990 was 484,853 (Table 4) and there were 539 doctors in that area at the time for a ratio of 900 people per doctor. Overall, the subject area population was 991,914 (Table 4) and there were 1,776 doctors, for a ratio of 559 people per physician. The entire state had a ratio of 671 people per doctor at the time.

By 1997, as shown in Tables 4 and 9, the population per physician ratios had changed to 362 people per doctor in the metropolitan area (538,407 divided by 1489), 872 in the rural area (510,127/585), and 506 for the total subject area (1,048,534/2,074). As a basis for comparison, the statewide population to physician ratio was 597 in 1997. The 1997 numbers represent a decline of 12 percent in the population per physician ratio in the metropolitan area (1.0 minus 410-362/410), which confirms that the physician population increased 12 percent faster than the general population over the same time period. For the rural area, the ratio decreased slightly less than 2 percent, so that the physician population increased 2 percent more than the general population over that time period. In total, the ratio decreased 9.5 percent.

Analysis Of Managed Care Effect On Physician Population

Overview

As described earlier, managed care generally has the impact of increasing demand for primary care doctors and reducing the demand for specialists. Because the numbers of capitated managed care lives increased so dramatically over this time period (Table 10) one would expect to see predictable changes in the census and composition of physicians. The following is an analysis of the growth of managed care plans in both the metropolitan and rural populations. It should be noted that some methods for counting membership to be reported to

the State Department of Health were changed in the interval between 1990 and 1997. Specifically, when HMOs first became operational in the state, the only counties in which the HMO product could be sold were those listed in the original license. Some members had home addresses outside the metropolitan area, for example, as a result of working in the metropolitan area and living in a surrounding county. In 1990, those people were included in the metropolitan area HMO statistics. Subsequently, HMOs expanded their coverage areas to include the entire state. Now the members' home addresses control the reporting and there are accordingly some members counted in 1997 in a different county than they would have been in 1990. The impact is not felt to be material on the results described herein.

The Metropolitan Area

In 1990, there were three HMO plans operational in Metro 1, as shown in Table 1. Those three plans, Purplecare, Greencare, and Bluecare, accounted for 89,093 members in their metropolitan service area. In 1997, there were 10 HMO plans operational in the metropolitan area (Metro 1, Table 2) with a total of 148,768 members. Since a normal industry expectation is that HMOs need 30,000 to 50,000 members, at a minimum, in order to sustain their viability, one can see that many, if not all, of these plans were sub-viable for the long run. The vast majority of the members are still in the three plans that were operational in 1990 together with one new plan, Pinkcare. Pinkcare experienced rapid growth

as a result of having been formed by the two largest health systems in the metropolitan area, who remain its owners.

With regard to physician requirements, the increase of 59,675 HMO members in the metropolitan area brings with it a requirement for 25 additional primary care doctors, if no other information is considered. If you consider that the change in population in the metropolitan area described earlier accounted for an increase of 31,346 people, you can see that about half of the increase in HMO enrollment had to come from people changing their existing health insurance plan to an HMO. The impact on physician requirements for those individuals is much less dramatic, but not non-existent. As described earlier, one would expect the need for more primary care doctors and fewer specialists with such a transition. The 30,000 new enrollees in the metropolitan HMOs would require 15 more new primary care doctors, all other things equal.

The rural area

In 1990, managed care was essentially non-existent in the rural area. In 1997, however, there were 47,824 members in the subject area, as detailed in Table 2. Over 70 percent of these members were in C and R counties, which are included in the metropolitan statistical area for other purposes. They are designated here in the rural service area because of the characteristics of their hospitals and physicians, but they are contiguous to the metropolitan area, and many of their residents work there as well. Outside of these two counties, no

single county has a concentration of more than 3,514 HMO members spread across all 10 plans. Even in those two counties, only one county has a concentration of more than 5,100 members in one plan.

According to most managed care experts, to achieve the economies of large-scale production that drive benefit from a financial perspective, a physician group must be responsible for a minimum of 5,000 members in an HMO plan. These loose plans in their start-up stages probably have very little of the expected impact on physician composition, and since these counties are in the rural service area, there is even less impact expected. That is, the principal impact of managed care changes in a rural service area is mostly the downstream specialty and hospital referral patterns together with the increased paperwork requirements of the HMO plans. Primary care markets are well set up to handle managed care by their nature since the generalist doctors are more prepared to manage a broad range of care needs than even their counterparts in secondary and tertiary healthcare markets. Referral patterns are affected, sometimes dramatically, by limitations on downstream contractual relationships set up by the managed care plans attempts to secure discounts from specialists and hospitals.

Archival Research

Background And Introduction

The periodical literature of the healthcare industry from January 1, 1985 to December 31,1999 reveals a substantial amount of information about mergers, acquisitions, and integration. In order to review the contents of the five selected journals over that period of time, the following nine categories of integration topics, which were selected to cover the range of possibilites for vertical integration in the healthcare industry, were derived:

- Hospital to hospital mergers and acquisitions;
- Physician to physician mergers and acquisitions;
- Insurance company to insurance company mergers and acquisitions;
- Hospital to physician mergers and acquisitions;
- Hospital to insurance company mergers and acquisitions;
- Physician to insurance company mergers and acquisitions;
- Health system formation issues;
- Hospital and physician joint ventures; and
- General integration topics.

The contents of one issue of each journal each month were reviewed in detail, and all articles that fit into one of the nine categories were summarized according to issue, category, number of pages, title, and page location in the issue. In

addition, the total number of pages of each randomly selected issue were recorded.

While the central topic is physician integration, this is a subset of a much larger topic, integration of the entire healthcare system. The social transformation of the physician practice is part and parcel of this larger trend. As such, information about hospital and insurance company mergers, health systems formation, and integration topics in the industry, was also obtained to better describe the historical context in which physician integration was taking place.

During the course of recording the information described above for analysis of content trends, the articles (some 1,740 of them) were reviewed as indicators of the integration process. This historical analysis yielded sources of data that reflect the thinking of leaders in the hospital, physician, and insurance industries as they struggled with the challenges and opportunities of integration for themselves, their organizations, and their competitors. The dearth of scholarly research into the subject matter makes this data among the best available to contemporary analysts in helping to set the context for integration activity at the end of the millennium.

The five journals reviewed were *Medical Economics*, *Hospitals and Health Networks Magazine*, *Modern Healthcare*, *Journal of Healthcare Management*, and *Health Care Management Review*. A summary of the topics will be presented on all of them, except *Health Care Management Review*, which had no physician specific content. Because each of the journals is owned by, and caters

to, a specific constituency, with a specific bias, this analysis is presented with all of the topics for each journal grouped together. It is hoped this presentation will clarify the findings that are presented.

Medical Economics

Medical Economics (ME) is a publication, read by most private practice physicians, that focuses on the business aspects of medical practice and physician lifestyle issues. Its pages are filled with tax tips, high-end automotive reviews, business structure advice, small office operations issues, and the like. Many of the articles are first-hand experiences of individual physicians written by the doctors themselves. It is a conservative folksy magazine that is heavily slanted toward physicians in private practice, and against cooperation with hospitals and insurance companies. For example, one doctor-author, on becoming an employee of a hospital, was granted anonymity by the magazine for his article. He said, "lured by growing promises, this doctor became an employee. Then he became a slave" (Anonymous, 1995:113). His advice, based on personal experience, was to put the money received from the practice sale away for a few years, since it might be the capital needed to restart your private practice.

The strong message that physicians should control every aspect of the medical business permeates its pages. Of the five magazines I reviewed, it was the slowest to address health system formation issues, although it contained

articles about the perils of physician mergers and acquisitions over the 15 years of this study.

In the mid-1990s *Medical Economics* did begin a series of articles on the impact of managed care on physician practices. Since managed care was the driving force behind most of the integration of the last fifteen years, these articles seemed to broaden the historical perspective of the journal. They provided a lot of information for business oriented doctors to consider. The timing also coincided with the public development of the proposed Clinton health plan, in which risk bearing vehicles owned by doctors, hospitals, insurance companies, or combinations of those, would contract with large coalitions of patients through their workplace sponsored health insurance programs. Many of these articles urged physicians either to look at expansion and acquisition opportunities in order to achieve the economies of scale necessary to remain competitive, or even to consider vertical integration with hospitals and insurance companies. But those articles also included very elementary reviews of the impact of managed care on physician practices. As early as 1985, one article, *How many health plans can one town handle?*, noted the change from zero to 11 HMOs and PPOs over the preceding two years. Several doctors and hospital administrators were quoted in the article, including this medical director of a hospital, "doctors are scrambling for any form of organizational protection they can find to preserve market share. They're willing to sacrifice a certain amount of income on a unit basis if they can just maintain their patient volume" (Frederick, 1985:98).

By the mid-1990s, however, the focus had shifted from elementary education of the impact of prepaid healthcare to more sophisticated responses. The education process in March, 1994 was entitled *Making sense of Alphabet Soup II* in reference to PHOs, MSOs, IDSs, and other such acronyms, instead of basic HMOs and PPOs (Murata, 1994, p. 29). The outgoing president of the American Group Practice Association (AGPA), Frank A. Riddick, Jr, was quoted in 1994,

> every group practice, large and small, seems to have done a deal, is in the middle of putting one together, or is actively looking for one. AGPA members see themselves as perfectly positioned to become these integrated organizations. They already provide outpatient services and some larger groups own hospitals. Others simply need to forge alliances with hospitals to be able to offer inpatient services. The third component—premium collection, claims processing, and risk sharing—requires insurance and actuarial expertise that could also be obtained through partnership (Riddick as cited in Murata, 1994:29).

It is not surprising that an AGPA officer would reiterate the traditional *ME* viewpoint, keeping doctors in charge, since its membership is primarily composed of large group medical practices. But it is interesting to note that the American Hospital Association president, obviously representing people with the same interest in control, but with a vastly different idea of who is in control, was quoted in the same article, saying "every hospital in the country has also done a

deal, is doing a deal, or wants to do a deal" (Davidson as cited in Murata, 1994:29).

A big part of the integration discussion recorded in the mid-1990s in ME was devoted to reviewing the growth of health maintenance organizations over the prior decade, and the implications of that growth. The bias seemed to begin with the proposition that HMOs are bad, because they contribute to the decline of the doctor-patient relationship, taking medical decisions out of the hands of doctors and putting them in the hands of remote nurses, non-practicing physicians, or rigid guidelines—cookbooks to practitioners. In the beginning of the time period under study, the doctor-patient relationship was one of those trump-card arguments. Doctors rallied around the sacredness of the doctor-patient relationship and were able to thwart any idea of a third party coming between the two. Gradually the economics of third party payment dynamics overcame this sanctity, and doctors were forced to accept review (interference) by remote third parties at the risk of losing their patient base. One 1995 article made it clear that doctors hate the hassle-factor involved in managed care plans, but fear losing their patient base more. A *ME* survey noted that 75 percent of doctors in private practice were signed up with one or more HMO plans in 1994, up from 66 percent in 1992. "They cited the need for patients and income as their two key reasons for joining an HMO" (Weiss, 1995:26). The same article noted the reluctance with which Americans will change physicians, even having recognized the economic advantages of HMOs.

But physicians clearly viewed themselves as having lost control of the medical process and the doctor/patient relationship by 1995. One staff writer for *ME* interviewed Uwe Reinhardt, a Princeton professor and frequent lecturer on the political economy of healthcare, asking him about the hazards of physicians regaining control. His answer was skeptical of doctors ability to control the process, and the propriety of it as well. That is, he pointed out, the view of Wall Street that doctors are "incompetent" at managing their businesses, at worst, or "lone eagles," at best, incapable of acting collegially enough to manage a vertically integrated health system, or even a horizontally integrated network of physicians. The propriety issue involved patient skepticism over doctors profiting if care is rationed. Reinhardt's own view is that only a viewpoint shift results, not a change in propriety, since the current system results in profits to doctors if unnecessary care is rendered (Reinhardt, 1995:72).

During the last half of the 1990s more journals covered the impact of physician practice management companies (PPMC). These organizations, many of them set up as public entities traded on Wall Street, were seen by some as giant Ponzi schemes, in which the last person pays for those who preceded him. These companies paid drastically inflated values of goodwill for physician practices, and, in return, took hefty management fees from the practices' subsequent operations. The impact, absent huge increases in alternative revenue streams such as ancillary services, was declining physician incomes. Realistically, an 8 to 12 percent management fee could not be earned through economies of large scale operation from consolidated physician practices.

One of the most visible PPMCs was the physician-owned Mullikin Medical Centers. This organization, one of the most highly visible genre failures absorbing substantial investments of three different owners, was highlighted in a positive fashion in a 1994 article in *ME*. The attraction to that journal was clear, given the large bold face type quotes set apart in the article. The physician CEO said, "Doctors have to be in control. Who else in the system is sworn by oath to do what's right for the patient?" And one of the lead administrators said, "a physician-owned system works better. You can't have insurance companies with actuaries making medical decisions" (Perry, 1994:64). The article also covered the negative side of the Mullikin experience, quoting doctors who had left the group believing the doctor-managers were non-responsive and too focused on making money (Perry, 1994:71). Once increasing numbers of physicians were affected, articles began to appear in *ME.* One quoted a disgruntled survivor of a PPMC experience, "forget your expectations. Physician practice management companies are out to please Wall Street, not you" (Brown, 1997:118).

After a disintegration lawsuits between doctors and publicly held companies are well documented in *ME*, so too are individual physician warnings to those considering such an affiliation. In addition, the journal documents the alternatives available to doctors considering the need for action. One article declares "all over the country, physicians who were holding out are realizing that practicing solo just isn't a viable alternative" (Terry, 1997:144). The same article documents the trend for generalists to sell to hospitals and specialists to sell to PPMCs.

Only two years later, however, the disintegration of the PPMC movement was well documented. One group, involved in a very public split with one of the largest PPMCs, traded shots with the CEO of the public company. On the one hand the doctors who left felt they were so miserable that competing with their former partners who stayed with the PPMC wasn't a problem. On the other hand, the PPMC managers blamed the doctors for not sticking with the original strategic plan. An investment banker, a third party to one such transaction involving a hospital noted that "physicians hold most of the cards. When you get right down to it, physicians can survive without the hospital. The converse is not true" (Grandinetti, 1999:88). That is certainly the mantra used by many physician groups in dealing with their local hospital.

A series of articles in *ME* in 1995 evaluated various alternative integrated structures that physicians and hospitals used in response to the pressure of managed care. The prototypical group model HMO would certainly have been Kaiser-Permanente, based in California. This long standing partnership between the Kaiser Foundation Health Plan, the Kaiser Foundation Hospitals, and the Permanente Medical Group, faced extreme competition in the early 1990s, then had to decide whether to remain the stable organization of its history or evolve into a more market sensitive player. One of its managers phrased it this way "there was a time when we felt we were stronger than the market. Then we realized that nobody is. We began listening to our customers much more attentively" (Azevedo, 1995a:84). They redefined their core business moving from HMO operator to health plan. They eventually instituted open-choice plans

that allowed patients a broader network of physicians from which to choose. But first they redesigned simple steps to create better patient service. The success of the HMO, built on this simple process, guided all patient encounters. Although tweaking that process was difficult for longtime Kaiser employees, it was essential for redefining the company.

Jeff Goldsmith became one of the most popular healthcare futurists. In 1995, Slomski quoted Jeff's concerns with vertical integration. He said "it is folly to expect hospitals, health plans, and doctors to exist harmoniously when they continue to have conflicting motives under America's dysfunctional healthcare system" (Goldsmith in Slomski, 1995:55). He differentiated the healthcare system from the industrial combines that achieved economies of scale through vertical integration. He also worried that healthcare systems needed new incentives and motives. And finally he believed that healthcare would work better in a system of "virtual integration" autonomously linked by information systems and care plans that focused on patient care improvement.

During the mid-1990s, physicians and administrators discussed the stage of managed care evolution in their particular communities. These conversations at professional meetings were highlighted in an *ME* article by Dennis Murray: *The four market stages, and where you fit in.* The article discusses the stages from independence to full-blown capitation. It is based on the organizational status of physicians, market share of HMOs, the consolidation of health plans, and the independence of hospitals in particular communities. This article, and others like it in different publications, affected integration activity of the time. Quoted

liberally, Jeff Goldsmith warned physicians not to throw away their leverage by selling out in a panic (Murray, 1995:44).

The next issue in the series of structural topics for physicians focused on clinics without walls. This particular organizational phenomenon was very popular in the early stages of capitation development. This model allowed doctors to merge their business offices and secure higher levels of administrative support, while still maintaining their independent offices and freedom of practice style. This model was seen as a way for physicians to test the waters of group practice, without having to dive in all the way at once. The article looked at three groups profiled two years earlier to review their progress. In the article several consultants made the point that this model is barely effective during a transitional stage, if at all, and delays the inevitable attitudinal changes that physicians must undergo to be successful under capitation (Mangan, 1995:129). The leaders of the three groups also made some interesting observations that are relevant in all integration processes. They warned of cutting costs too much in the early organizational stages. A badly designed 401k plan, for example, will cost the owners more to fix than one properly designed. In addition, they advised doctors to clarify the goals of the entity and accept new doctors congruent with those goals. According to their experience the headlong rush for growth is a bad idea. Movement toward a group mentality is essential. It can be fostered by such things as social encounters among physicians and staffs, regular meetings, newsletters, and educational programs. And finally, they advised vigilance of antitrust concerns caused by loose affiliations.

Another organizational model was highlighted in July 24, 1995 of *ME*. David Azevedo detailed the history of the 300 physician Lovelace Health System. That organization grew from an independent physician-owned system, to a joint venture partner of the largest hospital company in the world, to a system fully owned by a publicly traded insurance company, all in a fifteen year span of time (Azevedo, 1995b:62). Azevedo noted the availability of capital that comes from such an affiliation. When the Lovelace Hospital reached the end of its useful life, the hospital company made capital available to the doctors that allowed the group to remain in control of hospital services. The trade-off was loss of independent ownership. When the hospital company sold its interest out to an insurance company, with the doctors powerless to stop it, the dreaded "A" word was heard. "The Foundation sold us out, literally. We lost our autonomy," according to Patrick J. Quinlan, M.D. chief of the Lovelace medical staff. The CEO of Lovelace at the time tried, unsuccessfully, to put the best face on it. "If we can get the Lovelace system to perform well financially, we can have a non-intrusive partnership. If we can't, CIGNA will become more intrusive." Such are the desires of nearly every medical group, no matter the organizational structure.

Three of the most heavily concentrated growth areas for managed care in its early stages were California, Minnesota, and Massachusetts. Experts from each of these markets were brought together in a conference on primary care medicine sponsored by *ME*, and presented in the October 9, 1995 issue of the journal (Pincus, 1995:33). The mission of the conference was to share the state-of-the-art in heavy managed care markets with professionals in developing

managed care markets. Some comments that echoed sentiments found elsewhere included this one, from Dr. Eugene Ogrod of California: "hospitals do not know how to run outpatient systems. Don't rely on them. Hospitals have the money today; they won't have it tomorrow" (Pincus, 1995:34). The basic message was that capitation is not going away, and doctors would be better off accepting the inevitable. That way they could focus on better managing a population of people, than on fighting the transition. The idea, expressed in this article, of providing better patient care more economically through disease management was one of the most innovative notions that became popular in the mid-1990s. That is still the goal of many healthcare providers who recognize that the pressure to reduce costs and provide more economical healthcare is not going to go away any time soon.

Another doctor/author urged leaders of physician organizations to "forget democracy" (Guillory, 1996:192). This CEO of a 2,000 physician Independent Practice Association made a salient point that is the basis of the sociology of healthcare perspective: "physicians—busy, hardworking, perfectionist, and fiercely independent by nature and tradition—can be a difficult group from which to wrest cooperation and consensus" (Guillory, 1996:192). This perspective focuses on the basic challenge involved in creating an organization out of doctors—their basic inability to trade their independence for anything else. The article suggested that attempts to make doctor organizations democratic are doomed to failure, and should not even be attempted. Doctors will unite behind a sound business plan and make the organization work. Just as when they invest

in a publicly held stock, so too they will not have to address autonomy concerns. When the company no longer meets their needs, they might have to consider other options more limiting to their autonomy. Until then and as a transitional matter, this plan should work. This argument sounds good, but this is one of those folksy articles written by the principal. Given the megalomania feel around the edges, another author could easily challenge the article's basic premise.

Finally, after all this open discussion of alternative structures available to doctors, a 1998 *ME* article found its way back to the beginning. *Suits vs. Stethoscopes: Who's to blame when doctor-hospital mergers turn sour?* chronicled "Dr. Slacker" stories caused by faulty compensation programs. Experts concluded that some hospitals are "learning from their mistakes, and inviting doctors to become equity partners", the only way to fix the situation (Lowes, 1998:142). The issue is more than just fixed salaries which disincentive the doctor to see more patients. The issue includes the autonomy and independence questions discussed earlier. The article asked a question very much on point with this research study. "Is the employed doctor a slacker, or does he feel disempowered? If he's told, 'Do this or else' he may respond, 'Okay, but you won't see me working past 5 anymore" (Lowes, 1998:145). The ability to feel in control is central to a doctor's work life. The easy response is to assume, as this article did, that doctors have to have an equity position in their practice to feel control. And some may. But not all doctors feel that way, for empowerment, not ownership, is paramount. People really miss the point if they

generalize the anecdotal experiences and fail to accommodate their local situation, even as they apply the lessons learned from others.

Journal of Healthcare Management

The Journal of Healthcare Management (JHM, formerly *Hospitals and Health Services Administration)* is published by the American College of Healthcare Executives. It is devoted to research in current topics of healthcare administration. Since it is a refereed, academic journal, it is more theoretical and less timely than trade journals that reflect the current operational and strategic concerns of administrators and physicians. Neverthless, this journal features topics of concern with more attention and greater objectivity than the others do. The relevance of *JHM* can be seen in the following summaries.

For physicians, one intermediate step between totally independent solo practice and employment as part of a vertically integrated health system is a joint venture between a hospital and its medical staff. Many such joint ventures, focusing on ancillary department management and revenue sharing, were consummated between 1985 and 1990. Many of these were then undone between 1990 and 1995, as a result of a change in the law. An article published in (Spring, 1990) *JHM*, correctly made the point that there are two separate reasons for entering such ventures. One was financial, and the other collaborative (Blair, Slaton, and Savage, 1990:3).

The physician partners would probably tell you their motivation was financial, and that is probably why most of these ventures succumbed to a change in the law. But hospitals constantly search, not only for ways to unite their medical staff, but also to tie the entire staff more closely to the hospital. Although doctors often read this as CONTROL, the joint venture was the method of choice for some time. The author suggested a theoretical process that hospitals should undertake to insure the success of the venture, highlighting the relevant social and ethical issues involved in that process. For example, unless the joint venture included all physicians associated with the hospital, there was an issue of fairness for those left out of the partnership. According to the author, this approach satisfied both the doctors' autonomy and participation needs, which are key social factors in this development.

The results of many of these joint ventures indicated that hospitals chose to share a part of their pre-existing revenue stream with private practice physicians. They did that rather than have those doctors open competing ventures. If the joint venture was successful, the hospitals lost less money than they would in competition with a venture totally owned by the doctors who control referrals. In exchange, they often felt they were securing loyalty for other projects. But, in certain cases, the hospitals had a hold card—control of the revenue stream. In situations where the hospital already controlled the revenue stream, i.e. from managed care contracts, contracts with employers, ownership of an HMO, etc., the hospital would have less reason to joint venture.

Other concerns of hospital administrators in the 1990 timeframe relate to physician satisfaction with support from their hospital. Physicians had not typically wanted hospitals involved in their business. They had also exercised substantial control over hospital operations, since they controlled patient admissions and referrals, and demanded the hospital operate in a manner pleasing and comfortable to the doctor, as well as the patient. Survey results of Cleveland area physicians were reported in *JHM* (Goldberg and Martin, 1990:27). Conclusions about what doctors want from their hospitals included these: control of governance of the hospital, majority representation of board seats, joint venture bargaining with HMO and PPO plans, and a variety of support services for their practices (Goldberg and Martin, 1990:35). Surprisingly, the finding that doctors wanted help for their practices from their hospital contradicted other articles written from a physician perspective. However, hospital administrators (major subscribers) looked seriously at the opportunities to provide physician practice support services.

The cultivation of corporate culture is a primary responsibility of management and governance in any organization. The challenges for hospitals who employ doctors are enormous. An article published in *JHM* expanded this issue (Meyer and Tucker, 1992:465). They identified four areas of "shared understanding" that affect physician value and belief systems. More importantly, physicians rely on them in their practice. "Autonomy and entrepreneurialism, the fact that physicians relate best to other physicians, belief in science, and humanitarian ideals" represented both the guiding forces for physicians and

important issues for managers to consider when constructing organizational support systems. There is no question that physicians must be treated differently than other employees of the health system. It is that recognition that makes this dynamic unique in the American economic system. One would believe that physicians would respond to the same incentives as other employees, but it seems the circumstances had not evolved to the point in 1992 where that was a reasonable expectation. It probably still is not in 2000.

The Winter, 1993, journal contained two articles reporting results of the Health Systems Integration Study, funded by nine large integrated systems (Shortell, et al, 1993:447) and (Gillies, et al, 1993:489). One article defined such systems. Then it looked at the progress toward integration of each of the subject systems (Shortell, et al, 1993:447). The results in the 1993 timeframe were not surprising: moderate functional integration and relatively low integration of physicians and care processes in the systems. The easy part is accounting and planning; the hardest part is changing and standardizing care processes. According to this study, culture figured into systems most advanced in integration. From other readings of the time, superficial elements, such as support of the parent company through common advertising campaigns and stationary, defined corporate culture. For most articles, having a strong corporate culture never referred to accommodation of the different cultural needs of physicians and other system employees. To include this perspective then, would place them out of sync with other literary conclusions.

The other article from the Health Systems Integration Study, focused on the barriers and facilitators of enhanced integration. They identified the key characteristics of organized delivery systems as "breadth, depth, and geographic concentration" (Gillies, et al, 1993:489). The authors summarized eight major barriers to integration:

- failure to understand the new core business;
- inability to overcome the hospital paradigm;
- inability to convince the "cash cow" to accept system strategy;
- inability of the Board to understand the new healthcare environment;
- ambiguous roles and responsibility;
- inability to manage managed care;
- inability to execute the strategy; and
- lack of strategic alignment.

These barriers were well-stated and very important factors. Two of the most difficult to overcome were intimately related: overcoming the hospital paradigm and the "cash cow" accepting system strategy. In most cases the "cash cow" was the hospital, with its lack of initiation and the cultural inability to move from its paradigm of doing things the hospital way towards the system paradigm. Because hospitals had so much less experience with outpatient services, and since the new economics required more outpatient activity, it was natural that a mismatch of strategic orientation was present. This study provided relevant information then (1993) and now (2000).

Hospitals and Health Networks

Hospitals Magazine (*HM*) is published twice monthly by a subsidiary of the American Hospital Association (AHA). Its viewpoint reflects that of hospital administrators, whose dues payments support the publication. Nevertheless, physicians are at the top of the list of topics of interest to hospital administrators, since they control more things that happen in a hospital than administrators do. Physician goodwill is essential to the success of any hospital. In the April, 1986, issue, a noted medical group administrator, Bob Bohlmann, warned hospital administrators "the biggest mistake hospitals can make is to become the physicians' adversary" (Sandrick, 1986:50). And a physician administrator of an integrated system, David Ottensmeyer, said "many hospital administrators will have to change their ways of thinking...they cannot settle for a separate, independent, self-governing medical staff. They must bring physicians into the organization and give them a clear stake in the organization" (Sandrick, 1986:49).

The 1986 article also pointed out the growing strength of medical group practices. It is clear that large group practices were beginning to position themselves as the principal competitor for many hospitals, mainly because of their ability to organize managed care plans for employers and to attract large amounts of capital. The author believed that hospitals and group practices have been "integrating horizontally and vertically, developing alternative methods of healthcare delivery, and linking together to form networks and alliances"

(Sandrick, 1986:46). This was certainly one of the earliest forecasts of vertical integration.

Hospitals were already considering buying physician practices, in order to build the medical staff of its dreams, and to lock in referrals (Riffer, 1986a:74). And the increase of capitation programs and the ability to lock in the revenue stream prospectively, made it reasonable for medical groups to buy hospitals, and vice versa. The Mayo Clinic, for example, changed its long historical, free standing relationship with the two hospitals its physicians had exclusively used for years by purchasing both of them. This allowed them to coordinate incentives and increase opportunities (Shahoda, 1986:38).

Enough physicians had become employees of health systems by 1986, that the American Medical Association convened a special section at its annual meeting for employed physicians. They recognized three prime reasons for the growth in numbers of employed physicians, who "trade private practice for security: growth of alternative delivery systems, increasing competitive pressures caused by a larger physician supply, and the financial security sought by younger physicians" (Riffer, 1986b:66). Employed physicians expressed relief that the AMA finally recognized their different needs.

In 1988, *HM* reported the phenomenon of physicians buying hospitals. Researchers cited the growing trend of hospitals and doctors becoming aligned in the same entity. They observed that doctors buying hospitals was a natural outgrowth of hospitals buying doctor practices (Koska, 1988:81). They believed that the stronger of the two would buy the other out. They concluded that a

group of doctors would be stronger because they account for the majority of admissions to a hospital and want to control the revenue stream because of that.

Who controls the revenue stream is neither an abstract nor insignificant matter. Within the healthcare system, hospitals control most of the capital and the most community relations. But the increased competition between hospitals and physicians compelled physicians to offer more services, even those that were traditionally the province of hospitals. A healthcare consultant, Barry Moore, advocated this trend and tried to help hospital boards and managers understand such services were not God-given (Grayson, 1989:32). He argued that hospitals should work with doctors to add value to services being offered by the doctors for the first time. When hospitals were unwilling to work with the physicians, Moore concluded that the doctors went forward and left the hospitals out of the process. Sandrick (1990) estimated that 35 percent of total outpatient radiology procedures were performed in non-hospital settings, many of them in physician owned facilities. This study documented that hospitals were looking more like medical groups and medical groups more like hospitals. He concluded that the two groups should work together to provide the services (Sandrick, 1990:31).

Doctors and hospitals could also work together in opposition to managed care plans. Many observers noted the health plan "divide and conquer" strategy of separately negotiating rates with hospitals and their medical staffs (Johnsson, 1991:28). In order to present a unified front, the solution, according to Johnsson, was for doctors and hospitals to integrate. And not just for rates. Healthcare for

a population of capitated patients could best be delivered by means of coordinated care plans across a vertically integrated network of providers. By far, this became most popular strategic plan of the early 1990s. The exact nature and structure of the integrated network varied by local control and design (Philbin, 1993:46). The variety of integration models described by Philbin ranged from loose contract, multiple-entity models to fully integrated, single-entity health systems. But, as always, the reality of aggregating diverse incentives was more difficult than planning the best integration strategy. Another writer and futurist of the day, Jeff Goldsmith, preached virtual integration, not vertical integration, as the appropriate model to maintain the necessary flexibility for the marketplace. He defined virtual integration as "strategic collaboration in developing and marketing a product through contractual arrangements, rather than through common ownership" (Goldsmith, 1995a:11). He also predicted, for the foreseeable future, both a mix of competition and collaboration between partners in these virtually integrated systems, and an economic model that included capitation and fee-for-service payment methodology.

Montague consulted the largest physician driven systems about their methods of attracting new doctors (1993:22). While many used salary guarantees as the enticement, most believed incentive-based plans offered the most success. The Medical Group Management Association (MGMA) reported that physicians with incentive compensation plans made more money than those paid on fixed salary basis, regardless of the structure of the practice (Solovy, 1996:64). One special key for the larger groups was the ability to provide an

education to new doctors based on substantial experience with capitation. But all believed the availability of data—financial data merged with clinical data—was essential to successful integration.

Providing a group of doctors with actual data from patient care experiences significantly impacted the design of the care processes. But even using the data appropriately required making some very difficult decisions both in utilization matters and in network development issues. The doctors had to decide that their friends were wrong in certain cases, for example, and that they should send a patient home earlier than they wanted. They might stop using a particular referral doctor whose results were not as economically efficient as their competitors (Kaufman, 1995:58). Perhaps the more difficult issue for many doctors, however, was the loss of a complete trust vested in doctors by their patients. David Ottensmeyer M.D., the incumbent CEO of the Lovelace Health System at the time, phrased it this way: "a lot of physicians yearn for the past, but society doesn't believe the doctor knows best anymore. All we can do is say over and over what is going on in reality, and bring physicians to the realization that the world isn't the way it was in 1975, and that it's never going to be that way again" (Montague, 1993:22).

PPMCs became the subject of several articles in the mid-1990s. The spin of the first of these resembled Wall Street. Was the conclusion expressed in one article correct? Was healthcare a trillion dollar cottage industry, with woefully inadequate management? Would adding for-profit management to the mix do nothing but improve results and improve the physicians' preparedness for

capitation (Cerne, 1995:32)? Subsequent events proved that forecast drastically wrong, for the PPMC industry went down in flames. But the notion proved sound. Capital could help physician groups become more closely equal to hospitals and health plans, and therefore improve the balance among the three. Absent that equality, collaboration would be nearly impossible because of the independent nature of doctors and control orientation of hospitals. As Robert Laszewski said, "organizing primary care physicians in like herding cats, and that is why management of these local entities is so crucial" (Cerne, 1995:35).

Certain attributes of PPMCs contributed to their success, including stable management, information systems and managed care contracting expertise, open communication with physicians, and risk/reward sharing (Hudson, 1997:20). Certain failure was foreseen when strategic direction shifted, infrastructure needs were not addressed, and most importantly, doctors were treated as a commodity. Hudson profiled several failed networks including some of the largest PPMCs who were bought and sold outside the control of the physicians and without their concurrence. Regardless of the rhetoric, most of the failures were traced to the bankruptcy of the business plan, as described elsewhere in other journals.

Modern Healthcare

Modern Healthcare (*MH*) Magazine started as a hospital-focused, semimonthly publication and evolved overtime with a broader focus into a weekly format. It has always included news summaries of general interest, and more recently, a Washington desk that focuses on government activity. Although its news summaries reported the hospital mergers and acquisitions, *MH* said little about physician merger and acquisition activity, that is, until hospitals started buying physician practices. One such article reported on a key dynamic for physicians—if their local hospital is controlled by a system, it cannot be controlled by the local physicians as before (Greene, 1989:24). Other topics included insurance company mergers and acquisitions.

Toward the end of the eighties decade, more feature length articles covered the general topic of vertical integration. Highlighting a survey of eight major hospital systems, Shortell (1989:38) isolated five major strategic areas of integration: diversification, system affiliation, competition, physician relations, and issues of corporate culture. While the focus was clearly on hospital activity, strategic orientations began to shift toward physician and insurance issues. But one statement, meant to show the new sensitivity to physician involvement in the system, ironically lacked understanding of physician's strategic orientation and disregarded their needs. Specifically, the study reported concern among the hospitals for "selecting and developing physicians whose practice habits and career goals were consistent with the hospital's strategic orientation" (p. 42).

Over time that sentiment shifted to a better understanding of physician's strategic needs, but the beginnings were problematic for doctors.

In 1994, Don Wegmiller, a former CEO of a large Minneapolis hospital system who lost his job in a merger, pointed out the breadth of options available to physicians in the current market. He said that doctors were primarily interested in the strategic interests of hospitals they joined. They wanted to know both how the hospital planned to become effective in a managed care environment and how the hospital planned to involve them in governance. A central piece of every physician merger is the compensation program. Since much of their compensation is obtained from ancillary sources that are competitive with hospitals, well-planned, long term compensation programs are essential (Wegmiller, 1994:28).

Eight years after the original Shortell study (1989), for example, *MH* commissioned another integration survey. This survey revealed that integrating physicians proved the most difficult part of building an integrated system, by a 3 to 1 margin. The second most mentioned complication concerned re-orienting management incentives (Japsen, 1997:66). Japsen found that hospitals paid too much for physician practices and employed physicians were less productive than independent physicians. Board positions for physicians, a key measure of involvement to doctors, was not a big part of the strategy of the studied systems. Only 18 percent reported having added physicians to their governing bodies (Japsen, 1997:66).

In 1993, *Modern Healthcare* reported that hospitals were slow to align with physician group practices, but a vast majority were in the process of such an affiliation, or contemplating one (Burda, 1993:33). The journal's editor, Clark Bell, wrote that integration makes sense because "bigger is better" as evidenced by the experience of Columbia/HCA (1993:33). But he also cautioned against the development of too much bureaucracy, saying that it is important to "look before you leap." That advice was taken lightly in the early 1990s because "deal heat" generated by the merger and acquisition activity in the healthcare industry created a near panic. Reactions to competitors purchasing a medical group were contagious. In addition, the power of suggestion via reporting of such transactions in journals like *Modern Healthcare* was often irresistible. Even without empirical evidence of the success of these ventures, decision makers unanimously utilized this strategy.

In 1995, Jaklevic documented the development of six of the largest PPMCs (1995:26). According to him, their growth was fueled by the twin impact of HMOs concluding employment of physicians was too expensive and too limiting, and by the natural reluctance of physicians to be controlled by hospitals. Early reviews of these companies were upbeat and positive; Wall Street investors liked Caremark and PhyCor. Subsequent consolidation in this industry proved the doubts of skeptics of this business. They saw no long term sustained profits in a process where profitability was achieved mostly on the basis of declining physician income. However, the rapid growth and development of PPMCs cause a positive shift in the power dynamic away from hospitals towards

physician groups. Previously, hospitals held considerable sources of capital thereby controlling the landscape, while physicians (even with considerable control of patient referrals to other doctors and hospitals) were frustrated by a lack of capital. That scenario changed once publicly traded companies put capital in the hands of doctors. With this new capital, doctors could develop new revenue streams to maintain current earning levels. As a result, doctors became substantial threats to the control of future strategic directions of hospitals. Physicians developed ancillary services that dramatically reduced the earnings of many hospitals, and hospital administrators and boards were powerless to stop them. If these PPMCs had been sustainable, the power dynamic would likely have shifted permanently. As it was, many of the organizations developed by physician groups in the early 1990s were taken over by hospitals.

MedPartners became the largest of the physician practice management companies, and the largest corporation in Alabama, in only its fourth year of existence (Jaklevic, 1997a:43). It started by taking over relatively small practices in its home state in its first two years, and grew explosively in the next two years by acquisitions of other PPMCs and Independent Practice Associations. Their market strategy focused on capitating the entire healthcare services market, thereby taking over the revenue stream from insurers and hospitals. MedPartners CEO Larry House saw healthcare as a 3-legged stool consisting of physicians, hospitals, and insurers, in which the longest leg represented physicians (Jaklevic, 1997c:48). To the extent healthcare premiums supported the maintenance of physician incomes and profits for the public owners, the

capitation strategy remained attractive. When the premium levels fell or the medical risk experience was adverse, this strategy proved was deadly. In the late 1990s, development of capitation decreased as the main form of payment. For the first time in a decade, there was a possibility that a different payment mechanism might dominate the healthcare system. Ironically, that time period also recorded the decline and fall of MedPartners.

One failed network of hospitals blamed a large part of their failure on a shift in payment mechanism (Scott, 1997:138). The Columbia Basin Regional Health Network started after state legislators dictated most of Washington State's population would be covered by managed care plans. A subsequent law scaled back those plans and redirected many of those enrollees. Another key issue for this network was the absence of physician involvement and the lack of a visionary physician leader. The director of the failed network noted the availability of competing IPAs that took away the need for physician involvement in the system sponsored vehicle.

The chief regulatory threats to vertical integration, became antitrust rules (Jaklevic, 1997b:38). One of the major monopoly cases involved the Marshfield Clinic decision of 1994. Prosecutors targeted the largest clinic in Wisconsin for refusing to participate with a Blue Cross state program. Although significant parts of the decision were overturned on appeal, the expense and trauma of the case negatively affected physician-insurance company activities throughout the healthcare market. In addition, the article pointed out the reluctance of health

plans to bring such charges, even when known to exist, for fear of pricing or participation reprisals on the part of the physicians.

Interviews With Employed Physicians

The Physicians' Views of the Impact on Themselves

The overwhelming sentiment of the doctors who were interviewed, when asked why they joined the group, was the need for management expertise, and the related relief from management burden that joining the group offered. In some cases this translated into a higher potential for more income as a result of having more time to generate revenue, and as a result of having more professional management looking at the business as well as the environment. In other cases it translated into a better lifestyle as a result of being relieved of management responsibilities. As one doctor said, "finances were half the decision, and peace of mind was the other half." A related issue was the opportunity to recruit partners. In private practice, the recruitment and start-up costs were borne by the original doctor(s), but in this model someone else bore the expense, and the original doctors benefited by having improved lifestyle opportunities.

There was also a belief that the future of medicine was headed in the direction of large networks of physicians linking with hospital systems, and that the best time to cash in was now. This was "a hell of a deal—it made good business sense," in the eyes of one of the early entrants, and the "timing was better now than at retirement," because they were "worried there wouldn't be a very big chip to cash in at that time." Another doctor had a slightly different twist on that topic, he thought he could use the money better now than at retirement. He also believed that the group wanted him for his name, and were willing to pay him more than he thought he was worth.

From the standpoint of the development of the network, one doctor "saw it as a way to develop a quality network of doctors in order to get better control over our lives and our patients' lives." The control particularly had to do with negotiations with managed care plans. The expertise necessary to accomplish satisfactory relationships with third party payors was not going to be developed by a bunch of doctors in their own separate practices, even if it was legal for them to try, which it wasn't. One group in a remote site needed help dealing with the local hospital administrator, and hoped the system would eventually take over that hospital. Independent doctors had a hard time knowing they were being paid fairly. One expressed certainty that doctors down the road a few miles were being paid more for the same work, but he didn't find that out until he joined the group; joining the group also corrected the imbalance.

The doctors' expectations for themselves reflected these reasons for joining the group. One doctor expressed this very well in saying he "wanted to

be involved in concepts, not nuts and bolts. We wanted to be actively involved in strategic planning prior to changes, with someone else to implement those changes." Another doctor said "I didn't need to have the final say on issues, but I did need input and to know that I was heard. I wanted to just doctor, not worry about business issues." It is certainly interesting that the next thing he said was "at least that is what I preached, I'm not sure I believed it all." This dichotomy of public expression versus private doubt will be addressed a little later when the subject of loss of autonomy is discussed.

The doctors expected not only to be relieved from administrative hassles, but also to turn those over to someone with more administrative expertise than they possessed. This is an interesting phenomenon since most doctors, when asked before a merger, would say their business affairs were managed very well. They are also typically reluctant to "hospitalize" their operations by having hospital people involved in their practices. In this case, the doctors were more confident of the administrator's ability to help them because of the pains the founders of the group took to distance themselves from the hospital, and the fact that the doctors were so involved in defining the organization in its early stages. One doctor described this as an opportunity to "keep the best of the existing practice, and get rid of the bad."

One doctor saw it as an opportunity to become an administrative physician in a larger organization. He expected little interference in the day to day affairs of his practice, and viewed this affiliation as a way to get paid for something they were already doing voluntarily, apparently something for nothing in his view. But

he noted a change in perception among the members of his group after the affiliation. Whereas, before, the doctors understood they were obligated to pay their own way, and any money allocated to them had to come out of another doctor's pocket, now he sees signs of a shift. It is very surprising to him that some doctors now appear to act as if someone else (the system) will pick up the difference, especially since that isn't true.

The doctors also expressed some interesting intangibles in discussing expectations for themselves. Several looked at joining the group as a way to take the pressure off, one said "totally." Another sentiment heard repeatedly was the security of being part of a system with which they had a solid background. And one didn't want to be left out; he said "all the good groups were joining." While the experience hasn't always been what was expected, one doctor wondered where on earth "they come up with some issues," and another had the concern in the last year that the group would not survive because of their treatment of doctors, the interesting position of this minority group is that "soft" issues were overwhelmingly the most important part of the deal. One said that he got everything he wanted when he joined the group, including frustration over having given up control.

When asked about the balance between what was gained and what was given up, these doctors were strongly of the opinion that they got more than they gave up by joining the group. That is not to say that the experience was totally positive or that the transition was painless, and some recent actions on the part of the system have tested that balance. One doctor expressed this very well in

discussing training on coding for services performed, an important part of getting paid for the work that is done. He said, "consistency within the group on such issues is helpful, but limiting of freedom. Overall that is positive, because it is better to conform and get help than to have freedom and do it wrong." One doctor said he got more than he gave up, "even though I'm enough of an employee to feel it every now and then." Specialists felt that referrals from doctors outside the group were limited as a result of their affiliation, but were more than made up by the availability of referrals from within the group and the loyalty of other members of the group.

The regulatory concern of being a part of the larger group certainly costs money and increases overhead, according to most of the doctors. As simple a thing as writing off individual patient accounts at the discretion of the doctor is prohibited, for example. Another was frustrated by the employment policies. "In the past, if I came in one morning and didn't like what someone was doing, I sent them home. Now it takes a considerable effort to get rid of someone because of the rules." He also expressed the frustration of not being able to pay for things with pretax dollars the way he once did. That same doctor viewed the main positive in the exchange as more free time. It makes the rest of it worthwhile for him. "Giving up calling the shots was hard. There is a big control issue, but I must stay focused on why I did this in the first place—quality of life enhancement. As long as I stay focused on that, the rest of this nonsense is tolerable." Another said that he was "on the threshold of thinking it is not better at all. Right or wrong, it comes down to money. Billing and collecting has been disconnected

from the doctors, and they seriously need our input. Originally, we knew that administrators did business better than doctors, but now we're not sure."

One of the major issues that has surfaced increasingly over time is the intrusion of the health system (hospital) mentality into the medical group. As the health system has come to make its imprint felt more over time, the understanding among administrators of how doctors work has declined, and the bargain has been tested. The biggest indication of that was heard with respect to the system's decision to cancel a contract with one of the largest payors in the area. One doctor told of his finding, after the deal was done how, that the system had "hung the doctors out to dry" by never even addressing physician compensation issues. He said they agreed to doctor fee schedules without talking to the doctors, even though the doctor rates hadn't been changed in some time. His belief was that hospital negotiators worked on hospital issues exclusively, and didn't represent the doctor's well. He said, "if I told my partners what I've been told, they would storm the system."

Another doctor was very satisfied with the employment concept, enjoying the opportunity to let the bottom line take care of itself. He expressed the position that it would drive him crazy to be bottom line oriented; he is much happier this way. He believes medicine shouldn't be based on the bottom line. If a flu vaccine is cost effective, that's much secondary to the fact that it is good for patients. He said the key is getting over the fact that doctors are "brainwashed from birth" that they have to be ultimately responsible, and they are used to

seeing people jump when they want something. Since the employee concept for doctors takes that reaction away, the key is getting over the "autonomy deal."

The issue of feeling like an employee raises one of the most important issues found in the literature survey, and anticipated in the development of this group—the issue of loss of autonomy. It has been said that doctors who sell their private practice to, or merge it with, a larger group affiliated with a hospital or health system have traded money for autonomy. For example, one doctor said, "as soon as you enter the group you carry the accumulated baggage of the group. You are no longer an individual, you are 'that group' doc."

There were certainly some comments made in these interviews that would indicate that some loss of autonomy was felt by most of these doctors. One said, "there was more say in what happened in prior practice. You can't chew out an employee the way you could there." Another expressed the reservation that you "must somewhat alter your practice to fit corporate needs." Another said it "takes much longer to get things done, and the process doesn't improve outcomes much; my intuitive sense on personnel issues is better than what happens after study." Autonomy was also the issue in managed care contracting for some doctors. While they wanted help in that area since doctors were spending too much time going over "minutiae," they didn't want to lose input to the extent they have. There is a pretty strong feeling that they could have done it better themselves. Perhaps the most frustration was expressed in the feeling that the group has a "dishonoring" way of communicating with its doctors. That must be the ultimate way of expressing the loss of autonomy. The issue being discussed

at the time was annual conversations about compensation, and I was left to wonder how one honors an employee in talking about his compensation for the next year.

One especially thoughtful doctor tied the autonomy issue to the ego of the doctors. He said, "a certain amount of ego is required to do what doctors do. You must have a thick skin. There's a reason heart surgeons are such assholes. For primary care doctors, those needs are only a little less subtle. The group trounces on those ego needs routinely. Doctors are not flattered and humored in the way necessary." Communication goes a long way toward massaging the egos, and involvement in advisory committees is one way to improve the feeling of flattery. Absent that involvement, its easy to get tunnel vision and retreat into the one controllable—the doctor-patient relationship. A doctor thought that it is hard to have innovation when you have autonomy, and that you need a group to innovate.

The majority view, however, was it was more than an even trade. One doctor said the proof was found in looking at other doctors still in private practice in town. "They are more of a prisoner to business. I do what I want. I have more time off because of the group. The others are more burdened and therefore less autonomous." Another said he "hasn't lost much. Even though there are some limitations, its well worth it by a 10 to 1 favorable ratio. For every one thing I want to do and can't there are 10 things that get done that I don't have to do." An interesting point of view about this is the reduced friction between former

partners—one of the reasons some of the doctors joined the group. "Now I can go to administration rather than fuss with a partner over a business decision."

The communication process was raised in the literature survey as a consideration before a merger or acquisition. In this project, there was an interesting tendency to talk about communication when discussing loss of autonomy. "Have got to be able to talk. Everyone must be involved in talking about issues. Nothing is done behind anyone's back. Everyone is part of the process, and no one is left angry—it's all above board." Another was "very positive about the arduous process of having the chance to express myself. Everyone had input; this was very important to the formation of the group." Still another said we "can't make split second decisions. 80 to 90 percent of the time that is good; 10 to 20 percent of the time it is not good. You must prove the worth of an idea." The group's resident philosopher said, when asked what diminution of autonomy he felt, "None. I never felt autonomous. It's hard to back me into a corner that we can't negotiate our way out of. I never felt like I stood alone." One interesting trade-off with autonomy was innovation. The notion that innovation requires an organization was not something I would have guessed on my own. But more than one doctor had a similar sentiment. One doctor said he expected leadership from the group that never came. He wanted "hard nosed leadership" to help move from 23 different individuals to one united clinic.

The Physicians' Views of the Impact on Their Patients

For the most part, the doctors thought the impact on their patients would be negligible, that their patients would continue to be cared for in a quality manner. There were some service additions like laboratory and x-ray services that doctors thought would result in "more efficient one-stop shopping." Others thought that bigger had to be better and therefore easier for their patients, even after making allowances for the increased complexity of the bureaucracy. One specialist was concerned that the inability to perform post-partum tubal ligation procedures would negatively affect several of their patients each year, since they would have to undergo a separate surgery in order to accomplish the same result. He was very gratified, though, that the group let "patient demand take preference over the limited usage of system affiliated specialists" in every other way. As the numbers of managed care patients grew over time, however, the issue of which specialists to use became more time consuming and contentious. Much of the negative impact on patients was the result of deficiencies in specialist performance, according to these doctors, and that would have been solved by their ability to refer to whomever they selected.

One of the major worries of some doctors who were accustomed to small physical plant facilities was the move to "hospital-like facilities" that their patients would feel uncomfortable in. Another doctor answered this, after several years of seeing patients as part of the group, by stratifying the acceptance level of

patients by age. He said, "younger patients are very happy. Older people still moan and groan about bureaucracy—numbers of forms, impersonal nature of the place, different reception areas." He also made the interesting observation that people who move into town uniformly like it regardless of age.

A very strong sentiment, that may relate back to the ego issue raised earlier by one doctor, is the belief that it doesn't really matter to patients who the doctor is affiliated with, since they come for "what I have to offer." For the most part the rest is just trimming. The doctors expected their patients would have access to more services in a convenient setting, and better communication and referral arrangements between specialists and primary care doctors. In some cases those things happened, and in others they didn't, but the key is that nobody messed around with, or got in the way of, the existing patient-doctor relationship. The single exception noted by the doctors is the cancellation of the large managed care contract. That was seen as devastating to some individual patients who had been cared for by the same doctor for 15 or 20 years. In some cases those people had very complicated medical issues that were in balance to a large extent because of their doctor, and the patients had no options for change in insurance coverage that would let them continue with the same doctor. The doctors viewed this as a serious breach of trust between administration and patients, with the doctor caught in the middle, all because of some silly power agenda between a relatively few people.

One of the most important measures of impact on patients in this study is the affect this affiliation had on relationships with other outside doctors who might

be involved in the care of the same patients. This study asked for doctors' perceptions about relationships with referral doctors and with other doctors in the group they joined. For the most part, these doctors believed referral patterns were changed somewhat by the affiliation, and that patients were cared for equally well, in some cases a little better, because of the changes. In some instances the former referral doctor was hurt substantially by the loss of business, but in most cases the effect was negligible. As one doctor put it, "certain referral patterns developed that were good for the new doctor, bad for the old one, and neutral for patients." Another said that his affiliation didn't affect his relationship with other doctors much because "those relationships were superficial anyway. I don't like doctors much, as a rule."

Since this medical group is mostly made up of primary care doctors, the matter of specialty referrals is a very large part of patient satisfaction with their care, and of the quality of patient care. There was a fairly strong negative reaction to the intervention HMO's bring to their relationship with patients and with other physicians. Limitations on freedom of referral and imposition of the "mother, may I" system, in which referrals are subject to prior approval by HMO affiliated nurses or doctors, were unanimously scorned.

From the standpoint of personal relationships, there is a fairly strong perception that doctors who didn't join the group are more suspicious of those who did. In the area around the system's main hospital, there is a "healthy disregard" for doctors in the group, by those outside, that is often attributed to the bad relationship the doctors outside the group have with they system's founders.

One doctor said he wouldn't expect it to be any other way, "those guys are still very independent, and don't want it to change. The good things the specialists think of me are in spite of the group, not because of it." For doctors in the outlying areas, there is a different dynamic. The doctors outside the group are suspicious of the loyalties of those in the group. Before, they were competitors, but there was never a question of their loyalty to the same issues other local doctors have. Now there is a concern that issues are being driven by the remote system against the local interests, and that the doctors in the group are being bought off by the big system. I didn't find anyone who felt bought off in any way, but nevertheless the perception was found among doctors in the group.

With respect to relationships with other doctors in the group, most believed these relationships were enhanced. One said she "developed deep relationships with others in the group." Another said "relationships with doctors in the group have become stronger—we have developed power as a group that we didn't have as individuals. Deciding when to use it is a difficult subject." A third doctor said, "serving partners becomes as important as serving one's own patients. The Golden Rule becomes one must work with and consider the impact of one's decisions on the partners." A minority view of this point was expressed by one doctor who expected more camaraderie but didn't get it from the group. He felt that the doctors were so busy dealing with growing numbers of managed care plan enrollees that his peers were unavailable. He said it was ironic that he felt more singular than before.

When asked what decisions the group had made that the doctor felt were detrimental to their patients, the answers were diverse and relatively minor, except for the changing relationship with the managed care plan and the implementation of a new group practice management information system. Several said none, and then followed that up with an after thought like parking or capitation or not being able to do tubals. There were the inevitable complaints about bureaucracy, not getting enough help to get the job done, and doctors not being enough involved in the billing. One said "overall I believe I am a better doctor in a group practice, and that patients benefit from peer review, an enhanced performance expectation, the mutual education process, and the encouragement to go the extra mile—especially since if you lose a patient you lose them for everyone."

While the doctors expressed the view that they were still able to get most things done for their patients, there is still a view among the patients that something is different because of the group's development. It is sometimes hard to distinguish the roots of the detrimental effects on patients, whether those effects are because of the group's formation, or because of the introduction of so much added managed care. For example, one doctor expressed a strong negative feeling about the patient care committee—the body that reviews referrals to other doctors for the managed care plan. He attributes this to the health system, and he thinks the whole "mother, may I" approach is a mistake. But, left to their own devices, the managed care plans would be considerably more sterile about that process, and would involve the group's doctors a lot less.

Maybe this is an example where it would be easier if the "bad guy" were an outsider, and not a committee of one's peers.

The Physicians' Views of the Impact on Their Employees

The physicians expected their employees would have as good or better fringe benefits and pay scales as in the smaller private practices, and that their access to additional training would improve their career prospects. They expected to keep all of their employees through the transition, although they recognized consolidation of offices would increase the physical distance between some of them. Several doctors expressed the hope that productivity would improve with consolidation and access to additional training resources. One doctor's view was relatively unique. "I wasn't interested in the employees' interests at the time, and I wouldn't have cared if all of them had quit. I didn't think like a manager at the time." Another expressed a thought along the same lines in saying "he felt some indebtedness to employees based on longevity, but joining the group was a business decision for the doctor—a very personal issue."

In some cases, the employees' actual experience was a little different than the doctors' expectations. One physician said, "culture issues caused more turnover than we expected. The other practices used lower skill levels, not registered nurses." This doctor's former partner echoed that sentiment, saying, "we hoped our licensed people would stay on after the change, but all our nurses were phased out over two years. They liked the small private office, and the

boss changed. It was now corporate. The staff turnover was tough on patients." He went on to express an interesting value judgment. "In the end it was all for the best. It was going to have to happen, and it was better to blame it on the group than to have to take the blame ourselves." Another partner in the prior practice said, "we abandoned them and watched them leave one by one because of a salary dispute with the group."

One doctor thought it would "be harder on my employees because the jobs would not be as challenging or interesting as before. They moved into such narrower job descriptions, with more repetitive tasks, rather than solving a problem independently and then moving on." This was balanced by her belief that the employees would have more job security and more flexibility. "Before they had to take their vacations when I did."

The issue of employee loyalty was also probed. One doctor "would expect the intense loyalty developed in a small practice to break down. More people, more rules. No more special consideration raises." One doctor was more philosophical about it, saying "yes, loyalty was diminished, but I didn't take it personally. It became more aligned with the way it's got to be. They are not our employees any more, although turnover issues are hard." Another said, "they didn't stay around. Before they felt we were loyal to them, they should be loyal to us. The sale of the practice was a sell-out of that loyalty." Other doctors did not feel this was an issue at all, as a matter of fact, the doctors were almost evenly split on this issue. The most quotable of the doctors who did not believe there

was a diminution of loyalty said, "no, not at all. They bitched, but they always bitch. The truth is they got one of the best deals around."

There was also a noticeable difference in belief about the impact on type of employee. Doctor's office employees are often divided between "nurses" and "business people." Nearly all the doctors felt that nurses remained more loyal to the physicians than did the business people. But that would be almost inevitable. As offices were consolidated over time, the nurses still worked hand in hand with the same doctors every day, while the business people were pooled together with people from other offices, sometimes in remote locations. Perhaps the most important part of this issue, regardless of the belief about loyalty shifts, was expressed by a physician in this way. "The evolving loyalty to the group instead of me was hard, but patients were not affected. Both the doctors and the group made patients #1. Eventually the doctor and the group became one."

When asked if their employees gained from the affiliation after all is said and done, the major positive issue pointed to was the generous retirement plan. There was also a fair amount of belief that opportunities were increased, both in the sense of upward and lateral mobility. That is, personality disputes with a doctor or a doctor's favorite employee didn't have to result in the employee leaving the organization; there were multiple options in the larger company. Most believe, however, that the potential of upward mobility has not been fully realized. Also, the issue of cross coverage mentioned before was seen as a benefit of the larger organization to the employee. Employees don't have to come to work sick

and have the possibility of taking vacations at times other than those selected by the doctor.

So, how do the doctors feel about being relieved from most personnel issues? Was it a problem or a blessing? "Overall, a huge plus. Team leaders are really in tune with keeping doctors happy; doctors in other practices talk about staff with other agendas. Doctors in this practice have a high level of control, and don't have to fight administrators to set a straight agenda." The doctors uniformly did not miss the necessity of having to counsel employees. "We were winging it before, with a big liability as employers. It was sometimes a problem in changing roles. Before we were the employer, now someone else is; sometimes I forgot to take that hat off and leave it off." Another doctor said, "the downside is an inability to correct bad behavior of the employees. We can make suggestions; sometimes those suggestions fall on deaf ears and sometimes they are implemented." The most vocal doctor on this issue said this was a definite benefit for the poor performing employees, since the corporate policies of the group don't allow me to get rid of them the way I once did.

One doctor summarized his feelings as follows: "it was a blessing. I didn't want to be responsible for those people. We still get done what needs to be done." Another said, "it was a blessing for sure. It's not like I'm without input. Employees are not abused by the system; in fact they are protected from the abuse of doctors."

Governance Issues

Governance issues in a medical group are always difficult and usually contentious. It is not an easy matter to build consensus around a common vision for an organization when the people who are the principal reasons for its existence are known for their independence and for their adherence to a supra-organizational norm structure, their professional organization. Physicians come to ownership relatively quickly in private practice, and the typical buy-in is relatively small. The ego issues described earlier, and the way doctors are used to getting what they want, leave them thinking they deserve a larger voice in governance than they are able to justify to anyone except themselves, even their partners. Society grants them a lot of authority in business issues at a very young age, without much experience in that area.

These governance issues are exacerbated when the physicians are not the owners of the company. Mission is a much larger factor in the formation of health systems than it is in medical groups, where the typical mission is to make the doctors as much money as possible. Health systems are formed with regard to community, religious, governmental, benefactor, or even public shareholder goals that are much more complex than making money. Physicians are trained in a very competitive environment, where the good of anyone other than their patient is secondary.

These realities result in a conundrum for health system managers and board members, especially those systems dominated by a hospital or an

insurance company. How does one go about securing the cooperation of those who control the majority of resources in the system—doctors—when their views are not normally geared toward the best interests of anyone but themselves or their individual patients? One doctor expressed this very well, "it is important for the doctors to feel a part of something bigger than themselves. You give to it, and it gives to you." According to the physicians interviewed for this study, their medical group has some distance to go in making governance comfortable. One very interesting observation by a doctor was that this group has always been "led by a benevolent dictatorship, which, in the right hands, is best for a group of doctors. The benevolent should have one and one half eyes on the interests of the doctors and one half eye on the interests of the system, the way it used to be in this group. Governance by committee needs to be feared. This concept is hard for doctors, because they operate so autonomously. They have no notion of taking care of the herd, instead of themselves." The exact concept, benevolent dictatorship, was also used by one of the doctors in the independent group studied for this paper. On the one hand, the benevolence was shown by a non-physician who represented the funding source for the group, and on the other hand, benevolence was meted out by the senior doctor, speaking of himself.

How to meet the needs of the herd and the individual doctor, that is the question? Individual doctors might not be the best ones to ask about that since it is self-admittedly against their nature, but they did have some clues to the best way. One said the key was leaving as much of the decision process as possible

to the doctors who are there. This is what all the doctors miss the most. "The health system should provide advice and counsel, but not make the final go/no go decision. This issue is what causes doctors to leave groups and make considerably less money." Another said you cannot underestimate the importance for doctors of controlling their own destiny. The position of final authority is very important. When asked if it is possible to overcome not having the final say, one doctor repeated his mantra "you must stay focused on your original goal. Enhanced quality of life because of the group makes the loss of control tolerable (on most days)." This is the same doctor who thought that administrators should not have authority to make many decisions on their own, because he still wants to run his business his way, even acknowledging that he doesn't have the group's best interest at heart. His belief is that doctors should show how a deal would put more money in the doctor's pocket than it will cost. The collective weight of doctors' feeling a certain way towards money should convince all the doctors and administrators of the correctness of that deal.

Clearly, doctors having the final authority is not possible in a vertically integrated health system. The final authority must rest with the governing body of the system, and there are substantial legal issues involved in sharing that authority. Particularly in a not-for-profit system such as that which is involved in this paper, individual doctors cannot be left to control the company's assets in a way that benefits them personally. A person who feels that he must have final authority should really not expect to be fulfilled in such an organization. The issue is how much of the decision process can be left to individual doctors. One

suggested that the moneymen should be involved in deciding what should be done with the money, but that is overly simplistic since most things that are done eventually impact the money. Another suggested that doctors should know what is best for the patient and the group, and that should be best for the system, but that, too, is overly simplistic, since it doesn't provide a check on the actions of individual doctors.

One doctor seemed reasonable in saying that doctors should practice medicine in the way they choose, and administrators should manage the business affairs, and where those concerns intersect, communication is the key. The same doctor, a veteran of both types of organizations, said that doctor owned groups are more uncomfortable with regard to power issues, because of the egos, and the falsely assumed expertise. The doctor owned group discussed in this study reported a minimum of issues in which doctors felt that administrators made decisions that should have been left to them. That was true even though the doctors thought inappropriate board action was taken on a routine basis.

In either case, someone is left to do what others—patients, third-party payors, etc., wanted. Business decisions should not be the sum of individual doctor's decisions, according to one doctor, echoing the good of the herd comments noted earlier. There is some concern about the fact that business men have overtaken more of the decision making process recently, and doctor input has markedly lessened. They point to one of the remote sites as model of what should happen—a "very powerful model." The belief is that nothing gets

done without an open discussion that involves the entire group at that location, together with senior managers and operations personnel. The key seemed to be making it absolutely vital that all doctors have a sense of being heard. One recent matter that came to the front repeatedly was the implementation of a new practice management computer system. The doctors expressed having been essentially left out of that decision, and accordingly free to criticize what they considered to be a bad decision. One expressed no sense of control over the billing process because of the bad computer decision, and real frustration about that.

When asked about the decisions individual doctors should be able to make without board approval, all doctors focused on doctor-patient issues, and style of practice as inviolable. Most also said that they should determine when they work, how long they work, how many patients they see while at work, what patients to see, who to take call with, and when to take time off. Another thought that where he practices should be his choice, although he understood the need to consolidate offices as the group is formed, and the presence of a D.O. was very troubling to one M.D., especially since he had no input into the decision to add that particular partner.

For one doctor, this question set off a chain reaction of thoughts about his decision-making role. He said "the growth and development of this organization trades upon the charisma and personal appeal of certain key leaders. That is the key element to help sustain growth. If you have sterile, edgy personalities like we have had lately, you have a real problem. If you have a monthly 'required'

meeting in which 5 of 30 doctors routinely attend, what do you do? On this point another doctor was much stronger. "Why the f*#! doesn't Dr. X have to attend the monthly pod meetings?" When the obvious fact of his political connections was pointed out, it didn't help.

Back to the chain reaction, the doctor wondered how to develop loyalty among the younger doctors, and a sense of the organization so they can carry it forward. He concluded that the group's doctors must develop their own criteria for loyalty. He pointed out that one of his office mates has no interest in keeping informed, and, as a result, feels no need to help the young man grow or have much of a say in the business of the office. But he still feels it is essential for someone to have a plan to help him and others like him. The sense of urgency, coupled with total lack of acceptance of his part in the plan seems not at all inconsistent to him, and proves the notion of independence discussed earlier. His capstone comment was pretty informative, and also not totally consistent. He said, "a lot of us don't want power. We were raised to believe that if we went into medicine, maybe one day we'd be our own boss." A lot of what I heard from these interviews might cause one to believe the second part, but not the first.

Summary

The doctors who were interviewed for this project were generous with their time and their candor. They each had their reservations about the practice of medicine in a group, but the prevailing sentiment was that, after give and take,

this practice alternative was preferable to most others that are now available. And the distribution of this sentiment throughout the group is not uniform. These interviews were conducted over the period of one year, and across a substantial amount of geography because of the size and dispersion of the group. The most substantial single happening over that time period was the termination of the managed care contract. That event had widely disparate impact on individual doctors and their patients, but it had some geographical correlation because of the plan's enrollments across the area. In addition, a change of leadership at the health system brought with it a steadily declining regard for physicians. Interestingly, that made the interests of the specialists on the main campus more similar to those in the group, since the perceived disregard for physicians is universal, but it also increased the loathing felt by group members from those who remain independent.

The overwhelming sentiment about the group's formation was that open communication and the opportunity for all to express their views was sometimes painful and slow, but also essential to their support for this group. One doctor said, "the most important factor in forming a group is trust development. In this group it's based on communication." Another said, "communication is the key. You must be willing to give and take. Every doctor is headed this way, whether they know it or not. We just had the opportunity to be ahead of many others."

Interviews with Independent Physicians

Introduction

The social issues that impact physician organizations—struggles with autonomy, management, governance—are not limited to those groups that are formally employed by health systems. While most physicians must have some relationship with hospitals, if only for the admission of their patients, they do not have to become employees of an organization dominated by a hospital. Some doctors have tried to negotiate joint venture arrangements that will allow them to profit from ancillary services that have traditionally been operated by hospitals. Others have simply chosen to compete with hospitals for some of those services, with no attempt to share profits with the hospital. For those who remain independent but choose to practice in a group, there is still considerable effort at organization development and governance that is required to insure maximum chance for success.

In September, 1996, the merger of two pre-existing professional associations of physicians formed a ten-doctor group. According to participants in the merger, there could not have been two more divergent cultures. Even as recently as the first week of September, 1998, a full two years after the merger date, I found a fair amount of "yours" and "mine" in relation to operating policies of the group, and relatively few "ours". The doctors were trading conspiratorial

partners on a daily basis in the first week of September, 1998, and the only clear observation was that nearly everyone involved with the practice was miserable.

Description Of The Physicians

Doctor David 56 year old Neurosurgeon--Founder and sole owner of one preexisting group; 25 percent owner of subject group.

Doctor Paul 58 year old Injectionist--Founder and one half owner of other pre-existing group; 25 percent owner of subject group.

Doctor Timothy 44 year old Injectionist--Half owner of other pre-existing group; 20 percent owner of subject group.

Doctor Gideon 36 year old Neurosurgeon--Second surgeon in the group; 25 percent owner of subject group.

Doctor Matthew 44 year old Physiatrist--Employee of pre-existing surgery group; 5 percent owner of subject group.

Doctor Luke 34 year old Neurosurgeon--Joined subject group at the time of its formation; recently purchased stock for first time.

Doctor Mary 34 year old Physiatrist--Joined subject group at the time of its formation; recently purchased stock for first time.

Merger Preparation Issues

The roots of the post-merger misery appear to be two-fold. First, the doctors made uninformed decisions about structural issues like compensation programs—the single most important issue in a practice merger. They also failed to address intra-group referral/treatment protocols, a close second in importance, especially where complementary specialties are involved. The doctors and their managers failed to prepare the non-physician employees of the two practices for the trauma that is normal, and perhaps inevitable, with a merger.

With respect to the physician compensation issues, the cross-subsidization policies of one of the practices were accepted in the new entity without an open evaluation of the results of that policy, even though many hours of discussion of compensation issues preceded the merger. Cross-subsidization means that one doctor pays more than his fair share of the overhead of the organization so that another of the doctors can earn more than his fair share from the organization. It is a common occurrence in multi-specialty groups, especially where the earning power of the doctors is widely disparate. If it happens without full understanding of the physicians it can be the source of tremendous controversy when discovered.

With respect to the second issue, usually many hours are spent with employees involved in mergers, acclimating them to the circumstances of their new jobs or new employer and seeking their input into the selection of policies and procedures to be used in the new company. In this case, it was evident that very little time was allocated to employee transition issues. Most of these issues were decided by three managers, two from one practice and one from the other, who were named co-CEOs, and who were the bitterest of rivals. These three perpetuated the existing culture conflicts, created new conflicts in their jousting for position, and created armed camps within the new company. These circumstances resulted in hardening of positions among the doctors when the really important issues came to the group for resolution.

From the standpoint of the symbolic interactionist, the beginnings of the merger were an attempt to establish meaning in the professional lives of the physicians, and to embody those meanings in the make-up of a new professional organization. The doctors spent considerable time in the effort, and ended up fumbling this most basic notion—they left themselves with a jumble of meanings that were not shared. This was partly true because, for many doctors, clarity is the dreaded enemy, and ambiguity the staunch ally. The doctors also talked past one another in the hours of discussions and eventually made agreements based on trust in their administrative representatives whose agendae were not their own, and whose money was not ultimately on the line.

These doctors seemed very loyal to their advisors for at least some period of time, and were inclined to forfeit their reasoning capacity to these advisors

rather than take the time to sort through the issues themselves. Time would show, however, that once these doctors lost faith in their advisors, the lack of trust was complete. The advisors were blamed for the bad outcomes, rather than the owners who didn't adequately understand what they were doing with their money. None of the original three senior administrative leaders survived two and one-half years with the company, and two of them were gone in little more than one year. They may have taken an overly bureaucratic orientation into the merged companies, one that would have been very successful in one of the merger partners, and catastrophically unsuccessful in the other. On the difference between professionals and bureaucracy, Peter Blau (1974) said,

> Full-fledged professionalization entails not only expert skills, but also a body of abstract knowledge underlying them, a self-governing association of professional peers, professional standards of workmanship and ethical conduct, and an orientation toward service. Some of these factors may easily come into conflict with the discipline required by bureaucratic authority.

Diversity of the Merged Organizations

It is clear in this merged organization that the bureaucratic orientation of the one predecessor company was in no way compatible with the self-governing association of the other. Michael Hammer, one of the most recent popular

management consultants expressed the inevitability of conflict in a group, by defining the type of conflict that was helpful and supportive of the company's processes. He said,

> the culture of a process-centered organization must also encourage people to accept the inevitability of tension and even conflict. I'm not referring to the old political infighting and backstabbing, the turf protection and empire building, of corporate Byzantiums. Rather, I refer to the conflict that inevitably arises when independent people must work together to achieve multiple objectives in an environment of flux, ambiguity, and scarce resources. (Hammer, 1996)

The physicians who started this group had little agreement on objectives beyond completing the merger, and that failure allowed administrators to engage in their Byzantine machinations.

On the second year anniversary of the group's merger, the fourth administrative team in its history took over responsibility for managing the company's affairs. It seemed certain that the meanings assigned to the new organization by its owners were not clear, were not completely shared, and were not communicated with the employees of the organization in a manner that led to fulfillment of the owners' goals. Another Organization Development consultant, Ed Lawler derived the Star Model of graphically representing the interaction of

five key features of an organization—strategy, structure, rewards, processes, and people—in describing the "fit" of an organization.

> The best test of fit is the performance of an organization. If it matches the strategy, then good fit has been obtained. A second test of fit involves the positioning of information, power, knowledge, and rewards. When they are present in balanced amounts at all levels in the organization, it means that the five points on the star fit with each other. (Lawler, 1996:45)

There would certainly not have been a very pretty star had Lawler looked at this group last year.

In a perfect world, the symbolic interactionist would have each of the organization's processes support the meanings shared by the owners of the group, and foster its purposes. In this case, it was difficult to achieve that end when the physicians could not agree on the organization's purpose. One important factor in addressing that situation was the perception within the company of the individual owner's motives for merging their businesses. One group was motivated by the decline of their existing business, expressing a belief that they were not far short of bankruptcy. The other group was focused on the possibilities of practice expansion and providing a broader range of medical services for their patients. "Collegiality emphasizes processes of equality, consensus, and autonomy in which decisions emerge as a collective product and

are morally binding only on members; bureaucracy emphasizes processes of hierarchy, delegation, and accountability in which decisions are matters of individual responsibility and are imperatives for subordinates" (Waters,1989:961). It seemed clear that the bureaucratic processes preferred by the one pre-existing practice were in no way compatible with the touchy-feely methods preferred by the other. It was not to be expected by either group, however, that the combination would be easy or clear-cut. Even the group that despised bureaucracy recognized that

> the workforce of the post-bureaucratic organization would consist of temporary teams of specialists with diverse skills; each specialist would have divided loyalties, much as members of academic staffs do now. On the one hand, the specialist would pursue his professional goals, and on the other hand, he would pursue those of the organization (Kamenka and Krygier,1979:150).

From the beginning each of the two groups were led by a strong individual physician, although the nature of the two individuals could not have been more different. One was a visionary, a strategist who led his organization based on his feelings and emotions. The other was a detail-oriented individual who made decisions based on numbers and hard facts. One dealt with the possibilities that were in front of the group, and with a market approach that was most concerned with satisfying the needs of as many patients as possible. The other dealt with

the business as an internal system that needed continual monitoring and strong control of the various internal components in order to operate most efficiently. The non-physician personnel of the one practice were always charged to respond to patients with flexibility and freedom to make the patient's experience better. The employees of the other group were constrained to operate tightly within a set of policies and procedures that were developed by key administrators with input from the physicians. These processes served to limit variability in treatment among the practice's patients. In practice, sometimes, there is not a wide gap between professional authority and bureaucracy, but the distinction can be important. Peter Blau said in comparing the collegiality of Parsons and the bureaucracy of Max Weber, the father of bureaucracy, that both might be rational decision processes, just not for the same type of individuals. One rests primarily on competence and compliance follows based on enlightened self-interest, and the other on position where compliance is based on obligation or fear (Blau, 1974:246).

Diversity of the Founders

As can be seen from the description of the owners, this was a diverse group by age, by years of experience, and by specialty. That diversity was also reflected in the contribution of revenue to the company, and the expectation of income from the company. One of the original companies which spawned the subject group was started by Dr. David as a result of his having left his former

group in a very public, difficult "divorce". He said that he left that group "because they were unwilling to recognize the changing landscape of medicine and invest the necessary time, effort, and money toward the goal of remaining progressive and innovative in meeting the challenges ahead." He also said that every one of the reforms he was trying to institute in that organization was put in place by them, after he left, established a competitive group, and secured a dominant market position in short order. His vision was the original driving force behind the merger, and his rain-making ability drove much of the group's original success and growth.

Dr. Paul was the founder of a group of doctors committed to treating back pain without surgery, through a rather innovative (at the time) technique that delivers steroids, anesthetic agents, and other medicines directly into affected parts of the spinal column. He was one of the first to develop and perfect the process. He also was an innovator in the process of injecting dye into suspected abnormal areas in order to make a diagnosis. He operated a very profitable business for a long time, together with an associate, Dr. Timothy, who he trained and recruited to join him in practice. His focus was on maintaining a profitable practice in the face of increased competition, declining referrals, and lower revenues.

Without an agreement between the two founders there would never have been a merger. If, however, either of them had any idea what the next two years would have been like, it is doubtful they would have merged. The plan for the merger was based on a similar practice situation in San Francisco. The idea was

that surgeons should really only see patients who are ready for surgery, or have had surgery. Other doctors, more skilled in the conservative treatment of back injuries, should attempt those conservative methods until it is clear that surgery is the only treatment of choice. In the same way, patients whose surgery fails to correct their pain should be managed by the conservative care doctors as much as is possible. If the plan were to function as projected, the surgeons would be busy doing what only they can do, and generating high revenue streams in the process. The injectionists would keep busy taking care of chronic patients and evaluating new patients, and the physiatrists would be busy with rehab plans for patients throughout the spectrum of back pain diagnoses.

It appears to an interested observer that the plan never worked as designed. There was a dramatic difference of opinion among the physicians as to how patients should be treated. That is, the treatment protocols for the same diagnosis were strikingly dissimilar for the doctors who owned the two businesses that were merged. One group believed basically that you build a practice by taking care of everyone who wants or needs to see you, even if that means people who have had multiple surgeries, are dependent on drugs for pain relief, and who have almost no chance for relief of pain. The other group believed you take care of those people who fit the economic parameters of your practice, that you never facilitate drug dependency, and that you refuse to see people who don't fit, even if other doctors in the practice referred those patients. The result was a perception by Dr. David that Dr. Paul and Dr. Timothy were refusing to see patients referred to them by David, a clear violation of the original

plan and the rules, in his mind. Inevitably fewer referrals went from Dr. David to Paul and Timothy and their referral stream eroded. To make matters worse, as Dr. Paul says, "just for talking to David we were totally cut off by the five neurosurgeons in his former group." "When you take into account no more referrals from David and Gideon, you can see our position was precarious." It was not, however, precarious enough for them to modify their practice style to accommodate David, their referral source. In addition, they believed they had a mandate to remake the other merged practice in the image of their prior practice. They attempted to do that by trying to control the administrators who worked for their group in the past. This strategy succeeded in bringing the group to the brink of extinction.

Other Merger Complications

For the new doctors who joined the practice, there was considerable confusion over which process was superior. Since the new partners were beholden to others in the practice for much of their patients, it is not an inconsequential matter to figure out the right way to do things, and the politically correct way to do them as well. It was nearly axiomatic that the physician arguments over treatment protocols were couched in euphemisms like quality of care issues, good medicine, or sanctity of the doctor-patient relationship. The invocation of one of those lofty phrases acts to, and in most cases is intended to, cut off attempts by non-physicians to solicit common ground. When such issues

are raised between doctors, a cynic might say that an economic argument is being barely hidden, and the power of ambiguity is again at work. In this case, the ability to define the highest quality approach to care of patients with chronic back pain always disintegrated into the differing economic effects among the physician owners. The newer physicians in the group were left to their most recent training as a guide to action, but the academic perspective on these issues was often not very helpful. Meanings are not often shared between individuals who refuse to talk with one another beyond a restatement of the same position that has been expressed many times before. In this case, I attempted to force discussions between physicians that went beyond euphemisms and into the confluence of medical and economic arguments. In the end, of course, only the doctors could provide the meaning for this organization, but left to their own devices, the organization would fall before meaning could be integrated.

An economically important factor in the merger of the groups was a decision to undercapitalize the company from the beginning. This happened because the accounts receivable to the merging companies were not included as assets of the new group, and yet the doctors did not put enough cash in the company to fund operating expenses and physician salaries at the level the doctors expected. As a result, the new company borrowed a substantial amount of money and then attempted to repay it to the bank in one year. The method in which the debt repayments were allocated to the physicians, as reductions in compensation, was very controversial. It was probably not understood by any of them when it happened, and was disproportionately bad for the highest

producers, who were already paying more than their fair share of the overhead in the existing compensation plan.

Disintegration or Salvation?

When I first became aware of the situation, it was not very clear whether the object of the doctors was to manage the disintegration of the company or try to find a way to keep it together. A quick and dirty analysis of the situation made it clear that the same first steps had to be taken whether disintegration or salvation was the goal. One of the first things a consultant would do is look at the organizational documents, since in a perfect world those documents would spell out the meaning of the owners as agreed to at inception. In this case the findings were very interesting. The doctors had told me they had made it easy to get in the practice and difficult to get out. That was certainly reflected in the documents. One of the doctors who understood the agreement very well was fully prepared to buy his way out of the company when I met him for the first time, even knowing that he would have to pay nearly three million dollars to his partners to buy his way out. That illustrates both how miserable he was, and how difficult the original documents had made it to leave. The talk of dissolution was on the lips of every doctor in the first week of September 1998, although in some cases it was hopeful talk that some of the higher paid doctors would buy their way out so that the others would receive a windfall. Those who stood to benefit the most from the original agreements were totally unwilling to amend

them (with good reason), a process that required 100 percent approval of the owners.

After a couple of weeks of study, I highlighted the following areas of concern:

- the imbalance between ownership and revenue generation created a significant hurdle to overcome in the smooth operation of the medical group;
- the amounts due a physician at retirement were set to benefit the lower revenue generators at the expense of the higher producers;
- the covenant not to compete was very restrictive and expensive, resulting in the practical necessity for doctors to leave town if they left the group;
- the cross-subsidization of one group of doctors by another group was no longer acceptable to the higher producers, since acceptable service levels were not being provided to patients as expected;
- the administrative wars had to be settled in order to have any hope of calming the situation, and administrators had to be more aggressive in helping the doctors understand each other's position and less willing to stir things up by telling each of the owners what they wanted to hear;
- the debt repayment schedule, which was choking the owners, needed to be reviewed;

- the higher producing doctors, who were also the source of most new patients for the company, had to come to grips with the reality that the lower producers were controlling the company because of the existing governance structure and split between the neurosurgeons; and
- the original expectation of the owners, based on a belief of one of the original administrators, was that value in this company would be built by the profitability of its ancillary services and outreach activities. That was certainly not the result over the first two years of the group's existence.

These issues were addressed head-on in a series of confrontational, but very productive board meetings. These meetings generated a renewed commitment to the organization on the part of its owners, and a better concept of the shared meaning of the group. The keys to securing the renewed commitment were a new compensation program, a review and amendment of the debt repayment allocation methodology with retrospective application, a lengthening of the debt repayment schedule, a pledge of unanimity of purpose (and voting) among the neurosurgeons, and an acceptance of a different expectation about the profitability of the group-owned ancillary services. In addition, it was made clear that the only way a small, closely held company like a medical practice builds stock value is if the doctors leave their money in it. This was directly opposite to the original possibility that a regional or national group would value the operations of the new entity so much that they would acquire the

new group at a premium. This would have provided a windfall to the owners, but the changing medical practice environment took away that option. After these agreements were reached, and while the operations were being stabilized, the remaining key issue to be addressed was the governance of the group.

Governance

The doctors in this group were very open to addressing the issue of governance, and very appreciative of the opportunity to address this and other related issues directly. The responses to the questions of expectations were surprisingly diverse, but the assessments of the group's delivery on those expectations were unanimously, strongly negative. With respect to the vague questions on governance, the doctors' responses were generally equally vague, and an uneducated observer might conclude there was substantial disagreement among them, because of the wide variety of chosen euphemisms.

One doctor, for example, said that the key was the management team. He thought it was their responsibility to "calm the waters." Another said "as a rule, management and the board should come down on the side of those responsible for the group's success." Still another said "medical groups require benevolent dictatorship. Doctors are the single most immature and self-serving group of people. Any other group would be more mature." Another strong response was that the current structure allowed part of the board to bribe one individual to get his vote, which cannot possibly result in an appropriate

governance structure. My conclusion was that each of them was saying essentially the same thing: if the decisions go the way I want them to go, then I do not care how it is set up; if they do not, there is nothing that can be done to satisfy me. There was not an expression that we should be searching for the best way to make compromises, but rather a search for the best opportunity to get my way. Parsons believed that consensus is very important in professional organizations. He said, "all members of such organizations must participate in the decision-making process, and only decisions that have the full support of the entire collectivity carry the weight of moral authority." (Waters,1989:955)

On the specific questions about governance, however, there was an amazing amount of congruity in the responses. The doctors were nearly unanimous in their beliefs about which issues should be left to individual doctors or to administrators, and which should not be decided without formal board action. All the doctors believed that management—hiring and firing, common services such as medical records and transcription, and physical plant operation, should be left to the administrators within a set of very general guidelines provided by the doctors. All medical decisions should be the responsibility of individual physicians, except where quality of care issues need to be addressed by the board as a whole. And no expansion or physician hiring decisions should ever be made without formal debate and action by the board. In the probing that followed the initial questions, it was still pretty clear that there was not a general agreement on what the results of the debate would be, but there was consensus as to the process that should be followed.

The principle difficulty in governing and managing doctors (sometimes compared to herding cats) remains the independence with which they are trained. This independence is complicated by the stunted social growth that accompanies their being so focused on education and competition from the time they are 15 years old until they are well into their 30's. Perhaps the best approach is the one that was described to me by a Dean in describing his management style with faculty. He said you just set up boundaries and then patrol the fences. In the subject group, the task was to help the doctors describe and define the organization's outside boundaries as well as the internal fences between physicians. One doctor in this group described the challenge of doing that as similar to the United States Congress. "There are so many constituencies that must be accommodated in the structure. In our case, we have doctors with a lot of ownership and those with a little. We have high revenue generation, and we have relatively little. And, we are all doctors. We almost need a structure like the Senate, in which Texas and Delaware have equal representation, and a co-existing structure like the House where Texas has a lot more representation." Another said "the issue is which things get decided where, because the board is set up for one-man, one-vote, while the shareholders vote based on ownership percentages." Exactly so, and what do you do about the fact that different doctors brought in different assets to the new practice.

Establishment of an executive committee is one possible method of securing input from all owners affected by each decision, assuring the maximum amount of communication about the company's future, and maintaining a direct

relationship between those who have the most say and those who have the most at stake. This smaller group would be made up of the owners of the largest number of shares, and would be charged with responsibility for certain decisions that affect them disproportionately, for which they bear nearly all the risk. Day to day operations would be managed by administration at the direction of the board of directors, consisting of all the owners in a one-man, one-vote body. A potential complicator of this arrangement was spelled out by one of the doctors in this way, "there is probably not a high enough level of trust among the owners of this group to allow three doctors to act on their behalf in any significant way. Ideally it would be nice to have three people in a rotational system that allowed for one to be changed each year, but you would have to do it where all owners voted for all three slots on the committee." Lowery expressed this thought very well when he said "even the best-laid strategic plans just won't work unless the organization's leaders, staff, and other stakeholders trust one another. In the healthcare setting, trust can spell the difference between a merger's success or failure" (Lowery, 1997:117). If that is true, this merger was doomed from its second month.

Another complicator in governance is what to do as new doctors desire ownership in the group. The investment of the original owners was 10 or more times that required by other groups to attain equality of ownership. This goes back to the original assertion that the only way to build equity in a professional corporation is to leave your money in it. Most other groups have relatively small investments in assets, and therefore relatively small capital requirements for new

owners. One doctor said his friends who have been in practice the same length of time, are now equal owners in other specialty practices. "I can't see getting equal say in governance of this group, as my friends have in theirs, without a million dollar investment that has no chance of a return." Similarly, the payout of retiring owners is dependent on the continued earning power of the younger owners or the future recruitment of additional new doctors. The existing structure would make it very difficult to generate the additional ownership required to fund the retirements.

Summary

When a summary of these findings was presented to the board, more attention was paid to them than any other matter since the compensation plan was approved. While everyone was certainly dealing with the personal impact of changes in the governance scheme, the complexity of the analysis seemed to be sobering to the doctors. It was clear to me these issues were never addressed when the group was formed, that there never was shared meaning of the new company developed between the 2 groups, and there was very little internal examination of the impact on one another as the doctors considered alternative corporate structures. There was a very upbeat sense of challenge to keep the company whole and solve the challenges facing the group, and a commitment to develop a shared sense of the organization that seemed genuine. Although this process is a long way from completion, it is an excellent start. Again, Lowery

(1997:122) was helpful, in our experience during this and other projects, we learned a great deal about building trusting relationships during change initiatives. The following list summarized some of the most important principles we learned:

* all parties involved in the initiative must be willing to cooperate;
* the organization must value and encourage open communication;
* all parties must consider and respect each other's point of view;
* all parties in an evolving relationship must find a common ground;
* all parties must be willing to relinquish some degree of control or authority to demonstrate trust in each other; and
* all parties must be willing to share risk.

In working with physicians to create shared meaning for their merged practice while preserving the freedom to practice medicine according to their individual definition of meaning, these were very valuable guidelines. Open communication is not always cherished by professionals, whose independence coupled with a strong desire to avoid confrontation, often leads to passive-aggressive behavior that destroys openness. Willingness to cooperate, respect for the other's point of view, and the search for common ground are all antithetical to independence and autonomy. The challenge was to convince the doctors that the bigger villain is external to their professional organization, and that compromises with partners are much superior to losses to outsiders.

CHAPTER FIVE

DISCUSSION

I began this project wondering if my suppositions about the social influences on physicians who transform themselves from small business owners to employees of large corporations, who give up private practice in order to work in a health system dominated by non-physician employees, were documented by others. I began with a basic demographic study looking at the change in numbers of physicians by specialty in a geographic area. There were significant changes in those numbers, although not necessarily the changes that would have been expected. Then I tried to get a feel for those issues that were important to others in the healthcare industry, who lived through the same events I did over a fifteen-year period. I found a lot of people who wrote about conditions very familiar to me, and a few authors who looked at the environment from a very different perspective.

And finally I went to the object of these social changes and talked with physicians who had made the transition, as well as physicians who had contemplated a tighter relationship with a hospital/health system and decided to remain independent. Their collective insight was very helpful in highlighting what I knew to begin with: the key dynamic that operates on a generation of physicians (those over 40 years of age in 2000) is their sense of autonomy. Money is a major factor in motivating them, but they made it clear, in many different ways, that they value the freedom to exercise independence of judgement more than

money. They also believe, as a group, they are the prime, if not the sole attraction for their patients, and their patients' primary protector. They believe the people who were their employees before they sold their practice are better off in some ways, mostly financial, than they were before. They believe their former employees miss the closer relationship they once had with the doctor, but have seen more opportunity and freedom within the larger organization. And finally, they have a kind of cognitive dissonance about the best way to govern their organization. They would like to believe that no one can manage their affairs, and provide strategic direction for their organizations better than they, but they have a sneaking suspicion that someone can. They have an abiding mistrust of committee activities, interpret anything that slows down their decision timeframe as bad, and demand respect and honor from non-physicians as a way to maintain the social order.

Documentation of Physician Movement

Neither general population increases nor the changing managed care environment explains the physician population changes in the targeted area over the relevant timeframe. The most generous interpretation of population changes and managed care impact, assuming their impacts are additive, would not explain the addition of more than 30 primary care doctors in the primary metropolitan area, and 20 in the secondary area. Almost no rationale could be found for the addition of specialists in either area, except traditional explanations

like induced demand and a time lag between changes in the market and the reaction of those recruiting physicians. Induced demand refers to the phenomenon in which additional supply creates additional demand. It would not be out of character for hospital administrators in the rural market to promote recruitment efforts for specialists that would keep patients in their local community, rather than see them be referred to the next larger market. The additional supply is therefore justified by the local market, but certainly not from a global perspective.

In the same way, the 175 new specialists in the metropolitan area are not explained by a global rationale, especially since 59 of the new physicians were hospital-based specialists. Presumably the trend of fewer inpatients would argue for fewer radiologists, pathologists, and anesthesiologists, although an argument could be made that fewer inpatients doesn't mean less people being cared for, or much less service being rendered. It could simply mean that shifts in service location reduce the numbers of patients admitted to the hospital, and increase those treated as outpatients.

Journal Contents and Professional Sentiment

The selected journals, taken together, show a seven-fold increase in the proportion of their space devoted to integration topics over the relevant time period. My supposition in undertaking that analysis was that such a result would indicate a high level of awareness of vertical integration as the most rational

response to the changing payment structure in the healthcare market. A doctor and an administrator both said as much in the same article: every medical group or hospital they were aware of had either done a deal, was doing one, or wanted to do one (Murata, 1994). The number of articles is a reflection of the frenzy in which hospitals, physicians, and insurance companies found themselves, because there was no time to evaluate the value of the deals. Practices were purchased because others in the market were doing so, not because an integration plan called for it with an understanding of the long-term costs of the strategy. The editor of *Modern Healthcare* cautioned against the creation of too much bureaucracy because of the centralization, suggesting administrators and doctors should "look before they leap" (Bell, 1993).

The physicians who were interviewed also experienced the dilemma between caution and deal heat. One told me he did this deal because everyone else was. An often quoted sentiment was that this was the way healthcare was going, and it was better to be involved in the early stages in order to have a voice in shaping the entity. These same physicians were fiercely independent, not wanting to give up their right to control their own destiny. Other doctors made it clear they were asked to join the group, with the complementary implication that the group was to be built around a few stalwarts who would teach the others how it should be done.

Among the independent physicians, most of the discussion centered on the misery all the doctors in the system-owned group were feeling. There were constant rumors about various specialties preparing to leave the group because

of money, control, or inept administration. Several doctors also told of threatening statements made by the health system leadership about recruiting competition for the specialists, which certainly contributed to the drive to remain independent.

I would also have supposed that interest in reporting integration topics would have declined over the last three or four years, because of the negative economic impact of practice ownership, and because of the declining movement of patients to capitation. The journals began reporting, in that timeframe, the staggering losses being accumulated by hospitals that employ physicians. I believe the wording of that sentence is indicative of one of the major social problems felt by the physicians. Without an attempt to make physicians feel a sense of ownership in their practice, regardless of the legal technicalities, there is almost no way a smooth transition is possible.

In the same way, physicians who believe they can accept a buyout offer and remain totally in control, as before, are not being realistic. The necessity of aligning incentives brings with it the absolute mandate to compromise. As one doctor told me, compromise is not a word in many doctors' vocabularies. The doctor who told me that the Chief Financial Officer of the group had "dishonored" him by asking him a question in the middle of his office day, does not get it. Doctors have a special place in the health system, and always will, but it will not always be the place of honor in which his former office employees held him. The demands of the new environment require changes of everyone, and the

socialization process must certainly recognize and smooth out the implementation of those changes.

Physicians, especially those in private practice, have long regarded *Medical Economics* as a trusted friend. The journal, however, was like the timid friend afraid to be straight with you, and tell you the truth even when it hurts. It was the last of these five journals to regard integration as a major issue, and the first to significantly reduce its coverage of the issue. By doing so, *Medical Economics* missed an opportunity to help prepare doctors for the inevitable. It did report almost exclusively on physician integration issues when it entered the fray, and remained very loyal by staying with the anti-hospital position that made it so popular. The personal touch that comes with physicians submitting articles was also helpful to the typical, solo-practice independent.

The Physician as Patient Protector

The overwhelming response when asked about the physician's expectations for their patients as a result of joining the group was that the group would stay out of the way and let the doctor provide the best care possible. After a time, it dawned on me that the message the doctors were sending was this: I may be turning my business over to someone else, but I do not want or need any help taking care of sick people. I did not find a single doctor who thought the association with other doctors in the group would help in the one-on-one relationship with a patient in the exam room. The closest to that I heard was the

anticipation of having another doctor down the hall with whom to interact. Most of the early doctors in this group had been solo practitioners by choice. The thought of having a peer to talk to was both comforting and threatening. The threat was related to their protection of patients; they did not want to see "bus station" waiting rooms, and impersonal business office services and bureaucracy that would confuse and dehumanize their patients.

The doctors in one of the groups were particularly incensed over the health system's decision to cancel a contract with a large third-party payor. They used words like "it ravaged a sub-population of my patients," and "long time patients came to the office in tears" over the fact they had to change doctors. And the most telling comment was, "the decision seemed hard-headed and pretty wounding." These comments might have reflected the economic impact on the physician, and I am sure would be interpreted that way by some laymen. I believe, however, that these are the genuine sentiments of these doctors. Primary care doctors, in particular, often expressed the notion that theirs is a lifetime relationship with patients. Unless one of them fires the other, the relationship continues in perpetuity, unlike a surgeon who may have only a limited surgical episode with a patient. As one of the PPMC leaders said, the doctor is the only person involved who has taken an oath to serve the patient to the best of his ability (Perry, 1994). I believe these doctors were sincere in their efforts as patient advocates, and that they sincerely believed the administrators had abandoned patients by some of their decisions. The doctors also expressed

a strong sentiment on behalf of patients in being disappointed that they could no longer write off patient bills if they saw the need.

Perhaps the biggest place for patient advocacy is in the selection of referral physicians. These doctors took that obligation seriously, and cited it as one of the main reasons for joining the particular group that they did. The doctors at the main hospital talked a lot about the negative feelings independent doctors have for the group. One said that any good feelings they have for him are in spite of the group. But once more, the key was the ability to maintain good relationships with specialists they considered worthy of their patients.

Physicians and Their Employees

The loyalty developed in the relationship between the doctor and his medical assistant can be among the strongest of work relationships. Those assistants typically bear the full brunt of the doctor's bad days, and reap the benefits of his protective umbrella. The lengths to which physicians will go to protect a trusted assistant from other doctors or the organization itself have been well tested in the group of independent physicians I interviewed. One medical assistant was known to corner her doctor, and make certain he went into meetings with a predisposition to her views. The other doctors would have to wait him out, and bring enough other points into the discussion for him to realize what had happened. Another doctor was known to beg that someone take care of his assistant's issues, just so he would not have to deal with them.

Doctors who left solo practice and joined the larger group saw the loyalty of their business office people decline to the point of near extinction when they were merged into offices with other doctors. But they didn't see the same issue develop with their medical assistants, who remained intensely loyal. In one way, physician's burden to protect their employees is lessened when the loyalty strings are stretched by the larger group. In a similar effect, one of the largest benefits expressed by the doctors in joining the group is the relief from personnel issues. There is still a contingent who views giving up personnel issues as an assault on control, but that is a definite minority.

The doctors did feel there was some benefit to their employees of being part of a larger organization. The fact of the cottage industry is that the office is closed when the doctor is absent for vacation, education, or sick leave, and that is when employees are expected to vacation, also. When the doctor is in, the employees are expected to be there. With only two or three employees in the typical doctor's office, there is little room for cross coverage. Joining a larger organization, with managers responsible for securing temporary help for such occasions was seen by the doctors as a major benefit to them, and they thought a huge factor in giving employees freedom they never had before.

One doctor expressed the most extreme minority position when he said he didn't care about what happened to his employees in the transition, and that he never thought about them in considering the move. There is an element of that indifference which is evidenced by the turnover in some offices. Some doctors told me that was one of the downsides of being an employee, because "they" do

not provide me with stable help. However, because of the close relationship between doctors and their assistants described earlier, the stability of the help may have more to do with the physician and his relationship with the employee, than the administrator who provided the employee for the physician.

Autonomy versus Money

There was a sense just beneath the surface of the interviews that physicians had no real choice to remain independent. The burden, measured in money and tension, of continuing to administer a small business in such a heavily regulated industry was becoming too great. Additionally, patient decisions about which doctor they would see were increasingly made by third parties and not the patient. The traditional word of mouth marketing channels would not be able to overcome that threat. Those third parties were also very interested in having more control over the services they paid for.

These same sentiments were found in the journals. One veteran expressed his experience in trying to get others prepared for managed care. "When managed care finally begins to move, it's going to move very fast. So something that was once thought of as a communist plot, and something which no red-blooded American physician would do, is now becoming very popular" (Ottensmeyer in Montague, 1993, p. 22). Language like this was continually repeated in journals, hospital staff meetings, and professional education seminars in the early 1990s.

This environment forced physicians to consider the unthinkable—becoming an employee of a hospital. Hospital administrators saw the opportunity, for the first time since Medicare came into existence, to take control of their organization's revenue stream. They moved aggressively to wrestle control from physicians. And their allies were insurance companies. Insurance companies made doctors rich after the introduction of Medicare, but they did it on the doctors' terms, until this payment revolution came along. Insurance companies paid whatever legitimate bills the doctor submitted. Now, however, insurance companies were looking over the doctor's shoulder and asking questions about the things he did—before they paid him.

And so this was the direction taken by hospitals, large physician groups, third party payors, and eventually PPMCs beginning in the 1980s. Some of them came with money, some came with stock and stock options, and some came with promises of collegiality and maintenance of autonomy. All came with some intent to control a group of people who were socialized into a profession that would not be controlled, although the evidence of some forms of control was more subtle than others. The result was a potentially devastating assault on the autonomous spirit of the physician. "The group routinely trounces on ego needs." "Doctors are not flattered and humored in the way necessary." "We notice the diminution in autonomy from top to bottom." "Have to ask for things I used to spontaneously get." "Before, I was boss. Everything I said went. Now must go through committees, must lobby. Usually it dies before it gets done."

There is a sense, gained from experience, and bolstered by these interviews, that a subset of physicians would rather be free to do things their way, even if its wrong and costs them money, than to be part of a process that does things "right". One said, "we're not used to looking after the herd". Another talked of a colleague who left the group, knowing she would make substantially less money, but considerably more satisfied for having done so. Part of this is temporal, also. Some of these interviews occurred before a major upheaval in the health system, and some after. Raw nerves were evident in those interviewed after the upheaval.

There is also another undercurrent, and another subset of physicians, who have made the transition and arrived at a better place as a result. They believe they gave up "nothing that is missed." One said he felt the loss of autonomy, but could see the other side of it. Another said that he never felt autonomous, in his words, "I never felt like I stood alone." A related point of view is that the group is more liberating. For those focused on innovation, one expressed the view that autonomy limits innovation, one must have a group to innovate. For him at least, innovation is the stronger motivation. But the key point for doctors who have successfully made the transition to the employment model was expressed by one of the original doctors in this group: "compare us with other doctors in town. They are more of a prisoner to business. I do what I want, and have more time off because of the group. The others are more burdened and therefore less autonomous." Even one of the most autonomous, control-oriented members of the group emphasized that he didn't like the loss of control at all, but he just

keeps reminding himself why he did this in the first place—more free time with the family.

Governing Physicians—the Ultimate Cat Herding

The most interesting discussions I had about governance came when I asked them about Rousseau's notion of the formation of society. Basically, he said that people give up their freedom in the state of nature in exchange for a social contract that recognizes the freedom of equality for everyone. There is an exchange of the freedom to take whatever one wants by force, and keep it in the same manner, for the right to own property that is defended by all in society (Rousseau, 1968). He also said that is the only way that people could truly be free.

For the doctors to whom I posed that reasoning, there was theoretical sympathy. It made sense to them, if the alternative environment was bad enough—the "third-party behemoth" in one's words. Doctors would form a group, or become part of a health system, in order to be free from the hassles of business, the threat of loss of business from random insurance company choices, and to allow themselves the free time to see more patients or take more time off, but not initially because they wanted to.

Once inside the group, they unanimously believe they should be free to see patients as they choose, and treat them without interference. Uniformly, they saw the task of the group in terms of assisting them to see patients in their own

way. Governance of the group is therefore charged to support the autonomous (there is that word again) practice styles of each of its physicians. Occasionally, some criticism of the group for not standardizing patient care processes was expressed. Putting those two things together, one might assume they want the processes standardized as long as it is done their way. But, I do not think that is the case. I think they demand a right to participate with their peers in the decision making process, and will, to a point, go along with the group's determinations. Absent an acceptable voice, they will retreat into their own method and stonewall the group.

They would prefer, I sense, that non-physicians participate in governance issues as little as possible, and never about a medical matter. When asked specifically about the issues administrators should handle on their own, the responses from independent doctors were dramatically different than those of the employed doctors. The independents were much more comfortable with administrators acting on their own within certain limits. The employed doctors thought they should not be allowed to do much on their own.

My interpretation on this is related to who has the final say. Since the employed doctors felt they were excluded from ultimate governance, even those who are elected to advisory boards, and since they believe the current health system leadership does not have their interests in mind, they are unwilling to cede business issues to administrators. But they are also not of one mind that doctors can do everything better than businessmen. Many recognize the limitations of physician training and disposition. The doctors who own their own

practice, however, expect reports back from their administrators at monthly board meetings, and are comfortable they have the ultimate say, as a group, in the strategic direction of the group.

There was also an understandable disparity between the two groups with respect to the decisions that only the board can make. Since the governing body of the health system includes few or none of the employee doctors, and since the system is structured so that ultimate authority rests with that body, the employed doctors want a very decentralized system. The independent owner-physicians, on the other hand, want to control things from the board level. On the one hand, the doctors were very strong in limiting what individual doctors might do, such as hiring additional doctors. The employed physicians, however, did not believe the board should be allowed to hire a doctor and put him with another physician without prior approval of the existing doctor.

Social and System Integration

This study has documented considerable systemic motivation for change in the healthcare system of the 1980s and 1990s. The necessity for alignment of incentives among payors, hospitals, and physicians as a result of the shifting risk arrangements that followed traditional cost reimbursed, fee-for-service medicine was a powerful motivator. For physicians, this meant that new employment arrangements, once unthinkable, became commonplace. Hospitals and insurance companies seized the opportunity to use their resources to force

structural changes that reduced the power of physicians. Hospitals began to act more like traditional businesses in the American economy, securing their lines of future revenues by purchasing physician practices and starting their own insurance companies. The only problem is that these lines of future revenues are people/patients whose choice of physician and hospital is limited as a result of the hospital's action. This is system integration, change in the relationship of parts of the health system as a result of conflict and the "steering media of money" (Habermas, 1987:117).

Social integration focuses on the actors, their conflict, and resulting relationships. This micro-look at the health system is also documented in this study. The hospital administrator who lamented his lack of control of his own business because of physicians who control his operations understood this aspect of social conflict (Greene, 1997). The ability of that administrator to turn the tables on his physicians by employing them is another part of the social integration aspect that was played out in developing health systems, as the interpersonal power dynamic changed dramatically. In the same way, the changing social relationship between physicians was also well documented in this study. Among the most independent people in the economy, physicians learned to live together in the same organization in order to combat the power snatching described earlier, and protect themselves from further deterioration of their autonomy. In some cases, doctors expressed a stronger willingness to help hospital based health systems form groups, rather than band together with other physicians. Any attempt to label the actions of physicians (or anyone else, for

that matter) as a group, is bankrupt, but some consistent actions of doctors can be described.

Concluding Thoughts

Physicians who have been in practice since the early 1980s are the most socially impacted group as a result of the reorganization of the American healthcare system. They were for years the most socially autonomous group in the system, and therefore had the most to lose. The attacks on their power base, in order to control their freedom to treat and refer patients as they choose, are attacks on their most basic socialization. From the time they enter medical school until they enter practice they are taught independence and competition, not collaboration. They are taught that theirs is the only proper way to look at medical issues, and they are the final authority on medical matters. While newly trained physicians enter practice with the expectation of being employees, those with more experience never expected that for themselves. The doctors I talked with are fiercely protective of their patients, and strongly of the opinion that they know best what is in their patient's best interest. These doctors have, for the most part, adapted to the corporate practice model, and believe they can protect their patients and their most essential employees in that model, even though they are very disappointed, as a whole, with the leadership of their health system. They essentially look upon the system as non-essential to their relationship with their patients, and they hope for more opportunities to make the system patient-

oriented in the future. They are resigned to the exchange of autonomy for security, and have found a way to live with it.

The independent doctors have seen significant limitations on their autonomy also, but they have dealt with it in terms of having maintained the final decision authority over all issues, even if their options are not good. The independent doctors I talked with have looked at several joint ventures with the local hospital, but have been put off by hospital administrator actions they consider manipulative. They have been successful at maintaining, and even expanding, revenue streams that support the group's development and recruitment efforts.

Both groups are constantly thinking about the best way to control their own destiny through their respective governance structure, and there is no question the independent doctors feel more satisfaction with that part of their professional lives, since they feel like they have the final say, even though there is a very small range of differences between the two groups on what they can and cannot actually control, in my opinion. It is nevertheless the fact that they made the final decision that causes the social consequences. The rank and file doctors of both groups are equally uninformed and relatively happy. It is also my opinion that most of these doctors will feel the absence of autonomy from time to time, and will generally express unhappiness with their situation, but will think it is better than the alternatives. They will also look for the day when a changing payment structure will allow them to transform themselves into the next iteration.

REFERENCES

Abrahamsson, Bengt. 1993. *The Logic of Organizations.* Newbury Park, CA: Sage Publications.

American Hospital Association.1998. Putting managed care in its place: in managed care markets, deals between hospitals and doctors take some unexpected forms. *Hospitals and Health Networks* 72:1, 34-6.

------. 1996. Strategies for steering your integrated delivery systems. *Hospitals and Health Networks* 70:8, 82-3.

Anonymous. 1995. Selling your practice to a hospital—watch out? *Medical Economics* 72:4,113-7.

Archer, Margaret. 1996. Social integration and system integration: developing the distinction. *Sociology*, 30:4, 679-90.

Aristotle. 1992. *The Politics.* Translated by T. A. Sinclair. London, England: Penguin Books.

Azevedo, David. 1995a. Can the world's largest integrated health system learn to feel small? *Medical Economics* 72:2, 82-94.

------. 1995b. When downsizing hits the medical staff. *Medical Economics* 72:14, 62-71.

Bachrach, Peter, and Aryeh Botwinick. 1992. *Power and Empowerment: A Radical Theory of Participatory Democracy.* Philadelphia, PA: Temple University Press.

Bazzoli, Gloria, Stephen M. Shortell, Stephen, Dubbs, Nicole, Chan, Cheeling, and Peter Kralovec. 1999. A taxonomy of health networks and systems: bringing order out of chaos. *Health Services Research* 33:6, 1683-6.

Bell, Clark W. 1993. Most hospitals slow to join with group practices. *Modern Healthcare* 23:34, 33.

Benford, Robert D. 1993. 'You Could be the Hundredth Monkey': Collective Action Frames and Vocabularies of Motive Within the Nuclear Disarmament Movement. *The Sociological Quarterly* 34:2, 195-216.

Benhabib, Seyla. 1997. Between Facts and Norms: Contributions to a Discourse Theory of Law and Democracy. *American Political Science Review* 91:3, 725-7.

Bennis, Warren. 1990. *Why Leaders Can't Lead.* San Francisco: Jossey-Bass.

Berne, Eric. 1963. *The Structure and Dynamics of Organizations and Groups.* New York: J. B. Lippincott Company.

Blair, John D., Charles Slaton, and Grant T. Savage. 1990. Hospital-Physician Joint Ventures: A Strategic Approach for Both Dimensions of Success. *Hospitals and Health Systems Administration* 35:1, 3-25.

Blau, Peter M. 1974. *On the Nature of Organizations.* New York: John Wiley and Sons.

Blumer, Herbert. 1962. Society as Symbolic Interaction, *Human Behavior and Social Processes*, Arnold M. Rose, editor, Houghton Mifflin Company, 145-154.

Boren, James H. 1972. *When in Doubt, Mumble.* Van Nostrand Reinhold Company.

Bronowski, J., and Bruce Mazlish. 1960. *The Western Intellectual Tradition, from Leonardo to Hegel.* New York: Harper and Row.

Brown, Michael D. 1997. Don't let a PPM play you for a sucker. *Medical Economics* 74:118-20.

Brown, Rupert. 1988. *Group Processes: Dynamics within and between Groups.* Oxford, UK: Basil Blackwell Ltd.

Buechler, Steven M. 1995. New Social Movement Theories. *The Sociological Quarterly* 36:3 441-64.

Burda, David. 1993. Most hospitals slow to join with group practices. *Modern Healthcare* 23:34, 33.

Burns, Lawton R., Stephen M. Shortell, and Ronald M. Andersen. 1998. Does Familiarity Breed Contentment? Attitudes and Behaviors of Integrated Physicians. *Research in the Sociology of Health Care* 15: 85-110.

Calhoun, Craig. 1993. "New Social Movements" of the Early Nineteenth Century. *Social Science History* 17:3, 385-427.

Cant, Sarah, and Ursula Sharma. 1998. Reflexivity, ethnography and the professions; watching you watching me watching you (and writing about both of us). *The Sociological Review* 46:2, 244-64.

Cerne, Frank. 1995. Money and management. *Hospitals & Health Networks* 69:1, 32-36.

Chard, Jiri, Lilford, Richard, Gardiner, Derek. 1999. Looking beyond the next patient: sociology and modern health care. *The Lancet* 353:9151, 496-7.

Coddington, Dean C., Keith D. Moore, and Elizabeth A. Fischer. 1994. *Integrated Health Care: Reorganizing the Physician, Hospital and Health Plan Relationship.* Englewood, CO: Center for Research in Ambulatory Health Care Administration.

Cook, Bob. 1999. Thinking First. *Modern Physician* 3:4, 62-3.

Cook, Karen S., Gary A. Fine, and James S. House. 1995. *Sociological Perspectives on Social Psychology.* Needham Heights, MA: Allyn and Bacon.

Cutchin, Malcolm P. 1997. Community and self: concepts for rural physician integration and retention. *Social Science and Medicine* 44:11, 1661-75.

Dalby, Michael T., and Michael S. Werthman. 1971. *Bureaucracy in Historical Perspective.* Glenview, IL: Scott, Foresman and Company.

Drucker, Peter F. 1992. *Managing the Non-Profit Organization.* New York: HarperBusiness.

------. 1998. *Managing in a Time of Great Change.* New York: Truman Talley Books/Plume.

Frederick, Larry. 1985. How Many Health Plans Can One Town Handle. *Medical Economics 62:*98.

Gerth, H.H., and C. Wright Mills. 1958. *From Max Weber: Essays in Sociology.* New York: Oxford University Press.

Gillies, Robin R., Stephen M. Shortell, David A. Anderson, John B. Mitchell, and Karen L. Morgan. 1993. Conceptualizing and Measuring Integration: Findings from the Health Systems Integration Study. *Hospitals and Health Systems Administration* 38:4, 489-511.

Goffman, Erving. 1974. *Frame Analysis: An Essay on the Organization of Experience*. NewYork: Harper.

Goldberg, Joseph P. MD, and Harry J. Martin. 1990. Control and Support: What Physicians Want from Hospitals. *Hospitals and Health System Administration* 35:1, 27-37.

Goldsmith, Jeff. 1995a. It's time for virtual integration. *Medical Economics* 72:11,55.

------.1995b. Can the World's largest integrated health system learn to feel small? *Medical Economics* 72:28.

Goodsell, Charles T. 1985. *The Case for Bureaucracy.* New Jersey: Chatham House Publishers.

Gormley, William T., Jr. 1989. *Taming the Bureaucracy.* New Jersey: Princeton University Press.

Gouldner, A. W. 1979. *The Future of Intellectuals and the Rise of the New Class.* New York: Seabury.

Grandinetti, Deborah. 1999. Undoing the damage: How to reclaim the practice you sold. *Medical Economics* 76:13, 83-93.

Grayson, Mary A. 1989. Breaking the Medical gridlock. *Hospitals* 63:4, 32-7.

Greenberg, Warren. 1998. Marshfield Clinic, physician networks, and the exercise of monopoly power. *Health Services Research* 33:5, 1461-2.

Greene, Jan. 1997a. Integration therapy. *Hospitals and Health Networks* 71:15, 30-2.

------. 1997b. The confidence gap. *Hospitals and Health Networks* 71:15, 27-30.

Greene, Jay. 1989. Promises, promises. *Modern Healthcare* 19:42, 24-31.

Griffith, David. 1993. *Jones's Minimal: Low-Wage Labor in the United States.* Albany, New York: State University of New York Press.

Guillory, Gerard, MD. 1996. Leading a physician network: Forget democracy. *Medical Economics* 73:7, 192-5.

Habermas, Jurgen. 1984. *The Theory of Communicative Action, Vol. 1.* Boston, MA: Beacon.

------. 1987. *The Theory of Communicative Action, Vol. 2.* London, England: Polity.

Hammer, Michael and James Champy. 1993. Reengineering the Corporation. New York: HarperBusiness.

Hammer, Michael. 1996. *Beyond Reengineering.* New York: HarperBusiness.

Hare, A. Paul, Edgar F. Borgatta, and Robert F. Bales. 1967. *Small Groups: Studies in Social Interaction.* New York: Alfred A. Knopf, Inc.

Haydu, Jeffrey. 1999. Counter Action Frames: Employer Repertoires and the Union Menace in the Late Nineteenth Century. *Social Problems* 46:3, 313-31.

Henderson, Nancy. 1998. Managed care is toughest on women doctors. *Medical Economics* 75:2, 103-8.

Hendrick, Clyde. 1987. *Group Processes and Intergroup Relations.* Newbury Park, CA: Sage Publications.

------. 1988. *Group Processes, Volume 8.* Newbury Park, CA: Sage Publications.

Hobbes, Thomas. 1988. *The Leviathan.* New York: Prometheus Books.

Hudson, Terese. 1997. Ties That Bind. *Hospitals & Health Networks* 71:5, 20-26.

Hummel, Ralph P. 1982. *The Bureaucratic Experience.* New York: St. Martin's Press.

Hunt, Scott A., Robert D. Benford, and David A. Snow. 1994. Identity Fields: Framing Processes and the Social Construction of Movement Identities. Pp. 185-208 in *New Social Movements*, edited by Larana, Johnston, and Gusfield.

Jackall, Robert. 1988. *Moral Mazes: The World of Corporate Managers.* New York: Oxford University Press.

Jaklevic, Mary Chris. 1994. Staying single. *Modern Healthcare* 24:40, 71-6.

------. 1995. Doc practice management set to explode. *Modern Healthcare* 25:33, 26-30.

------. 1996. Docs are from Mars, Hospital Execs Venus. *Modern Healthcare* 26: 43, 74.

------. 1997a. Design & conquer. *Modern Healthcare* 27:2, 43-6.

------. 1997b. Outgunned. *Modern Healthcare* 27:46, 38-40.

------. 1997c. Practicing for Wall Street. *Modern Healthcare* 27:1, 48.

Janis, Irving L. 1973. Groupthink. *Yale Alumni Magazine* 36:16-9.

Japsen, Bruce. 1997. The reluctant doctor. *Modern Healthcare* 27:35, 66-7.

Jaques, Elliott. 1976. *A General Theory of Bureaucracy.* London, England: Heinemann Educational Books, Ltd.

Jenkins, J. Craig. 1983. Resource Mobilization Theory and the Study of Social Movements. *Annual Review of Sociology* 9:527-53.

Jewell, Linda N., and H. Joseph Reitz. 1981. *Group Effectiveness in Organizations.* Glenview, IL: Scott, Foresman and Company.

Johnson, David W., and Frank P. Johnson. 1991. *Joining Together: Group Theory and Group Skills.* Needham Heights, MA: Allyn and Bacon.

Johnsson, Julie. 1991. Developing a winning strategy for managed care contracting. *Hospitals* 65:19, 26-30.

Kamenka, Eugene, and Martin Krygier. 1979. *Bureaucracy: The Career of a Concept.* New York: St. Martin's Press.

Kane, Chris and Karen Duke. 1996. Ready. Set. Wait! Don't just make deals for the sake of making deals. Make them because it's the right thing to do. *Hospitals and Health Networks* 70:12, 51-2.

Katz, Daniel, and Robert L. Kahn. 1966). *The Social Psychology of Organizations.* New York: John Wiley & Sons.

Kaufman, Nathan. 1995. Power Notebook. *Hospitals & Health Networks* 69:3, 58-60.

Kerr, Eve A., Ron Hays, Brian Mittman, Albert Siu, Barbara Leake, and Robert Brook. 1997. Primary care physicians' satisfaction with quality of care in California capitated medical groups. *JAMA* 278:4, 308-13.

Kletke, Phillip R., David Emmons, and Kurt Gillis. 1996. Current trends in physicians' practice arrangements: from owners to employees. *JAMA,* 276:7, 555-61.

Koska, Mary T. 1988. Physicians now look to purchase hospitals. *Hospitals* 62:16, 81.

Krieger, Lloyd M. 1997. New health care companies: putting physicians in control. *JAMA* 278:17, 1454-6.

Kunda, Gideon. 1992. *Engineering Culture: Control and Commitment in a High-Tech Corporation.* Philadelphia, PA: Temple University Press.

Lawler, Edward E. III. 1996. *From the Group Up: Six Principles for Building the New Logic Corporation.* San Francisco: Jossey-Bass Publishers.

Lee, James. 1980. *The Gold and the Garbage in Management Theories and Prescriptions.* Oxford: Ohio University Press.

Locke, John. 1988. *Two Treatises of Government.* (Peter Laslett, editor) Cambridge, England: Cambridge University Press.

Lockwood, David (1964). Social Integration and System Integration, in G.K.Zollschan and H.W. Hirsch (eds) *Explorations of Social Change*, Boston: Houghton Mifflin.

Lowery, Joan E. 1997. *CultureShift: A Leader's Guide to Managing Change in Health Care.* Chicago: American Hospital Publishing, Inc.

Lowes, Robert L. 1995a. Can you make a killing with your own practice. *Medical Economics* 72:22, 85.

------. 1995b. Why we love capitation. *Medical Economics* 72:51-3.

------. 1998. Suits vs stethoscopes: Who's to blame when doctor-hospital mergers turn sour? *Medical Economics* 75:142-5.

Macdonald, Keith M. 1995. *The Sociology of the Professions.* London: Sage Publications.

Mangan, Doreen. 1994. Now look who's courting PCPs. *Medical Economics* 71:24.

------. 1995. The rapidly changing world of clinics without walls, *Medical Economics* 72:129.

Marcus, Leonard J., and Barry C. Dorn. 1997. Negotiating a good outcome to a practice sale. *American Medical News* 40:33, 21.

Maril, Robert Lee. 1989. *Poorest of Americans: The Mexican-Americans of the Lower Rio Grande Valley of Texas*. Notre Dame, Indiana: University of Notre Dame Press.

------. 1995. *The Bay Shrimpers of Texas.* Lawrence, Kansas: The University Press of Kansas.

Marx, Karl. 1983. *The Portable Karl Marx*. New York: Penguin Books.

------. 1988. *The Communist Manifesto.* New York: W. W. Norton & Company, Inc.

------. 1995. *The Poverty of Philosophy.* New York: Prometheus Books.

Matthews, Richard K. 1986. *The Radical Politics of Thomas Jefferson.* Lawrence, Kansas: University of Kansas Press.

McAdam, Doug. 1982. *Political Process and the Development of Black Insurgency.* Chicago, IL: University of Chicago Press.

McAdam, Doug. 1986. Recruitment to High-Risk Activism: The Case of Freedom Summer. *American Journal of Sociology* 92:1, 64-90.

McCarthy, John D., and Mayer N. Zald. 1977. Resource Mobilization and Social Movements: A Partial Theory. *American Journal of Sociology* 82:6, 1212-40.

McGill, Michael. 1988. *American Business and the Quick Fix.* New York: Henry Holt & Company.

Meltzer, Bernard N. 1964. *The Social Psychology of George Herbert Mead*, Center for Sociological Research, Western Michigan University.

Melucci, Alberto. 1988. Social Movements and the Democratization of Everyday Life. in J. Keane (ed.) *Civil Society and the State.* London, England: Verso.

Merton, Robert K. 1940. Bureaucratic Structure and Personality. *Social Forces*

Meyer, Paul G., and Stephen L. Tucker. 1992. Incorporating an Understanding of Independent Practice Physician Culture into Hospital Structure and Operations. *Hospitals and Health Services Administration* 39:4, 465.

Micklethwait, John and Adrian Wooldridge, 1998. *The Witch Doctors: Making Sense of Management Gurus.* Chicago: Times Books.

Montague, Jim. 1993. Straight Talk. *Hospitals* 67: 22.

Morris, William T. 1975. *Work & Your Future: Living Poorer, Working Harder.* Boston: Reston.

Morris, Aldon D. 1981. Black Southern Student Sit-In Movement: An Analysis of Internal Organization. *American Sociological Review* 46: 744-67.

Mouzelis, Nicos P. 1967. *Organisation and Bureaucracy: An analysis of Modern Theories.* Chicago, IL: Aldine Publishing Company.

------. 1997. Social and system integration: Lockwood, Habermas, Giddens. *Sociology* 31:1, 111-20.

Murata, Stephen K. 1994. Merger Mania: this is the year it will reach you. *Medical Economics* 71:5, 29.

Murata, Stephen K., and Uwe Reinhardt. 1995. Why doctors will take back health care. *Medical Economics* 72:24, 72.

Murray, Dennis. 1995. The four market stages, and where you fit in. *Medical Economics* 72:5, 44.

Nash, Russell, and Jess Parks. 1996. Health plan vs. provider: yesterday's adversaries, tomorrow's partners. *Best's Review* 97:3, 81-5.

O'Toole, James. 1995. *Leading Change: Overcoming the Ideology of Comfort and the Tyranny of Custom.* San Francisco, CA: Jossey-Bass Publishers.

Pallarito, Karen. 1997. The corporate model. *Modern Healthcare* 27:12, 62.

Perkmann, Markus. 1998. Social integration and system integration: reconsidering the classical distinction. *Sociology* 32:3, 491-508.

Perry, Kristie. 1994. Where salaried practice feels like private practice. *Medical Economics*, 71:64-71.

Philbin, Patrick W. 1993. From the Ground Up: Planting the seeds of network development. *Hospitals* 67:11, 46.

Pichardo, Nelson A. 1997. New social movements: a critical review. *Annual Review of Sociology* 23:411-431.

------. 1988. Resource Mobilization: An Analysis of Conflicting Theoretical Variations. *Sociology Quarterly* 29:1, 97-110.

Pincus, Carol R. 1995. Where health care is headed now. *Medical Economics* 72:19, 33-4.

Plato. 1987. *The Republic*, translated by Desmond Lee. London, England: Penguin Books.

Porter, Michael E. 1980. *Competitive Strategy: Techniques for Analyzing Industries and Competitors.* New York: The Free Press.

Rector, Robert, and Michael Sanera. 1987. *Steering the Elephant.* New York: Universe Books.

Reinhardt, Uwe. 1997. Economics. *JAMA* 277:23, 1850-2.

Rex, John. 1961. *Key Problems of Sociological Theory.* London, England: Humanities Press.

Riffer, Joyce. 1986a. Physician group practices going up for sale. *Hospitals* 60:11, 74.

------. 1986b. Physicians trade private practice for security. *Hospitals* 60:16, 66.

Robinson, James C. 1998. Consolidation of medical groups into physician practice management organizations. *JAMA* 279:2, 144-50.

Rothwell, William J., Roland Sullivan, and Gary N. McLean. 1995. *Practicing Organization Development: A Guide for Consultants.* San Francisco, CA: Jossey-Bass Pfeiffer.

Rousseau, Jean-Jacques. 1968. *The Social Contract.* New York: Penguin Books.

------. 1984. *A Discourse on Inequality.* New York: Penguin Classics.

Sandrick, Karen. 1986. Group practice: What's the attraction? *Hospitals* 60:7, 46-50.

------. 1990. Hospitals and MD's vie for imaging business. *Hospitals* 64:31.

Schneller, Eugene. 1991. The leadership and executive potential of physicians. *Hospitals and Health Services Administration* 36:1, 43-55.

Scott, Lisa. 1997. The doc's the anchor. *Modern Healthcare* 27:26, 138.

Shahoda, Teri. 1986. Mayo multis. *Hospitals* 60:38.

Shapiro, Eileen. 1997. *Fad Surfing in the Boardroom: Managing in the Age of Instant Answers.* New York: Perseus Press.

Shortell, Stephen M. 1989. Study shows what industry will need to succeed in 90s. *Modern Healthcare* 19:38-42.

Shortell, Stephen M., Robin R. Gillies, David A. Anderson, John B. Mitchell, and Karen L. Morgan. 1993. Creating Organized Delivery Systems: The Barriers and Facilitators. *Hospitals and Health Systems Administration* 38:4, 447.

Shortell, Stephen M., Teresa Waters, Kenneth Clarke, and Peter Budetti. 1998. Physicians as Double Agents. *JAMA* 280:12, 1102-3.

Sikes, Gini. 1997. *8 Ball Chicks*. New York: Anchor Books Doubleday.

Simpson, John D., and Malcolm B.Coate. 1998. Efficiencies or anticompetitive effects: vertical integration of hospitals into medical practices. *Antitrust Bulletin* 43:2, 375-401.

Slomski, Anita. 1995. Maybe bigger isn't better after all. *Medical Economics* 72:4, 55.

------. 1996. Employment contracts: look carefully before you leap. *Medical Economics* 73:3, 82-7.

------. 1997. Shoot-out in Wichita. *Medical Economics* 74:58.

------. 1999. After playing with fire, this group went down in flames. *Medical Economics* 76:17, 99.

Snow, David A. and Robert D. Benford. 1992. *Frontiers in Social Movement Theory*, edited by Aldon D. Morris and Carol McClung Mueller. New Haven, CT: Yale University Press.

Snow, David A., E. Burke Rochford, Jr., Steven K. Worden, and Robert D. Benford. 1986. Frame Alignment Processes, Micromobilization, and Movement Participation. *American Sociological Review* 51: 464-81.

Solovy, Alden. 1995. Predicting the unpredictable. *Hospitals & Health Networks* 69:1, 26-9.

Solovy, Alden. 1996. Paywatch. *Hospitals & Health Networks* 70:19, 64.

Starr, Paul. 1982. *The Social Transformation of American Medicine*. New York: Basic Books, Inc.

Strauss, Robert. 1999. Medical Sociology: a personal fifty year perspective. *The Journal of Health and Social Behavior* 40:2, 103-11.

Taylor, Kathryn S. 1994. Coming up to speed. *Hospitals & Health Networks* 68:4, 34.

Taylor, Verta. 1989. Social Movement Continuity: The Women's Movement in Abeyance. *American Sociological Review* 54: 761-75.

Terry, Ken. 1994. When health plans don't want you anymore. *Medical Economics* 71:10, 138.

------. 1997. Doctors on the Move. *Medical Economics* 74:144.

Thibant, John W., and Harold H. Kelley. 1986. *The Social Psychology of Groups.* New Brunswick, NJ:Transaction Books.

Tilly, Charles. 1978. *From Mobilization to Revolution.* Reading, MA: Addison-Wesley.

Tilly, Charles, Louise Tilly, and Richard Tilly. 1975. *The Rebellious Century, 1830-1930.* Cambridge, MA: Harvary University Press.

Touraine, A. Alain. 1988. *The Return of the Actor.* Minneapolis: University of Minnesota Press.

Turner, Ralph H. and Lewis M. Killian. 1987. *Collective Behavior.* Englewood Cliffs, NJ: Prentice-Hall.

Valocchi, Steve. 1996. The Emergence of the Intergrationist Ideology in the Civil Rights Movement. *Social Problems* 43:1, 116-30.

Van Eynde, Donald F., Judith C. Hoy, and Dixie Cody Van Eynde. 1997. *Organization Development Classics: The Practice and Theory of*

Change—The Best of the OD Practitioner. San Francisco, CA: Jossey-Bass Publishers.

Waters, Malcolm. 1989. Collegiality, Bureaucratization, and Professionalization: A Weberian Analysis. *American Journal of Sociology* 94:5, 945-72.

Weber, Max. 1948. *From Max Weber: Essays in Sociology*, translated and edited by H. H. Gerth and C. Wright Mills. London, England: Oxford University Press.

------. 1992. *The Protestant Ethic and the Spirit of Capitalism*. Translated by Talcott Parsons. New York: Routledge.

Wegmiller, Donald. 1994. Hospitals need to look at IPNs through doctor's eyes. *Modern Healthcare* 24:1, 28.

Weiss, Barbara. 1995. Managed care: there's no stopping it now. *Medical Economics* 72:5, 26.

Widegren, Orjan. 1997. Social solidarity and social exchange. *Sociology* 31:4, 755-92.

APPENDIX A

TABLES

Table

State Department of Health
HMO Annual Report
Membership Enrollment Statistics
December, 1990

TABLE 1

Statistic	HMO Plan							TOTALS		
	Bluecare		Greencare		Purplecare		Ccare	**Metro 1 Total**	Metro 2 Total	Statewide Total
	Metro 1	Metro 2	**Metro 1**	Metro 2	**Metro 1**	Metro 2	Metro 2			
Revenue per member month	$113.23	89.99	79.56	80.82	120.16	110.45	82.39	**95.75**	90.52	$92.99
Net Income per member month	$6.71	7.21	1.71	-4.67	-18.42	-2.33	-2.81	**-5.68**	1.34	($1.97)
Total Members @ 12/31	16,847	22,600	51,558	38,992	20,688	23,386	14,170	**89,093**	99,148	188,241
Member months for 1990	202,891	268,823	586,278	434,241	243,408	285,641	164,611	**1,032,577**	1,153,316	2,185,893
Total Ambulatory Encounters	80,867	95,648	163,492	125,732	83,283	147,387	45,281	**327,642**	414,048	741,690
Annualized Hospital Days per 1000	365	284	208	187	438	332	252	**291**	253	273

State
Health Maintenance Organizations
Membership Enrollment
Selected Counties in Northeast State
1998

TABLE 2

	HMO Plan										
	Acare	BlueCare	Ccare	PinkCare	Fcare	Hcare	HeCare	GreenCare	Pcare	PurpleCare	Total
LOCATION											
Metro 1	**640**	**26,517**	**1,164**	**38,837**	**956**	**5,019**	**2**	**53,675**	**0**	**21,958**	**148,768**
Rural Northeast State:											
M County	1	601	83	1,623	16	50		461		384	3,219
P County		541	3	1,131	68	369		73		188	2,373
Pi County		22	4	32	18	12		18		17	123
W County	3	148	23	214	4	53		223		128	796
Total Secondary	4	1,312	113	3,000	106	484	0	775	0	717	6,511
C County	48	3,522	65	3,346	275	617	1	5,097		2,039	15,010
K County		11		13	50	112		13		112	311
O County	1	597	20	792	34	136		645		533	2,758
Ot County		6		133	16	614		11		7	787
Ma County		1,657	43	515		559		492		248	3,514
R County	25	3,088	72	4,324	90	375		8,474		2,485	18,933
Total Primary	74	8,881	200	9,123	465	2,413	1	14,732	0	5,424	41,313
Total Rural	**78**	**10,193**	**313**	**12,123**	**571**	**2,897**	**1**	**15,507**	**0**	**6,141**	**47,824**
Total Subject Area	**718**	**36,710**	**1,477**	**50,960**	**1,527**	**7,916**	**3**	**69,182**	**0**	**28,099**	**196,592**
Statewide	**789**	**97,153**	**4,361**	**88,736**	**8,581**	**56,527**	**25,732**	**127,893**	**10,323**	**82,571**	**502,666**

Source: State Department of Health

State

TABLE 3

HMO Membership
Medicare and Medicaid Plans
1998

HMO	Medicare	Medicaid	Commercial	Total
Acare			789	789
BlueCare	4,526	29,847	62,780	97,153
CCare			4,361	4,361
PinkCare	10,173	21,513	57,050	88,736
Fcare			8,581	8,581
Hcare	2,286		54,241	56,527
HeCare		25,596	136	25,732
GreenCare	26,920		100,973	127,893
Pcare		6,547	3,776	10,323
PurpleCare			82,571	82,571
Total Membership	**43,905**	**83,503**	**375,258**	**502,666**

State **TABLE 4**

Population Estimates by County
Selected Counties in Northeast State
1990 and 1997

	Total Population			
	1997	1990	Difference	Per Cent
Metro 1	**538,407**	**507,061**	**31,346**	**6.2**
Rural Northeast State:				
M County	69,647	68,417	1,230	1.8
P County	64,390	61,543	2,847	4.6
Pi County	43,327	41,094	2,233	5.4
W County	47,532	48,435	-903	-1.9
Total Secondary	224,896	219,489	5,407	2.5
C County	66,273	60,951	5,322	8.7
K County	46,980	48,141	-1,161	-2.4
O County	38,340	36,583	1,757	4.8
Ot County	30,668	30,652	16	0.1
Ma County	37,164	33,526	3,638	10.9
R County	65,806	55,511	10,295	18.5
Total Primary	285,231	265,364	19,867	7.5
Total Rural	**510,127**	**484,853**	**25,274**	**5.2**
Total Subject Area	**1,048,534**	**991,914**	**56,620**	**5.7**

Source: United States Bureau of the Census

State

TABLE 5

Population Estimates by County
Selected Counties in Northeast State
1990 and 1997

Location	Population by Gender							
	Male				Female			
	1997	1990	Difference	Per Cent	1997	1990	Difference	Per Cent
Metro 1	**260,532**	**244,418**	**16,114**	**6.6**	**277,875**	**262,643**	**15,232**	**5.8**
Rural Northeast State								
M County	33,573	32,851	722	2.2	36,074	35,566	508	1.4
P County	32,332	30,730	1,602	5.2	32,058	30,813	1,245	4.0
Pi County	21,945	20,342	1,603	7.9	21,382	20,752	630	3.0
W County	22,936	23,242	-306	-1.3	24,596	25,193	-597	-2.4
Total Secondary	110,786	107,165	3,621	3.4	114,110	112,324	1,786	1.6
C County	32,378	29,635	2,743	9.3	33,895	31,316	2,579	8.2
K County	22,807	23,206	-399	-1.7	24,173	24,935	-762	-3.1
O County	18,595	17,639	956	5.4	19,745	18,944	801	4.2
Ot County	14,547	14,499	48	0.3	16,121	16,153	-32	-0.2
Ma County	18,315	16,460	1,855	11.3	18,849	17,066	1,783	10.4
R County	32,585	27,436	5,149	18.8	33,221	28,075	5,146	18.3
Total Primary	139,227	128,875	10,352	8.0	146,004	136,489	9,515	7.0
Total Rural	**250,013**	**236,040**	**13,973**	**5.9**	**260,114**	**248,813**	**11,301**	**4.5**
Total Subject Area	**510,545**	**480,458**	**30,087**	**6.3**	**537,989**	**511,456**	**26,533**	**5.2**

Source: United States Bureau of the Census

State
Population Estimates by County
Selected Counties in Northeast State
1990 and 1997

TABLE 6

	Population by Age								
	<20	20-65	>65	<20	20-65	>65	<20	20-65	>65
Location	1997			1990			Difference		
Metro 1	**155,592**	**320,739**	**62,076**	**147,973**	**300,602**	**58,486**	**7,619**	**20,137**	**3,590**
Rural Northeast State:									
M County	20,805	37,841	11,001	20,896	36,722	10,799	-91	1,119	202
P County	18,509	38,654	7,227	17,833	36,963	6,747	676	1,691	480
Pi County	11,343	24,278	7,706	11,094	22,534	7,466	249	1,744	240
W County	13,226	26,618	7,688	13,712	26,883	7,840	-486	-265	-152
Total Secondary	63,883	127,391	33,622	63,535	123,102	32,852	348	4,289	770
C County	20,188	37,534	8,551	18,960	34,131	7,860	1,228	3,403	691
K County	13,583	25,139	8,258	14,144	25,609	8,388	-561	-470	-130
O County	11,306	20,409	6,625	11,139	19,148	6,296	167	1,261	329
Ot County	8,442	16,447	5,779	8,864	16,104	5,684	-422	343	95
Ma County	10,854	20,462	5,848	10,079	18,210	5,237	775	2,252	611
R County	20,280	38,837	6,689	17,460	32,375	5,676	2,820	6,462	1,013
Total Primary	84,653	158,828	41,750	80,646	145,577	39,141	4,007	13,251	2,609
Total Rural	**148,536**	**286,219**	**75,372**	**144,181**	**268,679**	**71,993**	**4,355**	**17,540**	**3,379**
Total Subject Area	**304,128**	**606,958**	**137,448**	**292,154**	**569,281**	**130,479**	**11,974**	**37,677**	**6,969**

Source: United States Bureau of the Census

TABLE 7

Change in Physician Population
Selected Counties in Northeast State
1990 to 1997

Location	Total Physicians 1997	Total Physicians 1990	Difference
Metro 1	**1489**	**1237**	**252**
Rural Northeast State:			
M County	128	115	13
P County	82	67	15
Pi County	52	44	8
W County	81	77	4
Total Secondary	343	303	40
C County	36	39	-3
K County	62	69	-7
Ma County	17	19	-2
O County	31	28	3
Ot County	30	26	4
R County	66	55	11
Total Primary	242	236	6
Total Rural	**585**	**539**	**46**
Total Subject Area	**2074**	**1776**	**298**

State Physician Workforce--1990

TABLE 8

	Family Practice	General Internal Medicine	General Pediatrics	Obstetrics Gynecology	Hospital Based Physicians	Other Specialties		**Total Physicians**
Location								
Metro 1	**226**	**151**	**86**	**85**	**216**	**473**		**1237**
Rural Northeast State:								
M County	19	19	5	7	26	39		115
P County	14	13	6	4	13	17		67
Pi County	13	5	2	4	7	13		44
W County	16	9	4	4	15	29		77
Total secondary	62	46	17	19	61	98		303
C County	32				2	5		39
K County	25	6	3	4	11	20		69
Ma County	11	3		1	1	3		19
O County	14	5	1	1	2	5		28
Ot County	17				2	7		26
R County	21	8	6	5	7	8		55
Total Primary	120	22	10	11	25	48		236
Total Rural	**182**	**68**	**27**	**30**	**86**	**146**		**539**
Total Subject Area	**408**	**219**	**113**	**115**	**302**	**619**		**1776**

Oklahoma Physician Workforce--1997

TABLE 9

	Family Practice	General Internal Medicine	General Pediatrics	Obstetrics Gynecology	Hospital Based Physicians	Other Specialties		**Total Physicians**
Location								
Metro 1	**260**	**196**	**97**	**72**	**275**	**589**		**1489**
Rural Northeast State:								
M County	15	24	5	5	30	49		128
P County	18	15	8	7	12	22		82
Pi County	8	7	3	3	12	19		52
W County	14	8	5	5	20	29		81
Total Secondary	55	54	21	20	74	119		343
C County	29	1			2	4		36
K County	20	5	3	3	13	18		62
Ma County	8	3		2	2	2		17
O County	11	8	2	1	1	8		31
Ot County	16	2	1		4	7		30
R County	27	8	6	4	8	13		66
Total Primary	111	27	12	10	30	52		242
Total Rural	**166**	**81**	**33**	**30**	**104**	**171**		**585**
Total Subject Area	**426**	**277**	**130**	**102**	**379**	**760**		**2074**

State
Health Maintenance Organizations
Membership Enrollment Growth
Selected Counties in Northeast State
1990 to 1997

TABLE 10

			HMO Plan										
Location	**Year**		Acare	BlueCare	Ccare	PinkCare	Fcare	Hcare	HeCare	GreenCare	Pcare	PurpleCare	**Total**
Metro 1	**1997**		640	26,517	1,164	38,837	956	5,019	2	53,675	0	21,958	148,768
Metro 1	**1990**			16,847						51,558		20,688	89,093
Increase-1990 to 1997			640	9,670	1,164	38,837	956	5,019	2	2,117	0	1,270	59,675
Statewide	**1997**		789	97,153	4,361	88,736	8,581	56,527	25,732	127,893	10,323	82,571	502,666
Statewide	**1990**			39,947	14,170					89,550		44,074	187,741
Increase-1990 to 1997			789	57,206	-9,809	88,736	8,581	56,527	25,732	38,343	10,323	38,497	314,925

CONTENT ANALYSIS **TABLE 11**
Proportions by Journal by Year
1985 -1999

Year	Total Proportions					Total Pages		Total Proportion
	HHN	HCMR	JHM	ME	MH	Categories	Journal	
1985	0.00889	0.04156	0.01429	0.01451	0.02768	132.705	8002	0.01658
1986	0.01496	0.03385	0.03159	0.01848	0.02626	157.064	7582	0.02072
1987	0.00890	0.02590	0.01721	0.01714	0.01060	98.232	7323	0.01341
1988	0.01053	0.10317	0.04693	0.00289	0.02009	109.009	6049	0.01802
1989	0.01088	0.02105	0.05941	0.00157	0.04188	88.884	4868	0.01826
1990	0.03119	0.05914	0.10859	0.00233	0.04798	157.091	4535	0.03464
1991	0.07089	0.03136	0.08213	0.00669	0.01659	141.385	4242	0.03333
1992	0.03503	0.05348	0.09139	0.00894	0.04113	160.816	5263	0.03056
1993	0.13240	0.06952	0.10517	0.01362	0.05603	256.471	4526	0.05667
1994	0.10889	0.04046	0.03584	0.08651	0.08923	366.770	4484	0.08180
1995	0.10262	0.13613	0.01975	0.09718	0.07812	406.411	4571	0.08891
1996	0.11836	0.13351	0.16216	0.05943	0.12050	497.899	5310	0.09377
1997	0.09071	0.09375	0.18051	0.05834	0.11041	428.921	4796	0.08943
1998	0.10297	0.18487	0.10688	0.05755	0.09612	392.679	4548	0.08634
1999	0.04286	0.05851	0.13662	0.06998	0.09072	339.629	4573	0.07427
TOTAL	**0.04234**	**0.07252**	**0.07620**	**0.03335**	**0.05281**	**3733.967**	**80672**	**0.04629**

TABLE 12

CONTENT ANALYSIS
Means Table
Proportions by Year

Year	Mean	N	Standard Deviation
1985	0.0025	45	0.0069
1986	0.0030	45	0.0063
1987	0.0019	45	0.0049
1988	0.0042	45	0.0151
1989	0.0030	45	0.0106
1990	0.0055	45	0.0124
1991	0.0046	45	0.0105
1992	0.0051	45	0.0122
1993	0.0084	45	0.0202
1994	0.0080	45	0.0159
1995	0.0096	45	0.0234
1996	0.0132	45	0.0241
1997	0.0119	45	0.0236
1998	0.0122	45	0.0228
1999	0.0089	45	0.0180
Total	**0.0068**	**675**	**0.0167**

CONTENT ANALYSIS **TABLE 13**
Means Table
Proportion by Journal

Journal	Mean	N	Standard Deviation
Healthcare Management Review	0.0080	135	0.02328
Journal of Healthcare Management	0.0089	135	0.02145
Hospitals and Health Networks	0.0068	135	0.01382
Medical Economics	0.0038	135	0.00869
Modern Healthcare	0.0065	135	0.01070
Total	**0.0068**	**675**	**0.01667**

CONTENT ANALYSIS **TABLE 14**
Means Table
Category by Journal 1985-1999

Journal	Category	Mean	N	Standard Deviation
Healthcare Management Review	Insurance Company M&A	0.0000	15	0.0000
	Hospital M&A	0.0113	15	0.0244
	Hospital-Insurance Company M&A	0.0000	15	0.0000
	Hospital-medical group integration issues	0.0417	15	0.0486
	Hospital-medical group joint ventures	0.0000	15	0.0000
	Hospital-medical group M&A	0.0034	15	0.0100
	Health System Formation Issues	0.0089	15	0.0159
	Insurance Company-medical group M&A	0.0000	15	0.0000
	Medical group M&A	0.0071	15	0.0187
Total-*HCMR*		**0.0081**	**135**	**0.0233**
Journal of Healthcare Management	Insurance Company M&A	0.0000	15	0.0000
	Hospital M&A	0.0077	15	0.0122
	Hospital-Insurance Company M&A	0.0012	15	0.0044
	Hospital-medical group integration issues	0.0242	15	0.0268
	Hospital-medical group joint ventures	0.0083	15	0.0024
	Hospital-medical group M&A	0.0077	15	0.0121
	Health System Formation Issues	0.0294	15	0.0422
	Insurance Company-medical group M&A	0.0015	15	0.0059
	Medical group M&A	0.0000	15	0.0000
Total-*JCM*		**0.0089**	**135**	**0.0215**
Hospitals and Health Networks	Insurance Company M&A	0.0020	15	0.0023
	Hospital M&A	0.0096	15	0.0097
	Hospital-Insurance Company M&A	0.0022	15	0.0028
	Hospital-medical group integration issues	0.0328	15	0.0268
	Hospital-medical group joint ventures	0.0018	15	0.0024
	Hospital-medical group M&A	0.0030	15	0.0050
	Health System Formation Issues	0.0048	15	0.0077
	Insurance Company-medical group M&A	0.0008	15	0.0016
	Medical group M&A	0.0040	15	0.0061
Total-*HHN*		**0.0068**	**135**	**0.0138**
Medical Economics	Insurance Company M&A	0.0000	15	0.0000
	Hospital M&A	0.0000	15	0.0000
	Hospital-Insurance Company M&A	0.0000	15	0.0000
	Hospital-medical group integration issues	0.0146	15	0.0190
	Hospital-medical group joint ventures	0.0012	15	0.0030
	Hospital-medical group M&A	0.0053	15	0.0050
	Health System Formation Issues	0.0004	15	0.0015
	Insurance Company-medical group M&A	0.0028	15	0.0038
	Medical group M&A	0.0100	15	0.0087
Total-*ME*		**0.0038**	**135**	**0.0869**
Modern Healthcare	Insurance Company M&A	0.0041	15	0.0045
	Hospital M&A	0.0231	15	0.0163
	Hospital-Insurance Company M&A	0.0040	15	0.0067
	Hospital-medical group integration issues	0.0166	15	0.0130
	Hospital-medical group joint ventures	0.0004	15	0.0008
	Hospital-medical group M&A	0.0053	15	0.0062
	Health System Formation Issues	0.0011	15	0.0016
	Insurance Company-medical group M&A	0.0011	15	0.0010
	Medical group M&A	0.0026	15	0.0035
Total-*MH*		**0.0065**	**135**	**0.0011**
Total All Journals	Insurance Company M&A	0.0012	75	0.0028
	Hospital M&A	0.0103	75	0.0163
	Hospital-Insurance Company M&A	0.0015	75	0.0040
	Hospital-medical group integration issues	0.0260	75	0.0030
	Hospital-medical group joint ventures	0.0023	75	0.0109
	Hospital-medical group M&A	0.0049	75	0.0008
	Health System Formation Issues	0.0089	75	0.0263
	Insurance Company-medical group M&A	0.0012	75	0.0033
	Medical group M&A	0.0047	75	0.0101
Grand Mean		**0.0068**	**675**	**0.0167**

CONTENT ANALYSIS **TABLE 15**

Three Way Analysis of Variance

Tests of Between Subjects Effects

Dependent variable=proportions

Independent variables=categories, time (in three year blocks 1985-1999), and journal

Source	Variation	df	Variance	F value	Significance
Intercept	0.0312	1	0.0312	225.1220	0.000
Categories	0.0378	8	0.0047	34.1070	0.000
Journal	0.0020	4	0.0005	3.6240	0.006
Time	0.0075	4	0.0019	13.5020	0.000
Categories*Journal	0.0207	32	0.0006	4.6620	0.000
Categories*Time	0.0225	32	0.0007	5.0770	0.000
Journal*Time	0.0022	16	0.0001	0.9870	0.470
Categories*Journal*Time	0.0323	128	0.0003	1.8230	0.000
Within Cell Effects	0.0624	450	0.0001		

CONTENT ANALYSIS **TABLE 16**
Means Table
Proportion by Category

Category	Means	N	Standard Deviation
Insurance company mergers & acquisitions	0.0012	75	0.0028
Hospital mergers & acquisitions	0.0103	75	0.0163
Hospital-insurance company M&A	0.0015	75	0.0040
Hospital-medical group integration issues	0.0260	75	0.0304
Hospital-medical group joint ventures	0.0023	75	0.0109
Hospital-medical group M&A	0.0049	75	0.0082
Health System Formation Issues	0.0089	75	0.0226
Insurance company-medical group M&A	0.0012	75	0.0033
Medical group M&A	0.0047	75	0.0101
Total	**0.0068**	**675**	**0.0167**

Employed Physician Group
Physician Demographics

Specialty	Age	Gender
General Internal Medicine	56	M
General Internal Medicine	62	M
General Internal Medicine	45	M
General Internal Medicine	52	M
General Internal Medicine	34	M
General Internal Medicine	41	M
Pediatrics	52	M
Pediatrics	46	M
Pediatrics	54	F
Pediatrics	45	F
Family Practice	55	M
Family Practice	45	M
Gastroenterology	40	M
General Surgery	65	M
General Internal Medicine	35	M
General Internal Medicine	49	M
Pediatrics	60	M
General Practice	50	M
Obstetrics/Gynecology	45	M
General Internal Medicine	57	M
Family Practice	50	M
General Internal Medicine	38	M

APPENDIX C

Independent Physician Group
Physician Demographics

Specialty	Age	Gender
Neurosurgery	57	M
Neurosurgery	37	M
Neurosurgery	34	M
Pain Management	64	M
Pain Management	45	F
Physical Medicine & Rehabilitation	45	M
Physical Medicine & Rehabilitation	34	M

APPENDIX D

SAMPLE INTERVIEW QUESTIONS

1. Why did you join the (medical group)?
2. What did you expect for yourself from the (medical group)?
3. How is what you gained equal to or better than what you gave up when you joined the group? How is it not?
4. What diminution of autonomy have you felt as a result of joining the (medical group)?
5. What did you expect for your patients as a result of this affiliation?
6. Has your relationship with other physicians been affected in any way by your affiliation with the (medical group)? How?
7. What decisions have been made for you that were detrimental to your patients' interests?
8. What did you expect for your employees as a result of this affiliation?
9. Did you experience a diminution of loyalty from your employees as a result of joining the (medical group)?
10. Did they gain anything from the bargain?
11. How do you think the group would best govern itself?
12. What type decision should not be made without formal board action?
13. What type decisions should administrators make on their own?
14. What type decisions should individual doctors make without board review?

OKLAHOMA STATE UNIVERSITY
INSTITUTIONAL REVIEW BOARD

DATE: 11-19-98 **IRB #: AS-99-018**

Proposal Title: A STUDY OF THE SOCIOLOGICAL IMPLICATIONS OF PHYSICIANS JOINING GROUP PRACTICE

Principal Investigator(s): L.M. Hynson, J. Randall Mills

Reviewed and Processed as: Expedited

Approval Status Recommended by Reviewer(s): Approved

Signature: Carol Olson (SC) Date: November 19, 1998

Carol Olson, Director of University Research Compliance
cc: J. Randall Mills

Approvals are valid for one calendar year, after which time a request for continuation must be submitted. Any modification to the research project approved by the IRB must be submitted for approval. Approved projects are subject to monitoring by the IRB. Expedited and exempt projects may be reviewed by the full Institutional Review Board.

VITA

Jon Randall Mills

Candidate for the Degree of

Doctor of Philosophy

Thesis: WALLFLOWERS TO GLOWING BELLES: THE SOCIAL TRANSFORMATION OF PHYSICIANS IN PRACTICE

Major Field: Sociology

Biographical:

Personal Data: Born in Butler, Missouri, on August 20, 1954, the son of John R. and Mary Isabelle Mills.

Education: Graduated from Butler High School, Butler, Missouri in May, 1972; received Bachelor of Science degree in Accounting from Southwest Missouri State University, Springfield, Missouri in May, 1976 and Master of Health Administration from University of Colorado, Denver, Colorado, in July, 1989. Completed the requirements for the Doctor of Philosophy degree in Sociology at Oklahoma State University in July, 2000.

Experience: Twelve years as senior executive with a major health system, CEO of medical group, assistant administrator for health system development for tertiary hospital; four years as executive with state hospital association; two years CFO of small urban hospital; and four years as staff accountant with public CPA firms.

Professional Memberships: Fellow in American College of Healthcare Executives; Member of Healthcare Financial Management Association; Member of Medical Group Management Association; Past Board Member of large tertiary hospital; Past Board Member of Medical Education Foundation supporting local branch of State Medical School.