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The Limits of Professional Autonomy: An Interview-based Comparative Analysis of the Workplaces and Perceptions of Educators and Healthcare Professionals

Joseph Paul Cleary

Louisiana State University and Agricultural and Mechanical College, joecleary28@gmail.com

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THE LIMITS OF PROFESSIONAL AUTONOMY: AN INTERVIEW-BASED
COMPARATIVE ANALYSIS OF THE WORKPLACES AND PERCEPTIONS
OF EDUCATORS AND HEALTHCARE PROFESSIONALS

A Dissertation

Submitted to the Graduate Faculty of the
Louisiana State University and
Agricultural and Mechanical College
in partial fulfillment of the
requirements for the degree of
Doctor of Philosophy

in

The Department of Sociology

by

Joseph Paul Cleary Jr.

B.A., Franklin & Marshall College, 2003

M.S., Fordham University, 2008

M.A., Louisiana State University, 2013

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principal of the year). I have a lingering sense that my interviews with you (and the quality of their content) were the result of a number of forces converging. Principal Smith's putting in a good word for me was obviously critical. However, once I "got in the door", you welcomed me from the start and I never felt like a stranger in your office and school. Thank you for your kindness and your willingness to talk with me for a very generous amount of time.

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you love to use your hands when you talk (and the way you love to hear your own voice), your ability to tell a complex story in simple language, and most importantly, your relationship to your students and colleagues. Your professional ideals are my own. I strive to emulate your sense of humor, your will to succeed, your unwavering sense of optimism, your ability to connect with all sorts of different people, your truly unique ability to get so mad at complete strangers on TV (“They’re bums!” I am of course referring to sports games), and your unconditional love for your son. I look forward to many happy and fulfilling years ahead. I also look forward with great pride to the day when I take my son to Cooperstown (and have a catch on the side of the Interstate and ice cream in our hotel room!). I love ya, Paps.

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ABSTRACT

Workplaces are the locations of significant social outcomes that are worth studying in their own right. In addition to pursuing and achieving their own intended outcomes (i.e. a well-educated and healthy public, in the case of the American public education and American healthcare systems), they are resources on which individuals rely for social, psychological, spiritual, and economic fulfillment and identity. Central to a person's overall efficacy within the workplace is the extent to which they exercise influence over their time and behaviors. In contrast to sociological works on bureaucracies, research on professional autonomy tends to be symbolic-interactionist and qualitative in its theoretical approach and methods (the latter tending toward ethnographic and interview-based studies). There is significantly more sociological literature on bureaucracies than on professional autonomy.

The few works on professional autonomy have done little to change thinking on bureaucracies – perhaps because they have limited their focus to the needs and opinions of workers and not the needs and opinions of the bureaucracy (as expressed by the bureaucracy executives). The following 3-part, interview-based dissertation examines the perceptions and opinions about professional autonomy of two sets of professionals: 1) public high school teachers and principals in Louisiana, and 2) doctors and healthcare executives in one New England (U.S.A.) state.

Professional autonomy is revealed to be a highly subjective idea – that is to say that the way an interviewee defines and thinks about professional autonomy depends on the things that matter most to them in the workplace. A nurse, for example, defined professional autonomy as the right to be treated as a doctor's equal because she was very frustrated by people treating her as less than a doctor. Interviewees attempt to balance these desires with the needs and mandates

of their organization (and the superiors who enforce those mandates), and are often frustrated by their inability to accomplish both. Nearly every interviewee expressed strong emotions toward the experiences and feelings they associate with professional autonomy, and revealed their workplaces to be locations of emotionally intense conflicts about, and struggles over, influence in the workplace.

CHAPTER 1 INTRODUCTION

PRINCIPAL ERIC SMITH

You know, for some reason in education, and it's kind of like athletics, you know, it's funny; everybody is a better coach than those guys that are paid a million dollars. They can tell the coaches what they need to do, you know the players what they need to do, and they know better. Education's kind of the same way. You know everybody can sit outside and tell the principals what they should've done, what the teachers should have done, and that's just, that's not true. And it's like I told you in the beginning. All those people, all those government entities and the departments of ed., the department here and department there, they don't know better, they don't know better. These are the experts right here. The experts are right here in the schoolyard. Let's let us decide what to do because we're the experts, we're the ones. And if you get that, then I think you're gonna have a much better school. And like I say, I think most of the public, when you tell them that, they don't believe you. They say, 'No, you don't run that school right. Let me tell you what you need to do' (Smith interview).

As I watched Principal Smith's interview for the second time, I noticed again the signs of desperation and helplessness in his facial expressions and in the tone of his voice. Certainly they had been there, building up, long before I came to interview him. But on that crisp fall morning in 2011, they were coming out. Smith had spent more than a third of his life at Fryburg High School, a full 21 years: four as a student, two as a teacher, six as an Assistant Principal, and nine as its principal (he was in his tenth year as principal, and 22nd year overall, at the time of our interview). Scattered over his office walls were Fryburg Buccaneers banners and memorabilia (competing for space with LSU paraphernalia). Smith's siblings had attended Fryburg, too. He was as much a fixture of Fryburg High School as any living soul in East Baton Rouge Parish. Yet just two and a half school years after our interview, he would be gone. Principal Smith decided to take the principal job at a local Catholic high school where, perhaps he felt, he might

be free from all those voices, emails, phone calls, audits, and negative publicity that he endured at Fryburg.

I was not shocked when I learned that Principal Smith had left Fryburg. He appeared visibly exhausted in our interview and I left wondering whether or not he was on the verge of leaving. If, however, Smith had burned out in this job, it is hard to imagine anyone succeeding in it. Smith is not a quitter. He does not like blaming others for his problems. Instilled deep within the fabric of his persona appears to be a certainty of the morality of being a team player. Along with his faith and his love of sports (LSU football in particular), this is probably something that Smith was taught long before he became a teacher. Even though he did not share it with me, Smith appeared to have an intensity about him that he could summon at will, when necessary. He is a sort of adult jock. Smith appeared to be self-reliant to a fault – which is to say his first instinct is to blame himself when something goes wrong (a virtue he likely tried to instill in his players during his years as a coach at Fryburg). However, as I continued to watch our interview, it was becoming clearer to me that the limits of his sense of self-responsibility were struggling to contain his frustrations. Smith yearned for fewer forces and voices pulling him in multiple, different directions; he longed for a simpler, though not easy, approach to doing his job (and to public education in general) in which he could be freer to achieve the mandates given to him by the local school board; he ached for more professional autonomy. Ironically (and unfortunately), the Catholic school that Principal Smith left Fryburg for was closed only a year after Smith took the position, as a result of decreasing enrollment (a trend that had already been in motion long before Smith got there).

DR. JACK SNELLINGS

Jack Snellings is similar to Principal Smith in physical appearance and stature: He is white, middle aged (about only 10 years older than Smith, which is to say he is in his late 60s), and has a build of a former football or rugby player. He, too, possesses a boyish/jocular persona that resembles Horowitz's (1987) "college men"; he is a now grown up college man who, I sensed, could rotate back and forth between his professional and frat-boy-like selves (like Principal Smith). Snellings owns his own private "concierge" practice in an upscale New England suburb outside a major city. At one time in his career (and for a long time during that time), Snellings's professional life was just like Principal Smith's, defined by exhaustion and despair as a result of unwanted external forces pushing and pulling on him every day. Like most private practices, Snellings's had close to 500 patients, most or all of who paid with Medicare or some private insurance. Snellings told me of an impending "personal disaster" he felt due to all of the pressures to behave in certain ways – pressures that were, in his eyes, coming primarily from the private insurers. He had to treat patients in certain ways; he had to record notes about his patient interactions in specifically defined ways; and just about everything else he did was defined and driven by Snellings's interpretations of what the private insurance companies wanted him to do.

Snellings told me that he felt so overwhelmed as a result of the payer's requirements that it was taking a serious toll on his wellbeing. "I felt that I was on a crash course with some sort of personal disaster" (Snellings). Somewhere during his career, he believes, the insurance companies became much more powerful, and they began to determine provider reimbursements like they had not before (and, by extension, how many patients doctors had to see). Lower reimbursements resulted in Snellings having to see more and more patients, and spend less time

with each patient in order to achieve a comparable income for himself and his practice. He had to work longer and was increasingly beaten down by the conditions under which he practiced. He felt that the quality of his life (personal and professional) was on a sharp and fast decline, or as he said, "...a crash course with some sort of personal disaster" (Snellings).

Snellings struggled to develop relationships with patients like he had always loved to do in the past. He was uncomfortable. He struggled to talk to other doctors about his patients and craft. In addition to having to see increasingly more patients, Snellings felt like every decision he made had to be done with the private insurance company in mind. "Will they approve?" became ingrained into his mind. Although Snellings believed public payers (Medicare) to be a source of some annoyance (despite, as he said, their good intentions), the primary source of his frustration, in his view, were "...the more mean spirited private bottom line oriented private insurance companies" (Snellings). He believes their greed led to his worsening working conditions. Snellings felt exploited by insurance companies – like he was their pawn. Like Principal Smith, Snellings felt enormous pressures to do what others (outside of his workplace) were asking him to do. Just as Smith exclaimed that he and his colleagues, not the outside people and entities, are the real experts ("The experts are right here in the schoolyard"), Snellings believes that his external forces (the health insurers) are not qualified to tell him what to do because they care more about him filling out forms and lining their pockets than treating patients.

The insurance companies and Medicare really don't care about medicine. They just need the proper form filled out. Okay? If it's not documented, it wasn't done. So, you have to spend more time on your computer with a patient there and never look the patient, 'Did you do this? Okay. Did you have this? Okay. Did you do this and that and this?' And you spend the whole time looking at the screen and not making eye contact, and not having a relationship with the patient. And I hear that all the time from patients of mine who go to other doctors, specialists. They are always looking at the screen. They never, you know, they never have relationship with the patient. So, um, yeah, I feel that this way, I don't have to

look at the screen... [I used to be] furiously making sure that I was getting, you know, the family history, past medical history, certain elements. It's ridiculous. It had nothing to do with medicine (Snellings).

For these reasons, he decided to take the very drastic measure (in the eyes of his colleagues and fellow doctors) of discontinuing to accept health insurance and creating that rare breed of private practice known as “concierge medicine”¹. Since he created his concierge practice, Snellings has been a significantly happier doctor and person. He feels like he is doing the things that attracted him to the medical profession in the first place. He can once again emulate that Midwestern hospitality that so deeply appealed to him when he was a medical student in Minnesota. “And now, it's all medicine. I feel that it has been a total shift to, ‘What's the problem?’ rather than, ‘What's the form?’ if you know what I mean” (Snellings). All of this was possible because he, unlike Principal Smith, cut out the source of all his profession strain: external forces (health insurers in Snellings's case; the local school board and state department of education for Smith). In Smith's case, he seems to have tried to do a similar thing by leaving public school for private parochial school – however, as mentioned, that school would only last for one year after Smith arrived.

VICTIM AND VICTOR OF CIRCUMSTANCES

Principal Smith and Dr. Snellings's personalities are not identical; Smith is a bit more socially conservative and Snellings a bit more urbane (each projecting his own regional stereotype to some extent). But they are similar enough – united by their boyish, frat-boy personas – that I can envision them being close friends. I think they would most certainly have a great time together if they saw each other at a social outing, such as a wedding reception or a

¹ A concierge care practice is one that does not accept health insurance and is usually associated with wealthy patients due to high annual fees. However, as Snellings told me, concierge practices are not always limited to the super rich. Concierge practices are often viewed as providing more personable and friendly experiences for patients as a result of their not being as constrained by third party payers (i.e. paperwork requirements).

suburban barbecue. During such an interaction, they would most likely share passionate laughs and stories, imbibe in a little spirit, and most certainly talk sports. Had they progressed to talking about their careers and professional experiences, each would probably realize the other to be a (professional) kindred spirit. They would empathize with the other's frustrations toward outside entities, and feel the other's pain – a pain that cut both deeply. One might overhear cursing at school boards and health insurers, at school improvement plans and payer-preferred organizations, at meddling politicians and unreasonably critical publics. They would share a bond as a result of their homogeneous experiences and shared status as victims of professional siege by invading forces. However, after a certain point of shared war stories and commiserations, Smith might begin to feel envy toward Snellings. The conversation might begin to lose some of its initial energy and mutual appeal. After all, Smith has not been able to do what Snellings has done: evade those invading forces.

Snellings's decision to end his traditional private practice, and create a concierge practice, has had an enormously positive impact on his professional and personal lives (indeed, the two cannot be separated). Toward the end of our interview, when he took a brief phone call with his wife, I was struck by the casual ease of his tone. I felt like he and his wife had a very happy and peaceful existence together. Images of summer vacations to Cape Cod, lazy Sundays, and a stress-free home life came to my mind. Private insurers had made his life miserable just ten years earlier. Now, he was 180 degrees away from that moment in his past. He felt great about what he was doing, like he was doing real doctor work again – a true doctor. Smith, in contrast, could not escape his external agitators. Unlike Snellings, he has not enjoyed a professional renaissance.

Only a few years ago, Smith was principal of a struggling public high school. Just when it looked like he would break free and find a more fulfilling and comfortable professional existence, the rug was pulled out from underneath him. That imaginary conversation between Smith and Snellings would be forced to turn quickly back to sports, or family, or any of the many other topics on which the two could find common ground – because Snellings had been professionally liberated and Smith had not. What explains this contrast? Sociologically speaking, why was Snellings able to escape these pressures, and Smith could not? The following three-part dissertation explores these questions and others, and ultimately answers them through an up-close examination of the daily lives of public school educators and healthcare professionals. The short answer to this question, however, is that Snellings had an opportunity to remove external pressures (funding organizations) and internal pressures (bosses) from his professional environment, whereas Smith was forced to continue to place his professional fate in the hands of others – which, it will be shown, is the same boundary that separates the highly autonomous professional from their autonomously low brethren.

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CHAPTER 2

NEOLIBERALISM INSIDE TWO AMERICAN HIGH SCHOOLS

INTRODUCTION

University of Surrey (UK) political theorist, Mark Olssen, is arguably the world's leading scholar on the political economic campaign known as, "neoliberalism". According to Olssen, in the early 1980s, conservatives reversed their stance on the role of the state in Western society (Olssen 1996). Their new ideology was called, "neoliberalism", or new liberalism (Olssen 1996). Neoliberalism maintained traditional liberalism's faith in the free market as a natural and moral determinant of an individual's fate (Olssen 2010), as well as its indignation for the welfare system and welfare recipients. Unlike traditional conservatives, however, neoliberals believed that the state could be used to advance the conservative cause (Olssen 1996). Specifically, they began to use big government as a means of expanding the free market. Olssen explains, "... [N]eo-liberalism has come to represent a positive conception of the state's role in creating the appropriate market by providing the conditions, laws and institutions necessary for its operation" (Olssen 1996, 340). The target of neoliberals are individuals they deem to be lazy and selfish.

Traditional conservative theory assumed that individuals are motivated by self-interest and will voluntarily participate in the free market; thus, human nature supports the growth of the free market. Neoliberals were less trusting of the individual, and decided to discard the conception of "the self-interested man", or "homo economicus" (Olssen 1996, 340). Neoliberals regarded individuals as prone to lazy selfishness and in need of constant prodding. The new "manipulatable man" (340) would be influenced by the state through various forms of monitoring and measurement leading to more productive citizens, and ultimately, a more

productive free market society (a very real concern for the West during the Cold War). A handful of works by other notable critical theorists (Apple 1998; Apple 2004; Apple 2005; Apple 2014; Lipman 2005; Lipman 2008; Lipman 2011; and, insofar as the “culture wars” produced historical circumstances that led to the emergence of neoliberalism, Shor 1999) support Olssen’s account of neoliberalism, particularly as it relates to late 20th century and early 21st century developments in public education in the West.

Neoliberal education reforms in New Zealand

In the section titled, “Neoliberalism and New Zealand Education”, Olssen (1996) first describes New Zealand’s neoliberal education reforms of the 1980s and early 1990s, and then interprets the ideological meaning of the reforms (that they represent a shift away from “classical” liberalism toward “neo” liberalism for conservatives). This section is as good as any for understanding what Olssen means by neoliberal education reforms. Olssen begins by explaining that New Zealand’s Treasury Department changed the conception of public education in the country during the mid and late 1980s from a community or public good into a commodity. Analyzing a 1987 Treasury Department brief, Olssen points out that public education was going to be treated “...in a way similar to any other service... that...shares the main characteristics of other commodities traded in the marketplace, and that it could not be analyzed successfully as a ‘public good’” (New Zealand Treasury Department brief, Government Management, cited in Olssen 1996, 339). Neoliberals also wanted more government oversight for educators. Specifically, Olssen explains, “... the educational system lacked a rigorous system of accountability, there being a lack of national monitoring procedures or of any satisfactory ways of comparing the effectiveness of schools in order to account for the public resources

employed...” (New Zealand Treasury Department brief, Government Management, cited in Olssen 1996, 339).

There are two separate beliefs put forward by the Treasury Department here: 1) public education should be treated like a private good or service that is supplied and demanded within a free market (this is an ideologically claim only; no concrete explanation of what this means is offered), and 2) that educators need to be held more accountable for their actions, and that a national monitoring system should be devised in order to achieve this objective – a more specific and concrete idea. Thus, the Treasury Department argued for the ideological transformation of public education into a free market enterprise, and the actual implementation of a national accounting and monitoring system that measured educator performance. Olssen eventually provides more specific examples of New Zealand’s neoliberal education reforms. During the late 1980s and early 1990s, he says, New Zealand’s politicians and ministers implemented the following concrete neoliberal education reforms:

- 1) The decentralization of power. Power moves from the national government to local schools vis-à-vis “Charters” and “Boards of Trustees”. Local schools have responsibilities over: personnel decisions (“staff employment” – not teachers, though), property management, and the creation and managing of the school’s charter (contractual plan).
- 2) The elimination of school zoning (or what Americans call, “neighborhood schools”). This enables students and parents to act more like consumers because they can choose which school to go to based on performance, not where one lives.
- 3) The creation of two national regulatory bodies. The two regulatory bodies were the Education Review Office (ERO) and the New Zealand Qualifications Authority (NZQA).

The first two reforms remove barriers to “the ‘natural’ free-market contract between producer and consumer with all that entails for efficient and flexible producer responses to consumer demand” (Olssen 1996, 339). Thus, they are good examples of ways New Zealand politicians tried to make the delivery of public education more like a private good, and the system of public

education more like a free marketplace. These reforms are, of course, ideologically liberal; they are part of the classical liberal agenda. The difference, argues Olssen, between past conservatives and conservatives in the 1980s and '90s can be seen in the third reform: the implementation of two national regulatory bodies. Classical liberals (i.e. traditional conservatives) do not typically want more government oversight and intervention. According to Olssen, this peculiar addition to the conservative strategy is what makes a neoliberal a neoliberal. Neoliberal reformers wanted teachers to be watched and monitored because if left to their own devices, Treasury claimed, teachers act selfishly:

... [T]eachers and the educational establishment have pursued their own self-interest rather than those of pupils and parents, i.e. they had not been responsive enough to consumer interests and desires (New Zealand Treasury Department brief, Government Management, cited in Olssen 1996, 339).

What this meant in practical terms, one has to speculate because Olssen does not provide further insights. Presumably, teachers' selfish behaviors were, in some way or another perceived as threats to the implementation of free-market neoliberal reforms (excessive union activity? excessive salaries?). In his discourse on "manipulatable man" (later in the section titled, "Neoliberalism and New Zealand Education"), Olssen seems to be referring to teachers (among many other groups of individuals in New Zealand society) when he claims that neoliberals regarded certain individuals as prone to "slothful indolence" (340) who, therefore, are in constant need of being "continually encouraged to be 'perpetually responsive'" (340). According to Olssen (1996, 340):

... [I]n an age of universal welfare, the perceived possibilities of slothful indolence create necessities for new forms of vigilance, surveillance, 'performance appraisal' and of forms of control generally. In this new model, the state has taken it upon itself to keep us all up to the mark. The state will see to it that each one of us makes a 'continual enterprise of ourselves'...

The United States was experiencing similar demands on its public education system around this time. The 1983 government report, *A Nation at Risk*, for example, played a critical role in the intensification of oversight and surveillance on America's schools and educators. *A Nation at Risk* was a damning critique of the state of American public education that convinced millions of Americans that their education system was falling from grace on the global stage. The opening section of the report (first section after the Introduction) proclaims:

Our Nation is at risk. Our once unchallenged preeminence in commerce, industry, science, and technological innovation is being overtaken by competitors throughout the world... a rising tide of mediocrity... threatens our very future as a Nation and a people. What was unimaginable a generation ago has begun to occur—others are matching and surpassing our educational attainments (The National Commission on Excellence in Education 1983, 9).

This mirrors Olssen's description of the Treasury Department of New Zealand's opinion of their country's public education system in the early 1980s:

In short, Treasury argued that state-provided and state-controlled education had performed badly and would continue to do so unless radical changes were implemented. The Treasury buttressed its arguments for the necessity of change by reference to 'failing standards', rising mediocrity, and 'provider-capture'. They claimed that these threatened... [New Zealand's] future as a nation (Olssen 1996, 339).

Neoliberals in America and New Zealand regarded teachers as lazy and in need of constant surveillance; they were not as enterprising and competitive as they needed to be. Greater scrutiny and surveillance of teachers would prod them into being more competent teachers. This, in turn, would lead to improved student learning and student achievement – and, consequently, better futures for each nation.

Neoliberalism in Louisiana

In the southern American state of Louisiana, political leaders (most notably the Republican governor) are currently echoing the arguments made by New Zealand's political leaders (Treasury Department) in the 1980s and 1990s. Governor Bobby Jindal has, for example, argued for greater "choice" for students and parents (in terms of availability of schools). Teachers and schools, the governor has assumed, will be more "efficient" if they are forced to be more "competitive"; New Zealand's Treasury advocated for more "efficiency", "choice", and "competition", too (Olssen 1996, 339). Additionally, Louisiana's education system mirrors New Zealand's insofar as it, too, eliminated "neighborhood schooling" (i.e. zoning) and has undergone a similar effort to decentralize authority and responsibility to the local school level. This has been pursued most vigorously vis-à-vis Louisiana's recent (since the mid-2000s) movement toward charter schools (though, to be precise, although spending and personnel decisions are made by administrators inside individual schools, the oversight of such processes and decisions is located at the school board level in Louisiana).

These developments demonstrate that Louisiana's political leaders are ideologically and rhetorically aligned with New Zealand's education reformers of the 1980s and 1990s – and their education systems are similar in terms of actual reforms that made each operate more like a free marketplace. Moreover, Louisiana's neoliberal reformers parallel New Zealand's insofar as each has advocated for closer scrutiny, surveillance, and influence over the work of teachers and administrators. Louisiana's "school performance score" system, an evaluation process that assigns a letter grade to every public school based on standardized test scores and graduation rates, is very similar to New Zealand's "Framework and Evaluation Indicators for School Reviews" (Frameworks and Evaluation Indicators for ERO Reviews 2014). Neoliberals in

Louisiana and New Zealand share an unshakeable commitment to free market principles, as well as a belief in the necessity of shaping the work of educators.

Professional freedom is central to Mark Olssen's (1996) conception of neoliberal education reforms in New Zealand throughout the 1980s and early 1990s. In particular, his theory implies that New Zealand's political leaders viewed the country's teachers (and principals) as a "manipulatable man" (1996, 340) who is lazy and selfish, and needs to be prodded into being productive. Based on my own research and experiences as a teacher, I knew this to be true. However, I also knew that some teachers and principals are exempt from neoliberal scorn and surveillance – those who work at high-performing, non-poor public schools. Some educators are treated as "homo economicus" (Olssen 1996, 340). Based on interviews with teachers and principals at two high schools in the American state of Louisiana, this study addresses the following questions:

- 1) How do responses regarding professional autonomy compare and contrast between educators at a low-income high school and educators at a non-poor high school?
- 2) Do student socioeconomic factors relate to an educator's perceptions of professional autonomy, and if so, how?
- 3) How do teachers and principals of each school respond to perceived threats to their professional autonomy?

LITERATURE REVIEW

Educator autonomy defined

The word, autonomy, originated in the Greek language: autos- means self, and nomos- means law. Therefore, to be autonomous means to be ruled or governed by one's own laws.

Professional autonomy is self-law in the workplace. More concretely, professional autonomy can be viewed as the extent to which one is free to perform their job according to their own definition of success in that position, and through actions of their choosing toward achieving that vision of success. Professional autonomy in this sense is similar to the term, professionalization – the more professionally autonomous a profession is, the more professionalized it is, and vice versa.

Indeed, Olssen (2010) states that professionalization is based on, “professional autonomy and expertise” (10). Olssen also argues that some professions, including teaching and medicine, have de-professionalized in recent decades (Olssen 2010). Professional autonomy is positively associated with employee wellbeing, including better workplace attitudes (Terry and Jimmieson 1999), improved mental health (Deci and Ryan 2012), higher worker satisfaction (Bond and Bunce 2003), higher worker commitment and performance (Ingersoll 2007; Hodson 1996), and professional identity (Fine 1992). With regard to public education, researchers have found a positive relationship between teacher autonomy and student achievement (United States Department of Education 1997: 17).

There are other works on individual autonomy that are more philosophical in nature and which debate or discuss the possibility of the existence of “perfect” human autonomy or agency (Olssen 2005; Castoriadis 1991; and, to an extent, Mills 1959). The present paper, in contrast, is not concerned with the question of the existence of perfect and total autonomy; rather, the focus here is on comparative professional autonomy: Are some teachers and principals in public schools more autonomous than others, and if so, how and why? Interviews with teachers were guided by questions relating to a teacher’s autonomy primarily from their superiors (principal

and assistant principal) regarding the freedom to² design and implement curricula, evaluations, and the disciplining of students. Interviews with principals were conducted with questions pertaining to a principal's autonomy primarily from the local school board (and to a lesser extent, from the state department of education and federal department of education) with respect to their freedom to design and implement curricula, freedom to determine their time and schedule, and power over funding decisions. The central focus of this definition of principal autonomy is the degree of (perceived) pressure³ exerted on a principal by actors who are physically located outside of the school building, such as superintendents and staff at the local school board.

In most American states, local school boards (also known as a "Local Education Agency" [LEA]) are the "enforcers" for the state and national departments of education; they are the most obvious form of bureaucratic influence in schools. In Louisiana, local school boards monitor all public schools to determine the extent to which students are achieving the state of Louisiana's academic requirements in various academic subjects (which is measured by their performance on end of year standardized tests) as well as schools' graduation rates. Schools in which students are failing to meet state standards are vulnerable to a myriad of interventions by local school board personnel. Interventions revolve around "improvement plans", a document outlining the expectations for the schools' students with regard to performances on the state's standardized tests and graduation rates. There are a variety of measures taken to enforce the improvement plan: meetings, email conversations, and on-site evaluations. In addition to enforcing the state's academic standards, local school boards monitor schools that receive federal funds in order to ensure that principals are spending federal monies in previously agreed upon ways (ways that are

² Olssen (1996, 345) focuses on the difference between "positive freedom" and "negative freedom", e.g. "freedom to" and "freedom from". Freedom from state intervention is the emphasis of this paper (negative freedom). However, as participants' responses show, freedom from the state is highly valued because it leads to positive freedom (e.g. the freedom to teach how and what teachers want to teach).

³ As perceived by the principals themselves.

intended to improve student performances on standardized tests and graduation rates). The most important of these types of funds is Title I funds (which are more fully explained at the end of the next section). Despite local school boards' intense presence in schools, education scholars have shown that public schools are often able to "decouple", or somewhat distance themselves from bureaucratic influence (Coburn 2004; Meyer and Rowan 1977; Hallet 2010). However, as data collected in this study demonstrates, not all public schools are decoupled equally.

Prior research on the relationship between student socioeconomic status and educator autonomy

Lauder, H., et al. (2006) is one of only a few works on this topic. The authors found that British teachers with non-poor pupils were more likely to take part in school-wide decisions than teachers who serve poor students. They assert, "Perhaps the most striking pattern shows a connection between the number of agents exerting influence on decision making processes and the socio-economic status of a school" (Lauder, H., et al. 2006, 15). In a critique of Chubb and Moe's (1988) conservative (pro-private school) conclusions, Sandra Glass's (1997) multi-site case study argues that the socioeconomic statuses of a school's students, not its sector (public/private), are more likely to predict levels of educator autonomy. Glass alludes to the possibility of this relationship:

The schools examined here enjoy success in all conventional senses of the term. This favorable environment may shape the way the political system treats educators and how educators respond in return. One might have reason not to expect the same organizational effect obtaining in schools under the duress of poverty and social dislocation. The following themes that emerged from this research should be viewed with these cautions in mind (Glass 1997, 44).

Glass advises future research to analyze the potential connection between student socioeconomic status and educator autonomy. She asks, "In what ways do the social and economic circumstances of the students affect teachers' and administrators' autonomy?"

(51). The current study answers this call by examining the possible relationship between student socioeconomic status and educator autonomy. According to my searches, this is the first sociological study of its kind (Lauder et al. [2006] are education researchers).

Schools receiving Title I funds have greater restrictions

Since the 1960s, the United States has attempted to compensate for the “achievement gap” between poor and non-poor students with additional public funding – most importantly, Title I funds, federal tax monies given to schools in which 70% or more of the student body is eligible for free or reduced-priced lunch. Schools are suppose to use Title I federal funds in ways that will improve students’ performances in fulfillment of state standards – standardized tests and graduation rates. How, specifically, a school uses this money is determined by officials from the local school board in consultation with a school’s principal (the former is the ultimate decision-maker, though). Johnson (2011) argues that federal funds can compromise a principal’s autonomy because the administration of them requires a high degree of time, energy, and knowledge. Title I funds force principals to devote time toward administrative duties – time they may wish they could spend with teachers and students. Acting as the enforcer on behalf of the state and the federal departments of education, the local school board aggressively monitors Title I spending.

METHODS

I recruited participants by emailing high school principals within the East Baton Rouge Parish School District a description of my research and a request to conduct interviews (with their teachers and with them.) Only one of these folks, Principal Eric Smith of Fryburg High School, was willing to participate in my study (quite enthusiastically actually). After meeting

him, I asked Principal Smith if he could speak to the principal of Bridgton Magnet High School (also known as, Bridgton High School) on my behalf (this was a school in which I was trying to gain entry). I utilized a strategy that resembles Esterberg's (2002) model of snow-ball sampling. Principal Smith contacted Bridgton High's principal, and shortly thereafter, she (Bridgton High's principal) contacted me to let me know that she was willing to participate. By gaining access to Bridgton Magnet High School and Fryburg, I was able to interview teachers and principals from two socioeconomically different schools: Fryburg possesses a high poor student population; and Bridgton High School has significantly fewer poor students. This provided an opportunity to understand how student socioeconomic status affects an educator's sense of professional autonomy.

According to the National Center for Education Statistics' (NCES) Internet database, there are approximately 1,040 students in grades 8-12 at Fryburg High School. Approximately 73% are eligible for free or reduced-price lunch. Black students make up 79% of the student body, and white students constitute about 12%. It is located in a tree-lined, middle class neighborhood in south Baton Rouge (National Center for Education Statistics 2011).

Bridgton Magnet High School serves approximately 1,224 students in grades 9-12; approximately 41% are black and 44% are white. Additionally, 31% are eligible for free or reduced-price lunch. At the time of this study, it was located in the former Lincoln High School building, a run-down remnant of a time passed. This is not a permanent location, however; their actual school building is in the end stages of a \$58 million renovation (Portier 2012). The newly school looks like a school for the progeny of the power elite. It consists of two theaters, several sparkling new science laboratories, a "TV production area", manicured grounds, and a main

building that looks more like an Ivy League residence hall than an urban public high school (2012). Bridgton High's principal is well known to public educational insiders as a result of having received accolades at the state and national levels. The revered magnet school is one of the highest ranked public schools in the state and is perceived by many in Baton Rouge to be an essential institution for the city (National Center for Education Statistics 2011).

Data analysis

I used Charmaz's (2006) grounded theory to interpret my data. Grounded theory is a qualitative method that fulfills two objectives: it provides a practical means of organizing vast amounts of interview data; secondly, it provides a guide for developing a new theory. Before I coded the interview data, I transcribed the interviews (a total of 220 pages).

There are three stages of Charmaz's grounded theory: "line by line coding", "focused coding", and "axial coding". In line by line coding, the researcher "stays close to the data"; that is, she attempts to put each transcribed line of the interviewee's text (assembled in a Word document) into her own words (that summarize the point she thinks the interviewee was trying to convey). This stage involves some degree of deduction (or "implicitness") because it involves interpretation (albeit a strict interpretation). In focused coding, there is more deduction involved as the researcher decides on a handful of (anywhere from 4-8) "categories" that organize the coded lines from round one. Lastly, axial coding prompts the researcher to conceive a theory that, in a few sentences, explains the relationships among the different categories that emerged in focused coding. As the researcher proceeds through each of the three stages of grounded theory, she relies increasingly more on her capacity to make meaning of the interviewee's explicit text. Each stage (including the ultimate theory) rests on the foundation created by the first round of

coding – that is, on how closely the researcher’s restating of the interviewee’s spoken words mirrors those words. Grounded theory therefore involves a mixture of implicit and explicit analysis.

FINDINGS

Different students leads to different school performance scores

Two Fryburg teachers were visibly upset by Bridgton High School, which they claim, has hoarded the district’s highest performing students, leaving schools like Fryburg with the task of educating the city’s lowest performing students. To my surprise, a teacher at Bridgton High School confirmed this accusation, “... [B]asically we skim the cream of the crop and they’re all concentrated here” (John Jackson, interview by author, Bridgton Magnet High School, October 2011). This opinion mirrors previous research on magnet schools. “According to some, magnet schools attract the best and the brightest students in the school board, ‘skimming’ these students from the other public schools” (Gamoran 1996; Lee 1995; Martinez et al. 1998 quoted in Evans 2001, 12).

Another Bridgton High School teacher explained an additional competitive advantage for their school, “Well one of the reasons [why Bridgton High School is as successful as it is] is that... the kids have to maintain a certain GPA to stay here; so the ones that don’t do well, don’t stay. So they don’t become a part of the stats” (Wendy Swillow, interview by author, Bridgton Magnet High School, October 2011). In fact, some Bridgton High School students are so academically proficient that they tutor their college friends.

Bridgton Magnet High’s use of a “student filtering mechanism” explains its exceptionally low percentage of low-income and special education students. Since these two groups of students

historically underperform on standardized tests (Darling-Hammond 2007), the schools that educate them are more likely to be punished by what Apple (2004, 13) refers to as, “middle class managerial inspired regulatory proposals”. Bridgton High’s low percentages of low-income, special needs, and students of color play a role in its success. Fryburg, and the other low-performing schools in the city and state, are responsible for educating the state’s lowest-performing students; yet they are evaluated by the same standards as schools like Bridgton High School that benefit from receiving the city and state’s highest-performing students. Fryburg’s principal expressed frustration with this reality:

You know, when we get students that are reading on a third grade level and can’t do basic arithmetic, it is very difficult for us to teach them algebra and for them to read... And nobody takes that into consideration. All they look at is how your score, how did your kids do on those scores? And it’s just, so I don’t want to stand up and scream, ‘Not fair, not fair, not fair.’ But it’s not a fair system. It’s not fair. (Principal Smith, interview by author, Fryburg High School, October 2011).

Differences in students’ standardized test-taking skills and an incoming student filtering mechanism have contributed to what looks like a rigged academic competition whereby Bridgton Magnet HS is all but guaranteed to beat schools like Fryburg. A significant outcome of this situation is the relationships that the local school board adopts with the “victors” (schools like Bridgton High School) and the “losers” (schools like Fryburg): a hands-off relationship with the victor and a hands-on (micromanaged) relationship with the loser. This process materializes as a circular relationship among student socioeconomic status, school performance score, and state influence over educator autonomy (Figure 1). My purpose in revealing the differences between the two schools is to simply explain how schools like Fryburg habitually struggle, and are more likely to be the “manipulatable man” (Olssen 1996, 340) – inherently vulnerable to government intervention – and how schools like Bridgton Magnet High School (i.e. schools that have “better” students) are more likely to be treated like “homo economicus” (Olssen 1996, 340).

Fryburg's principal said that a "perfect school" would be one where both he and his teachers had much greater professional autonomy. He seemed to think such a situation was idyllic only – not a goal that he and his colleagues were actively striving toward. However, such a school exists across town in the form of Bridgton Magnet High School where their principal and teachers focus on their own plans for success. They spend little time achieving the state's standards because their students are already high performers on standardized tests before they walk in the door. "Rarely do you hear me talk about test scores", Bridgton High's principal informed me (Principal Nichols, interview by author, Bridgton Magnet High School, fall 2011). She added, "That's the easy part of what we do... That's not something I judge us on" (Principal Nichols, interview by author, Bridgton Magnet High School, fall 2011). A key difference between Bridgton High School and Fryburg High School in terms of professional autonomy, therefore, is that Bridgton's principal and teachers focus on goals that they are not mandated to achieve; they focus on "putting the cherry on top" (such as maximizing the number of Bridgton High School students who are "Presidential Scholars"). Fryburg's principal and teachers, in a profound contrast, struggle just to fulfill Louisiana's basic academic requirements.

Funding: The more you get, the more you give up

Different sources of funding are another reason for the gap in educator autonomy that exists between Fryburg and Bridgton High School. Roughly 70% of Fryburg's student body is eligible for free or reduced-price lunch, compared with only (approximately) 35% of Bridgton's student population. Consequently, Fryburg receives federal Title I funds, and Bridgton High School does not. The principal of Fryburg High responded in ways that are consistent with Johnson's (2011) findings – Title I fund administration can be overwhelming. Although he gets

help from several staff members at the local school board, he still is burdened by a continual influx of paper work. He explains:

We're dependent on a lot of funds that we get, that are federal funds, such as Title I funds. Well, with Title I funds come restrictions... Ok, if you're getting Title I funds, well then you have to do this, you have to show us that those funds are being used for this and show them how they're successfully educating kids. So we have a lot of [demands for] accountability there and there's a lot of documentation there, so it's kind of a tough deal and [sighs] I mean I understand, well if they're giving us the money, then they ought to be able to tell us [what to do] ...But it adds to the restrictions and to the hands being tied [behind our backs]... (Principal Smith, interview by author, Fryburg High School, October 2011).

For Fryburg's principal and principals of similar schools, Title I funds are both a blessing and a burden: They create an incredible amount of "busy work", but they also provide Fryburg with seemingly necessary resources. Fryburg's principal explains, "That just kinda adds to the bureaucracy, but I mean, if you want the funds, you have to do that" (Principal Smith, interview by author, Fryburg High School, October 2011). Fryburg and schools that receive Title I funds are forced to conform to "new forms of vigilance, surveillance, 'performance appraisal' and of forms of control generally" (Olssen 1996, 340). Such measures "continually encourage [them] to be 'perpetually responsive'" (Olssen 1996, 340).

In startling contrast, Bridgton High's principal utilizes her school's "alumni foundation" that supplies her school with "endowments". Non-governmental funding sources enable her to have greater freedom than Fryburg's principal. Bridgton's principal is aware of this advantage, as she informed me:

... [N]ow there are a lot of things that we don't have to tolerate, that we don't have to do because we are not Title I. There is a lot of paperwork that we are not involved in because we are not Title I. A lot of people think, well gee, you could be Title I if you... just did such and such. But I don't want to be [a Title I school]. That is one of the ways we are able to keep our autonomy (Principal Nichols, interview by author, Bridgton Magnet High School, fall 2011).

Since she is not dependent on Title I funds, Bridgton’s principal does not have as many education officials calling, emailing, and interrupting her as Fryburg’s principal. The executive director of her school’s alumni foundation is the only person in the foundation who has permission to contact Bridgton’s principal (except for, occasionally, one other individual). Fryburg’s principal, on the other hand, must respond to an excruciating number of emails, phone calls, and site visits by regulators who conduct periodic audits at his school in order to determine whether or not he is spending government funds as instructed. Each principal has had very different experiences with what Olivier (2010, 295) describes as, “...the ability to distance oneself from those agencies that constantly tend to ‘infantilize’ people, by treating them as if they are children, incapable of thinking and acting as (relatively) autonomous beings.” Fryburg’s principal and his teachers resemble Olssen’s manipulatable man, a “child” of the neoliberal state. In contrast, Bridgton’s principal and her teachers are treated like homo economicus, who is endowed with “an autonomous human nature and [who] can practise freedom” and are consequently, “relatively detached from the state” (Olssen 1996, 340).

“Outside⁴ help”

Since his school recently received a “D” on the state report card evaluation, Fryburg’s principal must participate in a myriad assortment of improvement plans and programs. He understands the need for supervision, though he believes the process through which he and his teachers are monitored has led to more harm for his school than school improvement:

Now you need to have a certain amount of oversight somewhere, but it would be nice to have one person or one entity... As it is now, since everyone is involved, we have all kinds of measures about what we’re supposed to do... And we spend

⁴ I refer to school board central offices and state departments of education as “outside” entities. I place “outside” in quotations because although they are perceived by participants to come from the “outside”, these entities belong to the same public education system as the schools and local educators.

all of our time making sure we're taking care of those things... [I]t's gotten to the point where it's too much. There's too much. Too many people are looking at us, too many people are throwing things at us and saying, 'Hey, you need to do this, you need to do that.' It's just gotten too much (Principal Smith, interview by author, Fryburg High School, October 2011).

Bridgton's principal empathized with principals who, like Fryburg's principal, endure such demands:

There is so much, so many plans, so much paperwork, so many reviews, people in your school monitoring and it seems like the harder it gets, the more paperwork, the lower the score; the harder it is to bring it up. It is hard⁵ (Principal Nichols, interview by author, Bridgton Magnet High School, fall 2011).

Luckily for Bridgton's principal, the state does not expect her to do these things.

Although she said her school is treated just like any other public high school in Baton Rouge, she revealed that an "unspoken relationship" has developed between her school and the local board office over the past six years⁶ (Principal Nichols, interview by author, Bridgton Magnet High School, fall 2011). Personnel at the East Baton Rouge Parish school board office grant her more autonomy than the principals of other schools because of her students' higher test scores. Unlike Bridgton High School, Fryburg has to "take whoever walks through the door" (Kate Mason, interview by author, Fryburg High School, October 2011), and cannot remove its lowest-performing students like Bridgton High School. This plays a significant role in Fryburg's inferior school performance score, and consequently, the greater level of intervention imposed on Fryburg by the local school board.

⁵ Her tone of voice changed considerably as she spoke this last sentence, and I sensed that she empathized with her peers whose professional lives are more difficult (than her own).

⁶ Perhaps not ironically, the unspoken, hands-off relationship between the board and Bridgton High School emerged shortly after Hurricane Katrina.

Bridgton High's "revolt"

Bridgton High teachers told me of a successful "revolt" at their school a year or two prior to our interviews that significantly undermined the state's influence in their school. Bridgton teachers were furious that the Louisiana State Department of Education began requiring all public high schools (including Bridgton High) to administer weekly tests intended to gauge student preparedness for the end of year standardized tests (called "Benchmark Tests"). Initially, Bridgton teachers and administration begrudgingly obeyed. After about a full school year, however, a group of aggravated teachers approached their principal and expressed their frustration. Bridgton's principal told her teachers to disregard the state while she "runs interference". One teacher paraphrased her instructions, "Look my job is to run interference for you. You do what you do that you know works" (John Jackson, interview by author, Bridgton Magnet High School, October 2011).

At the beginning of the next school year, Bridgton's principal informed her teachers that the state no longer required their school to administer the weekly Benchmark Tests (even though teachers at other schools across the state were still expected to conduct them). According to one Bridgton teacher, the principal said⁷, "We're not doing it anymore...Just do what you want. We're not going to play that game" (John Jackson, interview by author, Bridgton Magnet High School, October 2011). This teacher assumes that the state "gave up" after Bridgton's principal demonstrated strong opposition to state meddling. Bridgton's principal informed me that since they do not have to do the Benchmark Testing, her teachers are able to focus more on teaching:

[The state] give[s] us a choice at Bridgton [Magnet] High whether or not we do the Benchmark Testing... Which for us, we don't want to do it, not because we don't want to do it, we don't want to do it cause it takes so much time away from

⁷ This is Jackson's paraphrased account of Nichols's statements.

instruction (Principal Nichols, interview by author, Bridgton Magnet High School, Fall 2011).

One reason for the successful revolt, according to Bridgton teachers, was that the state is, in a sense, beholden to high-performing schools. The local school board and the state department of education both depend on schools like Bridgton High to bolster the weighted average (school performance score) of all public schools in Baton Rouge and the state of Louisiana. Politicians' political livelihoods depend on schools like Bridgton High. During our focus group interview, one Bridgton High teacher raised this point, "And don't you think the state wouldn't want to lose us as a stat?" (Wendy Swillow, interview by author, Bridgton Magnet High School, October 2011). A few of her colleagues agreed. One remarked, "I think just because of our school performance score... Yes, we had stuff that we could say, 'Look, look at what we're doing here'" (Deb Peterson, interview by author, Bridgton Magnet High School, October 2011). Regarding the likelihood of successful revolts at other schools, one teacher said, "That wouldn't work at a normal school" (Margaret Billington, interview by author, Bridgton Magnet High School, October 2011). A middle-aged male teacher, told me:

In other schools, and I taught at others, I felt like the migrant farm worker and I was just picking so many heads of cabbage every day and here I'm back at being a professional and they back us up and they back up what we try [to] do in our programs as we [try] to make it a richer learning experience... [W]e have an administration that does an excellent job of running interference for us toward their administration and the state... (John Jackson, interview by author, Bridgton Magnet High School, October 2011).

Similarly, another informed me:

Instead of policing us, they really leave us alone. I was shocked when I first got a job here... and it was my first time teaching ever... I was shocked at how much I was left alone. I mean, I was just left alone... And it was awesome (Amy Stone, interview by author, Bridgton Magnet High School, October 2011).

Bridgton teacher's enthusiasm toward their workplace is starkly contrasted by the frustration and resigned acceptance expressed by Fryburg's principal and several (though not all) Fryburg teachers.

DISCUSSION

What is being proposed here is a claim that neoliberalism (or the manipulation of state resources and power in pursuit of a free market-based society) explains why a relationship appears to exist between student socioeconomic status and educator autonomy in two Louisiana public high schools. Interviews with educators at two public high schools in Baton Rouge, Louisiana, U.S.A., reveal a pattern of differences in professional autonomy. The educators at the non-poor, high-performing school (Bridgton High School) are treated like, "... 'homo economicus', who naturally behaves out of self-interest, and is relatively detached from the state" (Olssen 1996, 340). In contrast, the teachers and principal at the low-income, low-performing school (Fryburg High School) are treated like "... 'manipulatable man', who is created by the state and who is continually encouraged to be 'perpetually responsive'" (Olssen 1996, 340). There is a kind of moral logic and justification to this reality: If a school is good enough to fulfill the state's academic standards on its own, it is left alone by the state. If it is not good enough, it is not left alone. Professional autonomy in public education is, therefore, a reward that is bestowed on high-performing schools. This social Darwinian logic resembles a laissez-faire explanation for winners and losers in the free marketplace: the winners outcompete the losers. This system of "earned decentralization" is in keeping with Olssen's paradoxical conception of neoliberalism: Free market forces should dominate all facets of public life; however, when individuals are not 'productive', the state must step in to correct their behaviors.

The neoliberal state is a force for good because it all but ensures a competitive and productive society.

This is the neoliberal explanation for the findings presented in this study. There are other possible theories that provide explanations as to why this relationship exists, and I will assess the credibility of three of these theories.

Desegregation and magnet schools in America

At about the same time that neoliberal education reforms emerged in the United States, magnet schools were becoming increasingly popular amongst middle class whites in the United States. Specifically, magnet schools were seen as an antidote to forced segregation throughout American suburbs (this was not limited to the South). They were American politician's answer to the increasingly angry and predominantly (though not exclusively) white opposition to forced busing. At first, magnets appeared to offer a lot of potential toward the achievement of desegregation goals. Over time, however, magnets became "... elite enclaves... potent symbols of the very inequality targeted by... federal court order" (Gelber 2008, 454).

The most desirable type of magnet school for white families were "perfect magnets" (Rossell 2005), or those in which every student had chosen to attend that school – usually following a competitive admissions process. Perfect magnets tended to have admissions criteria that filtered incoming students according to academic ability. The result was that perfect magnets had student bodies with high percentages of white, middle class students and low numbers of non-white, low socioeconomic, and mentally disabled students. According to Rossell (2005), approximately one-third of all magnet schools in the United States by the mid-2000s possessed admissions criteria for their incoming students (such as minimum standardized test score

requirements). Many of these schools are also able to remove students who do not perform at a certain minimum level in that school (such as maintaining at least a 3.0 grade point average). Teachers and principals in perfect magnet schools, such as those at one of the two schools in this study (Bridgton High School), had greater professional autonomy than educators at the majority of all public schools as a result of their superior political capital. Louisiana politicians allow schools like Bridgton High greater flexibility and freedom than schools like Fryburg because Bridgton's success is beneficial to politician's careers.

The State will intervene regardless of political party

Democrat and Republican politicians alike advocate for “school choice”, “accountability”, and the charter school movement. A seemingly business-minded approach toward public education unites the two political aisles in America. Despite whatever alleged improvements the Obama Administration's Race to the Top program has on the No Child Left Behind Act, the two are essentially the same thing: top-down, rigidly monitored and enforced efforts to control outcomes in individual schools. Both mandates rely on similar assumptions about the ability of state intervention to save struggling students and schools, or the assumption “...that minority children can become liberated from their debilitating circumstances through the salvation of education guided by performance-based accountability policies” (Jahng 2011). Although critics of neoliberalism such as Pauline Lipman and Mark Olssen associate it with the Republican Party in the U.S., Democratic Presidents Clinton and Obama have been equally entranced by neoliberal prose and policy as evidenced by a familiar infatuation with standardized testing and nationally centralized decision-making authority (Fuhrman 1994). In light of the evidence, it seems right to assume that something beyond a single explanation (i.e. neoliberalism) is called for.

Students' backgrounds

In a review of literature on the subject, Pinderhughes, Dodge, Bates, Pettit, and Zelli (2000) show that a family's socioeconomic circumstances are associated with parenting style. Lower socioeconomic and African American parents tend to value conformity and discipline (and the use of physical punishment in pursuit of these goals), whereas European American mothers and higher socioeconomic parents eschew conformity and advocate "self-direction" (Pinderhughes et al. 2000). A teacher of low-income students might want to teach her students how to think independently and creatively, but she is redirected toward her students' (and the parents') needs and pleas for predictability and the enforcement of clearly defined rules. Alternatively, wealthy, white students may expect teachers to foster their growing sense of individuality, adventure, and intellectual awakening. Given the relationship between student socioeconomic background and student expectations and desires, it seems plausible to assume that neoliberalism is not the only explanation for the relationship observed in this study.

Why neoliberalism works (as a theory)

Each of the three theories briefly summarized here explains, to some extent or aspect, the existence of the relationship between student socioeconomic status and educator autonomy that has been observed in two Louisiana public high schools. The "takeover" of magnet schools by middle-class white families, the non-partisan dogmatic belief in top-down state intervention in low-income schools, and the relationship between parenting style and students' and parents' expectations of teachers and principals – all three provide a clear narrative as to why low-income students are taught by educators who possess relatively low levels of professional autonomy (and

why non-poor students are taught by educators with relatively higher professional autonomy). But each theory exists within a conceptual vacuum, isolated from the merit of the others.

Neoliberalism, in contrast, is a broader theory, a conceptual umbrella under which each of the three alternative theories is located. Neoliberalism explains why the education decision-makers in America did what they did (the pursuit of free market society) and how they did it (the centralization of control within the national and state executive and legislative branches vis-à-vis the top-down regulation of individual public schools). In a free market society (which attempts to level the playing field through the hand of the state), one should not be surprised by the presence of segregation and attempts at desegregation (alternative theory #1); one should not be surprised in a capitalistic society that Progressives have been persuaded into accepting free market education reforms that are offered as the most promising solutions to educational and economic inequalities (alternative theory #2); and one should certainly not be shocked by the existence of vastly different parenting styles resulting from very different living conditions (alternative theory #3). Neoliberalism's broader narrative explains how each of these three forces contributes to the relationship between socioeconomic status and educator autonomy in the United States, and, more powerfully, why such a relationship was and is inevitable.

Public education, like other important institutions in the West (such as labor markets and capital markets), lacks the conditions that are necessary for fair competition – all participants do not begin at the same starting point. Bridgton High School is all but guaranteed to outcompete Fryburg because it inherits a group of incoming students that are far more academically advanced than those attending Fryburg. This inheritance seems to play a more significant role in Bridgton High's success than the “productivity and competence” of its educators, as

neoliberalism would have it⁸. This conclusion is supported by several teachers at Bridgton High School, one of whom rather candidly told me that the difference between his school and other schools' performance scores represents a "statistical bias" because his school gets most of the district's highly educated students (John Jackson, interview by author, Bridgton Magnet High School, October 2011). One of the not so obvious consequences of this inequity (among many) is an unequal distribution of educator autonomy. The implications of this disparity remain underexplored and represent significant opportunities for future research within the sociology of education.

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⁸ To be clear, I believe Bridgton High's teachers and principal are great at their jobs. However, they significantly benefit from their students' pre-existing academic capabilities.

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CHAPTER 3

THE DIFFERENT WAYS DOCTORS THINK ABOUT THREATS TO PROFESSIONAL AUTONOMY

INTRODUCTION

The research presented herein is preceded by a study conducted on the ways that public school teachers talk about perceived threats and intrusions upon their professional autonomy. At the onset of this study, I relied on several informants each of whom asserted that medicine and the work experiences of doctors were both similar and different to teachers and principals. They claimed that unlike teachers and principals, who often have confrontational relationships with their bosses, doctors (hospital doctors in particular) tend to have collegial relationships with superiors based on mutual respect and autonomy. If one wanted to understand doctors' mindsets and frustrations, they had to realize that their gripe is with "outside entities"⁹ (and the pressures put on them by these entities): they are private insurance companies and the government (federal and states), or what are commonly referred to as "payers".

One interviewee, a former president of Swift Hospital¹⁰, rejected my original informants' claims. She laughed at the suggestion that hospital doctors and hospital executives get along and respect each other. She proclaimed that doctors are treated like "commodities" and are not given much of a voice in organization-wide matters. Which narrative was more accurate? That is to say, what has a greater impact on a hospital doctor's sense of professional autonomy, external forces (i.e. public and private payers) or internal forces (their superiors)? I entered the field and approached interviews with this question at the forefront of my attention.

⁹ Each of my two earliest informants was a white, elderly male, and retired general practitioner doctor who told me to focus on the external entities rather than relations with bosses (one more than the other).

¹⁰ Swift Hospital is one of three hospitals belonging to the Yankee Health Network, the network within which I conducted research.

LITERATURE REVIEW

Sociological literature on professional autonomy

Most sociological studies on professional autonomy treat it in two ways: 1) as an individual phenomenon, and 2) as an independent variable with implications for worker satisfaction and productivity. In a review of a decade of literature on professional autonomy, Terry and Jimmieson (1999) found that increases in job control are associated with higher productivity and better workplace attitudes. Professional autonomy is also positively associated with improved mental health (Deci and Ryan 2012), higher worker satisfaction (Bond and Bunce 2003), and higher worker commitment and performance (Ingersoll 2007; Hodson 1996). Indeed, Ryan and Deci (2011) claim that all human beings possess a need for autonomy. Karasek (1979) similarly concluded that individuals with too many (and too intense) job demands and too little autonomy experience “job strain” – which is positively associated with mental strain. Ingersoll (2007), in a study of teachers, acknowledges the relationship between job demands and job autonomy. He writes, “It makes no sense to hold people accountable for something they do not control or to give people control over something for which they are not held accountable” (5). He found that, at least for teachers, professional autonomy leads to “commitment, efficacy, and engagement” (Ingersoll, 3).

Similarly, self-determination theory posits that all individual human beings possess needs for autonomy (Ryan and Deci 2011). Two of the theory’s most influential researchers, Ryan and Deci, argue that human “well-being”¹¹ is dependent on the fulfillment of autonomy (and two other basic needs – competence and relatedness [2011]), and argue that one’s environment thwarts or promotes the individual’s autonomy. They assert “... [T]he effects of environmental

¹¹ The other term the authors use to describe happy individuals is to say they are “full functioning” (59).

influences can be analyzed in terms of the degree to which they tend to support versus thwart need satisfaction" (Deci and Ryan, 2011, 58).

Workplaces can, therefore, be analyzed or judged through the following question: Does it provide its members (employees) with sufficient autonomy? If not, it is likely, according to Deci and Ryan (2011), that its employees will experience a lack of wellbeing. Hodson (1996) discovered effort and pride to be higher amongst employees in "participative environments" than in less participatory workplaces (such as mass production/assembly line workplaces). Nathanson and Becker (1972) and Ingersoll (2007) found that the influence a professional has over the decisions made in his or her workplace is negatively associated with conflict in the workplace.

Workers who yearn for greater professional autonomy and who feel threatened by pressures on their autonomy, resemble Durkheim's characterizations of the victims of fatalistic suicides: they feel overly regulated by society (Durkheim 1951). Editor George Simpson explains, "The individual's needs and their satisfaction have been regulated by society; the common beliefs and practices he has learned make him the embodiment of what Durkheim calls the collective conscience" (Durkheim 1951, xv).

As one of the preeminent sociologists of workplaces in the United States, Gary Alan Fine claims that too few researchers understand the importance of employees' needs for creative expression. He asserts:

... [T]he feeling for form or creative impulse, as well as its limitations, needs to be empathized in theorizing on the structure of work and occupations. Not doing so gives a distorted picture of the workplace, making it alternatively seem too instrumental (denying a sense of identity and craft to workers)... [W]orkers have craft standards by which they judge work products and performance that transcend the narrow goals of producing things with efficiency and to bureaucratic specification. This connection between the worker and the work is

central to occupational identity of workers. Craft is a part of all work life (Fine 1992, 1270).

Thus, Gary Alan Fine argues that traditional studies within the sociology of work fail to grasp an elementary truth about workplaces: the individual employee's desire for creative expression matters and, as such, it deserves attention as a subject onto itself. "We require a sociology of work that treats aesthetic choices and decisions about quality as partially autonomous from production" (1992, 1289). Fine (1984, 242) advocates for a "more traditional interactionist/social psychological approach" that focuses on the individual and his needs and struggles for professional autonomy. Gary Alan Fine has written more on the topic of professional autonomy than any contemporary sociologist of work that I am aware of. His studies on chefs (1992) and weathermen (2006) are particularly noteworthy for their detailed depictions of the rituals and routines inside idiosyncratic and competitive workplaces, as well as the sense of an insider's perspective that each conveys. Fine makes the sociological argument that these workplaces are locations in which culture is produced (Fine 1992) and intensely protected (Fine 2006).

Fine's (1992) ethnography of chefs in Minnesota/St. Paul, reveals professional autonomy as an individual phenomenon. Fine wanted to understand how each chef views and defines the importance of "craft" in their work¹². Do they regard themselves as artists? How does each participant navigate the struggle between artistic desires and financial constraints of the restaurant industry? Fine (1992) hopes to achieve a sociological theory that he calls, "the culture of production" –an argument about the ways employees balance their own needs with their organization's needs. Chefs, for example, learn to be vigilant about making sure food is served on time and the cheapest ingredients are utilized. Like the prisoner who assumes the role of the guard in Foucault's theory of the panopticon, the chef becomes her own boss.

¹² This was an ethnographic study. Fine spent one month at each location.

Craft is also a deeply personal process and an expression of self-identity and truth. “Each task or set of tasks [within a given job] conveys self-images and implications for identity...” (Fine (1996, 112). Craft is expressed from the unconscious; chefs instinctively know the smells, tastes, and appearances that they are trying to achieve in their dishes. Not surprisingly, Fine (1996) reveals that chefs compare themselves to conventional artists (painters, for example). He explains:

Workers in many occupations, even unexpected ones, liken themselves to artists. Locomotive engineers (Grzyb, 1990), bullfighters (Mitchell, 1986), and bartenders (Bell, 1976) each claim the mantle of art. As noted, cooks, too, make that claim, especially when audience and creativity are salient (Fine 1996, 102).

Fine’s work on chefs demonstrates how professional autonomy can be a deeply personal struggle. In his more recent study on national weathermen, Fine (2006) reveals that it can also be socially created and shared.

Professional autonomy as a shared experience

Most works on professional autonomy treat it as an individual phenomenon. In contrast, Fine’s (2006) ethnography of National Weather Service (NWS) forecasters illustrates the ways in which the past influences the present in terms of an employee’s perceptions about professional autonomy – specifically, how much autonomy they are entitled to. It demonstrates that an individual’s professional autonomy is interdependent upon the collective professional autonomy (the autonomy of his workplace). Throughout the second half of the 20th century, the Chicago office was known throughout the NWS for its reputation as the most bold and brazen branch. It possessed a kind of freedom and autonomy from the national headquarters that was non-existent at other offices. This was due, in part, to the fact that the Chicago office used to have more responsibilities than other local offices – which resulted in national headquarters giving them

greater freedom than other offices. Over time, Chicago forecasters took this situation for granted and came to expect preferential treatment even as their workload and responsibilities became more in line with that in other offices. Toward the end of the 20th century, the Chicago office gradually lost its power and preeminence¹³ and became just another local office. Nevertheless, remnants of the “old office” persisted. Current forecasters still expect to be treated differently than forecasters at other local offices. They still feel entitled to more professional freedom and deference.

Fine proclaims, “... [T]he most salient feature of the Chicago office culture is the forecasters’ resistance to authority and desire for autonomy, a point repeatedly made by both administrators and workers” (Fine, 2006, 6). At least two forecasters at the current Chicago office refer to obedient employees at other offices as “good little Nazis” (Fine, 2006, 6). The culture of the Chicago office was not only resistant to conformity; it was not in its DNA to conform to HQ’s orders. Comparing the other offices to the Chicago office, Fine exclaims, “The issue is not competence in forecasting, but rather, the virtue of hierarchical control as a means of organizing the routines of labor” (2006, 7). Underscoring the importance of inter-office culture at the National Weather Service is Fine’s observation that differences in office sub-cultures can lead to different forecasts (based on the same weather phenomenon).

Fine’s work on weather forecasters mirrors Cahill’s (2011) findings on the ways that some professions are better than others at fending off perceived threats to their professional

¹³ Fine does not explain why this is so. He does not, for example, reveal if the Chicago office lost its responsibilities and role as a regional office.

autonomy. Such professions are noted for their "...practitioners' sense of... distinction and honor" (Cahill 2011, 118)¹⁴. An employee's sense of self-importance protects her autonomy:

When it comes to occupations, the practitioners' professional view of themselves may be as important a source of jurisdictional power as public prestige. Individual professionalization begets collective resolution. Such resolution cannot counter all threats to an occupation's license and mandate, but it does stiffen resistance (Cahill 2011, 118).

Fine's work on weather forecasters also mirrors Levitt and March's (1988, 324) thesis on "collective understandings of history" on how dominant historical narratives are created and maintained over generations inside organizational workplaces. It diverges from Meyer and Rowan's (1977) study of organizational "myths" insofar as myths are an organization's blueprints and formal language about how an organization is supposed to operate (what you might find in a company code of conduct) – as opposed to the more informal, yet equally powerful, narratives and perceptions told and held by Fine's Chicago weather forecasters. The weather forecasters illustrate how professional autonomy is both an individual and a collective phenomenon, and how the individual's perception of his professional autonomy is supported by, and dependent upon, his workplace's sense of professional autonomy.

Workplace 'culture'

I define workplace culture as the ritualized (i.e. routine) and normative (i.e. proper) ways of thinking and acting (i.e. behavioral norms) in a specific place of work that is simultaneously physical (i.e. the hallways of a workplace) and psychological (the thoughts and feelings one has whether she is physically located in the workplace or not). Workplace culture refers to individual

¹⁴ Braude (1961) made the similar, though not the same, argument that individuals achieve and maintain professional autonomy when others perceive their work to require expertise beyond that held by a layperson.

ways of thinking and acting, as well as the relationships amongst co-workers – and the ritualized and normative ways that co-workers think and act.

Fine's (2006) study on weather forecasters demonstrates how professional autonomy is collectively constructed and experienced, varying in degree based on a workplace's history and reputation. It reveals professional autonomy as an integral component of a workplace's culture – the norms, rituals, and reputation (shared histories) that guide behaviors of and relationships amongst members of an organization. Like cliques or groups of friends, organizations possess behavioral norms and pressures that reflect the accepted dispositions and behaviors of that group.

New members of bureaucracies, such as hospitals, are also socialized through organizational myths or storytelling. Levitt and March (1988) claim organizations try to create shared consciousnesses or what the authors call, “collective understandings of history” (Levitt and March, 324). Historical knowledge (of the meaning of historic events, ongoing processes, or behaviors within an organization) is created and learned by organizational participants according to the perspectives, or “frames” (324), of the storyteller (colleagues or superiors who have been at the organization longer than the actor being told the story). Stories teach new members, and reinforce within the old members, the normative ways of thinking and behaving within the organization.

Workplace culture is largely shaped and determined by the relationships amongst members of that workplace – which is to say that workplace culture is a product of a network or networks, and the behaviors (ways of thinking and acting) that that network, or networks, imposes on and regulates within its members. Traditional theories on conformity contend that networks cause individuals to conform (or not conform) because individuals wish to maintain

relational harmony with others in their networks – and, as such, conform to and adopt the attitudes and behaviors of their networks¹⁵. Smilde’s (2005) mixed methods study of Evangelical conversion in Venezuela argues that individuals possess greater agency than traditional theory assumes because individuals play a role in determining their “social location” – or networks¹⁶. Whereas traditional social conformity theory conceptualizes networks as “direct transmitters of influence”, Smilde’s theory perceives networks as “culturally constituted, frequently contested, sites of interaction” (McAdam 2003, 290, cited in Smilde 2005, 767). An individual chooses his or her network that, in turn, exerts social pressures on the individual (leading to conforming to the group’s beliefs). Smilde’s theory applies to workplaces as much as religious conversions.

Individuals choose to interact with some colleagues and avoid others because the individual perceives the former as benefitting her career, and the latter as hurting her career. This also parallels Swidler’s (1986) “culture as a toolkit” theory insofar as individuals acquire the “right” culture (and, in Smilde’s analysis, the “right” network) in order to advance their own professional self-interests. Such individuals are likely to have similar professional beliefs and use similar vocabularies, or what Charles Tilly called, “vocabulary of motivation” (Tilly 2006).

Social psychologist, George Mead, called this “imitation” (Mead, 1934). Mead (1934) articulates and argues for his brand of social psychology that he calls “behavioralism”. To Mead, the human mind is deeply social. “Mind arises through communication by a conversation of gestures in a social process or context of experience ...” (Mead, 49). Mead explains that human

¹⁵ Traditional theories on social conformity tend to assume a passive individual. See, for example, Mortimer and Simmons’s (1978) theory on role conformity.

¹⁶ Fligstein (2001) similarly argued that “new institution” theories fail to give individuals adequate and accurate degree of agency (he believes actors have more agency). Although Fligstein is sceptical about the “myth of individualism” (Fligstein 2001, 110), Fligstein exclaims that individuals play a role in shaping structural circumstances insofar as they are self-motivated to reproduce their own power by recreating its conditions. So he does not violate the spirit of the argument against the myth of individualism (a spirit of cynicism and doubt). He extends it.

¹⁷ Individuals, according to Smilde (2005), play a role in their conformity processes.

beings naturally “imitate” each other and that social imitation is part of the process in which the mind, or self, develops. He explains:

If you go into a locality where there is a peculiar dialect and remain there for a length of time you find yourself speaking the same dialect, and it may be something which you did not want to do. The simplest way of stating it is to say that you unconsciously imitate (Mead, 59).

Swidler (1986) offered a slightly more practical analysis of organizational culture when she claimed, “Culture influences action not by providing the ultimate values toward which action is oriented, but by shaping a repertoire or ‘tool kit’ of habits, skills, and styles from which people construct ‘strategies of action’” (273). Swidler, therefore, perceives culture as a scarce resource that individuals draw on in order to pursue their self-interests. She continues, “... [I]f culture provides the tools with which persons construct lines of action, then styles or strategies of action will be more persistent than the ends people seek to attain. Indeed, people will come to value ends for which their cultural equipment is well suited” (Swidler, 277). Swidler's (1986) ‘culture as a tool kit’ theory offers a unique way of analysing individuals’ workplace behaviors. Most significantly, it suggests that individuals embrace organizational values (which are usually a result of the organization conforming to industry-wide values) in order to advance in that organization. Lin (2001) similarly theorizes about self-interested individuals who pursue limited resources of social capital in order to acquire more of some kind of capital (social, economic, or cultural). Individuals draw on human resource (a friend, a group one belongs to, one’s family, a friend of a friend) in order to advance their own professional self-interests. Swidler’s and Lin’s conceptions of culture (such as the culture of a workplace) complement Mead’s and Smilde’s: The former demonstrate that culture can be highly competitive; the latter illustrates that humans have a strong tendency for conformity – especially when it is used as a tool for personal gain.

METHODS

The primary method of research employed in this study was semi-structured, one-on-one interviews. A total of twenty interviews were conducted at multiple workplace locations with Primary Care doctors¹⁸ and one nurse. These workplaces consisted of two different hospitals within a single hospital network, three different private practices and one community health clinic¹⁹; all are located in Yankee County, USA. The audio recorded interviews lasted, on average, 45 to 50 minutes each, with a low of 28 minutes and a high of 1 hour and 48 minutes, and produced an approximate total of 275 single-spaced pages of transcribed dialogue between interviewees and myself. All but one interview was conducted in-person at the interviewee's workplace (in a room or office of their choosing with no one else present). One interview was conducted over the phone.

A key informant helped facilitate most of the interviews for this study. He has been employed as an Internist (a hospital-employed doctor in the Department of Internal Medicine²⁰) at Landahl Hospital since 1979. He approached many of his colleagues inside and outside of Landahl Hospital and asked each would-be interviewee if they would be willing to let me interview them (contacting them in person or by email). He gave a brief description of my research to each, explaining that I was conducting research for my dissertation that related to physician autonomy, and focused specifically on the external factors affecting physician

¹⁸ All but two of the physician interviewees are Primary Care doctors for adult patients, which is to say that they belong to the specialty of Internal Medicine. Some of these Internal Medicine doctors further possess training and employment within a sub-specialty area such as Anesthesiology. The two interviewees who are not in Internal Medicine are a Pediatrician and an OB/GYN doctor.

¹⁹ One of the two private practices, Tuttle Medical Incorporated, has a professional contract/relationship with Landahl Hospital/YHN. The second private practice, Downington Medical Group, does not appear to be as closely connected to Landahl Hospital; however, I believe Dr. Snellings has admitting privileges at Landahl Hospital. The community health center is affiliated with Landahl Hospital.

²⁰ At Landahl Hospital and hospitals across the country, the departmental title, "The Department of Internal Medicine" is often shortened to, "the Department of Medicine", as is the name of the specialty ("Internal Medicine" is shortened to "Medicine"). In this paper, I use the longer, formal names when referring to the department (the Department of Internal Medicine) and when referring to the specialty (Internal Medicine).

autonomy – namely the private and public payers. There was, to my knowledge, little or no mention, by my informant, of an inquiry on my part into the merger between Landahl Hospital and the Yankee Health Network. Most or all of his colleagues expressed some degree of willingness to be interviewed, with responses ranging from friendly acceptance to overt enthusiasm.

This informant then provided me with a list of the names of approximately 20-25 doctors (along with their email addresses) whom he felt were most willing to be interviewed. I emailed each doctor individually with a brief summary of my research and a request for an interview. Most responded very soon after, and agreed to be interviewed. Several of these individuals spoke on my behalf to their colleagues, ultimately resulting in a “snow-ball sampling” (Esterberg 2002) effect – that is to say, these individuals successfully facilitated interviews, for me, with some of their colleagues.

I secured a total of 16 interviews as a result of my original informant’s help and the help of my snow-ball informants. I secured an additional interview by emailing a doctor who neither my original informant, nor my snow-ball informants, contacted. This was a semi-cold call, but not a pure cold call, since this person worked in the same hospital network as my original informant (however they did not know each other). I selected this individual (who is both an Anesthesiologist and ‘Medical Director of the Operating Room’ at Swift Hospital) in order to include at least one MD perspective from that hospital (the remaining hospital-employed doctor interviewees worked at Landahl Hospital).

It should be noted that my key informant is very clearly a “Landahl man”, having worked there for the last nearly 40 years. As such, his opinions and feedback ought to be viewed in light

of the fact that he is biased toward a favorable thinking of Landahl Hospital and a less favorable attitude toward Landahl's rival, Stewart Hospital. However, this key informant was not nearly as vocal and upset as some of his (former) peers in the Department of Internal Medicine at Landahl Hospital. Additionally, about six months prior to the time of interviews, he began a position within the network that requires him to spend a lot of time interacting and working with people from Stewart Hospital (executives and doctors) – spending much more time there than ever before in his career. Nevertheless, his opinions are shaped by decades of commitment and service to Landahl Hospital and should be interpreted with this in mind.

Data analysis

I employed Charmaz's (2006) grounded theory to analyze data. Grounded theory is a qualitative method that achieves two purposes: it provides a practical guide of organizing vast amounts of interview data; and, secondly, it provides a guide by which one may begin to develop a theory based on the organization of that data. Before coding data obtained in interviews, I transcribed the data (i.e. the participants' interview responses).

There are three stages of Charmaz's grounded theory²¹: 'line by line coding' (which is part of 'initial coding'), 'focused coding', and 'axial coding'. As the researcher proceeds from line by line coding onward, their decision-making responsibilities increase. In line by line coding, the researcher 'stays close to the data'; that is, they attempt to put each transcribed line of the interviewee's text (assembled in a Word document) into their own words (that summarize the point they think the interviewee was trying to convey). So even this stage involves a degree of 'implicitness'. The researcher possesses even greater decision-making/inference power in focused coding. It is in this step that the researcher decides on a handful (generally anywhere

²¹ Charmaz (2006) outlines another kind of coding, "theoretical coding", (63). I chose not to conduct this step because Charmaz implies that it is, essentially, interchangeable with axial coding (albeit more complicated).

from 4-8) of ‘categories’ that will become the main themes of research (‘grounded’ in the data). The researcher may also elaborate on each category by adding one or several sub-categories to each category (but not too many; perhaps 1-2 for each). Lastly, axial coding requires the researcher to conceive of a theory that explains the relationships among the different categories.

As the researcher proceeds through each of the three stages of grounded theory, they rely less and less on the interviewee’s text, and more on their conclusions about the text. All of their inferences should be grounded in the text/data, however; they must continually check and recheck their decisions (this is true in every stage, but it is particularly important to remember during focused and axial coding). For this reason, the researcher’s original line by line summaries from the first step must ‘stay true to the text’ as much as possible – they must have a solid foundation for the rest of the analysis. Ultimately, grounded theory involves implicit and explicit interpretations of data.

The Sites

Located in Landahl City, Landahl Hospital is a “community teaching hospital” that serves a diverse urban population of approximately 88,000 (6th largest city in the state). Landahl Hospital was founded in 1893 and has steadily grown since then. It is known for its prestigious teaching program (medical residents and medical students) and, relatedly, its ability to place students and residents into top programs after their tenure at Landahl Hospital. Landahl Hospital employs approximately 2,500 employees including 500 doctors. Annually, it has approximately 50,000 emergency room visits and approximately 11,000 admissions²² (U.S. News & World Report Health, retrieved online January 2016). Landahl is approximately 50 miles from a major

²² According to one Landahl interviewee, these numbers (number of patients treated) give a more accurate indication of activity than bed count.

city. Like the surrounding towns in lower Yankee County, Landahl is close to the major city in physical distance and in the collective feelings and experiences. In 2014, Landahl Hospital officially joined (merged into) the Yankee Health Network.

Founded in 1885, Stewart Hospital²³ is a community teaching hospital located in Stewart City, home to approximately 80,000 residents (seventh largest city in the state). Like Landahl, Stewart has a diverse urban population and is located approximately 20 miles northeast of Landahl in upper Yankee County. It is about 70 miles from a major city, and is the flagship and founding hospital within the Yankee Health Network. Formally, Stewart Hospital is one of three units (hospitals) within the Yankee Health Network. Informally, however, a group of participants (Landahl Hospital doctor interviewees) believe that Stewart Hospital, and the physician executives who have worked there many years (who interviewees call “Stewart people”), control the network. With the formation of the Yankee Health Network, these Stewart Hospital executives became “network-level” executives. Stewart Hospital employs almost 4,000 employees including 750 doctors. Annually, it sees approximately 70,000 patient visits to the ER, and approximately 18,000 admissions (US News & World Report Health, retrieved online January 2016).

Landahl Community Health Center (LCHC) was founded in 1999 and is located only a few miles from Landahl Hospital along a busy commercial stretch of US Route 1. Like other federally qualified health centers, LCHC’s primary mission is to serve low-income patients. Most of their patients receive Medicaid or are uninsured: Approximately 40% receive Medicaid, 40% are uninsured, 10% receive Medicare, and 10% pay for private insurance (according to one or two interviewees). LCHC pays for the services of a handful of doctors from Landahl

²³ Although I did not conduct research at Stewart Hospital in this study, I chose to include its description here because it plays a prominent role in this study (i.e. it is the subject of many of the interviewees’ responses).

Hospital's Department of Internal Medicine – many of whom spend one day a week at the health center seeing patients (and some who spend 3-5 days per week). LCHC is located in an impressive, modern 24,000 square foot facility, and appears, based on my observations, to have an active influx of patients. In total, LCHC employs or consists of:

- Approximately 16-25 doctors (this includes Landahl Hospital-employed doctors who work here periodically, ranging from 1-5 days per week)
- Six non-MD administrative leaders
- A handful of support staff (approximately 7-10 people)

Tuttle Medical Incorporated (TMI) is a bustling private practice located in an office and shopping park within the heavily trafficked Route 7 commercial district in Landahl City. TMI employs 26 providers (including 21 doctors and 5 non-MD providers²⁴) and 10 support staff in three different locations in lower Yankee County.

The Participants

Landahl Hospital:

- 6 doctors in the Department of Internal Medicine (including the Chairperson)
- 1 doctor in the Department of Obstetrics (this person is also the department Chairperson)
- 1 doctor in the Department of Pediatrics (this person is also the department Chairperson)
- 1 doctor (this person is also the Chief of Medical Staff of the Hospital)

Swift Hospital (also known as, “The northern campus of Stewart Hospital”):

²⁴ These five non-MD health professionals are: 3 nurse practitioners, 1 nutritionist, and one Physicians Assistant

- 1 doctor in the Department of Anesthesiology (this person is also the ‘Medical Director of the Operating Room’)

Landahl Community Health Center:

- 5 doctors (Internal Medicine)
- 1 nurse

Tuttle Medical Incorporated (TMI):

- 2 doctors (Internal Medicine)

Other Private Practices:

- 2 doctors (Internal Medicine)

FINDINGS

I refer to payers herein (and the obstacles to financial reimbursement that they create for doctors) as “external pressures”. I also refer to a hospital merger, and the series of actions related to its implementation, as an “internal pressures”. This is problematic insofar as a merger between two organizations is, to a certain degree, an “external pressure”. This is most true in the months leading up to the official announcement of the merger, and the initial months that follow. When I refer to “the merger”, I am specifically referring to the integration process throughout the 18 months since the official announcement of the merger (at the time of interviews, approximately 18 months had elapsed since the merger had officially occurred). Perhaps the term “integration” would have been more precise here; however, the interviewees refer to this phenomenon as “the merger”, so I did, too. Eighteen months removed from its official announcement, the merger between the two hospitals is no longer an external event. It is not surprising that Landahl’s

doctors perceive Stewart's executives as their bosses. For these reasons, I believe I am justified in calling "the merger" an "internal pressure".

The ways doctors talk about external pressures

Most participants expressed gripes about payers. Doctors shared their frustrations about having to see too many patients per day, not getting to spend as much time with each patient as they would like, having to go through tedious measures to obtain payer's authorization for procedures and medications, and a handful of other issues. In each of these cases, the doctor's frustration is connected to the payer's (quite successful) attempts at minimizing their costs and maximizing their profits (two sides of the same coin); this applies to public²⁵ and private payers (insurance companies).

Prior authorization. The process of "prior authorization" is an experience not unlike having to call the cable company: a doctor calls an 800 number; she waits 10-15 minutes to speak to someone; she is put on hold again; she speaks to another person for whom she must re-explain her situation and needs; and finally, after enough persistence, she comes across someone who might possess enough authority to adequately address her needs. One doctor at the Landahl Community Health Clinic told me that when she calls payers, she is almost always directed to another office (with its own phone number), and she is given a "case number" (Smokov). Although doctors are almost always successful at ultimately obtaining authorization for the treatment that they wish to perform on their patient (i.e. promise of reimbursement from payer to doctor), it often takes a lot of time, energy, and headaches to get there. This is an intentional act by the payers, according to interviewees: If it is harder to get permission, doctors might be less likely to seek it – or so the payers hope.

²⁵ Public payers are further classified into two types: federal (Medicare) and state (Medicaid).

Respondents' emotions toward these tactics ranged from resigned aggravation to outbursts of contempt and angry desperation. One private practice doctor in his late 60s felt so overwhelmed by the myriad amount of rules and regulations that he nearly suffered what sounded like a mental breakdown (ultimately causing him to discontinue accepting health insurance). He personified Karasek's (1979) conclusion that the higher the level of what he called "job strain" (i.e. too little autonomy for too high job demands), the higher the level of mental strain²⁶. The increased patient load resulted in this doctor feeling like he was "on the verge of cutting corners" (Snellings). A Nurse Practitioner at Landahl Community Health Center similarly told me how the payer's demands sometimes lead to burnout:

Yeah. I don't know if they just douse you with paper, paper, paper... And it's like, 'Oh, my Gosh. Do I have [to]?' ... The administrative burden, the amount of paperwork, the amount of sitting there going through results. The amount of clicks that we have now have to go through for meaningful use and all the requirements. All this paperwork that we are flooded with delays us to be able to sit in a room with a patient and really talk to them... Um, so, that's where burn out comes into play. And it's not even so much, like, 'I am not doing this paperwork.' It's like, 'Am I in the right field? Do I want to keep working in health care?' Because it takes so much out of you (Mitchell).

Whereas one doctor's gripes were directed at private insurance companies, other doctors asserted their frustrations with public payers. Four doctors, all of who work at a community health center²⁷, described in detail the process of obtaining prior authorization from Medicaid and Medicare. This process, as previously noted, is similar to the experience of calling the 1-800 customer service number for a cable company, or a telephone company, or any large corporation.

Private insurers have been requiring doctors to obtain prior authorization for a long time, whereas Medicaid has not. Before 2-3 years ago, a doctor could order any test through Medicaid,

²⁶ Karasek conceptualizes mental strain by levels of worker exhaustion and depression.

²⁷ A community health center is the formal name given to a "community clinic" (the latter perhaps being the more familiar name to laypeople).

and it would just get paid for, no questions asked. However, according to one doctor at the Landahl Community Health Center, Medicaid recently (about 3 years ago) started requiring doctors to get permission for some advanced tests such as cat scans and MRIs. Now, doctors are confronted with a very similar prior authorization process when dealing with Medicaid as they do when trying to obtain financial reimbursement from private insurers. On this one doctor said (although she was explicitly referring her to public insurers, I infer that the same can be said about private insurers):

... I think that what they think is that since you have to go through all of this, you will say, 'You know what, never mind.'... I think that, too, by the time that it gets finally approved, whatever the problem was, may have resolved (E. Kepler).

Sometimes payer representatives (both public and private) ask doctors unnecessary and "ridiculous" (E. Kepler) questions. Such questions, according to one doctor, feel like a stall tactic. She told me:

There are often kind of, seemingly ridiculous things. You know. Somebody who is losing weight and is a smoker. And you are worried about lung cancer and you order a cat-scan of their lungs. This was a true one. And so the questions that came back were, 'How much weight did she lose? How much was she smoking?' Information that really, you know, small details that really did not um, impact on her risks. She was a smoker who was losing weight and having lung symptoms. There really was no way that she shouldn't not have the test done... It seemed more of a delay tactic (E. Kepler).

In other cases, payer representatives genuinely do not understand the doctor's order or request. This is due to the gap in medical knowledge between the non-MD payer representatives and the doctors, and it, too, leads to miscommunication and delays. A doctor may be using words to describe a condition that are slightly different from the words on the payer representative's cheat sheet. Even though the doctor's diagnosis refers to the exact same diagnosis on the representative's list of pre-approved and reimbursable treatments, the representative is not authorized to make such a judgment call and, consequently, the doctor's request is rejected until

he or she uses the exact words (for the illness and the test/order/medication) as they appear on the representative's cheat sheet. Although the doctor eventually speaks to another doctor in most cases (who is employed by the payer), he or she must always interact with the non-MD representatives because they are the payer's first line of defense. Even when a payer approves the doctor's request, this information sometimes does not make its way back to the doctor.

And sometimes you call to get the approval and they have already approved it. So they tell you that they have denied it, and you spend time getting through the phone system to the person, and they will say, 'That actually was approved.' (E. Kepler).

Initially, prior authorization served a logical purpose: It was meant to curb unnecessary tests and medications ordered or prescribed by doctors (which seems to have been a legitimate concern). However, it now appears, to several interviewees, that prior authorization has become a stall tactic meant to dissuade doctors from going through the lengthy process of successfully requesting financial payment from payers. One doctor exclaimed:

This is the way that the system is set up. And I think that really in the hopes that I will just say, 'You know what, I don't have time for this. I am just going to prescribe whatever medication' (E. Kepler).

Although this doctor has always succeeded in getting a denial reversed, the entire process is taxing. The process of obtaining prior authorization has become so tedious that Landahl Hospital has hired a consulting company to help them.

Other doctors at Landahl Community Health Center expressed similar gripes with the prior authorization process. One doctor told me, "It's a very long process. Time consuming, frustrating..." (Smokov). And although she has never failed to get a denial reversed, this doctor said, "It is a difficult process and I am not saying that it is something that... you look forward to..." (Smokov). Similarly, another doctor exclaimed:

It's frustrating. It takes a lot of paperwork. It is unnecessary red tape. It's kind of ridiculous. It's not um, it's not um, you know, the same for each different [insurance company]. Each different insurance company has their own requirements and their own changes (Federici).

Regarding "delay tactics", or the highly strategies payers employ to make it difficult for doctors to receive financial reimbursement, one doctor told me:

It's just that you are fighting with the insurance companies in the sense that they want certain things done... They want this pre-certified, this pre-certified. Even Medicaid and Medicare demands that... And I understand. They don't want doctors ordering which they tend to do over ordering. They want to make sure, but a lot of times the private insurances particularly [are thinking], 'Anything that I can do to make the doctor work a little harder, maybe the doctor won't order... We never said that you can't do it. We're just saying that we are not going to pay for it unless you put in the time to do it' (O'Donovan).

An additional source of delays is attributed to the frequency by which payers (particularly private payers) change the drugs for which they provide reimbursement. This is the result of new contracts with different drug manufacturers. One doctor condemned private insurers for their practice of frequently changing their "formularies"²⁸:

They come up with new preferred medications and then someone will reject your [order]. For example, right now Truvada is covered by some Medicaid and Truvada is not the preferred medication and Januvia is out. So all my patients on Januvia are getting rejected left and right and it's a big added headache right now... because suddenly the insurance company is getting a better deal out of Truvada manufacturer rather than Januvia manufacturer. So they are changing preferred agents... And then we find out by the letter from the patients. The pharmacy requesting us to switch over... It's frustrating. I mean, it's frustrating... It is what it is... It is also wasteful in that ... I could be seeing another patient, helping another person, having a conversation... [r]ather than be doing paperwork. And um, imagine the system. So it's inefficient (Federici).

Dealing with payers as a dutiful challenge to be overcome. Although incredibly annoying, frustrating, and a factor in burnout, the doctors in this study perceive such struggles with insurers to be their duty to their patients (certainly all but one did). Two doctors (one at

²⁸ A formulary is a list of the drugs for which the payer will reimburse the provider when the provider orders a drug for a patient.

Landahl Community Health Center and the other at Landahl Hospital's Department of Internal Medicine), for example, partially define professional success as successfully overcoming the barriers created by payers. One such obstacle is the forced use of the payer's computerized record-keeping systems, or what is known as electronic medical records (or "EMR")²⁹.

Doctors have always had to complete paperwork. Now, however, they are being forced to master computer literacies that are taxing for most, and nearly impossible for others (usually they older doctors). Payers have forced doctors to utilize these software programs when making any request for payment – in other words, something they have to use on a daily basis. Despite the promise of a more efficient and quicker delivery of medical treatment, electronic medical records are, according to doctors, a tremendous burden on their time and energy – not the least of which because the software programs are frequently changing (or "updating"). Forced use of EMR makes it harder on some doctors to see as many patients as they need to be seeing (in order to achieve their organization's minimum financial needs). One doctor explained:

[All practicing doctors] have to deal with this, the pressure of, 'How can I do what I have to do and follow all the demands of what the EMR requests and does versus what the regulation agencies are in the time that can make it so that we are not fired or the company doesn't collapse' (O'Donovan).

It should be noted that support staff at Landahl Hospital and Landahl Community Health Center assist doctors with their EMR needs. They do not, however, eliminate the doctor's responsibility for getting involved with EMR.

²⁹ EMR (Electronic Medical Records) is the record-keeping and documentation process by which doctor sends payer record of service performed and makes request for reimbursement. The payer then uses this record to determine whether or not to approve reimbursement and/or how much to give. If payer denies the request (an "initial denial"), the doctor is notified and usually asked to provide more information and documentation to support their request. Although the length and specific steps involved varies by case, every interviewee told me that they have never failed to get an initial denial reversed into an approval. This is often a very time consuming process for doctors.

Despite their incredible burdens, the effects of EMR on a doctor's influence over their time can be mitigated. A Landahl Hospital doctor (Department of Internal Medicine) describes a strategy she's developed:

... I like to see all my patients earlier in the day. Just to know how they look and what's going on.... And then I save the documentation for later and that way like if I have seen them and I've looked at all their data I do that to first then see them and then I know what I need to do for them. So I can take action and then I save the documentation for later because that's the part I feel like it's the time, you know that doesn't directly benefit my patient (Kashun).

This same doctor later explains how she feels it is her duty to get payers to pay for her patients' medical needs and services:

... I don't, well, maybe wouldn't say love [it], but ... it's part of my job and I don't mind, like I don't mind doing it... Because I think it helps the patient to like when I do the utilization management and actually talking to insurers to get them to pay more for a patient that was here... So that I feel actually benefits my patients, I don't mind doing that (Kashun).

This particular doctor rationalizes her haggling with insurance companies by defining these experiences as one of her job responsibilities. Another doctor takes a very similar approach and even takes pride in her ability to persuade payers to fully pay for her patients' treatments. She views this as a skill that she has acquired over her years as a doctor (a hard fought and earned skill). She explains:

Federici: Um, private companies in general ... have the most amount of paperwork, but also you can get the resources for your patients that they need... In general, they will ... have the best access to care.

Cleary: Okay. Because they have the financial resources.

Federici: Because you can keep fighting the insurance company ... If you write enough letters, at some point they will get the care that they need.

Cleary: And that's something that you do?

Federici: Absolutely. That is my whole goal. My goal is to be, to be here for my patients.

This doctor went on to explain how, after a decade of experiences with payers, she has learned how to write letters in the right way to get them to approve and pay for her patients' treatments:

Sometimes it is denied and you just write letters. For the most part, I haven't had anyone rejected indefinitely. Well, I have had a few cases but they haven't been rejected indefinitely. If you know how to word things, you will get the care that they need. If you make sensible referrals, you can talk to somebody who will eventually see on your page. And that's a skill that you need to develop over time as a practitioner to be able to access the system for your patients. So, I have been working for a decade. I can most of the time be successful... Once they talk to me, it is hard for them to say no to me... At least I hope so. It's frustrating. It takes a lot of paperwork. It is unnecessary red tape. It's kind of ridiculous (Federici).

A Nurse Practitioner views electronic medical records and payer-related documentation ("paperwork") as a challenge to be overcome. She admits it can be a daunting challenge at times (which sometimes leads to burnout); for her at this stage in her career, however, this is a challenge that she has responded to through effort and determination. This exchange illustrates the point:

Cleary: So when do you do that then? At the end of the day?

Mitchell: Take it home.

Cleary: You take it home?

Mitchell: Oh, yeah. Because those patients prescriptions need to be sent and the labs need to be reviewed. It's people's lives on the line and you can't just sort of say, 'Okay, I am just going to leave that for tomorrow.' So, you'll find that's a huge trend. People are up till 2:00/3:00 in the morning writing their notes, to make sure that the billing is in for the quarter end, and you are getting all your stuff done, so that you are not walking in the next day with even more. Because it doesn't go away. So, you take it home, you work on the weekends. And you do what you need to do.

This individual went on to explain how she as she has had more success in obtaining approvals from payers, after a few years on the job:

Cleary: ... How often do you get ... an order or test or anything denied?

Mitchell: So, I would say when I first started to practice, it was much more frequent. Um, reason being is that there is a certain order to how insurance likes to see processes... Um, so now that I have been in practice for three years, I have been working here for about 17/18 months, and I think that I have seen 4 denied. So it's a small amount. But when I first started practicing and I didn't know the guidelines, and I think that they have everything published like, 'In order to get this approved, you need to make sure that you do X, Y and Z.' Um, now I sort of know the expectations, I get the expectations and we follow the process... So it's justifying that we are ordering these tests for valid reasons. And um, we are doing everything in an evidence-based fashion.

One doctor at the Landahl Community Health Center has developed similar coping strategies for overcoming payers. She explains:

Smokov: ... [T]he insurance might initially deny a test. Or deny a certain medicine. However, there are ways around it including appealing the decision.

Cleary: Oh, you can appeal that decision?

Smokov: You can, a denial. Let's say if an insurance company does deny a certain test ... you [can] ... appeal that decision and um, even have a peer to peer conversation...

Like her colleagues, this doctor has never failed to reverse a payer's initial denial, as she informs me, "It doesn't really happen to me to date to be denied" (Smokov). A female doctor in Landahl Hospital's Department of Internal Medicine succinctly summarized interviewees' thoughts on the obstacles and challenges in their jobs created by payers. She said, "... I was always trained that you provide the same care to all of your patients and then when [you] ... hit roadblocks because of, you know, resources are limited ... you just work around that" (West). In short, doctors respond to external, payer-created challenges through persistence and a sense of duty to their patients. They view such external pressures as individual battles in which they are obligated to participate and fight. In the next section, I examine a different type of pressure on doctor autonomy: a merger between two hospitals. Responses reflect surprisingly different attitudes toward internal pressures (imposed and enforced by superiors) than opinions about payers (which exert external pressures).

The ways doctors talk about internal pressures

Initially, the merger was an external event for Landahl Hospital doctors – a foreign entity (Stewart Hospital) took control over their workplace. Doctors felt their way of life was being forced to change as a result of this outside force. So, to this extent, the merger is an external event. The merger also represents internal phenomena for Landahl doctors since they are now part of the Yankee Health Network; their bosses' bosses are "Stewart people". Interviews focused on interviewees' reactions to the integration of Landahl into Stewart Hospital/the Yankee Health Network. Moreover, interviewees' responses were observed 18 months after the merger had officially taken place. By this time, interviewees perceived Stewart Hospital executives to be their bosses; they perceived themselves to be a part of the Yankee Health Network. Although data on the merger partially reflect doctors' opinions resulting from the initial shock of the merger (i.e. the merger as an external event), the merger is assumed to be an internal phenomenon because interviewees think of the merger more in terms of the 18 months of "integration" since the initial shock/event.

When talking about their concerns and gripes related to the merger (and the hospital network executives leading the merger), doctors focused on the effects to their workplace and the culture of their workplace. Eighteen months had passed since the merger by the time of interviews, and Landahl doctors shared a feeling that it was not the "merger of equals" that Yankee Health Network executives (i.e. their new bosses, many of whom were "Stewart Hospital people") had sold them on. It felt much more like a "takeover", according to many Landahl doctors. Landahl doctors believe Stewart was the "meaner" and "tougher" hospital that was "bullying" Landahl Hospital into doing what it wanted to be done. Additionally, Landahl doctors feared that the merger jeopardized their collegial work environment – a significant point since

for many of the Landahl Hospital doctors who I interviewed this was explicitly stated to be the primary source of their professional satisfaction. In particular, they worried that the Stewart hard-charging and business-oriented persona would replace the collegial and “homely” environment at Landahl.

“We were bullied”. One Landahl doctor claims there was a gap between what network executives were telling Landahl doctors about the merger, and what Stewart doctors on the ground were saying. She informed me:

... [Y]ou know they kept saying to us ... that it was equal, blah blah blah, but then as you would talk to the people on ground they're like, 'And we took you over', and so that already creates this negative feeling and that started happening right from the beginning. I would run into people that I knew ... [at] Stewart and they're like, 'And our takeover' ... [Y]ou definitely get a bad taste in your mouth when ... cause they just treat us like somebody that they have now acquired under their control and they're going to do with us what they want ... I was a little skeptical [in the early stages] about the merger and now everything is kind of coming true. I haven't seen what the good side of it is yet. I mean the positive side of it (Kashun).

The Chairperson of Landahl's Department of Internal Medicine agrees and even says that some at Landahl feel like they were lied to by network people:

And the way that I looked at quite frankly is Stewart Hospital has been fairly heavy handed. They kind of, one of the administrators had likened it to coming in here with jack boots... [T]hey kind of come with jack boots and they were pretty heavy handed. It was presented very differently. It was presented as an affiliation or merger ... [N]ot true, just not true, just not how it was painted out. So I think there is a sense that we've been misled. I think there is a sense that we've even been lied too (Olzner).

A doctor in the department echoed her colleague's claims:

...I know when it was first being marketed, you know the first thing being discussed at the hospital, and it was all very positive and that Stewart needed Landahl methodology, that Stewart loved Landahl's model. It was going to be incorporated... And that, that's how it was all being, you know being sold to us...

And of course that as time has gone on it appears to be less and less of this case (West).

Another doctor in the department similarly reflected on how what he and his colleagues had initially perceived to be a merger of equals, so to speak, has felt more like a takeover. He said:

I think the average Landahl person on the street, we thought, this is a ... true merger ... that we are equal partners. We are on equal footing financially. You know, all those kinds of things. And what it's felt like more over the last, especially over the last year or year and a half, is a takeover. The Stewart Hospital took over the Landahl Hospital ... (M. Kepler).

This doctor spoke at length about his concerns that Landahl had been overpowered by Stewart.

He and at least one of his colleagues attribute the power imbalance to the perception that Landahl Hospital is less worthy (less significant, less prestigious) than Stewart Hospital. Stewart views Landahl as, "the redheaded stepchild... that they are the big show and that [we are not]" (M. Kepler). Landahl is almost a "subsidiary" (which this doctor views as a less powerful entity). "... [Y]ou know, subsidiary might be a little strong but not terribly far off..." (M. Kepler). A colleague echoed this doctor's views:

Yeah I would think that um that the voice that is consistently being heard is the Stewart voice... And there is very little sense of Landahl identity anymore or a voice of people still trying to maintain that Landahl voice. Yeah, it's kind of you know being eaten up... By um, a large predatory entity... They just see us as being weak and underpowered and more of a, you know, just kind of a pesky problem that they are going to have to deal with. So it's a real bad attitude (West).

This doctor feels like she and her colleagues at Landahl are now part of a large and impersonal organization that is very different from that which she and her colleagues are accustomed. She reflected, "You know nothing more than a, you know, like a part of a very big machine" (West). The department chairperson goes one step further than his subordinates. He feels like Stewart Hospital has bullied Landahl Hospital. He said:

Olzner: Um, I also felt like at times that we were bullied a little bit. Because I think the process was being driven more from the Stewart campus than the Landahl campus... So as I have had some time to think about it... I think that was probably... one of the many kind of failures that I have observed during the course of this integration.

Cleary: Do you still have that concern about the bullying ... ?

Olzner: Um, yeah, I think so, yeah, I think a little bit. You know, I know that term bullying is kind of a 2015 term my kids tend to use it a lot because they teach it a lot in school, but that is probably the best way for me to verbalize it ... I don't know if this has been intentional, but um, but certainly down here myself included I think there are a lot of times when we feel like, you know, it has to be one way or another and it's going to be their way... I know people frown upon the use of this term 'us and them', but it going to be the way it's being done [at Stewart Hospital] ... and that makes you feel like everything that you have done in the past really hasn't been valued and that the message ... is that you just were not functioning at the high level that you thought. And I think that undermines people's professional satisfaction" (Olzner).

Another Landahl doctor similarly explained how Stewart people perceive Landahl people as "weak".

West: And it's pretty sad... So I sit on a bunch Stewart committees. And you know I go to these and they all, they all have kind of the same common thing theme which is ... they immediately jump to the conclusion or they have this message this evening which is that Landahl is very weak.

Cleary: What do you mean by weak?

West: Well let me try to give you some examples ... [L]et's say it's a meeting where they are talking about a resource... something simple... Their IT resource. And I will be sitting in and at the very end, it will say, 'And you know we have to figure out how to incorporate, um, Landahl's needs into our model...' You know, rather than saying at the beginning, 'Hey we just had six meetings with Landahl, man they have a great idea! ... [T]hey had great concepts! Great tools, great skill and let's harvest from that... [and] We are so excited about... this alliance.' It's more like it's just this afterthought. Like... '[W]hat's the deal with this, um, you know, other problem, this Landahl thing?' (West).

An Anesthesiologist at Swift Hospital echoed Landahl doctors. He told me that since the merger of Swift into the network, he thinks Stewart has not respected Swift's culture, and has attempted

to replace it with its own. He exclaimed, “It was like, ‘This is the way that we do it now. You can throw yours out. This is the way that we are doing it now’” (Zordich). The loss of Swift’s Obstetrics center was particularly painful for he and his colleagues, as well as the community. “It hurt the hospital. It hurt the perception. It hurt the community” (Zordich).

One commonly cited reason why Landahl doctors feel that Stewart is more powerful is the inequitable distribution of power throughout the network’s executive leadership team. Most of these senior-most executives are “Stewart people”, doctors and administrators who came from Stewart Hospital (i.e. people who worked in Stewart Hospital prior to the formation of the Yankee Health Network). On this issue, one Landahl doctor told me:

... [E]verybody at least down in Landahl looks at ... the head of the network and that is a Stewart guy. And I think that has a psychological effect on people. Now the number two guy is a guy ... who [used to be President of Landahl Hospital] ... but virtually everybody else other than [name omitted] is at Stewart Hospital. Everybody! I mean without with one or two exceptions... So when folks down here say that this really seems like it’s a Stewart takeover, I mean that’s a big part of it... I know this place pretty well and I know the people here, I know the culture here and maintaining this hospital is really important. At the same time I also have to be very mindful of what the needs for the network are... (Olzner).

Stewart people, not Landahl people, are calling the shots. However, Landahl is partially to blame for this, according to one Landahl doctor. “Frankly, we were not run aggressively as they were historically. And I think that that hurt us” (Kepler). (It should be noted that this doctor was also critical of the ways in which network executives communicated the merger process to Landahl doctors). Another doctor in Landahl’s Department of Internal Medicine similarly claims that Landahl has not been as aggressive as it should have been during the merger, and this contributed to their lack of power.

You realize that they are keeping the Landahl vote way far away for any position for power. So Landahl completed under played their hand. Landahl completely

blew it as far as I'm concerned. We should've had somebody powerful on every single committee (West).

Several other Landahl doctors agreed that Landahl Hospital executives underplayed their power within the network. According to the hospital's Chief of Medical Staff, for example, Landahl's top executives had an opportunity to get rid of "dead wood"³⁰ (Atkins) prior to the merger, but they failed to act. Immediately after the merger, the new network executives fired these folks. Landahl employees (particularly non-MD staff personnel) interpreted these firings as a network effort to fire as many Landahl staff as possible. This, according to Landahl's Chief of Medical Staff, could and should have been prevented by the hospital's top brass.

Different personalities. Prior to interviews, a key informant told me that Stewart had more aggressive personalities than Landahl, and implied that Landahl had better doctors and better quality of care. In one of my earliest interviews, I asked one of the informant's colleagues at Landahl Hospital whether or not this claim had any merit.

Cleary: ... What is the sort of basis for their feeling of superiority? Because as I understand it, the narratives that I know are that quality of care... is higher here but I have also heard that there is maybe more of a business mentality there. Which makes me think ... more aggressive personality. So, um, is it just that they are more aggressive people there? I mean, why the reason for them feeling like they are more powerful than you guys?

Kepler: Yeah, I think that there is a couple of things... [O]ne is that, yeah, I actually think that they do have more [aggressive personalities]. I think that you are reading it right. I think that they do have more aggressive personalities. No doubt about it.³¹

This doctor believes Stewart's more "aggressive personalities" is one explanation for why Stewart seems to be more powerful (and 'bigger' in the 'importance' sense) than Landahl.

³⁰ Atkins is referring to support staff (secretaries, janitors, dining hall employees, etc.) at Landahl who should have been fired.

³¹ This doctor (and the other doctor interviewees at Landahl Hospital) share many or most of the opinions about Stewart Hospital as a key informant. Therefore, this study's interviewees could not be expected to provide insights into the perspectives of Stewart Hospital's doctors and executives. One network executive quite correctly articulated this concern. "So, I think the issue between, let's just say, Landahl and Stewart is, you know Landahl well because ... [my key informant] was there. You know somewhat peripherally about Stewart... There are selective things that you hear about Stewart" (Benson). My solution to this problem was to incorporate the opinions of Stewart executives into this dissertation. In the next chapter, I present their views based on interviews with four of the senior-most executives within Stewart Hospital and the Yankee Health Network.

Similarly, Landahl's Chief of Medical Staff calls Landahl the "nicer hospital" (Atkins), and claimed that Stewart's administration was known to be more authoritative than Landahl's.

Landahl was a nicer hospital... [The] Stewart philosophy was to take over ... physicians or to run the roost and Landahl was always a little bit more cooperative. That administration worked with the physicians a little bit more. Physicians helped run the place versus Stewart... [which] wasn't necessarily physician driven (Atkins).

A Stewart-based network executive confirmed Atkins's claim, as did a handful of Landahl's doctors. In the above quote, Landahl's Chief of Medical Staff alludes to the practice of buying up private practices in the community. This is not an uncommon thing for hospitals to do as it leads to a consolidation of market power. However, comparatively speaking, Landahl Hospital is not nearly as aggressive with this strategy as Stewart Hospital (and, likewise, Stewart private practice doctors are more willing to be hospital-affiliated/owned than Landahl private practice doctors). A doctor at the Landahl Community Health Center confirmed this in the following exchange:

Cleary: Yeah. Okay. Of course, now, the trend is that everything is hospital owned.

E. Kepler: Except in Landahl [City]. <laughter>

Cleary: Really?

E. Kepler: Yeah.

Cleary: Okay.

E. Kepler: There is a lot fewer hospital-owned. I mean, they are starting to um, buy practices. But I think compared to some like Stewart, um, there are many fewer... hospital-owned practices in Landahl. Almost all of the physicians in Stewart work for Stewart Hospital.

Cleary: Huh. That's a little surprising. I would think either Stangfield³² [Hospital] or Landahl [Hospital] might buy those up. Um, just based on how competitive I have heard that health care has become.

³² Stangfield Hospital is a rival hospital (to Landahl) and is located in neighboring Stangfield City.

E. Kepler: Right. Right. Well, I think that you still have to want to be bought. <laughter>

Cleary: Right. There is no hostile takeovers?

E. Kepler: Well, there are but, not in Landahl.

Since the 1960s, Stewart Hospital executives have had a fairly tight grip over the hospital's medical staff, which is not the norm for American hospitals and their medical staffs³³. Relatedly, Stewart has historically had more employed physicians than Landahl Hospital, whereas Landahl has more non-employed/private practice-based physicians on its staff. These are key factors in Landahl's being regarded "more employee friendly" (Atkins). However, these differences makes Stewart Hospital, and its doctors, better prepared than Landahl for the "revolution" currently underway as a result of the payer-led reforms. These changes are causing many hospitals throughout the country to join large networks. Stewart's longer history with employed doctors puts it at an advantage over hospitals like Landahl that have traditionally had more "non-employed" doctors (i.e. doctors out in the community, in independent private practice, who are not employed by the hospital). Landahl's Chief of Medical Staff remarked:

So the big culture change now is um, the employed physicians, which Stewart did a really good job on managing. The Landahl employed physicians are having trouble assimilating into that system easily... Because our system is a little different and more employee friendly than theirs is. Um, so making that change and having to follow the 'Stewart' way, rather than the network way, is a little bit more difficult to swallow. And having the Stewart way or more hospital owned physicians, looking at our culture here where we have more non-hospital affiliated or owned physicians... And realizing that the future is going to mean more employed physicians because those independent physicians will not survive on their own (Atkins).

³³ A hospital's medical staff is comprised of two groups of doctors: hospital-employed doctors and the private practice doctors in the community that treat patients at the hospital in addition to in their own practices. The latter group usually outnumbers the former.

³⁴ In the 1960s, there was an influx of young, new, hospital-employed doctors that occupied positions of power within Stewart's medical staff. These individuals were actively sought out by hospital executives, who were eager to form alliances with new-blood doctors on the medical staff, in order to gain the upper hand in the bitter conflict they had been waging with the independent-minded private practice doctors on the Stewart Hospital medical staff since the 1950s. I am indebted to one New England-based author's work on the history of Stewart Hospital. I apologize to you, sir, for not acknowledging you by name here. The need to protect my participants' identities prevents me from doing so.

In addition to Landahl's Chief of Medical Staff, I was able to interview a former Chief of Medical Staff at Stewart Hospital. I could hardly imagine two different individuals, in personality and professional attitudes. Landahl's Chief of Medical Staff has been self-employed for his entire career³⁵; Stewart's former Chief of Medical Staff has been employed by Stewart Hospital for three decades, and is a fiercely loyal employee. These two individuals seemed to epitomize the purported "cultural differences" (as conveyed by Landahl's doctors and one Stewart executive) between Landahl Hospital and Stewart Hospital: Landahl's Chief of Staff is independently employed, easy-going, and an affably aloof clinician; Stewart's Chief is an intense company man who values order and control³⁶.

The implications of being the "nicer" hospital. One Landahl doctor explained why she believes Landahl's culture is so different from Stewart's³⁷:

They're different places... They're very different and here maybe it's the, we are not that much smaller necessarily, I feel like um, everybody here, you know we still got business done... but like it's just the feeling would be much more homey, you know comfortable and 'familyish' type stuff, it was like everybody was your family type of feelings ... colleagues and administrators, and just I don't know it was different and now it's much more of a business like, you know, yeah work you work here, but you're just an employee type of, that's my perception of it (Kashun).

Indeed, many of this doctor's colleagues share her point of view. The Chairperson of the Department of Internal Medicine expressed this sentiment to the point of repetition, "Oh culture is, it's very [different]. Yeah I think culture is very different. Culture down here is very different and sort of merging those cultures has been one of the biggest the biggest challenges" (Olzner).

He added that the merger has resulted in a "huge culture change" (Olzner) for not only himself,

³⁵ Like many doctors in private practice throughout America, Landahl's Chief of Medical Staff is a partner at a private practice. His private practice is affiliated, but not owned by, Landahl Hospital. He is not, therefore, an "employee" of the hospital. In contrast, there are "hospital-employed doctors" who are directly employed by a hospital (like Stewart's former Chief of Medical Staff).

³⁶ Both appear to be well respected and admired by their colleagues.

³⁷ Note that this doctor includes Landahl's administrators in her positive assessment of Landahl's culture.

but also his colleagues (the hospital-employed physicians at Landahl). Another doctor in the Department of Internal Medicine asserts that the key difference between the two hospitals' cultures has to do with integrity and shallowness:

Cleary: Um, so I wonder if you could just talk about how, any changes you noticed to your work place since the merger got under way³⁸?

West: "... [The Stewart way of doing things] has very little to do with ... seasoned physician's attitude[s] ... [a]nd old fashioned culture of academia... [o]r its integrity... The new system is a much more shallow [system]... You know the conditions, the relationship we have with the leadership it's just, you know, curtly ... We're losing that sense of ... achievement-ship and sense of having value" (West).

In contrast to their opinions of Stewart Hospital, the consensus amongst Landahl doctors is the belief that their Department of Internal Medicine is (or used to be) an extremely close-knit and family-like group. The Landahl doctors derive a significant degree of their professional satisfaction from the relationships they have with their colleagues. When asked if he would still chose to work at Landahl Hospital again if he knew then what he knew now, one doctor told me:

Assuming that I met some of the people who I met back then...[then] yes... I largely based my decision to come here on the people that I met and the bosses that I was going to have. And so, if the people I met and the bosses that I was going to have ... were the same and you know, enjoyed them as much, [then] yeah, I would come here again (M. Kepler).

Another doctor provided a similar description of the culture of Landahl's Department of Internal Medicine:

It used to be a very autonomous group. There used to be a culture ... The culture at Landahl was ... a belief that everybody is working to their maximum ability.

³⁸ This is a leading question insofar as it seems to have assumed the existence of the very relationship and perception that I am attempting to reveal/prove (that interviewees are more concerned about the effects of internal pressures on group culture than on the effects to their individual experiences), and, as such, influenced my interviewee's response. Since the overall argument in this study is to reveal the existence of such a relationship through interviewee's responses, this question has implications on the robustness of my overall theory. I chose to include this excerpt, however, because this question and answer led to additional responses by this interviewee which were less and less dictated by this initial leading question, and are, thus, more supportive to this paper's overall theory and argument (the existence of the perception that internal pressures most influence the group, not the individual).

Everyone had a good strong moral compass ... providing excellent care to our patients. In other words, we all felt valued and we all felt empowered. And we also defined our workday based on how much how much good had we done that day (West).

The merger with Stewart has caused Landahl doctors to fear the loss of a workplace culture that they have enjoyed over many years. They believe Stewart's "aggressive personalities" have already begun to change the Landahl culture, as one doctor explains:

Then it took a little more time, but they're set like the way they run things. I feel like it's definitely infiltrating into, um, the way Landahl always was. I feel like it's a very different place. It was a great place to work. It had a great family, not like family with me and my kids, but just like with people you work with... (Kashun).

The culture and collegiality of Landahl's Department of Internal Medicine has not completely vanished or been completely replaced by the Stewart culture. A doctor told me:

For us at the ground level it's still such a friendly, like our group is fantastic and um, and I always feel a lot of support from them as well so it's not just like yeah you see each other and you had you know nice to each other, but they're like such supportive group (Kashun).

However, this doctor also said that if there were an influx of people³⁹ like the ones who ran a recent meeting with Landahl doctors regarding the reworking of doctors' contracts, and an exodus of her current colleagues, she would leave. "I mean for me I think I would have to leave this hospital setting if a lot of my colleagues left this hospital setting and then the people coming in were of that mindset ..." (Kashun). Her colleague similarly told me:

And we will just see what happens. But if ... Stewart squeezes us all out... [a]nd turns a whole department into a group of very dissatisfied and very unhappy, um, Trojan horses⁴⁰ that do nothing but work, work, work... Then, you know that's not the model that I ever, ever looked for... It would be pretty sad if that

³⁹ These were, according to Kashun, "Stewart financial people" (i.e. administrators from the network headquarters who were not, presumably [to Kashun and to me] doctors).

⁴⁰ Pat's definition of "Trojan horse" is a worker with low autonomy that is easily replaceable. As she said later: "That they were nothing more than just a, um, you know ah, a widget in the system. That they were replaceable and that they were Trojan soldiers or Trojan horses or whatever you want to call them, that we were nothing more than employees on a factory assembly line" (West).

happens. Because the residency is one of the finest jewels you know that there is and so that means the residency would take a real big hit... Because if we go to the Stewart model ... I've spoken to these doctors myself ... [and] I'm looking at their personalities, who they are, what they are all about. I would have a real hard time believing that they would stick around (West).

DISCUSSION

Studies on professional autonomy in particular (and symbolic interactionist sociologists of work in general) tend to conceive of workplace autonomy as an individual phenomenon, focusing on the individual and his needs for creative expression in the workplace. This study, like Fine's (2006) ethnography of Chicago forecasters, bucks this trend by revealing an additional dimension of professional autonomy that is more social and collectivist in nature. Interviewees' most emotional responses had to do with their fears and uncertainties about the effects of the hospital merger on their beloved workplace 'culture' – which, as they informed me, refers to the relations and relationships they have developed over years with their colleagues in the Department of Internal Medicine⁴¹. The sociological literature on professional autonomy also tends to lump external and internal pressures together, treating all workplace pressures on employees equally. The interviewees in this study show that this is not an accurate portrayal of the reality of a workplace.

The doctors in this study think very differently about pressures put on them by insurers than they think about the pressures imposed on them directly by their bosses and their bosses' bosses. These doctors are frustrated, inconvenienced, and in one case, exhausted, as a result of the interactions and obstacles they must go through in order to receive financial reimbursement from public and private insurers. They firmly believe that payers undermine their efforts to be a good bedside doctor because all of the payers' demands – especially those relating to electronic

⁴¹ Although external threats (pressures from public and private insurers) affect the doctor's workplace, the interviewees think about these threats as an individual matter.

medical records⁴² and prior authorization – cut into time they could be spending with their patients. However, many of the doctors in this study also believe that it is the duty of a good doctor to overcome these challenges. It is an obligation to their patients to successfully navigate these obstacles. They described these experiences as an individual struggle.

This is a stark contrast from the ways interviewees spoke and think about the recent merger between Landahl Hospital and Stewart Hospital. Interviewees focused on the merger's effects on their beloved workplace culture. This was a consistent finding throughout the study. The doctors in Landahl Hospital's Department of Internal Medicine are unified by a collective sense of pride toward the ways they do things in their department – ways that set them apart from other workplaces. It is not too surprising, then, that they are equally united by a collective sense of fear and uncertainty regarding the recent merger with Stewart Hospital – a merger that they see more as a takeover.

Most Landahl interviewees believe the merger was handled in a manner that has been draconian, disrespectful, and largely unstoppable. They are angry at the way they have been treated by Stewart Hospital. I did not interview one doctor in the Department of Internal Medicine at Landahl who did not love their workplace and also fear its demise (or, at the least, the ill effects on their beloved workplace culture as a result of Stewart Hospital's "meaner" culture "seeping in" to theirs). In their study of the effects of an organizational "restructuring" on the wellbeing of employees in one psychiatric hospital, Bordia, Hunt, Paulsen, Tourish, and DiFonzo (2004) found a positive relationship between uncertainty and mental strain.

⁴² Although younger doctors report less frustration with computerized medical recordkeeping than older doctors, there are aspects to EMR that frustrate any doctor regardless of age. This includes the constantly changing nature of EMR (i.e. "software updates") and the rigidity of the EMR coding system. For example, a doctor might be unable to locate the code for his diagnosis because he did not type in the exact spelling or wording of the diagnosis as it exists within the software system. Suppose, he types in "diabetic" and the diagnosis is programmed in the software as "diabetes", he will not be able to diagnose his patient's illness.

“Uncertainty is a major source of psychological strain during organizational change” (Bordia et al. 2004). Subjects in their study reported a lack of control, leading to uncertainty, and ultimately, mental strain. Similarly, the Landahl Hospital doctors in the present study reported uncertainty about the future of their workplace, which they blamed on poor communication by network executives.

I did not interview one doctor in the Landahl Department of Internal Medicine that spoke about the effects of the merger on their own circumstances and experiences. This surprised me. Surely, I thought, at least one interviewee was worried about his or her own livelihood following such a significant organizational change. This may be true, but the doctors did not tell me about it. Instead, they focused on their workplace ‘culture’. I did not sense they were hiding anything; I attributed their decision to talk about their workplace culture, instead of their individual situations, to a greater concern about the effects of their merger on their workplace culture than on their own interests⁴³. Interviewees wanted me to know that they fear losing something that has been the primary source of their professional satisfaction and pride since they began working there. They also shared the collective opinion that Stewart Hospital is a “meaner” and “more aggressive” hospital than Landahl. This has been true for years, they say, but it was not until recently that this perception mattered in a meaningful way to them.

Sociological meaning of the different responses to internal and external pressures

Why do the doctors care more about the effects of the merger on their workplace culture than on their own personal autonomy? I do not conclude that the doctors in this study are so selfless that they put their workplace above themselves. I conclude instead that doctors

⁴³ One could certainly say that the two are tightly interwoven; however, it is assumed that each interviewee also possesses individual goals and needs such as those related to salary and promotion.

responded the ways that they did for two reasons. One, pride in their workplace is more important to the doctors in Landahl Hospital's Department of Internal Medicine than needs for individual autonomy. I attribute this, in part, to the fact that the members of this department have historically felt like they had an ideal or sufficient degree of personal professional autonomy – and, thus, were not as inwardly focused on their own professional survival as individuals in less autonomous and professionalized (employee-friendly) workplaces. I also conclude that interviewees perceive internal pressures to be more dangerous threats to their collective workplace autonomy (and probably to their own personal autonomy) than external pressures. External pressures are an inconvenience; internal pressures are potentially game changing (i.e. would cause interviewees to think about leaving their workplace). More specifically, the responses in this study suggest that threats to one's workplace culture are treated as more serious threats because individuals have less power and ability to overcome these threats than they do external threats. A future study should look at hospital executives' opinions about payers and about a merger. Such a study would, in conjunction with the present study, contribute a comprehensive understanding of professional autonomy from both employees' and employers' vantage points.

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CHAPTER 4

A MANDATE FOR POWER: THE IRONIC WAYS HOSPITAL EXECUTIVES RESPOND TO EXTERNAL PRESSURES ON THE ORGANIZATION

INTRODUCTION

The last study revealed that doctors were upset by hospital executives who they described as bullies. Doctors claimed they were not merging but, in fact, being taken over by a hospital whose people (the executives in particular) were singularly committed to their own ways of doing things, and cared little about their own expertise and ways of practicing medicine. Most of the Landahl Hospital doctors interviewed believed Stewart executives had ruled by the ultimatum, “the Stewart way or the highway” (this author’s quotes, not interviewees’). This certainly was not the first time in the history of organizations and mergers that the “losing side” (members of the firm being acquired) had expressed such views. I was nevertheless surprised by the consistency of their anger, frustration, and despair. It challenged informants’ claims about doctors’ work experiences – specifically, the notion that they enjoy collegial relations (mutual respect and power) with their superiors, unlike less professionalized occupations (such as teaching and public school administration). Findings contradicted this particular hospital’s reputation as a place where doctors, not administrators, were in charge.

Despite its purported autonomous and non-conforming work environment, a pervasive response arose throughout the course of research conducted at Landahl Hospital, a homogeneous narrative explaining why it merged with rival Stewart Hospital. From the network’s top executives to Landahl Hospital doctors, and all the way down the organizational hierarchy to a

nurse's aide⁴⁴, the thinking was the same: Landahl (like other hospitals across the country) had to merge with another hospital in order to financially survive⁴⁵. Even though the doctors in Landahl's Department of Internal Medicine strongly oppose the ways in which the merger was handled, they share Stewart executive's belief in the necessity of a merger. If Landahl doctors accepted the premise that hospital mergers were made essential by the American healthcare system's dire financial straits (which they did), should they not expect some "tough decisions" to be made along the way? There seemed to be a disconnection between doctors' perceptions about the broader narrative of the current state of the American healthcare system (that they necessitated change), and what was happening on the ground in their workplace (they resisted change). Were hospital executives being unfairly judged, or were Landahl doctor's complaints warranted? What specific strategies and policies illustrate the ways in which Yankee Health Network executives are implementing the merger? I would address, and ultimately answer, these questions by asking YHN executives themselves. A picture of the merger could then be presented that revealed not which side was right; but, rather, why one side felt like it was being bullied and what the "bully" thought about this.

LITERATURE REVIEW

External mandates to conform

Bureaucratic organizations, like individual human beings, are sensitive to pressures to conform. According to Meyer and Rowan (1977), "isomorphism" (the process of becoming similar to another form) and the institutionalization of rationality (i.e. the popularization of

⁴⁴ The official title of this position is a "Patient Care Advocate".

⁴⁵ This narrative and behavior (i.e. hospitals merging with each other) transcends Yankee County. Hospitals throughout the country are merging in response to adherence to this exact narrative. When pressed for specifics, some adherents told me that larger hospital networks can negotiate better deals with insurance companies than stand-alone hospitals (better reimbursement rates with insurers). Whether or not this claim is statistically significant is beyond my comprehension.

rationalization as an organizational doctrine) throughout modern organizations contributes to the homogeneity and legitimacy of organizations. The authors argue that such bureaucracies' success "... depends on the confidence and stability achieved by isomorphism with institutional rules" (354). Organizations will mirror the "best practices" of their peers because their peers are doing it - not necessarily because it will lead to increased output. In fact, even when conforming to a new best practice does not increase a firm's output, they'll still adopt it simply because it's an "industry best practice". Unlike most researchers who measure "variance", the authors are concerned with likeness and homogeneity. DiMaggio and Powell (1983) describe a kind of organizational peer pressure that causes actors within an organization to conform to industry norms (i.e. school principals are now called "school leaders" who deliver "returns on investment"). Organizations feel pressure to adopt best practices in order to be "legitimate" in the eyes of their peers, and to gain the support (financial and social) of more powerful organizations.

The key to distinguishing organizations is their level of bureaucratic influence. Engel (1969), for example, distinguishes three types of bureaucracies: "non-bureaucratic, moderately bureaucratic, and highly bureaucratic" (Engel 30). He concluded that moderately bureaucratic professionals feel most autonomous; whereas employees in highly bureaucratized organizations feel the least professionally autonomous. Nonetheless, even moderately bureaucratic organizations feel pressures to conform to industry (and societal) normative behaviors. DiMaggio and Powell (1983) assert, "...[O]rganizations are increasingly homogenous within given domains and increasingly organized around rituals of conformity to wider institutions" (150).

Organizations conform to the norms that have been collectively and historically established within their industries in order to be perceived as legitimate, a process that DiMaggio

and Powell (1983) call “normative isomorphism” (152). This is a kind of organizational professionalization that leads to greater professional distance or autonomy for its members as it “...establish[es] a cognitive base and legitimation for their occupational autonomy” (152). Regarding inter-firm relations, Granovetter (1985) argued, “... [S]ocial relations between firms are more important, and authority within firms less so, in bringing order to economic life...” (501). Granovetter refers to such mutually beneficial and informal relationships as “embedded” relations. Companies navigate the free market by relying on these relationships, some of which have existed for decades among companies. Through embedded relationships, members of different organizations constantly interact (almost as de facto colleagues, in some industries, e.g. investment banking and financial capital markets). Constant interaction between members of different organizations leads to assimilation and proliferation of shared behaviors and attitudes.

Organizational conformity is enforced through organizational edict and mandate. Leaders of an organization feel pressures to conform to what their peers are doing in other organizations, and henceforth, they order their employees to behave accordingly. Organizational isomorphism, therefore, begins as a “pressure to conform” (felt by decision-makers at the top of an organization), and proliferates throughout an organization through top-down decree.

Predictability (lower variance in quality of product or outcome) is what distinguishes truly bureaucratic organizations from informal, “ad hoc” groups (Hannan and Freeman, 1984, 153). Organizational predictability is inextricably linked to organizational conformity because the more an organization adheres to industry norms, the greater is the predictability of its actions. Hannan and Freeman (1984) explain:

Norms of procedural rationality are pervasive in the modern world.
Organizational legitimacy, in the sense of high probability that powerful

collective actors will endorse an organization's actions... depends on ostensible conformity to these norms... These forces favor organizations over other kinds of collectives... (153).

Zucker (1987) supports this argument, claiming, “Organizational⁴⁶ conformity to the institutional environment simultaneously increases positive evaluation, resource flows, and therefore survival chances, and reduces efficiency” (Zucker, 1987, 445). Efficiency in this context is the degree of freedom that an individual employee possesses to respond to unforeseen challenges in the workplace in ways that do not conform to the organization’s accepted behaviors. The higher the “efficiency”, the lower the predictability of the organization’s products and outcomes.

Efficiency, in this sense, is detrimental to an organization’s predictability, and by extension, its conformity to “norms of procedural rationality [that] are pervasive in the modern world” (Hannan and Freeman 1984, 153). In order to be perceived legitimate, and ensure its financial survival, an organization must minimize employee deviance and maximize employee conformity. In healthcare, public and private insurers are more likely to financially reward hospitals that conform to current definitions of institutional success: namely, by transitioning away from the “fee for service”⁴⁷ reimbursement model toward a more “accountable” payment system. Organizations demonstrating high industry conformity (and low efficiency) tend to be difficult places for employees to make their own, unique decisions based on local circumstances.

Zucker claims such organizations are places in which:

⁴⁶ Zuker’s conception of “organization” is best understood as an adjective that explains the way in which human beings consistently perform routines and procedures over time in a particular workplace location; it is closer to the definition of what most sociologists know as an “institution”. In most cases, it does not refer to the actual school or hospital itself, or to any general or specific “organization” as in a physical place where people work, pray, manufacture cars, etc. (though sometimes it does).

⁴⁷ Doctors used to be paid, or reimbursed, by health insurers (both public and private) for everything they did to a patient. This resulted in perverse incentives to “not get it right the first time” (which were unethical as well as financially unwise). Suppose, for example, a surgeon performed a colon operation (partial removal of the colon) on a patient. The surgeon would be paid for this procedure. Further assume that the surgeon failed to cut out all of the cancerous parts of the colon, and had to perform a second operation on the patient. The surgeon would then be paid a second time. This describes the “fee for service” reimbursement model – a way of paying doctors that is on its way out the door. The new model, that health insurers are pushing on hospitals is one that incentivizes doctors to “get it right the first time” by paying a pre-defined sum for a particular procedure. If the doctor makes a mistake and has to re-operate, the health insurer does not pay the doctor a second sum. This new model is referred to as the “accountability model” (there are likely other names used to describe it).

‘... [M]anifestations of powerful institutional⁴⁸ rules...function as highly rationalized myths’... not explainable by direct task contingencies... Thus, organizations become a passive ‘audience’ for institutional knowledge... because the rules are formed in the state or even world system, external and hierarchically superior to the organization (Zucker 1987, 450)⁴⁹.

Organizational change and communication. Hannan and Freeman (1984) espouse a theory of organizational change that they refer to as “evolutionary theory”. This theory posits that successful organizations are those that most efficiently adapt with changing external conditions that affect organizational success. In an apparent contradiction, the authors also observed that successful organizations tend to show little variation over time. To reconcile this contradiction, Hannan and Freeman merged two theories: organization evolution theory and organization ecology theory. The authors henceforth argue that successful organizations (those able to adapt to environmental shifts) are “selected” and that a consequence of their selection is “structural inertia” (Hannan and Freeman 1984, 150). Their theory possesses the constantly changing and adapting feature of organization evolution theory, as well as the equilibrium concept that is central to organization ecology theory.

Kadushin (2012) argues that ideas spread throughout organizations and industries of competing organizations through a variety of different networks. There are formal networks, for example, comprised of actors (typically management) who subscribe to formal “corporate” culture. There are also informal networks, which can be adversarial to formal networks (employee cliques). Networks also exist between and among competing organizations that mimic each other’s innovations, norms, and “best practices”⁵⁰. Management’s power within a single

⁴⁸ “Institution” is conceived of as supra-organization, e.g. an industry or field.

⁴⁹ Author seems to contradict himself with this quote because earlier he claimed, “Institutional order is negotiated and emergent, never systematically controlled” (447). I believe his argument is consistent, however. Although organizations cannot be directly controlled by their industry, they can be indirectly controlled by group (industry) pressures to conform to industry norms.

⁵⁰ An example of this occurred when Facebook’s executive “team” adopted some of the features of Google’s informal culture, e.g. a corporate “campus”, employees participating in leisure activities such as ping-pong.

organization exists insofar as workers accept and carry out management's orders. Orders are only followed out if workers believe it falls within their explicit job role. According to Foucault's (1977) concept of "power-knowledge relations", there are no powerful or knowledgeable individuals; rather, power and knowledge is the subject and humans are the carriers or transmitters of power and knowledge. Power and knowledge exist in people who "...know...the objects to be known ..." (Foucault, 1977, 27). From this perspective, one could view healthcare reforms (insurer-led reforms such as changing the way doctors are paid [from the "fee for service" model to the "accountability model"]) and, more significantly, the narrative about these reforms (that they are necessary and they are the way of the future), as power. The doctors, nurses, and executives who espouse this narrative are its transmitters. Foucault's (1977) conception of "knowledge" is synonymous with mainstream collective consciousness, and is manipulated and pre-determined by those in power (i.e. the transmitters of the dominant knowledge). By treating "knowledge" as something for others to "learn", the messages [of those in power] spread throughout a society (and an organization) like a virus. He exclaims:

When you have thus formed the chain of ideas in the heads of your citizens, you will then be able to pride yourselves on guiding them and being their masters. A stupid despot may constrain his slaves with iron chains; but a true politician binds them even more strongly by the chain of their own ideas (Foucault, 1977, 103).

The internal implementation of external mandates

Employee Monitoring. Shapiro (1987) argues that the "principal-agent relationship" is one in which a financier or investor entrusts his or her money to another individual (the agent) for an agreed upon service⁵¹. Shapiro argues that the key to such relationships is trust; or, more accurately, enforced trust. Principals must monitor agents in order to ensure the agent does not misuse their capital, and principals must have the ability to take corrective action against the

⁵¹ Individuals who pay financial advisors, for example, are "principals"; the financial advisor is an "agent".

agent if the agent does not follow their contractual agreement. Similarly, the employee/employer relationship is guided by impersonal and forced trust: If the employee does not perform his or her job responsibilities, the employee is vulnerable to reprimand or termination. Like agents, employees are monitored by impersonal measures (i.e. performance reviews) and personal measures (in-person, surprise visits by the boss). Large bureaucracies, such as hospital networks, tend to rely on impersonal forms of monitoring. On this Shapiro (1987) claimed, "Agents bridge the social and physical distances that otherwise limit social exchange. Agents incite and facilitate collective forms of action" (Shapiro, 626). Autonomous employees are thus perceived as threats to the bureaucracy's ability to implement top-down mandates and changes such as the standardization of employee behaviors.

Executive decisions within multi-site bureaucracies (those with multiple physical locations) are often made in one location and enforced in another. On distant relationships within bureaucracies, Shapiro (1987) writes:

Impersonal trust arises when social-control measures derived from social ties and direct contact between principal and agent are unavailable, when faceless and readily interchangeable individual or organizational agents exercise considerable delegated power and privilege on behalf of principals who can neither specify, scrutinize, evaluate, nor constrain their performance (634).

Employers and executives possess informal and personal relationships with actors in other firms and organizations (such as a hospital CEO's relationship with a CEO of a private insurance company). Sociologists describe these interactions by the term, "embedded relations" (Granovetter 1985). Executives' relations with their own employees are often much more formal and much less personal. On the relations between employers and employees, Shapiro (1987, 634) claims, "... [E]mbeddedness, however desirable, sometimes proves elusive... [T]he basis of trust, if any, is therefore impersonal." Bureaucracies seem to employ the same "guardians of trust"

(Shapiro 1987, 635) that Shapiro claimed govern the principal-agent relationship. Guardians of trust are the “social controls” (635) imposed on agents (or employees) on behalf of distant⁵² principals (employers) who are unable to monitor agents in person. Such bureaucratic influences are “... a supporting social-control framework of procedural norms, organizational forms, and social-control specialists, which institutionalize distrust” (Shapiro 1987, 635).

Following Shapiro’s work on principals and agents, Kiser (1999) studied the ways different government employees are monitored and influenced, in order to carry out the intended functions of their positions. Kiser focused on government agents – employees who work in departments, or agencies, each of which possesses a budget and spending power (provided by tax payers) – and their relations with those in charge of government agencies (politicians). Kiser’s government employees are synonymous with Shapiro’s (1987) “agents” in the principal-agent relationship.

Like any bureaucracy, hospitals must coordinate the efforts of hundreds or thousands of employees. Kiser (1999) calls this the “agency⁵³ problem” (149). Although Kiser focuses on government agencies, his ideas are applicable to any large organization (several hundred employees or more). Citing Adam Smith, Kiser argues that the chief problem with the monitoring of employees in large bureaucracies is “the separation of ownership and control” (149). Weber similarly believed that politicians could not properly monitor and influence the work of government employees (Kiser, 155). According to Kiser, “[Weber] stresses that rulers face a problem in controlling these agents, because the interests of the agents often differ from

⁵² Shapiro defines distance here is both literal or physical, and social or psychological (“social” and “physical” distance [Shapiro 1987, 631]).

⁵³ Agency in this sense is synonymous with “organization”, not “free will”.

theirs” (157). The modern bureaucracy’s remedy to this problem is increased impersonal and scrupulous surveillance of agents and their professional lives.

Like Shapiro, Kiser focused on the problem of trusting strangers that exists in most principal-agent relationships. Adam Smith warned of such “separation of ownership and control”, according to Kiser (1999, 149). Michael Apple (1986) similarly outlined the problems of delegated decision-making in public education. Ideas that are created by bureaucrats and superintendents are separated from the teachers who implement these ideas (Apple 1986). Kiser has his own term for this problem, "Bureaucratic drift" (154). Meyer and Rowan's (1977) theory on myths and ceremonies and Weick’s (1976) theory on "loosely coupled systems" address the same fundamental issue: the problem of delegated authority and decision-making.

The solution to this problem has been intense monitoring and surveillance of government agents. Kiser asserts, "Since the central problem in all agency relationships is information asymmetry, agency analyses naturally tend to focus on monitoring" (154). Legal sway over agency budget allotments (e.g. “sanctions”) enables politicians to influence employees’ work. The farther the employer is physically located from employees, the more difficult it is for them to monitor employees’ activities. Drawing on Weber for support, Kiser exclaims:

[Weber's] understanding of the importance of monitoring capacity is perhaps best indicated by his argument (ibid.:224) that the development of technologies of communications and transportation (essential foundations for adequate monitoring) were necessary conditions for the emergence of bureaucratic administration. Since monitoring problems increase with distance, the farther officials got from the ruler, the more they ‘evaded the ruler’s influence’ (ibid.:1051) (159).

Standardization. A common form of employee monitoring is the standardization of employee behaviors. Standardization enables employers and executives to implement and enforce their will on the organization. The government created “professional standard review

organizations”⁵⁴, or PSROs, regulate the treatment of Medicare patients by ensuring standardization of clinical practices (Boyd 1998). Their goal is to "... minimize differences in the costs and quality of care across the country by implementing standardized treatment criteria⁵⁵" (Boyd 1998, 201). According to Prechel and Gupman (1995), private insurance companies are the loudest advocates for cutting costs of U.S. healthcare. Private insurers, like Medicare and Medicaid, require doctors to follow standardized protocols and clinical behaviors because doing so allows them to maintain influence over the financial reimbursements of said procedures and treatments.

Employees in smaller, less bureaucratic organizations are more likely to stray from standardized behaviors in order to act "efficiently" (1977, 355), or practically, based on the day to day, and moment to moment, challenges and crises that arise in their workplace. Meyer and Rowan argue that attending to practical day to day needs as they arise is good for the short-run. Over the long-term, though, adherence to the organization’s standardized behaviors, or what they call “myth and ceremony”, is necessary for the long-run survival of the organization. It is, for example, equally or even more important for doctors and hospital executives to appear to be doing what health insurers want them to do – than for them to be actually doing what payers want them to do. The practical, day-to-day needs of the doctor and the hospital are divorced from the "myths" or ideals held by health insurers regarding the proper behaviors of doctors and hospitals. Large, formal institutions (and the actors in them) succeed based on their adherence to ceremony and myth, not practical needs. Adherence to myths and ceremonies enables actors inside and outside an organization to assume that organizational actors are acting appropriately

⁵⁴ Although PSRO’s have been around since the 1970s, they became more important after the intensification of managed care in the early 1990s.

⁵⁵ Standardization of product/service in medicine is very similar to that seen in public education. However, there is not as much “self-regulation” within public education as healthcare. Employers (principals) are charged with regulating employees (teachers).

and, therefore, that the organization will continue to function appropriately. This belief enables the individual actor to continue to act efficiently (practically). In short, loose coupling allows organizations to "... absorb uncertainty while preserving the formal structure of the organization" (Meyer and Rowan 1977, 358). The authors conceive of a dual reality in which employees and employers must appear to be responding to the concerns of all relevant outside groups (citizens and politicians). On the ground, as it were, they must be immediately concerned with pressing issues that affect their job on a day-to-day and week-to-week basis (especially those that have implications for funding). These concerns may or may not overlap with outside concerns.

METHODS

The primary method of research employed in this study was semi-structured, one-on-one interviews. A total of ten interviews were conducted at multiple workplace locations with healthcare executives and administrators. These workplaces consisted of three different hospitals within a single hospital network (with a primary focus on two), one private practice and one community health clinic⁵⁶; all are located in Yankee County, USA. The audio recorded interviews lasted, on average, 45 to 50 minutes each, producing an approximate total of 150 single-spaced pages of transcribed dialogue between interviewees and myself. All but one interview was conducted in-person at the interviewee's workplace (in a room or office of their choosing with no one else present). One interview was conducted over the phone.

⁵⁶ One of the two private practices, Tuttle Medical Incorporated, has a professional contract/relationship with Landahl Hospital/Yankee Health Network. The second private practice, Downington Medical Group, does not appear to be as closely connected to Landahl Hospital; however, I believe the doctor I interviewed there, Dr. Snellings, has admitting privileges at Landahl Hospital. The community health center is affiliated with Landahl Hospital.

Several of these individuals spoke on my behalf to their colleagues, ultimately resulting in a “snow-ball sampling” (Esterberg 2002) effect – that is to say, these individuals successfully facilitated interviews, for me, with some of their colleagues.

Data analysis

I employed Charmaz’s (2006) grounded theory to analyze data. Grounded theory is a qualitative method and methodology that achieves two purposes: it provides a practical guide of organizing vast amounts of interview data; and, secondly, it provides a guide by which one may begin to develop a theory based on the organization of that data. Before coding data obtained in interviews, I transcribed the data (i.e. the participants’ interview responses).

There are three stages of Charmaz’s grounded theory⁵⁷: ‘line by line coding’ (which is part of ‘initial coding’), ‘focused coding’, and ‘axial coding’. As the researcher proceeds from line by line coding onward, their decision-making responsibilities increase. In line by line coding, the researcher ‘stays close to the data’; that is, they attempt to put each transcribed line of the interviewee’s text (assembled in a Word document) into their own words (that summarize the point they think the interviewee was trying to convey). So even this stage involves a degree of ‘implicitness’. The researcher possesses even greater decision-making/inference power in focused coding. It is in this step that the researcher decides on a handful (generally anywhere from 4-8) of ‘categories’ that will become the main themes of research (‘grounded’ in the data). The researcher may also elaborate on each category by adding one or several sub-categories to each category (but not too many; perhaps 1-2 for each). Lastly, axial coding requires the researcher to conceive of a theory that explains the relationships among the different categories.

⁵⁷ Charmaz (2006) outlines another kind of coding, “theoretical coding”, (63). I chose not to conduct this step because Charmaz implies that it is, essentially, interchangeable with axial coding (albeit more complicated).

As the researcher proceeds through each of the three stages of grounded theory, they rely less and less on the interviewee's text, and more on their conclusions about the text. All of their inferences should be grounded in the text/data, however; they must continually check and recheck their decisions (this is true in every stage, but it is particularly important to remember during focused and axial coding). For this reason, the researcher's original line by line summaries from the first step must 'stay true to the text' as much as possible – they must have a solid foundation for the rest of the analysis. Ultimately, grounded theory involves implicit and explicit interpretations of data.

The Sites

Located in Landahl City, Landahl Hospital is a “community teaching hospital” that serves a diverse urban population of approximately 88,000 (6th largest city in the state). Landahl Hospital was founded in 1893 and has steadily grown since then. It is known for its prestigious teaching program (medical residents and medical students) and, relatedly, its ability to place students and residents into top programs after their tenure at Landahl Hospital. Landahl Hospital employs approximately 2,500 employees including 500 doctors. Annually, it has approximately 50,000 emergency room visits and approximately 11,000 admissions⁵⁸ (U.S. News & World Report Health, retrieved online January 2016). Landahl is approximately 50 miles from a major city. Like the surrounding towns in lower Yankee County, Landahl is close to the major city in physical distance and in the collective feelings and experiences. In 2014, Landahl Hospital officially joined (merged into) the Yankee Health Network.

⁵⁸ According to one Landahl interviewee, these numbers (number of patients treated) give a more accurate indication of activity than bed count.

Founded in 1885, Stewart Hospital is a community teaching hospital located in Stewart City, home to approximately 80,000 residents (seventh largest city in the state). Like Landahl, Stewart has a diverse urban population and is located approximately 20 miles northeast of Landahl in upper Yankee County. It is about 70 miles from a major city, and is the flagship and founding hospital within the Yankee Health Network. Formally, Stewart Hospital is one of three units (hospitals) within the Yankee Health Network. Informally, however, a group of participants (Landahl Hospital doctor interviewees) believe that Stewart Hospital, and the physician executives who have worked there many years (who interviewees call “Stewart people”), shape the network. With the formation of the Yankee Health Network, these Stewart Hospital executives became “network-level” executives. Stewart Hospital employs almost 4,000 employees including 750 doctors. Annually, it sees approximately 70,000 patient visits to the ER, and approximately 18,000 admissions (US News & World Report Health, retrieved online January 2016).

Landahl Community Health Center (LCHC) was founded in 1999 and is located only a few miles from Landahl Hospital along a busy commercial stretch of US Route 1. Like other federally qualified health centers (FQHC’s), LCHC’s primary mission is to serve low-income patients. Most of their patients receive Medicaid or are uninsured: Approximately 40% receive Medicaid, 40% are uninsured, 10% receive Medicare, and 10% pay for private insurance (according to one or two interviewees). LCHC pays for the services of a handful of doctors from Landahl Hospital’s Department of Internal Medicine – many of whom spend one day a week at the health center seeing patients (and some who spend 3-5 days per week). LCHC is located in an impressive, modern 24,000 square foot facility, and appears, based on my observations, to have an active influx of patients. In total, LCHC employs or consists of:

- Approximately 16-25 doctors (this includes Landahl Hospital-employed doctors who work here periodically, ranging from 1-5 days per week)
- Six non-MD administrative leaders
- A handful of support staff (approximately 7-10 people)

Tuttle Medical Incorporated (TMI) is a bustling private practice located in an office and shopping park within the heavily trafficked Route 7 commercial district in Landahl City. TMI employs 26 providers (including 21 doctors and 5 non-MD providers⁵⁹) and 10 support staff in three different locations in lower Yankee County.

The Participants⁶⁰

Landahl Hospital:

- The Vice President of Medical Affairs (a doctor who is primarily an administrator)
- The Chairperson of the Department of Internal Medicine (this person is a doctor)
- The Chief of Medical Staff (a doctor)

Stewart Hospital/YHN:

- The Chief Executive Officer, Yankee Health Network (a doctor)
- The Chief Operating Officer, Yankee Health Network; President of Landahl Hospital (not a doctor)
- Former President, Swift Hospital, Northern campus of YHN (not a doctor)
- The Chief Medical Officer, Yankee Health Network (a doctor)

⁵⁹ These five non-MD health professionals are: 3 nurse practitioners, 1 nutritionist, and one Physicians Assistant

⁶⁰ The order in which participants appear reflects their position within their organization's formal hierarchy. Dr. Jack Milligan, for example, is at the top of the hierarchy for the Stewart Hospital/YHN list and Dr. Elias Zordich is at the bottom.

- The Chairperson of the Emergency Department at Stewart Hospital, and recently retired Chief of Medical Staff of Yankee Medical Group/Stewart Hospital (a doctor)

Swift Hospital (also known as, “The northern campus of Stewart Hospital”):

- The ‘Medical Director of the Operating Room’ (a doctor)

Landahl Community Health Center:

- The Chief Executive Officer (not a doctor)
- The Chief Medical Officer (a doctor)

Tuttle Medical Incorporated:

- The Executive Director (not a doctor)

FINDINGS

Executives’ opinions about the merger

The second study in this dissertation focuses on a group of doctors in Landahl Hospital, and their reactions to their “integration” into the Yankee Health Network (YHN). The other hospital that was also taken over by (Stewart-led) YHN is the much smaller Swift Hospital. A former President of Swift Hospital shares Landahl doctor’s opinion that YHN (which, informally speaking, refers to Stewart Hospital executives) overpowered her hospital. She similarly focused on the effects of the merger on her former workplace’s culture. The 92-year old Swift Hospital was known to be “touchy feel” (Zordich) due, in part, to a former President’s (not the one interviewed in this study) tireless effort to abstain from firing a single employee (he was very successful). In recent years, Swift encountered significant financial losses. The merger, or integration, into YHN appears to have saved it from financial ruin – and, at the same time, to have permanently changed its employee culture. A former hospital President explains:

Wilson: So the face organization is completely different than it used to be prior to the merger. Prior to the merger it was a full service local community hospital. Post the merger it's an outpost for Stewart Hospital, um, its primary referral source.

Cleary: Okay.

Wilson: In from the market to the door.

Cleary: Okay, okay.

Wilson: It's very different.

Cleary: Okay. And so Stewart referring to Swift not so much the other way around?

Wilson: Never the other way around.

Cleary: Okay, okay. For what types of services other than the ER?

Wilson: Eh! Everything goes down to Stewart now. Obviously all the OB cases, all the Ped[iatric] cases... And anything that was remotely hospitalist that again because of low volume practitioner's skills become concerning. So if it was out of the ordinary and not your quasi bread and butter case you would get transferred.

This former hospital president explains how the merger with Yankee Health Network broadly, and the closing of the OB/GYN unit specifically, changed the "fiber" of Swift Hospital. In fact, the decision to close the OB/GYN unit upset the culture and history of the hospital overnight. In the following exchange, the former president describes the effects this decision had on the Swift community as well as the employee culture at the hospital.

Cleary: Okay, I actually did see a few articles about [the controversial closing of Swift Hospital's OB unit] ...I guess I would call it a minor uproar at least that umm.

Wilson: Mmmm.

Cleary: Um,

Wilson: Hard to say minor.

Cleary: You would not say minor?

Wilson: I would not.

Cleary: And that's from the public, local citizens?

Wilson: No it was more from internal in the organization which was really kind of never captured in the press.

Wilson went on to explain how the closing of the OB/GYN unit at Swift Hospital was indicative of a deeper lack of respect amongst Stewart executives toward Swift Hospital:

Now you got a group of people...They're probably worked there 20 to 30 years...And you're changing the fiber of what they are and what they do, you know, it's tough...Uh for the most part they were not offered positions at Stewart...You know...this often happens in integrations. Is that the larger hospital is deemed as you know, smarter, faster, all knowing whatever...[and] the smaller of the two...[is] assumed to be incompetent. So there wasn't an offering of you know bringing people to Stewart to add to their fiber of their organization and in particular and Stewart is very bad at this in terms of their culture in that allowing that behavior and belief to kind of foster and that's going to make future integration more difficult for them...[Stewart Hospital is] not good at ... really engaging their employees in the change process and ... developing a positive culture (Wilson).

The former hospital president became uncomfortable with the direction top executives were going, and specifically, she began to regret the increasingly dishonest ways in which she believed she was treating her employees. She said:

And you know I at the end of the day couldn't look people in the eye that I worked with and you know I had pumped them up for several years, you know hang in there, this will get better, this will be great and I couldn't do it at the end of the day. You know it was more important to me to have my own personal integrity and needed to move on... But I believed in it that much that I decided to leave (Wilson).

This former President of Swift Hospital ultimately became the president of a large hospital within a network in a neighboring state. She is much happier in her new position, and believes her new employer is much better at seeking employees' input than the executives at the Yankee Health Network. Indeed she believes it is a far more effectively managed system. Whether or not she was just expressing "sour grapes" toward her former employer is tough to say. But I can say that her statements were very similar to the things Landahl's doctors told me (many or all of

whom, I presume, she never met). In addition to her, I spoke with several current network executives. One in particular expressed definitive opinions about the merger – specifically on how doctors at the “losing” (acquired) hospitals ought to behave following the merger.

This individual has been employed at Stewart Hospital for the past three decades. He is currently the Head of the Stewart Hospital Emergency Department, and formerly Chief of the Yankee Health Network Medical Staff. He is the quintessential company man. Not once did he have anything critical to say about his employer (YHN/Stewart Hospital) and on several occasions he recited his organization’s “values” as if he had memorized them long ago. He is a religious man and he is deeply self-reliant. He sees his workplace in terms of individuals who, through their own behaviors and beliefs, are responsible for their own fates. He spoke reverentially about two of his heroes, President Lincoln and the legendary Scottish revolutionary, William Wallace, as portrayed by Mel Gibson in the movie, “Braveheart”. His admiration of both figures reflects two ideals of his workplace persona and identity: He strives to be “out there with the troops, in the field” (Lincoln) and he strives to lead by example rather than word (like Mel Gibson’s character). He is also consciously selfless. A central component of his definition of a “good employee” is to put the organization above one’s self.

His responses toward the merger (and, more specifically, toward Landahl doctors’ reactions to the merger) alternated between judgment and empathy, with more belonging to the former. Though at times he acknowledged that he might think differently if the merger had adversely affected him or his department, he repeatedly affirmed his belief that individual employees can and should make the best of the situation through hard work and commitment to the overall good of the organization. If one takes this approach, he opined, good things will inevitably happen. He told me:

Now it's interesting, when mergers comes together, it does seem like there are some people that are vying for positions of authority in this new structure. Um, but it goes back to what I said earlier. I think if you do the best job that you can, and you treat people with respect, you function with integrity, you live the values of the organization... and you don't aspire necessarily to get ahead for just the sake of getting ahead. But if you do all those things and there is an opportunity for you in this new entity, then you are going to be invited to a seat at the table. If you are not invited to a seat at the table, people shouldn't take things personally. They should say, 'Okay, let me do a little bit of introspective look-see and see why this happened' (Benson).

He trusts the network CEO who he has known for about two decades – unlike Landahl doctors who met or only heard of the CEO less than two years ago. He reveres the CEO in much the same way that he idolizes Lincoln and Mel Gibson's William Wallace character, as evidenced in the following exchange:

Cleary: ... [H]ow would you respond to people/doctors who are concerned that the network is stacked with Stewart people?

Benson: So that has kind of come up in the undertones of some of their responses... So again, this is my perspective... We have a very visionary leader of the organization. Somebody that I have known for over 20 years. And I find people ... in the leadership position of the organization to be ethical, moral and be functioning with integrity. So if I have that as a foundation, that I believe that they are moral, ethical and they are functioning with integrity, I have to put a certain degree of trust in much of the decisions that they are making... We all have different stations in life when it comes to who we are leading and who is leading us. So we are very fortunate in that we have a leader who has a great vision and he's inspiring.

I raised this issue of network representation (or the alleged lack thereof) with network CEO. I asked him to respond to the claim that the network felt like a Stewart network (as the Landahl doctors had repeatedly told me).

Cleary: What if I were to say the Yankee Health Network seems like Stewart Hospital...under a robe. And the robe is the Yankee Health Network Logo. But it is really Stewart Hospital. To an outsider, that's what it seems like... What do you think?

Milligan: Yeah. I think that that would be ... an inaccurate and even unfortunate ... characterization... What it is today and what it is going to be 5 or 7 years from

now, I think are different things. Right now, it is largely viewed, I think, as a collection of hospitals – Swift, Stewart and Landahl – and my hope is that each community views its hospital as the most important hospital in the network.

Later in the interview, I asked the CEO about the location of the network’s executive headquarters. We specifically talked about the physical location of the network executives’ offices. I suggested that since the executive team (or most of it as he informed me) is located at Stewart Hospital, it appears that that is where the power is located.

Clery: If this was, if the Yankee Health Network say, Executive Headquarters, your office, and the other network, you know, executive offices, um, was located say in a fourth city, that wasn’t Landahl, Stewart or Swift, then I would think that it’s much easier to see it as not being just a cloak over Stewart Hospital. So it’s something about just the–

Milligan: And that’s a completely fair point. And I will give you the relatively pedestrian answer to it. That was the plan. And then, when we got faced with these financial cuts, we thought, ‘Wait a second here. How do we justify leasing some fancy space so that I can sit there with my executive team increasing the overhead of the organization? Without bringing any new value just expense?’ And for that reason and that reason alone, we have [kept executive offices mostly at Stewart Hospital]. Now we do have pieces of the executive team located in Landahl. For instance, if you want to go to meet with the marketing team or the PR team or HR, it’s largely headquartered in Landahl.

Clery: Okay.

Milligan: So there are elements of the corporate infrastructure that are distributed... [I]f it had been done purely on the basis of optics, we would have done what you said. We would have found a corporate location and a fourth location and said, ‘This is where we go.’

If the majority of the network’s executive apparatus was physically located in a location other than Stewart Hospital, the doctors and staff at Swift and Landahl hospitals might be less likely to assume that they were being taken over by Stewart Hospital. A larger and well-established hospital system might get away with this, but it is a “harder pill to swallow” when the acquiring hospital is your rival. The Chairperson of Landahl’s Department of Internal Medicine articulated this view, which, he believes, explains how people at Landahl feel about the merger:

Um, and I think that if somebody was going to come in here heavy handed, if it was [hospital system name removed], I think we would have accepted it... Because they are [hospital system name removed]. But Stewart Hospital was not

[hospital system name removed]. Maybe it will be someday, but it's not. So I don't think any of us expected that and I think it is a lot harder to accept.

That the network CEO regards the relocation of network headquarters from Stewart Hospital⁶¹ to a fourth, neutral location as “optics” could suggest that he is not aware of Landahl Hospital doctors' perceptions and concerns about a takeover, or that he is aware but does not take them seriously (I believe it is the former – a point which is not entirely his doing⁶²). This issue was further discussed in the following exchange:

Cleary: Isn't it a little bit more than optics though? ... Wouldn't it do something to the hearts and minds of doctors and let's just pick on Landahl. Wouldn't it do more to convince them that this is separate from Stewart and not being taken over by the Stewart Hospital?

Milligan: ... [T]he truth be told, most of my job is an external, you know, I am supposed to be outward facing. So I'm trying to influence policy at the state level and at the regional level. Trying to continue to grow the network so I am often in discussions with um, you know, other organizations and then trying to forge relationships with [them]... I have a meeting later today with the Dean of the University of⁶³ ... to try to forge a relationship... I am meeting with a payer later this afternoon. The president of one of the major insurance companies. So I am often out on the road, not at any particular hospital.

A little later in the interview, the CEO questioned my use of the word, “YHN”, and seemed to advocate a different conception of the Yankee Health Network than the one endorsed by Landahl doctors:

Cleary: Okay. I asked that because if I'm, you know, and it's just a simple thing. The building that once was Stewart Hospital. That is Stewart Hospital where YHN is, so it just –

Milligan: You mean that's where. When you say that's where YHN is, do you mean by virtue of where its executive team sits?

⁶¹ To be fair, the CEO pointed out that not all of the executive units are located at Stewart Hospital. Public Relations and Human Resources are, for example, located at Landahl Hospital. (There are no major bureaucratic units at Swift Hospital). In the strict sense, therefore, there is no centrally located “headquarters” for the network – even though most of the organization's operations are run out of Stewart Hospital.

⁶² Some of the Landahl doctor interviewees told me that “Landahl Hospital” (which refers to Landahl executives and, presumably, Landahl doctors) has not been good at advocating for its own interests – historically speaking and with regard to interactions with Stewart Hospital during the merger.

⁶³ Name of university removed to maintain anonymity.

Cleary: Yes. In the ‘headquarters’ of the network.

Milligan: I think to a certain extent that’s a fair observation. It’s an incomplete one though in that some members of the YHN, there are three locations that, where the team is distributed ...” (Milligan).

Hospitals contain formal and informal power structures (Freire and Azevedo 2015).

Formally speaking, Stewart and the Yankee Health Network are separate entities: Stewart is one of three units (hospitals) under the umbrella of a single parent network (YHN). Formally speaking, each hospital within the Yankee Health Network is one unit within the overall network. The CEO of the Yankee Health Network and his executive colleagues expressed both of these points loudly and clearly. And, formally speaking, they are correct. On the distinction between formal and informal workplace culture, Granovetter (1985) exclaimed:

The distinction between the ‘formal’ and the ‘informal’ organization of the firm is one of the oldest in the literature, and it hardly needs repeating that observers who assume firms to be structured in fact by the official organization chart are sociological babes in the woods (Granovetter, 1985, 502).

Informally, YHN is perceived as a Stewart-controlled network. Nearly every Landahl doctor interviewed believes that Stewart is formally and informally more powerful than Landahl Hospital. They also believe that “Stewart people” are more aggressive⁶⁴. This might explain why Stewart Hospital, not Landahl, initiated the network and the mergers. The notion that Stewart Hospital has “more aggressive personalities” is not confined to Landahl Hospital.

One network executive who has worked most of their career at Stewart Hospital asserted, off the record, that Landahl Hospital has had a weak administration for years, and that the doctors there have been unsupervised for a long time (that they have been too independent). But, I inferred, this was going to come to an end (perhaps not all at once) because Stewart executives

⁶⁴ Two Landahl doctors also claimed that Landahl Hospital has been less effective at acquiring local private practices than Stewart Hospital.

were now in control of Landahl Hospital. Since we were off the record, I had to get this executive's permission to use this information. I presented to this person my interpretation of what they told me (regarding the historical reputation of Landahl's administration and doctors – and, particularly, the lack of supervision by the former on the latter), and they responded by telling me that I had accurately understood their point and agreed to my using this information in this dissertation.

In addition to its aggressor reputation, Stewart Hospital and its executives have a mandate: Payers want them to be as aggressive as humanly possible in reducing their costs.

Payer-led reforms

All executives (hospital and non-hospital) expressed very similar interpretations or narratives regarding the origins, as well as the reasons for (and mechanics of), public and private payers' reforms. Specifically, they spoke about reforms related to the ways that doctors and places of care are reimbursed and, more generally, payers' efforts to dramatically reduce healthcare costs in America. There was great homogeneity throughout the executives' responses regarding this narrative. However, the hospital executives, unlike the non-hospital executives, take it one step further: they actively and aggressively embrace these headwinds that are transforming American healthcare. Whereas the non-hospital executives and administrators deal with and have adapted to payer-led reforms, the hospital network executives in this study revealed a coordinated strategy playing out within the Yankee Health Network – and, indeed, throughout hospital chains across the country – to actively embrace and commit to payers' reforms.

Yankee Health Network executives have been charged by their CEO to fully embrace the new payer reforms. Most notably, this includes the move away from the “fee for service” reimbursement model toward the “value” or “accountability” model, and the effort to minimize emergency department patient loads by strengthening primary care provider networks (the latter effort is known as “population health management”). Hospitals and hospital networks that are quicker to revamp their operations in accordance with this new vision of healthcare will be rewarded by higher and more frequent reimbursements by public (state and national) and private payers. In addition to an overt embracement of these reforms, the hospital executives in this study reveal a systemic of competitiveness toward the achievement of these goals (systemic in the sense that it seems to have been mandated by the CEO). They want to “out-conform” rival hospitals and thereby win lucrative reimbursement relationships with public and private payers.

Yankee Health Network executives have responded to payers’ reforms affirmatively, by competing with other hospitals and hospital networks for payers’ limited dollars by doing what is asked of them. Winners are those that out-conform their rivals. It is up to YHN executives (as they told me numerous times) to minimize costs while keeping the quality of their outcomes (i.e. care) at, at least, the same level. In the following passage, YHN’s Chief Medical Officer explains the central theme of the network’s strategy of competition against its rivals: they are trying like hell to outcompete other hospitals and hospital networks in their ability to implement the payers’ reforms. He said:

We are competing with other hospitals and other health care systems for patients. That’s certainly true. And ... the way that we want to differentiate ourselves is around value. You know, healthcare is changing. It used to be volume based. The more you see, the more you do, the more money you make and that’s what it’s all about. And that’s not a good model for health care. The model for healthcare has to be value based. Which is quality over cost. We want to be able to provide the quality at a lower cost. In the long run, in the future state, we want people to stay

out of the hospital. We want them to stay healthy and we are going to get paid by Medicare or Commercial Payer or whatever it is. Um, to keep people healthy. And to help manage their health. That's the ultimate goal... But it does have to be value based. It's not about making more money. We are not for profit. We want to support the organization, pay the people properly for their work here and have enough money left over to invest back into the infrastructure... Um, so what we have to do [is] to do that better than our competitors. Other hospitals, other health care systems... But we think we can do that better in this... model... [W]e believe that we could just do as well or better than they can at a lower price. We would rather have our patients stay here rather than feel that they have to go to [names of two rival hospitals⁶⁵] or whatever to receive that care. There is that kind of competition (Mats).

Implementation of payers' reforms within the hospital network. Yankee Health

Network executives expressed a unanimously enthusiastic embracing of payers' reforms. This unified front is largely the result of a mandate from their CEO to embrace the reforms⁶⁶. The CEO's mandate specifically addressed the need to transition away from a "fee for service" reimbursement model⁶⁷ toward an "accountable care organization" reimbursement model. The network's Chief Operating Officer⁶⁸ described the network CEO's directive to he and his executive colleagues about four years earlier:

So we, we had been given a charge from our CEO at the time... [S]o Dr. Milligan said, 'There is a change in the health care environment that is going to happen and that was around the accountable care.' And we fully subscribe to accountable

⁶⁵ Actual names removed to maintain subjects' anonymity.

⁶⁶ The two physician executives also base their acceptance/embracing of payer-led reforms on their many, many years of clinical experiences.

⁶⁷ A "reimbursement model" is the way in which public and private health insurers pay hospitals and doctors. Traditionally, hospitals and doctors were reimbursed for whatever service or treatment they performed on a patient. Suppose, for example, a doctor performed a colonoscopy on a patient and it cost \$1,000. Further suppose that after a week since the operation, the patient returns to the doctor complaining of severe soreness and it is determined that the operation was not completely successful. The doctor has to perform additional operative work on the patient and fix or complete what he did not complete in the first operation. The doctor would then bill the patient's insurer for this second service for an additional \$500. In total, the insurer pays the doctor \$1,500 for two separate operations. Payers did not like this model because it incentivized doctors to perform more than was medically necessary services and treatments on patients. In short, it was financially inefficient and medically unethical (because doctors were, in a way, incentivized to keep patients sick and in continuous need of services and treatments). Payers, therefore, prefer a reimbursement model that pays doctors a one-time, pre-determined fee (value of dollars) based on the condition and service being performed. Payers have been attempting to reform reimbursement in this manner since the 1980s (Mats), however it has only been recently (roughly the last 10 years) that they have achieved some measure of success with its implementation (Mats). Now, under this new reimbursement model (what will be referred to here as the Accountable Care Organization reimbursement model), that same doctor who performed the colonoscopy on a patient would only be paid a one-time reimbursement of \$1,000. He would be expected (by the payer but even more so by his employer, the hospital) to get it right the first time in order to prevent extra costs stemming from a less than perfect initial operation that leads to a second operation.

⁶⁸ This individual is also the President of Landahl Hospital.

care. We fully subscribe to you know, incentivize us for good outcomes and stop incentivizing us for just doing more things to people. You know? And of course, Dr. Milligan is a physician. So, you know, he's fully bought into that. And he's leading us down that path of accountable care (Diller).

Later in the interview, the COO tells me that he and his colleagues accept and embrace what the payers are attempting to get hospitals and doctors to do. He said:

I think that it is getting increasingly difficult for the small practices to try and keep up with everything that is being asked of them by the payers, by Medicare, whether it is appropriate or not what they are asking. And we believe that it is appropriate. We believe incentivizing for good outcomes ... is the right way to incentivize health care providers (Diller).

Further illustrating his and his colleagues' embracing of payers' reforms, he explained:

So what ... [Medicare is] saying is, 'Do it once, right the first time. You are going to get this payment to care for this patient for this type of procedure. And that's it.' And we believe in that... [A]nd some of that incentivization is keeping patients out of the hospital, which is sort of counter to what we wanted in the past which was to get more people in the hospital. Now our goal is to keep people out of the hospital (Diller).

The source of some of the sentiments behind YHN executives' statements is network CEO. In the following passage, he explained some of his views behind his opinion that the American healthcare system needs to move from a "culture of entitlement" to a "culture of accountability".

This sentiment mirrors the conceptual arguments behind the payers' reforms. The CEO exclaimed:

I think this society, our nation is in trouble with health care ... And there is all kind of reasons for [that] ... but fundamentally I think there is a culture of entitlement, that extends certainly to physicians but also beyond physicians. I think physicians do feel entitled as you say... I also think that patients feel that they are entitled to the latest technology, the most sophisticated technology, [and the patients say,] 'There isn't going to be a co-pay, is there?' And, 'You're going to give me lobster bisque tonight, aren't you?' And, 'I want the appointment next week.' Other patients around the world don't experience that level of satisfaction service and they are less entitled. I think ... hospital administrators are entitled ... And I think you get the pharmaceutical companies who are a little entitled ... And it is this culture of entitlement that I think extends to patients, to physicians, to

hospitals, to insurance companies who have made, you know, gazillions of dollars, to medical device manufacturers and pharmaceutical companies ... [who feel] entitled to this money and this prestige and this autonomy. I think what we have to shift to is, the culture of accountability. Where we say, 'I need to be held accountable for the costs and the quality of care that I deliver.' And I think that's what is happening. It's painful. I think that it's necessary. But I think that physicians need to be held accountable. Hospital executives need to be held accountable and hey, you know what else? You're a patient and you are going to have the 32 ounce Coke everyday? Well, I can only do so much. But you've got to take your meds. Now we have to recognize that there are social determinants of health as well. But everybody needs to have skin in the game. But I think that we have to move from entitlement toward accountability (Milligan).

The network CEO's call for greater "skin in the game" mirrors the network Chief Medical Officer's interpretation of what Medicare is trying to do through its reforms ("... [O]ne way or another, payers want to put hospitals and doctor's systems at risk" [Mats]). The CEO's call for less entitlement and greater accountability was strongly heeded by the Head of the Emergency Department at Stewart Hospital; he personifies the 'company man' or 'good soldier' (or 'good lieutenant' since he has management responsibilities). When asked what the least favorite part of his job is, the ER Head responded:

The sense of entitlement that some people have with regard to a health care and the, the lack of acknowledgement about how fortunate we are to have what we have. Let me just expand on that with an example. You know, I have traveled the world, worked in under served countries, Central America, Africa, and we are very blessed that we are very fortunate to have what we have. And nothing is perfect. You know, we have issues. We always have to work to improve this and that. But we are very blessed to have what we have. That you could come in and be in a very bad car accident and you could receive all the services you have and then, at the end of two weeks, you could walk out of the hospital and be alive. That doesn't happen in much of the world. So we are very blessed and fortunate to have what we have (Benson).

In addition to the moral logic behind the move from entitlement to accountability, there is a belief that these reforms are the way of the future in American healthcare and if they do not get on board now, they will be dead in the future. The network's Chief Medical Officer expresses this opinion in the following exchange:

Cleary: ... And so these external changes are happening, and you guys are adapting to them and in a sense um, you know, sort of adapting to them, sort of doing what those changes are asking you to do. As opposed to resisting those changes.

Mats: We are, I think we are trying to. Not every hospital is.

Cleary: Okay. Right.

Mats: Some stick their heads in the sand and say, 'I hope this all goes away.' Um, or want to shrink to greatness, by saying, 'Well, I won't just do this anymore. I won't do this anymore.' And hunker down. I think that the hospitals that can foresee the changes and adapt to that, as you said, react to it. Um, are the ones that will succeed. I mean, you mentioned businesses because of the cost of health care and ... the payers can't afford it anymore, so it is changing this dynamic. That's why they are pushing more and more of the cost of healthcare to the employee. Because the biggest chunk of their expense for a company that has to ensure their own employees. So the whole model will change" (Mats).

Hospital executives demonstrated a competitive spirit with regard to their (and their hospital network's) ability to attract public and private payers. They want to be seen by payers as an attractive hospital network with which to do business. They want to be seen as a low-cost hospital network and a partnership with them will be profitable for payers. The Head of Stewart Hospital's ER explained:

But I will tell you why we are consolidating and why we are looking to come together. Everything is about scalability and size... The payers, with both federal and private, dollars are shrinking. They want better value for their dollars. So hospitals are coming together with physician groups ... to leverage their size ... [I]f we are buying a 100 gadgets versus buying 10 gadgets, we can get a better price for that... [I]t's for self-preservation of hospitals to come together ... How can we offer [Federal, State and private payers] ... the best costs with the best outcomes? ... They want best outcomes, and they want a lower price. So if you are a hospital that can manage your costs, and you can produce quality outcomes, payers want you. If you are a single hospital out there where you are very expensive, and your outcomes are marginal, payers don't want you. That becomes a second tier hospital for them. So what we want to do by coming together and you know, in our situation, three hospitals, we want to be a tier one referral for, you know, these third party payers because we've been able to control our costs by some scalability in size and ... we want to demonstrate that as a network, coming together, we have stellar outcomes. So good outcomes, lower costs. Why wouldn't you want to partner with us? So that's my lens of why insurance

companies and why hospitals are coming [together]. It's really for self-preservation. You can't be ... a lone place out there and expect to survive. Not only that, but the Affordable Care Act and all this, they've mandated um, electronic medical records. Many costly things. If you are a sole practice out there, it's very hard to afford the change that needs to take place (Benson).

Network wide standardization. Yankee Health Network's Chief Medical Officer (a long-time doctor leader at Stewart Hospital) is informally the second most powerful individual in YHN (a claim based on observation and conversations with interviewees). He has served as a doctor and an administrator in a progression of leadership positions at Stewart Hospital since the early 1980s. He is a committed doctor and an effective bureaucrat. He is as knowledgeable as any interviewee on the history of the American healthcare system. He appears to be a gritty old veteran of his profession (but, to be sure, very well spoken and personable). He is also a loud advocate, and enforcer, of standardization. Network-wide standardization of medical practices is, perhaps, the most important of his many job responsibilities, and he appears to be the "standardization czar" of the Yankee Health Network. Standardization is necessary because it is the key to bureaucratic influence over all three of the network's hospitals (which enables executives to achieve their specific goals – not the least of which is implementing the reforms being demanded by public and private payers). The Chief Medical Officer believes (hopes) that by coming together to form one network, the three hospitals of Yankee Health Network will achieve what wonks refer to as "synergies" – the whole will be greater than the sum of all the parts. He explained:

The interesting concept is how do hospitals like ours, of our size, differentiate ourselves from very nice, high quality, small community hospitals on the academic center? Interesting thought is that, and we all in hospitals like our size, wrestle with this. Well, are we hybrid? Do we bring the personalized care, the personal touch, the attention to the individual, and the service aspect of a smaller hospital, with the high quality medicine of an academic center? And I think that we do, but ... that doesn't differentiate you, right? It just says, 'Well, I can do this stuff like the small hospital. I can be touchy feely and ... I can also really do

cool stuff and have high quality doctors.’ That sounds like a hybrid bicycle to me. And that’s not so great on a highway, and no so great in the dirt. It’s just pretty good. And you can accomplish both. But I think that if you can bring both skills together ... the total is greater than the sum of the parts. Because you can truly personalize the care. And deliver some exceptional quality outcomes with great docs. That makes it the better of the two. You know, it’s the ideal place to go to get care. And maybe it’s ‘pie in the sky’. But that’s, that’s the way that I would like for us to think of ourselves. I think that you have to be big enough as our three hospitals are to pull that off. But, that’s the aspiration goal (Mats).

The Head of Stewart Hospital’s Emergency Department is a strong ally of the Chief Medical Officer’s in the fight to standardize the network. When asked what he does in a given week, the ER Head responded by saying that running his department is his number one priority. His second is to ensure that the ER is abiding by the procedures and protocols that are sent down from above (i.e. conforming to standardized, network-wide clinical behaviors and practices). The purpose of standardization efforts (which the ER Head wants to be “in lock step with”) is the maximization of conformity with payers’ demands and reforms. He explained:

Number two is to make sure that ... we are looking at the strategic direction for the department and to make sure that we are addressing many of our goals around ... patient care. Around population health management, making sure that we are in lock step with the hospital network as it pertains to health care reform around population management... We are trying to reduce unnecessary testing. Make sure that we are doing things appropriately. Managing with minimal variability, which is going to kind of get a little bit to our autonomy, um, to make sure that the doctor’s are adhering to clinical guidelines, best practices ... making sure that directionally the physicians are ... in sync with what we are doing in the network. Making sure that we are developing a strong primary care network. Make sure that we are having an appropriate base of referrals to medical specialists, surgical sub-specialists, etcetera, etcetera (Benson).

When advocating his belief in standardization, the network’s Chief Medical Officer rhetorically asked me if I would like to go to a restaurant (that belonged to a chain of restaurants) that had a menu that was different from the other restaurants within that chain (he implied that I would not want to do that because, I assume, I would eschew the unpredictability of such an event). The effort to standardize clinical practices is very real and, some might say, intense at Yankee Health

Network. The Chairperson of Landahl's Department of Internal Medicine believes the network's standardization efforts have been "pathological" at times. He exclaimed:

At times it almost feels like a pathological reliance on standardization so that you know you really have to try you know take a square peg and put into a round hole it feels like sometimes because we built everything around us for the way that we operate and then to think that we're just going to start behaving very much like another hospital (Olzner).

Similarly, an Anesthesiologist at Swift Hospital said, "... [A]ll the departments have pressure on them by the network to cut cost and to... and to standardize techniques and drugs and equipment" (Zordich).

The image of the hospital executive: Brilliant director or wolf in a sheep's suit? The network's Chief Operating Officer is particularly adept as a communicator. Throughout our interview a theme emerged about the way he approaches his job as a senior network executive: He sees himself as somebody that is there to help doctors adjust and adapt to the payers' mandates and demands. He is a professional middleman. The COO's characterization of his middleman function was surprisingly complex and detailed. Payers, he explained, are asking doctors and hospitals to drastically change the way they do business in terms of how they are paid and how they record and report (to payers) the details of their interactions with patients (i.e. details of the ways they treat their patients). The COO and his executive colleagues help doctors navigate the new and unknown pitfalls and peaks of payer-led healthcare changes. The responsibility of a hospital executive, according to the COO, resembles movie directors who claim that their job is "to get out of the way" (of the actors). The COO agreed with this analogy in the following exchange:

Cleary: You know, I saw a documentary recently on Robin Williams... [H]e said in an interview, that the best directors are those that act as sort of, just the gentle, cone on the highway, that ... doesn't push you, but keeps you within where you are

supposed to be going. A guide in a sense. It seems like your job is very similar to that...

Diller: ... I would say, yes. I mean, that's a great analogy. I think um, there are times where a physicians are outliers in their behavior, um, in their attitude or responsiveness or their um, their willingness to comply with the rules, if you will. They are few and far between. But they are out there. So those you have to, I think, you have to have a little stronger relationship with. But the vast majority of them are, they are out their doing good work and you want to just be here to support them and you want to give them the resources they need – whether it is in the O.R., or up on the floors, or in their practices – to continue to do good work and try to make it easier for them. A lot of health care bureaucracy and a lot of health care policy and changes. It's not making life easier for the physicians. It's making it much more difficult... And I think that we in administration would love to be those people that are trying to make it easier for them, because a lot's being asked of them from external environments.

The COO presents this aspect of his public-professional self (the image of an executive who likes to get out of doctors' ways) in sales pitches he makes with doctors from the community – whose private practices he (and the hospital network) wants to partner with or outright acquire.

He described one such meeting here:

It's a meeting with a private practice that, um, we really want to get on board... And so it sort of a quasi employment where they are still an independent practice but they are contracted with us to provide professional services in one of our primary care offices... [W]e really wanted them to sign on ... And they didn't want to be told how to practice medicine. And my first conversation with them was, 'I am not coming here to tell you to practice medicine. But I am coming here to tell you that you need to change the way you are delivering care, or at least reporting on how you are delivering care, because the payers are asking for it. And that's all that I am here for. You know, I don't want to get in the middle of how you address a certain patient. Every patient is an individual. You need to have the autonomy to make the right decisions for that patient. But while you are making that decision, you also need to report out what it is that you are doing with that patient. And so that's what we are here to talk about, not how I want to tell you how to practice medicine. But how you need to report on how you are practicing medicine. And to ensure that [how] you are practicing medicine is in fact the way you should be, in terms of... the protocols and what the government's asking you to report on. Those types of things' (Diller).

The job of a network executive appears to be slightly more hands-on than the movie director analogy implies. The COO approaches his job with the ideal goal of being as hands-off as he

possibly can much like the movie directors who resemble “cones in the highway”. But it seemed like he is able to be more hands-on when he needs to be. Indeed, he explained that, as an executive, one has to have “the stomach” to make tough decisions:

Um, but it’s getting more and more difficult to find those big buckets of money that are just sort of sitting on the sidelines. The sacred cows⁶⁹ that we are not willing to address because we have addressed a lot of them over the last three years and I don’t want to say that we have gotten good at it, but you know, we’ve gotten to the point where we understand how to make those hard decisions and why it’s important to make those hard decisions. And we make them. Some of them we don’t like to make, but we have to... [A]nd you know, it’s about survival. It’s about, you know, doing what’s best for these assets that are community assets. And making sure that they are here for the future. That’s what this is all about... You have to have a strong stomach for some of this stuff, you know. Like a surgeon going into the OR and they really have to be prepared for it. Um, the concern is that balance. How do you balance the morale and how do you balance that you want your employees to know, ‘We do care about you’, while you are making these changes. Like, ‘Well, how could you care about us if you are making these changes?’ Well, these changes are necessary and we care about you because we want to sustain your job. We want to keep you employed (Diller).

Like the COO, the network Chief Medical Officer claimed that the hospital network’s bureaucracy (its “infrastructure”) makes a doctor’s job easier. Specifically, he claimed that a hospital support staff enables a doctor to spend less time on non-MD (administrative) work, and more time on traditional doctor work. In the following passage, I asked the network Chief Medical Officer if the trend out of sole proprietorship into hospital employment⁷⁰ should be a source of concern about the professionalization (or de-professionalization) of doctors. He told me:

I think that the ... movement towards employment is real, and, just as the consolidation of hospitals. Some of it is for business reasons and the efficiency parts, you are absolutely right, it makes sense, but it’s also what we are responsible for as we become more responsible for the cost of health care. So we

⁶⁹ I believe he is referring here to two recent measures taken by network executives: the firing of full-time employees (more staff than doctors), and the reduction of pension payments. These are, I believe, the “sacred cows” Diller is alluding to.

⁷⁰ Between 1983 and 2008, the number of doctors who owned their own private practices in the U.S. decreased by approximately 20% (Kane and Emmons 2013).

have to become more efficient... But, um, I don't think that they become autonomotons or lose their commitment to medicine. I think what can happen if you do it right, is yeah they are part of a bureaucracy if you become employed, but they also have an infrastructure that is managed by an efficient organization. So they can actually spend more time focusing on taking care of their patients, with better information brought to them... [The bureaucratic infrastructure] permits the doctor to spend more time on what they went to medical school for which is taking care of patients... So I am not worried about the sense of a commitment of a doctor to take care of patients changing. Maybe I am naive but I like to think that we can build a system, and it's not going to happen over night, that will support [the doctor] ... to be able to ... spend time doing what he's best at... I want doctors, I want all health care professionals ... [to] use their best skills efficiently rather than waste their time doing other stuff. So it's actually the reverse. I am hoping that this model of care, even though there are bigger systems, will support the individuality of the doctor/patient relationship. I don't want to lose that (Mats).

Both the Chief Medical Officer and the Chief Operating Officer define the responsibility of the hospital executive as one of helping doctors adapt to the new administrative burdens expected of the 21st century doctor. They do this by providing hospital doctors with the necessary “infrastructure” that makes it easier for doctors to handle new administrative burdens (i.e. EMR) and new payment structures. The COO proclaimed, “Because now we just support ...[doctor's] work and we build that infrastructure around them” (Diller). The COO expands on his role as a middleman or mediator between the payers and network doctors.

Diller: And yes, if there are outliers, people who aren't getting on board with that, I guess that ultimately we have to become an enforcer of that. Um, but the initial step is let's help everyone get there. Because we have great doctors. And we have great mid-level providers and they want to do the right thing. And the more that we can show them data, the more that we can show them how to get there, the more that we can make it easier to follow certain EBM's or protocols and you know, best practice processes, then they will get on board. They want to do the right thing. So—

Cleary: Okay.

Diller: So how do we help them do that?

Cleary: Okay. So, they don't, I mean, all their time is spent seeing patients and being experts on being doctors, they don't have time to, you know, deal with the state but much less learn the game of dealing with the state. So that's your job.

Diller: That's what we want to help them do, right.

Cleary: Okay.

Diller: Yeah, because we can bring in the resources and the infrastructure to understand what is being asked of us. And then support them in their practices to accomplish it.

Cleary: Okay.

Diller: And ultimately, if we have outliers become the enforcer, I guess, you're right. That's the role that we have to play if people aren't getting on board. But I think that we will have very few of those types of folks. And when you sit with a mid-level providers, you sit with the nurses, you sit with the doctors, they all want the best outcomes for their patients. That is their number one priority. So I think, you know, if you can show them ways and how to do that and give them, give them information to help them do that better, they'll get on board. They are all here for the right reasons, you know.

It is noteworthy that the network COO describes doctor's acceptance of payers' reforms as "the right thing". When he says he believes most network doctors "want to do the right thing", he seems to mean that these doctors are willing to conform to the wills of the executives and the payers.

Although he and his executive colleagues clearly embrace the payers' reforms, the COO stressed that it is the payers, not the network executives, who are calling for these reforms. In the following quotation, he explains his role "an enabler":

And you know, I am the guy in the suit that comes into the office and they assume that is what we need to do because administration is saying that. But you know, it's not us. We're being asked at the hospital for the same thing from Medicare and from the commercial payers. 'You need to reduce your costs. You need to show us better outcomes. And if you can do that, we will start to share some of those savings with you. And that's the way that you are going to be incentivized in the future. You are not going to get increases year over year on our reimbursement to the hospital.' That's what the payers are saying. 'You need to start thinking this way.' Okay, so how do we shift our thinking and shift our investment and resources to accomplish that. So I look at it more as an enabler position than an enforcer. You know, we have to meet those standards, but we have to make it easier for the providers to do that (Diller).

DISCUSSION

This is the second of two studies conducted on two hospitals inside a single hospital network. The first study found that doctors in Landahl Hospital's Department of Internal Medicine are greatly concerned by their hospital's recent merger into the Yankee Health Network. The merger has underscored the one thing they value more than anything else in their jobs: their beloved workplace culture. The present study focused on four network executives (3 MD's and one non-MD) who have spent most or all of their careers at Stewart Hospital. It found that these individuals, like the doctors from the first study, view the merger as a necessary event: That is, if the hospitals did not merge, each would suffer financially, and risk eventual closure.

The additional ways, however, in which each executive justified the merger revealed a coordinated effort by Yankee Health Network's executives to actively embrace payer-led reforms and demands for change (regarding the ways that doctors are paid and the ways providers [i.e. medical workplaces] report patient information to health insurers) – an effort that Landahl Hospital doctors perceive to be overly aggressive and draconian. The sociological significance of this study is in its revealing how an organization's executives derive their power from externally imposed pressures and calls for action. Payers' demands do not limit the hospital executive's professional power in the same way that they impact a doctor's professional autonomy. On the contrary, they strengthen it. American health insurers are the original source of current healthcare reforms; however, hospital executives have self-interest to embrace these reforms (beyond their own paychecks) because they provide the moral, logical, and financial justification for their personal and collective bureaucratic influence and power.

A future study might elaborate Granovetter's (1973) theory on weak ties/strong ties by comparing the different kinds of relationships and motivations that exist within a firm, depending on one's position in the hierarchy. The employees in this study (the doctors) have very strong relationships with colleagues in their immediate workplace. In contrast, their employers (especially the network CEO) possess relationships with actors outside of the firm. Indeed, the CEO revealed that most of his job is outward, or external, facing and involves interactions with executives of private insurance companies as well as deans of medical schools (in addition to a list of other external actors including but not limited to state government officials⁷¹). That is to say that the network and social bonds connecting employees in this study are comprised of strong ties, whereas executives' relations are both a mix of strong and weak ties. Whereas the doctor is more intrinsically motivated, the executive is comparatively more extrinsically driven. One could expand Granovetter's work by integrating it with theories on motivation, such as those by Deci and Ryan, as well as theories on social interactions, such as Randall Collins's Interaction Ritual Chain Theory. Both sets of theories complement Granovetter's work insofar as each theory looks at a separate, but interrelated, aspect of the social dynamics of the employee-employer relationship within an organization (IRC theory explains the interaction between employee and employer; reward/motivation theories explain the motivations of both actors in the interaction; and Granovetter's theory extends the emerging understanding beyond the interaction between employer and employee by examining the relations amongst each set of actors [i.e. the relations amongst employees, and the relations amongst executives as well as between executives and external actors]).

⁷¹ Relations between state officials and YHN executives are "cool" and, in some instances, overtly controversial (but a relationship exists nonetheless).

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CHAPTER 5

CONCLUDING THOUGHTS ABOUT THE LIMITS OF PROFESSIONAL AUTONOMY

The “modern bureaucracy” has been sociologically relevant since Max Weber and Frederick Taylor separately wrote about scientific rationalism and bureaucratic influence in the early 20th century⁷². Applications of bureaucracy research have been diverse, ranging from the professions (such as public education and healthcare) to the bureaucratization of the mafia (Haller 1992). A good deal of sociological research in the late 20th century and early 21st century has concerned itself with making bureaucratically structured organizations more bureaucratic (more efficiently managed). Structural-functionalist perspectives dominate this research. There is also a considerable body of literature (though not quite as much) that is phenomenological, and attempts to understand how individuals experience phenomena in their workplaces. Such literature is generally ethnographic and symbolic interactionist in nature and design and usually focuses more on the experiences of employees than the experiences of employers.

The participants in this study reveal professional autonomy to be a multi-layered phenomenon. Professional autonomy can also be a social construction and a shared experience. Landahl Hospital doctors illustrated this idea, with prideful and fearful responses about their beloved workplace culture; Bridgton’s teachers similarly demonstrated a collective sense of pride in their very autonomous workplace.

An individual’s sense of professional autonomy is a product of the individual’s professional environment, specifically, the external and internal bodies that respectively fund and

⁷² Scholarly interest on bureaucracies likely predates Taylor (1914). The purpose of this statement, and this section, is to provide a brief history of sociological literature on bureaucracies, and to establish a beginning point of my sociological analysis on bureaucracies. I am not attempting to provide an exhaustive historical account of scholarly interest on bureaucracies.

manage the individual's workplace. More importantly, each workplace is structured according to the needs of the external funder at a particular historical moment: Autonomy in public education is presently a function of public sentiment (i.e. measures of student academic performance and the resulting effects on the politicians and educational bureaucrats whose jobs depend on student performances); hospitals are affected by monolithic pressures, coming from payers, to constantly cut their costs. Individual public schools win professional autonomy for their members (teachers and principal) vis-à-vis superior student academic outcomes. Hospitals earn professional autonomy for doctors and executives by outcompeting (and "out-conforming") rival hospitals in the high-stakes game of cost minimization. Individuals and organizations within each field that deliver external funders that which they desire (political goodwill or lowest costs) are declared "winners" by their respective external bodies. Their "prize" is professional autonomy (those who fail to win do not get as much of the prize).

A common sentiment expressed in discussions about public education and healthcare in America, by practitioners and the popular public at large, is the idea that any argument or opinion about either institution is best advanced by explaining how said argument or opinion leads to "better outcomes" for students and/or patients. This pervasive and unexamined presumption has infiltrated American discourse. Turn on the TV and listen to a discussion on CNN (or FOX, MSNBC, CNBC, PBS, etc., etc.) about public education in America, and you are likely to hear any number of different ideas on how "we" should reform our schools in ways that maximize "student achievement" (at the moment, charter schools and "school choice" seem to be garnering the most headlines). Attend a parent teacher organization meeting, and you are likely to hear similar, redundant (though passionate) protestations of "doing what's best for the kids." You are just as likely to hear this sentiment in a TV program as you are to read it in scholarship

on public education: If it leads to “better outcomes” and “higher achievement” for students, then it is a good idea or argument. Similarly, popular and academic consciousnesses assume that any healthcare reform that is worth talking or writing about must be rooted in patients’ interests. Such discourse belies what should be intuitively recognizable: the people in these professions are not sacrificial lambs; they are like any adult who possesses their own, self-oriented needs. But this point struggles to see the light of day in America because it is deemed selfish and un-noble.

Sociological literature on bureaucracies reflects and indeed strengthens this popularly held sentiment. This is particularly true of structural-functionalist works like the ones that were summarized in this dissertation. Symbolic-interactionist works are not immune either. Like the layperson, this research assumes bureaucracies to be highly instrumental entities that can be manipulated in order to achieve particular outcomes. As iterated throughout this dissertation, such thinking pursues general goals of efficiency and profit maximization; specific goals include “reforming America’s public schools” and “revolutionizing the way healthcare is delivered in the United States.” Weber (2010) argued that bureaucracies were the most powerful invention to ever seek and attain humanity’s economic and social goals. However, the problem with the popularly and scholarly held sentiment (that the purpose of a bureaucracy is the attainment of goals in service of others) is that it ignores a significant component of them: employers’ and employees’ needs and wants. Sociologists of work who employ a symbolic-interactionist framework, such as Gary Alan Fine, tend to focus exclusively on employees but not employers.

Employees interviewed for this dissertation were sympathetic to the needs of their employers. Their pursuit of emotional fulfillment did not prevent their awareness of and support for the employer’s goals. Despite incredible frustration and burnout, Principal Eric Smith is a “team player” who follows the orders of the Louisiana State Department of Education and the

local school board. "...I mean I understand, well, if they're giving us the money, then they ought to be able to tell us [what to do]..." (Smith). And, despite strongly resenting the way in which the recent merger was handled, the doctors from Landahl Hospital's Department of Internal Medicine believe that merging with another hospital was necessary for financial survival (even though many might wish it had not been with Stewart Hospital). Although their primary sense of fulfillment and identity is associated with patient care, they believe not only that a hospital has to have its business affairs in order, but that a good doctor accepts this reality. A Landahl doctor embodies their measured acceptance of business-related needs, "... [O]ur residents are much more aware of the business of medicine than I was... when I was a trainee 20 years ago now... I think that that's actually a good thing" (M. Kepler).

Throughout all three studies, I found interviewees to possess a similar mindset that balanced the realities of employed work with their own personal needs of fulfillment. Each interviewee expressed some professional desire, and their descriptions of their professional desire informed their experiences with, and their conception of, "professional autonomy." The interviewees did not strike me as radicals, deviants, or even "odd." They are mainstream, everyday Americans. I found many to be compassionate, empathetic, and intelligent. Yet not once during the course of my research did any interviewee support their claims by referencing "the good of the students" or "the good of the patient." They spoke of professional autonomy as if it is necessary to the performance of their work. They believe they do their best work when they possess sufficient autonomy.

The interviewees in this dissertation demonstrate that a bureaucratically structured workplace is more than just a black box of efficiency and profit (even if it is "the greatest human intervention" toward the realization of those purposes, as Weber [2010] once prognosticated). It

consists of fears and desires, of camaraderie and conflict, of employees and employers. Both groups desire professional autonomy, and both groups often wish they had more of it. All the professions studied in this dissertation – teachers, doctors, school principals, and hospital executives – possess perceptions about their level professional autonomy that are molded by people, organizations, and forces that are outside of their profession.

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APPENDIX A INSTITUTIONAL APPROVAL (EDUCATOR'S STUDY)

Application for Exemption from Institutional Oversight

Unless qualified as meeting the specific criteria for exemption from Institutional Review Board (IRB) oversight, ALL LSU research/projects using living humans as subjects, or samples or data obtained from humans, directly or indirectly, with or without their consent, must be approved or exempted in advance by the LSU IRB. This Form helps the PI determine if a project may be exempted, and is used to request an exemption.



Institutional Review Board
Dr. Robert Mathews, Chair
203 B-1 David Boyd Hall
Baton Rouge, LA 70803
P: 225.578.8692
F: 225.578.6792
irb@lsu.edu | lsu.edu/irb

- Applicant, Please fill out the application in its entirety and include the completed application as well as parts A-E, listed below, when submitting to the IRB. Once the application is completed, please submit two copies of the completed application to the IRB Office or to a member of the Human Subjects Screening Committee. Members of this committee can be found at [http://appl003.lsu.edu/osp/osp.nsf/\\$Content/Humans+Subject+Committee?OpenDocument](http://appl003.lsu.edu/osp/osp.nsf/$Content/Humans+Subject+Committee?OpenDocument)
- A Complete Application Includes All of the Following:
 - (A) Two copies of this completed form and two copies of parts B thru E.
 - (B) A brief project description (adequate to evaluate risks to subjects and to explain your responses to Parts 1 & 2)
 - (C) Copies of all instruments to be used.
 - If this proposal is part of a grant proposal, include a copy of the proposal and all recruitment material.
 - (D) The consent form that you will use in the study (see part 3 for more information.)
 - (E) Certificate of Completion of Human Subjects Protection Training for all personnel involved in the project, including students who are involved with testing or handling data, unless already on file with the IRB.
Training link: (<http://cme.cancer.gov/clinicaltrials/learning/humanparticipant-protections.asp>.)

1) Principal Investigator: Joseph Cleary Rank: PhD Student Student? Y/N Y

Dept.: Sociology Ph: 2037336259 E-mail: joecleary28@yahoo.com

2) Co Investigator(s): please include department, rank and e-mail
* If student, please identify and name su this spat

Dr. Susan Dumais (Supervising professor)
Department of Sociology
(225) 578-5347 dumais@lsu.edu

Title: Public Freedom in Baton Rouge: A Study of Teacher and
School Autonomy

Study Exempted By:
 Dr. Robert C. Mathews, Chairman
 Institutional Review Board
 Louisiana State University
 203 B-1 David Boyd Hall
 225-578-8692 | www.lsu.edu/irb
 Exemption Expires: 8-11-2011

4) LSU Proposal?(yes or no) No If Yes, LSU Proposal Number _____
 Also, if YES, either This application completely matches the scope of work in the grant
 OR
 More IRB Applications will be filed later

5) Subject pool (e.g. Psychology Students) High School Teachers and Principals
 • Circle any "vulnerable populations" to be used: (children <18; the mentally impaired, pregnant women, the aged, other). Projects with incarcerated persons cannot be exempted.

6) PI Signature Joseph Cleary ** Date 8/23/2011 (no per signatures)
 **I certify my responses are accurate and complete. If the project scope or design is later changed I will resubmit for review. I will obtain written approval from the Authorized Representative of all non-LSU institutions in which the study is conducted. I also understand that it is my responsibility to maintain copies of all consent forms at LSU for three years after completion of the study. If I leave LSU before that time the consent forms should be preserved in the Departmental Office.

Effective August 1, 2007, all Exemptions will expire three years from date of approval, unless a continuation report, found on our website, is filed prior to expiration date

IRB# ES47 LSU Proposal# _____
 Complete Application
 Human Subjects Training

Screening Committee Action: Exempted <input checked="" type="checkbox"/> Not Exempted _____ Category/Paragraph _____		
Reviewer <u>Mathews</u>	Signature <u>Robert C Mathews</u>	Date <u>9/17/11</u>

APPENDIX B INFORMED CONSENT (EDUCATOR'S STUDY)



Consent Form

Study Title:

Academic Freedom in Baton Rouge: An Ethnographic Study of Teacher and Principal Autonomy

Performance Site:

The actual sites of 2-4 local, Baton Rouge Area high schools.

Investigators:

Joseph Cleary (Principal Investigator), Phone number: XXX XXX XXXX

Dr. Susan Dumais (Supervising Professor), Phone Number: XXX XXX XXXX

Purpose of the Study:

The purpose of this study is to better understand how important teachers and principals view autonomy as it relates to their ability to do their jobs. I am also seeking to compare the relationship between school sector (private vs. public) and autonomy with the relationship between student's socioeconomic status and autonomy.

Subject Inclusion:

5-10 Teachers at each school, as well as the principal of each school. Teachers are selected by the principal. I will ask principals to select two master teachers, two beginner teachers, and two random teachers.

Number of Subjects:

15-40 subjects

Study Procedures:



This study has two phases. One phase will consist of teachers and principals completing a survey. This will take approximately 10-15 minutes. The second phase consists of a video-taped interview which will last approximately 15-25 minutes.

Benefits:

Teachers and principals will receive credit in the video ethnographic documentary that will be created with the taped interviews (credit will be given anonymously; i.e. "I want to especially thank the teachers and principal of XXX XXXX High School for the time and effort which they graciously gave for the making of this film").

Risks:

Since teachers and principals are going to discuss their opinions about their schools and working environments on film, they risk saying something that may upset a boss or colleague. (Suppose, for example, if a teacher exclaims, "I have no autonomy at this school! I can't stand it here!"). If I believe a subject has said something that may get him or her into trouble, I will do one of the following: 1) Discard the footage; or 2) Keep the actual remark(s) and hide the identity of the subject. I will further minimize risks by not disclosing the name of the school where each teacher and principal works (I will only mention school name in credits).

Right to Refuse:

Subjects may choose not to participate or to withdraw from the study at any time without penalty or loss of any benefit to which they might otherwise be entitled.

Privacy:

Results of the study may be published, but no names or identifying information of individuals will be included in the publication. Subject identity will remain confidential unless disclosures are required by law.

Signatures:

The study has been discussed with me and all my questions have been answered. I may direct additional questions regarding study specifics to the investigators. If I have questions about subjects' rights or other concerns, I may contact Robert C. Matthews, Institutional Review Board, (225) 578-8692, irb@lsu.edu, www.lsu.edu/irb. I agree to

participate in the study described above and acknowledge the investigator's obligation to provide me with a signed copy of this consent form.

Subject Signature: _____ Date: _____

**APPENDIX C
INSTITUTIONAL APPROVAL (DOCTOR'S STUDY)**

ACTION ON EXEMPTION APPROVAL REQUEST



TO: Joseph Cleary
Sociology

FROM: Dennis Landin
Chair, Institutional Review Board

DATE: July 8, 2015

RE: IRB# E9414

TITLE: The Relationship between Patient Socioeconomic Status and Physician Autonomy

Institutional Review Board
Dr. Dennis Landin, Chair
130 David Boyd Hall
Baton Rouge, LA 70803
P: 225.578.8882
F: 225.578.5883
irb@lsu.edu | lsu.edu/irb

New Protocol/Modification/Continuation: New Protocol

Review Date: 7/8/2015

Approved **Disapproved**

Approval Date: 7/8/2015 **Approval Expiration Date:** 7/7/2018

Exemption Category/Paragraph: 2a

Signed Consent Waived?: No

Re-review frequency: (three years unless otherwise stated)

LSU Proposal Number (if applicable):

Protocol Matches Scope of Work in Grant proposal: (if applicable)

By: Dennis Landin, Chairman 

**PRINCIPAL INVESTIGATOR: PLEASE READ THE FOLLOWING –
Continuing approval is CONDITIONAL on:**

1. Adherence to the approved protocol, familiarity with, and adherence to the ethical standards of the Belmont Report, and LSU's Assurance of Compliance with DHHS regulations for the protection of human subjects*
2. Prior approval of a change in protocol, including revision of the consent documents or an increase in the number of subjects over that approved.
3. Obtaining renewed approval (or submittal of a termination report), prior to the approval expiration date, upon request by the IRB office (irrespective of when the project actually begins); notification of project termination.
4. Retention of documentation of informed consent and study records for at least 3 years after the study ends.
5. Continuing attention to the physical and psychological well-being and informed consent of the individual participants, including notification of new information that might affect consent.
6. A prompt report to the IRB of any adverse event affecting a participant potentially arising from the study.
7. Notification of the IRB of a serious compliance failure.
8. **SPECIAL NOTE:**

**All investigators and support staff have access to copies of the Belmont Report, LSU's Assurance with DHHS, DHHS (45 CFR 46) and FDA regulations governing use of human subjects, and other relevant documents in print in this office or on our World Wide Web site at <http://www.lsu.edu/irb>*

APPENDIX D INFORMED CONSENT (DOCTOR'S STUDY)



“INFORMED CONSENT”

This document explains my interview-based study. By signing it (bottom of next page), you indicate that you consent to participating in it as an interview subject. Note that:

This study has been approved by the Institutional Review Board (IRB) at Louisiana State University.

Study details

1. Study Title: The Relationship between Patient Socioeconomic Status and Physician Autonomy
2. Performance Site: Various places of medical care in XXXX XXXXX including but not limited to: a large, urban hospital; a community health center; and various stand-alone private practices.
3. Investigators: Mr. Joseph Cleary (Head Researcher) and Dr. Wesley Shrum. The head researcher is available for questions about this study, M-F, 09:00 a.m. – 05:00 p.m. The researchers contact information is:

Mr. Joseph Cleary
Jclear1@lsu.edu
XXX XXX XXXX
Department of Sociology
Louisiana State University
Baton Rouge, LA 70802

Dr. Wesley Shrum
Shrum@lsu.edu
XXX XXX XXXX
Department of Sociology
Louisiana State University
Baton Rouge, LA, 70802

4. Purpose of the Study: The purpose of this interview is to determine whether or not a relationship exists between patient socioeconomic status and physician autonomy, and, if so, how and why this is so.
5. Subject Inclusion: Medical professionals over the age of 18.
6. Number of subjects: 20-35
7. Study Procedures: This study consists of in-person interviews lasting 20-40 minutes with each participant/subject. In most cases, only one interview is conducted with each participant (however, when

necessary, follow-up interviews and/or conversations will be conducted). Each interview is recorded with an audio recording device (cellular phone application). Audio files of interviews will be kept in secure location to which only the Head Researcher has access.

8. **Benefits:** This study may yield important insights into the delivery of medical care in the United States.
9. **Risks:** The only study risk is the publication of sensitive information yielded in the interview (the interview deals with questions related to subject's opinions about their work experiences). However, every effort is undertaken to thoroughly protect and maintain the complete confidentiality of all subjects.
10. **Right to Refuse:** This is a voluntary interview. Subjects may choose not to participate or to withdraw from the study at any time without penalty or loss of any benefit to which they might otherwise be entitled.
11. **Privacy of Study Participants:** This is an anonymous interview. Results of the study may be published, but no names or identifying information will be included in the publication. Subject identity will remain confidential unless disclosure is required by law.
12. **Privacy of Your Organization:** If you wish to keep the name of your organization anonymous, check the box below. If you do not check this box, you acknowledge that the name of your organization may be identified by the author in his writings (published academic journal article, PhD dissertation, etc.).

Yes. I would like my organization's name to remain completely anonymous.

13. **Signature:** The study has been discussed with me and all my questions have been answered. I may direct additional questions regarding study specifics to the Head Researcher, Joseph Cleary. If I have questions about subjects' rights or other concerns, I can contact Dennis Landin, Institutional Review Board, (225) 578-8692, irb@lsu.edu, www.lsu.edu/irb. I agree to participate in the study described above and acknowledge the Head Researcher's obligation to provide me with a signed copy of this consent form.

Subject Signature: _____

Date: _____

**** This study has been approved by the Institutional Review Board (IRB) at Louisiana State University.***



VITA

Joe Cleary was born in 1980 in the United States. His scholarly interests include the sociology of workplaces, inequality, public education, social psychology, qualitative methods, philosophy, and the history of sociology. As a teacher, he is driven by a desire to entertain his students' intellectual curiosities (in the role of a performer), and pursue intellectual challenges with them (in the role of a mentor). He expects to graduate with a Doctorate in Sociology in the spring of 2016, and is currently pursuing teaching positions in and outside of the United States.