

THE EFFECT OF THE MEDICAL REFERRAL
SYSTEM ON MANPOWER DISTRIBUTION AND COST

by

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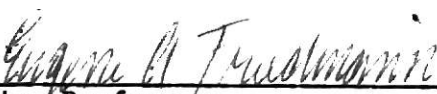
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CHAPTER I

Social Organizational Perspectives on the Health Care Delivery System

OVERVIEW

The health care delivery system of a society is a product of the history and tradition from which it comes. The U. S. system has evolved as a combination of private practitioners, high technology and independent organizations. This grouping has created a complex delivery system which, in the last few years, has been characterized by non-integrated operations of the elements of the system resulting in inefficiencies and increased costs. The escalation of the cost of medical care has become a matter of national concern. The problem is highlighted by data from the U. S. Department of Health and Human Services as reported in the "U. S. News and World Report" (September 1, 1980). These new government projections show that in the 40 years, from 1950 to 1990, medical costs will have increased 50 times over, from 12.7 billion dollars in 1950 to an estimated 757.9 billion dollars in 1990. This amount was 4.5 percent of the nation's gross national product in 1950, in 1980 the percentage of the GNP spent on medical care was expected to be 9.5 percent and this amount could reach 11.5 percent by 1990. We are spending an increasing share of our resources on health and the amount is expected to continue to rise. In spite of the technological capability of the U. S. and the wealth of resources spent a substantial portion of the population does not have minimally adequate care (Coe, 1970: 350). More money and more legislation to control the system have not solved the problems of cost of health care or access to that care.

The element of the system most important is the physician. He works in a fee-for-service system in which he is free to choose where and in

what field he will practice and what he will charge for services, a highly attractive position for the physician. Other elements of the system include public and private health insurance companies which pay "usual and customary" fees charged by the physicians and hospitals, and which fail to monitor and determine whether or not the charges made are appropriate. Excessive charges inflate cost. Availability of insurance has also increased the demand for services by the public. Hospital administrators, a third element, manipulate the insurance system for the benefit of their institutions (Institute of Medicine, 1976: 57). A fourth element, medical training schools, socialize their students into the professional's desire for autonomy (Mechanics, 1974: 16), and emphasize giving the best technical care possible--the only constraint is the "state of the art"--without consideration of cost. The training schools set standards of professional performance. There are increasing numbers and types of allied health workers, physician assistants, nurses, therapists, being used for improved and increased services. As new or enlarged groups they add to the cost and complexity of managing the system. These several elements, and others, working without adequate communication and coordination become the system typified by inertia, inefficiency and tremendous cost.

The reasons for the fragmented system are many. There have been enormous developments in medical knowledge and technology. This has spurred specialization, particular categories in medical practice. One reason given for the increase in specialization is that it is more comfortable and more easily possible to be competent in a limited area than competent in the full field of general medicine which has so enlarged. As knowledge has increased, so have methods of treatment increased and

become sophisticated. There has been a dramatic increase in medical technology (diagnostic X-ray, radiation therapy, electronic monitoring), which leads to continual changes in patterns of health services as new ones are introduced or old ones become obsolete and others are changed. Such technology calls for technicians to operate the equipment and administrators to coordinate their use. In this way the body of health workers proliferates and division of labor becomes more pronounced. Added pressure is applied to the system by a public which is becoming more knowledgeable about seeking care (Cockerham, 1978: 76) and has financial access due to health insurance. These forces, then, contribute to the uncoordinated system which consists of many groups with conflicting interests and no central direction.

FEE-FOR-SERVICE SYSTEM

Professionals and the public are seeking ways to understand and improve the system. A rational first step in understanding would be to put the medical professional's contribution in perspective. Scarcity economics points to the fact that resources, in the world, are scarce in relation to human wants, and we cannot all have everything that we want. This is true, as well, of health care. Some method is used to divide among the population the existing amount of health care. In the U. S. availability of medical care has been dependent on the ability to purchase it. As Mechanic (1979: vii) says, we have been rationing our medical care with our fee-for-service system. This system is oriented toward the professional where the physician is an entrepreneur in a free market. This has resulted in access to care being dependent on ability to pay. The physician has become autonomous in his field and has

developed a monopoly for the licensed physician--the prototype of a professional. The physician's usual amount of influence or his autonomy is acquired by being a member of an organized profession. A profession is defined by Ritzer as an occupation which has been able to acquire or convince others (clients, law) that it has acquired many characteristics the public comes to believe describe a profession. Goode (Cockerham, 1977: 116) says there are two basic characteristics necessary and basic to the profession: prolonged training in abstract theory and a service ethic.

THEORIES OF PROFESSIONAL ORGANIZATION

There are various theories that look at the ways groups organize as a profession. Parson's structural-functional approach (Ritzer, 1977: 48) suggests that the community and the law recognize professions as having a special body of theory in an area where outside control would reduce the quality of performance. The professional is accepted as being altruistic and requiring authority over the client. The power-process approach (Ritzer, 1977: 56) suggests physicians obtain a set of rights and privileges from the community that would not otherwise be granted them because they work in an area of uncertainty (life, death) and because this work cannot be routinized. Freidson suggests the social-structural approach which emphasizes organization of environment rather than individual's knowledge, values and motives as most important.

Another step toward the understanding and improvement of the health care system would be to isolate and evaluate separate aspects of professional organization. The most prominent aspect of current medical organization is the division of physicians into specialties and sub-specialties (Stevens, 1971: 3). These specialties need communication

with other specialties and general practitioners alike. The referral system is a technique for communication and cooperation among physicians which make possible a professional division of labor. The experts or specialists may become consultants to the non-expert in the specialists' field. The concept of referral impacts upon the larger system of medical professional organization in at least these two ways. It affects the number and distribution of general practitioners and specialists in the health care system because professional status and success are defined in terms of being able to refer to other physicians those cases not desirable or interesting (Freidson, 1971). The referral system is also open to economic and other abuses as the professional looks to his own dollar income and protects the particular special area from which this income and his prestige arise.

The following pages will look at specialization and the referral system by 1) comparing the social-structural theory of organization, which suggests that changes can be made in the delivery system with changes in the social structure of the system, with the power approach which suggests that the power of the professions is exaggerated and is likely to decline in the future, 2) examining the history and characteristics of the referral system, 3) looking at access to care and abuses in the system, and 4) detailing the long range planning process of a local medical society and analyzing the plans in terms of the power approach to organization.

THE SOCIAL-STRUCTURAL AND POWER APPROACHES

A PROFESSION

Eliot Freidson employs the social-structural approach for analysis of professions. He uses social organization concepts as his criteria

for evaluation rather than social psychological norms, attitudes or ethics. He sees organization as being more closely related to predicting behavior than are individual characteristics. He chooses to use the medical profession as the basis of study because of its position of prominence among professions. Freidson feels medicine has acquired this pre-eminent position because of its systematic connection with science and technology, the prevailing ideology of the twentieth century.

Medicine, for this sociological usage, is defined as "an organized consulting occupation which may serve as discoverer, carrier and practitioner of certain kinds of knowledge." It is not simply a body of knowledge but an occupation. An occupation which, in this instance, is a profession.

Freidson uses this definition of profession: "it is an occupation which has assumed a dominant position in a division of labor, so that it gains control over the determination of its work." Autonomy is the most important criteria in distinguishing professions from other occupations (1971: 82). The occupation maintains its position by persuading others of its unusual trustworthiness and skills in its field. When an occupation deals with problems brought in by clients (consulting profession) the occupation develops its own way of looking at the problems and tries to manage both problems and client. The practitioner's autonomy allows him to interpret the problem his way rather than the client's way. Autonomy also means that outside evaluation of the profession's work is not legitimate.

Freidson argues with Goode's criteria for professions, prolonged training in abstract theory and a service ethic. He feels that prolonged training in abstract theory is not precise. It is not training in theory

but control of the condition of their work which characterizes a profession. Nursing is an occupation which has prolonged training in abstract theory, however, nurses work under the supervision of a physician. Goode excludes them from professions because their training is "a lower-level medical education" but Freidson says the difference is that physicians not nurses define the work area. Nurses do not control the content of their work--they are not autonomous--they are not a profession. Technical training does not provide the criteria for a profession but rather control of the content of training which is gained by political and social processes. Freidson argues that the stated ethic of service to the community is not adequate to define a profession because there is no empirical data to show that the service ethic is stronger and more widespread in the professional than other groups. Goode argues that while nursing is not a profession, it has a service ethic. The assertion of a service ethic for the individual physician or for the "institution of medicine" is unsupported by evidence. These arguments improve Freidson's claim that autonomy is the only uniform criteria for a profession.

Freidson sees two major problems to be analyzed, how is autonomy developed and maintained, and what is the relationship between the professions knowledge and procedures (practice) to the professional organization, and to the lay world. The following pages will examine autonomy, social control or accountability, and authority or physician-patient relationship in the social-structural framework.

AUTONOMY

Describing the characteristics of professions, Freidson provides this preface. The aim of healers has not changed over the centuries,

but the position of the healer has changed. The physicians of the Western world, as opposed to folk-healers, came out of the universities of the middle ages and they were a scholarly or learned group who were respected as educated members of the elite, but had little authority as healers. It wasn't until the development of physics and chemistry that there was a systematic scientific foundation for medicine. These bodies of theory allowed physicians to give technical reasons rather than individual judgments as causes of illness. As technology improved it became clearer to the public that there were predictable and reliable results from medical care. Physicians could solve practical problems brought to them. In the United States, by the 1890's, the public was willing to accept a consulting profession of medicine and physicians began occupational organization. The professional societies gained recognition from the state and negotiated with the state to gain control of their work. The state delegated authority to the medical professional organization and they became a monopoly in the healing arts. They became the basic, formal, quasi-legal framework through which the profession controlled itself (licensing is one example). The organizations are private, national, and loosely organized with firm roots (chapters) at the local level. The American Medical Association is the greatest single influence on medical care in the United States. The A.M.A. is important because it has power to control other occupations, control medical schools and thereby set minimum standards for the profession and control access to training. The A.M.A. also attempts to control the socio-economic areas of medical practice. Consequently, the physician is free to practice with a few formal constraints the association has not instituted. The A.M.A. argues that if the present, individualistic, fee-for-service

organization of care (preferred by the A.M.A.) is interfered with, the quality of medical practice would be in danger.

Freidson argues, in spite of the strict control by the profession of the profession that the autonomy is not absolute. In the United States the states themselves are the final authority in their geographical area. The individual physician practices in a "social and political space cleared and maintained for his benefit by political and formal occupational mechanisms" (Freidson 1971: 24). The control is political in character and subject to the state. Freidson feels, in opposition to the A.M.A. policy, that a professional need not be an entrepreneur to be free. The state can control the social and economic areas that the professional now dominates and in the process leave the profession intact. The profession would have control over technique and skill and monopoly over practice in the areas where it has expertise--that is, to diagnose and prescribe according to criteria rooted in medical knowledge. The physician determines what is medically valuable; he is not, however, competent to decide what is in the public interest outside his expertise. "Autonomy of technique is at the core of what is unique about the profession," (Freidson, 1971: 44). Autonomy over technical work gives the profession the necessary characteristics to be a "free" profession, even though it is dependent on the state to grant autonomy.

ACCOUNTABILITY

In Freidson's view a profession is granted autonomy with the understanding that it will regulate the performance of its membership. Self-regulation is the test of professional autonomy. If the theory that the normal distribution curve represents the distribution of a trait through

a population is accepted, there is no reason to believe that traits of a professional group would not correspond to the curve as well. This signifies that not all physicians work can be expected to be average or better; therefore, regulation is necessary.

There are attitudes common to professionals which influence the way they regulate their work. Individualism is a dominant element in behavior of the medical professional. Practitioners are action oriented--to do something is better than to do nothing. Contrary to lay expectations such intervention tends to revolve around experience as much as scientific theory. This orientation to practice maximizes individual opinion based on experience, and one result is the reluctance of professionals to criticize colleagues or to be criticized. It is considered that mistakes are bound to happen due to the nature of the work. One consequence is that formal sanctions of colleagues are few. The common reaction to poor work by a colleague is the personal boycott. This is not an attempt to change the offender's performance but an attempt to avoid working with him and keeping one's own patients away from the offender. Freidson (1971: 183) says that the personal boycott is "the most analytically important mechanism of control" found among professionals because it shows how one conscientious professional can work aside another who is not conscientious without causing undue tension between the two. The boycotted physician finds a circle of practitioners at his own level of practice and a segregating process is observed. There is little professional contact between such levels, and therefore there is little leverage to influence the performance of the poorer practitioner.

Client complaints are handled in local medical societies which handle them so that the public hears little about them and knows little

of their right to a hearing. Where there is more formal regulation, by peer review of records, the benefit of the doubt is given to the colleague performance, and deficiencies are overlooked in favor of presumed good intention. Physicians have made no effort at regulation of economic policy and little on rectifying abuse. These observations suggest that observation and regulation of the profession by itself is at a minimum.

AUTHORITY

Freidson looks at the client-professional relationship and sees that it is a mixture of professional authority and elements of bureaucratic office. The physician expects compliance with his decisions through faith in his expertise, gained through scientific training. This is a special type of authority predicated upon trust in the "profession" and not necessarily in the competence of the individual physician. The consulting professional seeks this authority when dealing with clients because he may be pressured to yield to clients wishes when the professional feels them inappropriate, but with professional authority he can refuse claims by use of this authority rather than explaining and persuading the patient that his professional judgment is well grounded. The professional expert normally has only the authority to withhold services the client wants. In the case of the medical expert he controls not only the knowledge and skills but also the exclusive rights to goods and services (drugs, hospital care) the client might need to manage his problem independently. "The more strategic the accessories controlled by the profession, the stronger the sanctions supporting its authority" (Freidson, 1970: 117). This institutionalized practice (through licensing and control of facilities) limits and channels the behavior of the layman

into consulting with the professional in a situation where he has few alternatives. The emphasis by the physician is not on having the patient accepting advice because the client is persuaded it is valid but accepting because he has faith in the professional's evaluation because he is a professional. Freidson says the professional expert, in this case, acts much like a bureaucratic official who has sanctions attached to the bureaucratic office rather than as an entrepreneur, as the medical profession prefers to be thought of. Freidson has emphasized that the client should have care that is both technically qualified and humane. The technical expert should treat the client with the dignity and status of an adult.

One central concern of the theory arises from the comparison of the professional with the bureaucrat. Recent theory has held that professions and bureaucracies are antithetical processes because professions are characterized by individualism and peer control and bureaucracies by a framework of rules and regulations and control comes from the top. Currently and historically, Weber's analysis, there is recognition that there is no necessary contradiction between professionals and organizations. Professions and organizations are not structurally incompatible (Ritzer, 1977: 151) although when professionals work in organizations there is potential for conflict. One source of conflict for professionals in organizations is that an organization has goals which the professional must contribute to and in so doing he loses some autonomy. Freidson argues that while the bureaucratic type of organization is no more ideal, in practice, than a professional organization, the rights of the patient and quality of care would be better assured by checking the autonomy and dominance of professional authority with the use of administrative authority.

In summary, Freidson's view is that the present system relies too much on the dominant medical authority which does not regulate itself adequately. A reorganized framework is needed which would protect the legitimate needs of the professional while making it necessary that practice be regulated by the professional according to the professional ethic. The citizen-client needs be an active and participating member of the planning and regulatory process.

POWER APPROACH

The power approach to the study of professions focuses on the power needed by an occupation to acquire professional recognition as well as the power such an occupation wields once it has achieved professional status. The power advocates are concerned with the question of why an occupation moves up or down on the continuum reaching from non-professional to professional. Ritzer defines professions, viewed in the power approach, as an occupation having undergone a developmental process whereby it has acquired, or has convinced significant others it has acquired, characteristics accepted as denoting a profession. Ritzer defines power, for this approach, as the ability of an occupation, through its leaders, to obtain a set of rights and privileges from society that otherwise it might not obtain. Power advocates disagree with the characteristics of professions as hypothesized by the functional approach; these characteristics are systematic knowledge, norms of autonomy, and altruism and authority over clients. Power advocates agree that there is no difference in the basic nature of knowledge between the professional and the non-professional although the professions "engage in a systematic effort to create the illusion that there is something distinctive about their knowledge" (Ritzer 1977: 49). Where

qualitative differences are seen to exist, they have been artificially created by the professional's ability to deny knowledge to others. The norm of self-control is challenged by the power approach as, historically, autonomy of occupations has varied with the change in skill content and cultural significance of the occupation (Johnson, 1972: 44). They argue that the code of ethics is not set up to protect the client but to conceal the activities of the professions from the public by being allowed to police themselves. Autonomy is not a requirement of professions, and the service ethic is a myth.

The power advocates further say that "uncontested" authority of the professional over the client has never existed, and whatever authority exists now is likely to decline in the future as clients become more questioning of authority. The argument is made that a questioning clientele is likely to push the professional to a higher and not lower standard of performance. The power approach argues that the professions develop a set of characteristics which they claim in order to set themselves apart from other occupations and in order to establish control over that occupation. The power approach looks for the source of power which permits professions to do this. They focus on three variables of power: the margin of indetermination, the level of uncertainty, and ideology.

The margin of indetermination is a term meaning the degree to which an occupation's task can be broken down to a series of simple actions which most people can learn. Tasks that cannot be so routinized are the basis of professions. A portion of the power of the physician comes from the margin of indetermination. Ritzer says the medical profession has not relied on the natural level of indetermination but has used its

power to protect medical practice from routinization (by a kind of mystification of the public and control of medical accessories) and to expand non-routinization.

A second source of professional power is labeled the level of uncertainty. The physician deals with an area of acute uncertainty for his patients--health impairment. Another area of uncertainty for the patient is created by social distance between a patient and a physician; it also creates a tension or uncertainty (Johnson, 1972: 41). The profession protects and expands these areas of uncertainty by avoiding public scrutiny and by having a political arm in their professional organization. These are two sources of professional power.

Ideology, as a third variable, is the prime tool used by occupations in the effort to professionalize and by the professions to maintain and improve their position. Ideology is the way of thinking, by the public, about the professions. The public has been convinced of the myths of autonomy, service ethic, and authority--so say power advocates. Such myths "become reality when the public and law react as though they are real." Ritzer says the professions have used these idealized characteristics as levers to increase their power and protect their established position from threat to its power. Johnson (1972: 45) seems to summarize, when he defines a profession as a means of controlling an occupation.

Johnson says professionalization is a historically specific process which occupations go through in a particular time and is not a step by step process that all occupations must go through to become a profession. Johnson chooses to look at professions by focusing on the "core of uncertainty," the producer-consumer relationship. He sees three ways, historically identifiable, of resolving the tension between the producer

and the consumer. The first, where the producer defines the need of the consumer, is exemplified by autonomous occupational association, or professionalism, which is an outgrowth of the guild system in medieval Europe. The second, where the consumer defines his own needs, grew from patronage by aristocrats of artists, architects, and physicians in the past. The modern expression of this idea is in consumer politics where consumers deliberately set out to control quality of goods and services. The third way of reducing tension is by the use of a mediator between the producer and the consumer. Capitalism exemplifies one type of mediator which intervenes to rationalize production and regulate markets; another example of a mediative body is the state. A powerful centralized state may intervene to define what the needs are or the manner in which the needs should be met, as with the growth of welfare policies.

One effect of the state type mediation has been to extend services to consumers on the basis of citizenship rather than ability to pay. Another effect has been to "guarantee" consumers to providers. One consequence of the guarantee "is that the referral system which is so important under professionalism in ensuring continuous colleague contact" is less important when the state is mediator. State mediation provides several other opportunities for change. It gives the consumer an expanded role with input into the system, by shifting emphases it could change the distribution of power in the community and could change the basis for recruitment into the profession. Under state mediation, occupations are increasingly taken into government agencies, solo practice may be replaced as the norm, practitioners may be salaried and clients have more control. In addition, the bureaucratic role becomes interwoven with the professionals

in government agencies. "Dualistic systems of practice," a division of labor between general practitioners and specialists, is less likely under hierarchical organization. The result is a proliferation of generalists or creation of separate but equal specialties. Where the function of maintaining standards is taken over by the state, or provided for in legislation, the professional association is transformed into a pressure group and loses its power to prescribe the manner of practice. The mediative role of the state may also lead to technical and ethical questions being removed from the occupation's control. Efficiency becomes the yardstick for comparing forms of organization in the delivery system. The state, then, manages aspects of uncertainty by reducing the possibility of exploitation in both directions.

The power approach assumes there is no qualitative difference between professions and non-professions other than the greater power of the professions. Forces such as social change and technical change impact on professions. The professions will be changed by those forces. Western civilization is moving from an industrial society into a service oriented society. With this change it is probable that controls over the health delivery system will change. Johnson suggests that the strain produced in the system by such forces may lead to modification in the institution of professionalism and eventually reduce and in the long run eliminate the condition of professionalism itself.

COMPARISON OF POWER AND STRUCTURAL APPROACHES

Freidson's structural approach and the power approach to organization of professions are similar although not the same. Both focus on discovering how professions come to control their work area and how they

maintain their control after recognition. Both approaches use the method of inquiry into the relationships among social organizations in order to analyze professions. They analyze the organization of the environment.

The two approaches differ in that they emphasize analysis of different components of the system. Freidson emphasizes, in his inquiry, how autonomy of professions develop and is maintained by describing the relationship between the practitioner and 1) the professional organization, and 2) the lay world. Power advocates inquire into how professions obtain power to be recognized as a profession and how they maintain the power after recognition. Freidson emphasizes relationships at the individual level; power advocates emphasize historical and societal level relationships.

Although the two approaches come to their conclusions by separate routes of analysis, their conclusions are compatible, and possibly complementary. For example, proceeding from separate perspectives both can and do, argue that professional authority must be checked in the interest of the patient through the use of administrative authority.

CHAPTER II

The Growth of Specialization and the Referral System

HISTORY OF SPECIALIZATION

The profession of medicine has developed in the United States over the last one hundred years. Before that time the practice of healing was carried on by trial and error. While Europe had a tradition of physicians with a university degree the first practitioners in the United States were mostly ship's surgeons, apothecaries with apprenticeship training, or New England ministers who prepared themselves for life in the new world. The expanding frontier of the U. S. had the effect of creating practitioners who were, all at once, consultants, dispensers of drugs and surgeons unlike their European counterparts who were consultants only, while other occupations dispensed drugs and did surgery. Governors, planters, college presidents, many educated men gave medical advice because there was little alternative. The first hospital in the U. S. was begun in 1751 for the sick poor, it was also used for educational purposes. Better care was to be had at home so doctors made house calls to see patients. The first medical training school in the U. S., 1765, was in the College of Philadelphia. They offered hospital training in addition to medical studies. Their faculty was influenced by the Scottish Edinburgh Medical College graduates. By 1800 medical schools had mushroomed, many were proprietary schools (non-university) which meant there was no standard quality for physicians. By 1850 it was possible to get a diploma with an elementary education, a few medical courses, plus passing an examination (Mechanic, 1978: 316). State medical societies or the state licensed physicians to practice. In 1860 the average practitioner worked in a rural setting with a private independent practice.

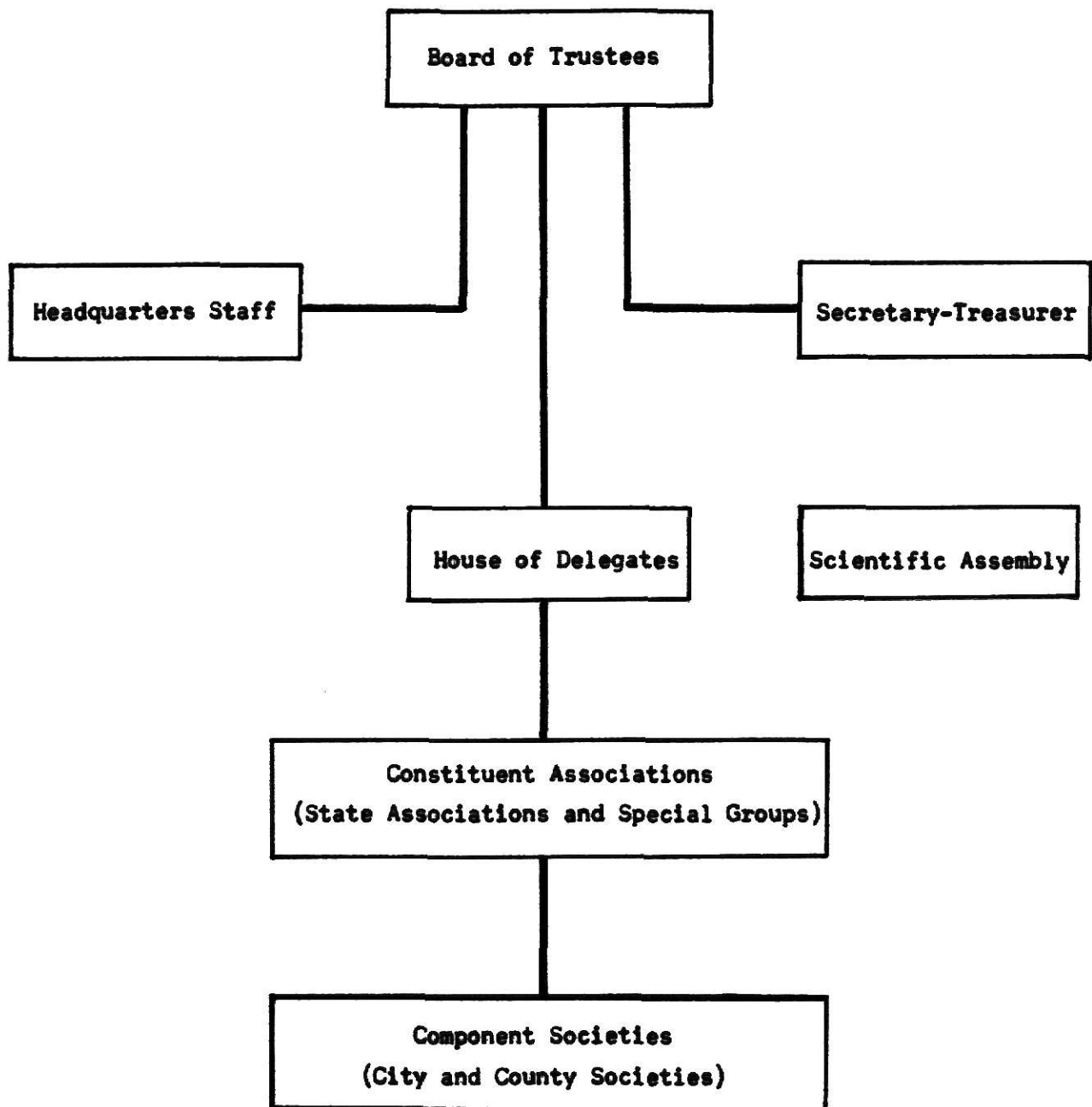
By the mid-1800's the foundation of medicine had changed. Pasteur's germ theory was recognized (although it occasioned much controversy in American medical societies), the stethoscope was invented, antiseptics were used in surgery and endocrinology was defined. By the twentieth century medicine was acquiring its specialized knowledge and becoming scientific. Social changes were affecting medicine as were technical changes. With the immigration and urbanization of the country from 1860 to the 1900's the use of hospitals was stimulated. With the increased use of hospitals medical specialization was stimulated and those who were specialists began to call for organization of the medical community (Stevens, 1971: 34). The American Medical Association (A.M.A.) was begun in Philadelphia in 1847, but did not become influential until it started its own medical journal in 1883. This journal, among 275 others, provided the latest medical information and techniques. A differentiation between general practitioners and others was already apparent. Eminent medical school teachers and the new type of clinical scientist were on their way to becoming specialists with unusual recognition. In 1865 the A.M.A. ruled that no advertisement of skills would be allowed, this in order to reduce competition of specialists with generalists. The case which brought about this ruling also stimulated the A.M.A. to establish a Specialties Committee. Another A.M.A. committee, in 1866, the Committee on Ethics, complained that specialists' fees were too high. In 1864 began the formal organization of specialist groups. The eye specialists established their own society, The American Ophthalmological Society, and other specialties followed. They were scientific groups who met for the purpose of discussing the latest research. By the 1870's the generalists were battling in a competitive market against the growing

technological elite. Also, by this time there was a class of city physicians whose first concern was money and increased social status (Stevens, 1971: 49). They were well educated and often chose specialties because the work was easier and the hours more regular. This type of specialist threatened the generalist in terms of finances and social and professional standing. Medicine was very "commercial" (Stevens 1971: 50), as were other professions at the time. Surgery was a specialty capable of high monetary rewards and "kick-backs" were known, a transaction where part of the fee was returned from surgeon to general practitioner who sent the patient to the surgeon.

The A.M.A. was competing with the specialist organizations that were forming. In 1901 the A.M.A. sought close connections with the state medical associations and its present structure was established. The Board of Trustees is composed of officers of the Association and twelve members of the House of Delegates. The Board implements the policies of the House and manages the Association when the House is not in session. The Secretary-Treasurer is selected from the membership of the Association by the Board and the Headquarters Staff (approximately 850 people in 1970, Coe, 1970: 195) is responsible to the Board. The House meets twice a year and formulates policy ranging from positions on National Health Insurance to comments on U. S. foreign policy. Members of the House are elected from area societies (Constituent Associations) on the basis of one delegate for 1,000 active A.M.A. members. Each Federal service is represented, military, Veterans Administration and the Public Health Service, and one representative from each of the medical specialty sections of the Scientific Assembly. Local physicians belong to their local society which makes them eligible for state and national membership.

Local societies set their own qualifications for membership and there is no appeal from the local societies decision, a very powerful sanction since there is no alternative. Membership in the society affects hospital appointments, referrals, consultations and influence of membership. Local societies had and have powers to enforce conformity at their level. It is difficult to acquire power in the A.M.A. as the House of Delegates (representatives from the states) elect the top officers and the Board of Trustees.

The A.M.A. Journal has remained a powerful tool for the organization, printing their official policies. The focus, in 1901, of the newly organized A.M.A. and the medical schools was to reform and upgrade the standards of entry into the profession. In 1904 the A.M.A. established the Council on Medical Education whose aim was to suggest ways to improve education and to be the agency for implementing change. Supported by money from Carnegie Institute, Abraham Flexnor visited all the medical schools in the country and made a report. His report highlighted the lack of quality in American medical schools. Only three schools, Harvard, Western Reserve and Johns Hopkins were fully approved by the Flexnor qualifications. He suggested standards for entry into medical schools be raised, that schools should have a full time faculty and both laboratory and hospital facilities for the students. He recommended that medical education be conducted by universities on a graduate level, that research facilities be available, and that there be no more than one medical school for a city. The Flexnor Report had a major impact on upgrading medical training and the A.M.A. now became the main source for rating medical schools. They had a monopoly over educational regulation. One effect of this regulation was to limit the supply of physicians.



Organization of the American Medical Association

The emphasis on research increased the orientation toward specialization. By 1920 medicine was the model of professionalism (Cockerham, 1978: 122) with control over their work area by regulating entry into the profession and by local influence on state licensure. States granted licenses to qualifying physicians. After World War I the family doctor was found only in rural areas, scientific medicine had pushed toward specialization. After 1920 the A.M.A. was active in opposing health insurance, although it was common in W. Europe, because they realized that compulsory health insurance was a threat to private practice and struck at the basis of the fee-for-service system. Health insurance would require fee schedules, regulations and possible work review plus the fact that it would set up an organization which would be outside the doctor-patient relationship over which the doctor would have no control (Stevens, 1970: 138). A situation not desired by the professional. By 1929 seven out of ten physicians had privileges to use hospital services and fewer home visits than previously became the rule. There was still no defined referral system from the general practitioner to the specialist. Stevens suggests that the general practitioner could have established control over the central coordinating role in medical care, at this point, by being interested in compulsory health schemes and group physician practice.

With the discovery of antibiotics, hormones, insulin and technical advances in techniques such as blood transfusions, "old" diseases such as typhoid fever and diphtheria were conquered. There were new disease conditions brought to the fore, allergies, diabetes, and arthritis, which called for new specialists. In 1928, 74 percent of practitioners were general practitioners and in 1942 only 49 percent were general practitioners (Mechanic, 1978: 322). The A.M.A. continued to oppose

any government influence in organizing medical care and called such interference "socialist dogma." They had become a protective trade association (Cockerham, 1978: 120). Truman, in 1945, tried to pass a health program but was not successful. This had the effect of reinforcing the existing pattern of laissez-faire medical organization in the U. S. while Europe had linked the producing and functioning of health professionals to estimates of national and regional manpower needs.

The G. I. Bill of 1944, by paying for residency training, stimulated returning veteran physicians to take further training and qualify as specialists. A great demand for specialist training created a greater supply of programs, but without increasing the programs for general practitioners. General practitioners did, however, receive recognition through a section created for practitioners in the A.M.A., a first step toward establishing a specialty board of their own. The A.M.A. made it official policy, in 1947, that hospitals should not refuse staff privileges because a physician was not a board certified specialist (which helped the practitioner). This policy is still in effect. The action came after a court battle between A.M.A. with the Medical Society of the District of Columbia and a group which started a health cooperative in D. C. The A.M.A. excluded the participating physicians from the medical societies and from hospital affiliations. This latter by threatening to withdraw A.M.A. approval of hospital internship and residencies if the hospital accepted the cooperative physicians on staff. The group association sued and the Supreme Court held for the group finding the A.M.A. guilty of restraint of trade under the Sherman Act (Stevens, 1970: 300).

The question of regulation of initial medical training was settled but there was now the problem of deciding who would control specialties.

Additional specialty boards began to organize and the Advisory Board for Medical Specialties was formed whose job was to coordinate the existing specialty boards yet there was much confusion. Each specialty board remained autonomous. The boards certify (allow a doctor to call himself a certified specialist) a physician who completes a certain required training and who passes a special examination in a specific specialty. Board certification, which has no legal status, may bring higher income. The larger boards include many sub-specialties. By 1973 there were 22 specialty boards awarding certificates in those specialties and 45 sub-specialty areas. Establishment of boards for specialties and sub-specialties is as much a political process of monopoly over a special area as it is a concern for quality care for the consumer (Stevens, 1971: 331). The traditional concept of the specialist was as a consultant who helped generalists with problems of some complexity, but present day specialists are involved equally as much with defining their turf. The most recent distortion of the concept of the consulting physician was the creation, in 1969, of a Board of Family Practice. The new family physician was to be an expert in physician-patient relationships and put emphasis on sociological as well as scientific "skills" (Stevens, 1970: 313). This circumstance illustrates the pressure on the professional for peer recognition as well as a desire for increased educational standards. Stevens says that in 1981 (1981, MANHATTAN MERCURY, "The Nation's Health"), 90 percent of practitioners are certified specialists.

The uncoordinated framework of specialty boards is not flexible enough to meet the needs of the dynamic process medicine is experiencing. It is a "byzantine" web of specialties, sub-specialties and examination

boards. There is little open discussion about how such a system affects health care. There are efforts to address the problem. The Advisory Board of Medical Specialties has strengthened its organization and changed its name to the American Board of Medical Specialties, the possibility exists that it could develop into an important forum for medical specialty policies and development. Its old duties were approving new specialty boards, issuing the Directory of Medical Specialists and providing a platform for discussion among the various specialties. The new duties of the board are to generate educational and manpower studies including "proportionate production of medical specialties and their relationship with members of allied health professions" (Stevens 1970: 345), as well as being a representative organization for all specialties including family practice. Stevens sees this development as encouraging but suggests that groups change "not out of committees or structures, but from a combination of personal leadership and outstanding pressures." She adds that specialty boards have never been willing to take responsibility for deciding whether or not the health care system needs more or fewer general practitioners, more or fewer surgeons. The need for such decision will force some organization, government or private or a combination, to assume such responsibility.

REFERRAL SYSTEM

Freidson (1970: 99), in examining the system of referral which is the system which moves patients from one physician to another, usually from a general practitioner to a specialist, suggests that it is an informal organization of the profession which links the formal structure given to the medical profession by the medical associations to the

performance of the individual professional in the work setting. To understand how the informal organization and formal are intertwined gives a better understanding of the profession than to understand the formal association and codes of the profession which have been used in previous assessments. Freidson, for purposes of examination, divides medical practices into categories. The first is called client-dependent practice in which the physician attracts his business by satisfying his lay clientele. In some measure, then, his practice may have to conform to lay standards in order to be successful in attracting clients. Because of competition for clients he may have little cause to cooperate with or observe the work of colleagues. The opposite extreme is the colleague-dependent type of practice which does not attract its own clients, but depends on referrals from colleagues. In this case he must "honor the prejudices" of colleagues and will conform more to professional than lay standards. His work decisions are dictated more by colleague considerations than client considerations.

Cooperative arrangements develop between physicians which are called colleague-networks. Freidson cites Hall's study which describes this system as controlling those who can and cannot enter the network. Those who have come to positions of authority in a community decide, informally, who fills positions that are available, when promotions are to be received and the extent to which one has patients referred to them. Older physicians may sponsor a younger one coming into the community. This introduces the younger physicians into the system but obligates him to do the less attractive work such as night calls, and to fill the minor positions. The protege system is important to the continuance of the networks. Hall's study points to an "inner fraternity" that is most

powerful. He saw that in the urban areas there are four major groups of physicians. An inner core or inner fraternity, which consists of specialists who control hospital positions, outside the inner core are recruits who will one day take positions in the inner core. Next are general practitioners linked to the inner core by referrals and last are the physicians on the outside edge who have little or no contact with the core. The inner core is able to control the system because they are a group with high solidarity and authority. They have similar educational and socio-economic backgrounds and have daily contact with one another. They are integrated socially as well as professionally, and they are able to organize the medical market by controlling the process of referral. This study was done in 1946 when medical practice was more simply organized than today and later studies suggest that in smaller cities, especially, the colleague-network is less hierarchically organized than Hall's study suggests (Freeman et al., 1978: 301). Because the network is informal it has weaknesses. Often the network cannot completely control the treatment environment so the younger physicians may remain outside their control. Personal jealousies and antipathies may also jeopardize the system.

JURISDICTION

Freidson (1975: 69), defines the referral system as the, "social mechanism by which cooperation among physicians around an individual case is instituted." In a pure health care system the primary practitioner first sees a patient and then if the patient needs specialized care for further examination and possible treatment, he is sent to a specialist colleague. At this point each physician comes to play a

specialized roll in a professionally organized division of labor (Freidson, 1975: 69). One becomes a consultant to the other. The question of when the general practitioner calls on a consultant is the question of content of work or "boundary of jurisdiction." Freidson sees these boundaries as the core problem in analyzing the referral relation among physicians. Freidson feels the boundaries between specialist and specialist and even more so between general practitioner and specialist are not "givens" in some technologically necessary way, but are the result of social and institutional arrangements negotiated by the participant physicians. Freidson says that the work of specialists can be conceptualized as a combination of substantive and normative issues. Specialists do not restrict their work to only one organ, one type of procedure or technique (substantive concept), but include in their work those tasks that have been designated or understood as appropriate for them (normative concept). This designation of what is appropriate is a function of the social organization of the system.

Freidson says that a successful career is measured by the ability to be able to choose the area one will practice in and confine one's practice to that area. A surgeon may start out practicing as a general surgeon and then, gradually, limit the practice to the cases he prefers. What is generally preferred, within the specialty area, is the important rather than the trivial, the major rather than the minor, the unusual rather than the common, and the interesting rather than the routine (Freidson, 1975: 73). Career success means being a sub-specialist success, career failure means not being able to become a specialized specialist. Career status is determined by sub-specialty success.

As a rule, patients first see a primary physician and do not see a specialist on their own initiative. In this way, patient care can be controlled and coordinated by professional standards. In practice, however, referrals are not always made for purely technical reasons. Patients sometimes insist on referral to a specialist although the primary physician does not think it is necessary. Referrals may be made to allay fear of patients, reassure them and make them easier to handle, or to establish the physician's own diagnosis. A "covering" consult may be asked for in order to protect the physician from malpractice litigation. What is referred out of the primary practice varies with the physician and where he sees his boundary of expertise or need for help. This could be conditioned by his patient load or other economic considerations such as will the patients return to him or will the specialist keep him as his own patient. In one study of negro doctors it was found that they referred patients to white specialists on the theory the white consultant would not want to keep black patients and so refer them back (Freidson, 1971: 93). Decisions of the primary physician to refer a patient may be made on technical, personal and financial grounds.

In Freidson's study of physicians working in a group practice, Doctoring Together, where referrals were made within the group, the routine referrals were made by written communication and the emergency referrals were made by direct communication. When direct communication was had there were few problems of cooperation and coordination. In contrast routine referrals which were made by filling out a written form and putting a note on the patient's chart telling of the reason for the referral, caused problems. One consultant analyzed the referrals sent

to him by the primary physicians, who were all board certified physicians such as internists, and said that 80 percent of the referrals were unnecessary, although some of the 80 percent were pardonable. He felt that he knew by the name of the referrer whether or not the patient had a serious problem. Some physicians sent minor complaints, out of insecurity, he thought, some always had good reasons for their referrals. Sometimes he thought a patient referral with no organic disease was necessary for "good public relations." Considering similar comments by other consulting physicians in the group-practice it seems that if a line should be drawn between what the primary physician deals with and what he should refer on it does not seem clear where that line should be drawn. The consultants themselves varied in the way they responded to or accepted patients they considered to have been sent to them without warrant. At times primary physicians will send on patients, without giving them a physical examination, or refer them on the basis of patient complaint. For instance, a patient with an accumulation of wax in the ears may be sent to an ENT specialist unnecessarily. Some specialists refuse to accept this kind of "trivia" while others will accept and treat them. Such differences in willingness to accept broader or narrower jurisdiction, which changes the boundaries of a specialization, may be influenced by several factors, financial security of the specialty in a given geographical area, the philosophy of the individual consultant, as well as the segment of the specialty in which he works.

The lines drawn between the work of the general practitioner and specialist and between specialist and specialist as defined in the referral system seem to be a matter of opinion and a matter of perspective. The term specialization is then elastic in nature and determined

by the physician's conception of "dignity and career success" rather than from "impersonal technical imperatives" of the work itself. Since the criteria for specialty designations are based on social conventions as well as technical ones, this means that new or different methods of organizing the referral system are possible. New jurisdictional boundaries for specialization are conceivable even though skills and technologies have not changed. The process of specialization in modern medicine which started before the 20th century, continues to evolve and is the center for prestige and success in the profession.

CHAPTER III

Manpower Distribution and Cost of Health Care System

INTRODUCTION

There is awareness of the incongruity of the gap between elementary care which is not available to the poor and the sophisticated successes of the operating room and medical therapy. There is a widening gap between what can be done and what is being done. Stevens (1971: 2) suggests this is not necessarily a breakdown of the system but is caused by the great increase in technology plus the greater social demand for equitable distribution. Distribution of health manpower, those who provide services, is one of the more complex problems of the overall health care system. One reason for its complexity is that manpower is a human resource which does not lend itself to allocation as do land or capital.

There is argument over what is an adequate supply of physicians. Some argue there is a shortage of physicians, professionals usually argue there is not a need for greater numbers and others argue that there is not a generalized shortage but a maldistribution of available physicians. Statistical analysis has been applied to the problem. Hiestand and Ostow (1976: 129) argue that the supply-demand question is statistically unanswerable because collection of pertinent data is difficult (it must come from individuals, practitioners and institutions which are reluctant to give information which might not be to their advantage) and because the information available cannot be expected to be analyzed impartially, in the academic sense, because of the direct stakes that groups, institutions and individuals have in the issue. Since this tool is only marginally useful it is important to understand the mechanisms that influence the location of physicians both geographically and professionally.

The mechanisms include the informal referral system, economics, cultural and racial background of the physician and his choice of specialization or general practice. All of these tend to influence manpower distribution which in turn influences access to care.

STRUCTURE AND RATIONALE OF ACCESS TO CARE-- PRIMARY CARE PHYSICIAN

The primary care physician, as we have noted, is the physician whom a patient first contacts when he is in need of care. This physician will usually be a general practitioner, internist, or pediatrician, and we have seen that there is increasing inaccessibility to the general practitioner. The primary care physician cares for the ambulatory sick, is knowledgeable about the patient and his family, and keeps permanent records for them. The percentage of patients seen in the primary physician's office is much greater than the percentage of those seen in the hospital by the specialists. Here rests the concern with the diminution of general practitioners. There are more ambulatory sick than hospital patients, but fewer primary physicians available. As we shall see, the most costly portion of medical care is hospital costs. Primary medical services are relatively inexpensive as compared to specialized service (Mechanic, 1972: 19), and with the increase in specialization cost increase follows.

The job of the primary care-takers requires a variety of roles relative to the patients he sees. One of his major responsibilities is to identify the conditions of the patient that require treatment. He also has to deal with the need of the patients for alleviation of worry and fear. The doctor is trained to diagnose illness by using the disease model. He evaluates the complaints presented to him and compares those

complaints with various medical norms based on scientific observation and research and, in part, on experience. He then defines the problem or makes a diagnosis in terms of the complaint and observation while bypassing the psychological, social, and physical environment. Once the diagnosis is made the physician can proceed with the treatment required. A limitation of this model is that many complaints and problems do not fit into this framework because the emphasis of the disease model is on the physical. To the extent the primary physician relies exclusively on this model in judging complaints, he will feel frustration in coping with them (Mechanic, 1972: 11). Mechanic says that the physician needs to sensitively balance a variety of functions that demand different approaches. He needs clinical qualities that are not easily taught. The primary physician sees patients who greatly differ in individual personality and his diagnosis would be helped by knowing the background of his patients. He must, in choosing a type of therapy, balance the risks and gains of medical value against social values.

Another of the primary physician's functions is coordination of work done for an individual patient and making possible continuity of care. Mechanic sees this as the most "profound problem" in the organization of health services. The complexity of functions of the primary care physician make tremendous demands for judgment and sensitivity on the part of the physician. Although Mechanic feels that there is no doubt that an effective system of health care depends on a viable system of delivery and coordination by the primary care physician the United States has no mechanism to help keep the general practitioner in practice.

REASONS FOR CHOOSING TO BE A SPECIALIST

Becker (1961) suggests that medical students use four main criteria when deciding between a general or specialty practice. The first is the time it will require in further education to qualify as a specialist. Secondly is how broad the style of practice will be, a general practitioner with a broad area or the more limited specialty practice. Thirdly, the amount of work a particular practice will require, being a general practitioner is seen as involving hard work while a specialist can limit his practice more successfully and will be required to make fewer emergency calls. The fourth criteria is the opportunity to get to know one's patients well. Becker suggests that students choose primarily on the basis of the second criteria. They feel a general practice requires so much knowledge that one man cannot acquire it all, therefore it is better to be skilled in one smaller area. His research showed that students tend to choose a specialty on the basis of its "intellectual breadth." Their future work should make use of all they know or the field should not be so large as to preclude their doing a good job. Students, in Beckers research, see Internal medicine as the broadest of the medical specialties, requiring great knowledge and willingness to continue learning. They see dermatology as limited, routine and dull with little opportunity to use the knowledge they have learned or to exercise medical responsibility because the diseases are not life threatening.

Mechanic (1978: 383) feels that choice of a specialty includes also consideration of social selection, personal interest, opportunity and accident. For instance, a student may develop an interest in an area in which his school is especially strong. There are, however, some "substantial general differences in social background, personality and values

among recruits to various specialties." Surgery, radiology and urology tend to be all male, with more women in pediatrics, anesthesiology, dermatology and psychiatry. Jews are drawn to psychiatry, the more politically liberal to psychiatry and pediatrics. The internist is seen as a problem solver and the surgeon as more aggressive and active. The family practitioner tends to be less conceptual and more gregarious than the internist. Psychiatry draws recruits who are abstract and "playful" about ideas, while surgeons are more concrete and moralistic. The relative social standings of specialties change with advances in science and technology and therefore choices tend to change as well.

DISTRIBUTION OF PHYSICIANS IN THE PROFESSION

Most medical students enter medical school expressing the desire to become a general practitioner but by graduation have decided on a specialty. Alford, writing 14 years after Becker, says that this is a response to high status and high income that specialty medicine affords. Mechanic (1974) says "reasonable practice suggests that approximately 1/5 of all physicians should be in the consulting specialties," but 4/5 of American physicians are specialists. Mechanic goes on to say that the most numerous of all specialists are surgical specialties and observers believe that these practitioners are responsible for the fact that the rate of surgical operations in the United States is double the per capita rate in Britain. The United States is not alone in experiencing the exaggerated trend toward specialization. Britain, which has made a special effort to retain a balance between generalists and specialists with legal regulations, has found it a difficult process. In Sweden the government has "vastly" increased the number of physicians trying to

eliminate a persistent shortage of generalists. In such countries as Russia and China, where they have greater control over allocation of manpower and resources, they have found it necessary to provide basic services to the population with para-professional workers. Alford feels the current distribution in the United States is a result of the use of the power of the profession to increase the income, power and prestige of its members and that the limits to the spiral of increasing specialization are not internal but depend on the degree to which society will support the cost necessary for specialized care.

REASONS FOR DISTRIBUTION OF PHYSICIANS IN THE PROFESSION-RENUMERATIVE SYSTEM

The ethical considerations subscribed to by physicians suggest service to the patient and community is the uppermost consideration. However, medical training complete through the residency period often extends to the age of 30 and many students have acquired a significant debt by this time. It has been hypothesized although not confirmed (Mechanic, Freeman: 1979) that these financial problems reinforce an excessive emphasis on the economics of practice.

The physician's commitment to his work depends on the rewards he receives for his services. These rewards include income, status and esteem, appreciation of patients and satisfaction of doing ones work well (Freeman, 1979: 181). Because the office based doctor's work is not visible to the public or to colleagues the physician's income tends to become an important symbol of his success. Most United States doctors prefer a fee-for-service payment system where the physician is an entrepreneur in a free market. The theory of a free market suggests that the patient chooses the best service at the best price and as a result of

competition incompetent providers will be driven out of the market. The fee-for-service system is attractive to the physicians because it allows them to decide what branch of medicine they will work in, where they will practice, how many patients they should have, how many hours per week they should work and what they should charge for their services. However, the health care delivery system is not a good example of a competitive free market-place. Medical doctors have a monopoly on the knowledge required for healing and in addition have control over techniques and medicines used in treatment of diseases and disease conditions. The physician can manipulate the market. As we have seen, United States physicians resist any change from their entrepreneurial system, but there are alternative methods of payment for services. Payment by salary is one: a fixed amount is paid for hours or sessions of work. Capitation is a second: a fixed amount is paid for each unit of time for each client or family accepted as part of a program. Case payment a third: a fixed sum is paid for giving patients all necessary care.

Fee-for-service has the advantage of encouraging physicians to work hard and have commitment to their patients (Mechanic, 1976: 99). One disadvantage to the system is that it gives leeway for the physician to decide how much service is needed and at what price. He can create income by ordering unnecessary services and increasing fees. This induced demand for service and flexible fee schedule allows the physician to attain an arbitrary income target or level at the expense of the clients or insurance payers (Dyckman, 1980: HEW). The open-market fee-for-service theory gives the physician an extreme amount of influence on the price of medical care at the expense of those who pay the cost. Specialists, as experts, are paid the highest fees.

CULTURAL EFFECTS ON DISTRIBUTION-STATUS AND INCOME

The role of the physician has exceedingly high prestige in American society, it ranks in prestige with that of Supreme Court Justice or governor of a state and has status higher than other professional groups (Mechanic, 1978: 379). Physicians in the United States earn extremely high incomes, the average net income for 1973 was 50,000 dollars (Mechanic, 1978: 395), in 1978 Ginzberg says \$50,000 is the salary for new graduates. Medicine is therefore an attractive occupation for those who value status and income, an opportunity for service, challenges, and an interesting occupation. Parents want this opportunity available for their children. Entry into medical school has become very competitive with nine applicants for every position (Mechanic, 1978: 380). The average cost per student per year in 1974 was 9,700 dollars (Freeman, 1978: 78) and very little of this amount was paid by tuition, federal funds comprise half the medical school revenues. High tuition costs and scholastic competition for entry into medical school have been a barrier to the poor and minority groups for entrance into the profession and a disproportionate number from higher status families have been selected. Although there have been efforts to widen the selection recently, Mechanic (1978) says, "medicine will remain disproportionately white, male and upper-middle class in its recruitment for a long time to come."

PHYSICIANS PREFERENCE FOR PATIENTS

Physicians respond not only to their own economic and personality needs, but also to the characteristics and behavior of their patients. Physicians identify more easily with patients who share their cultural background and life style. They have concepts of more or less worthy patients and may give different service to different patients

(Mechanic, 1978: 394). A preference to serve one social class of clientele is labeled "client specialization" (Johnson, 1972: 60). Since physicians tend to be white, male and upper-middle class, minority races, females and the poor stand to receive less care and possibly lesser quality care.

GEOGRAPHIC PREFERENCE OF PHYSICIANS

Access to care is effected not only by cultural prejudices of physicians but also by their geographical distribution. Fuchs (1974) says it is "perfectly clear" that physicians prefer to locate in urban areas. He points out that there are three times the number of physicians, per capita, in metropolitan counties as in non-metropolitan counties in the United States. Physicians who have been trained in large medical centers with hospital facilities, available colleagues in related specialties, and a variety of other accessible health workers are becoming more unwilling to practice in rural areas where they feel isolated, or inner city areas where middle class standards do not prevail. This is not a phenomena of the United States alone. China, to meet rural needs, developed "barefoot doctors" for first-line medical care in smaller agricultural communities. Ginzberg (1978: 113) suggests that physicians will not practice among groups and in locales where they cannot fully utilize their skills and sense of medical responsibility. Nurse practitioners and physicians assistants could be used as primary care providers for isolated and low-income groups, among others in the United States.

EVALUATION OF MANPOWER DISTRIBUTION

Some sociological thinking holds that economic resources or geographical location should not determine a person's eligibility for medical care. Medical care is not a privilege, but a right. Caution

is sounded by Ginzberg (1968: 25) who says that quality medical care is not necessarily a right inherent in citizenship while Mechanic (1972: 18) sets as a high priority minimal standards of health care for all. The goal is to distribute manpower and facilities to insure that those in need will have accessible services and can receive assistance. We have seen that organizational, economic and cultural factors present barriers to such minimal care.

SPECIALISTS AND HOSPITAL COSTS

The specialist's primary work place is the hospital where specialized procedures are centralized and consultations are easily arranged. The hospital is the most costly part of the health care system. Of every 100 dollars spent for health care 40 dollars goes to the hospital, 20 dollars to the physician and 10 dollars for drugs (Fuchs, 1974: 58). This illustrates that 50 percent of health expenses is for hospitalization and drugs. Hospital costs need to be curbed if the system is to be brought under control. Fuchs says the high hospital cost is due in large part to overutilization, inefficiency and excess capacity.

The community hospital, which has one-half of all hospital beds accounts for 92 percent of all admissions and 78 percent of all hospital expenses (Fuchs, 1974: 82). The size of the hospital is important to its economic operation. Fuchs says studies and experience show that hospitals with 200 to 500 beds are most efficient. In the United States 40 percent of hospital beds are in small hospitals, 40 percent are in medium size hospitals (200 to 500 beds) and 20 percent are in hospitals with more than 500 beds. Excess or unused capacity is costly in terms of equipment and personnel and this points up the need for a systematic approach to meeting the needs of a region without duplication of services.

After 1965 hospital expenditures began to explode. The most compelling reason was the introduction of Medicare and Medicaid in 1966. This resulted in an increased demand for services which were paid for at the cost designated by the hospital administration. This increased income gave the physician and administrators an opportunity to expand and improve the quality of care--as they saw it. More sophisticated technical equipment was purchased and increased diagnostic tests were ordered. The intensity of care of the individual patient was increased. This increase in resources devoted to hospital care did not seem to show improved health in the population. The treatment of breast cancer in six Boston hospitals provides an example. In 1965, 20 percent of the cases were treated with both surgery and radiation, 80 percent received only one or the other treatment. In 1967, 40 percent received both types of treatment but the outcome, of patients who died within three years, was essentially the same for both groups (Fuchs, 1974: 95).

The dominant role of the physician is especially important to the problem of cost in hospitals. The physicians influence equipment purchased since hospitals compete for physicians and compete through technological excellence. Physicians control admissions, discharges and services used. Third party payers, although they do not, are in a position to insist on quality and efficient care for which they pay. Hughes (1978) suggests a restructuring of the insurance system to give more opportunity for the consumer to choose care-providers on the basis of cost and quality. He suggests lifting restrictions on advertising of physician fees, hospital charges, drug charges and the price of medical devices. He feels a major effort should be directed toward measuring the value of quality. Quality means care that produces

improvement in outcome. He feels this restructuring should take into account social and psychological aspects of care. He believes that more competition in the field, use of HMO's and alternative insurance plans, would decrease inefficient use of resources and show benefits in decreased costs. Utilization review, review of doctors' use of facilities by doctors, is another helpful way of monitoring the efficient and inefficient use of hospital services.

EXCESSIVE AND INAPPROPRIATE PROCEDURES AND SURGERY

Mechanic (1972: 292) says the typical practice of medicine includes use of procedures that are "dangerous and costly beyond any conceivable value to the patient." Fuchs (1974: 70) suggests a reason for unnecessary procedures, is that physicians, as they are now being trained, involve a waste of resources, "for some specialties, such as surgery, are already in oversupply." He cites a study in a New York suburb of general surgeons that revealed the surgical physicians' workload as about one-third of what experts considered a full schedule. He considers this study to be typical of the United States as a whole. Physicians did not use the extra time in other medical pursuits but for their own personal purposes. One would expect surgery fees to be reduced with such competition, but this is not the case. Fuchs says the reason for this is not clear, but might be that lowering fees might provoke colleagues to deny hospital privileges.

The problems and some of the causes of unregulated surgery are noted in Millman's study of hospital functioning in "The Unkindest Cut." She discusses one surgical procedure, coronary bypass, and its effects on the health care system. The operation has become one of the most widely used and costly procedures performed in the United States. In 1976,

80,000 patients in 500 hospitals underwent surgery at an average cost of 12,000 dollars per patient. The purpose of the surgery is to increase blood supply to the heart. Much of the enthusiasm for this surgery comes from the dramatic relief it affords chest pain. It relieves pain in 75 to 85 percent of patients. Some surgeons who are convinced that the operation relieves pain and allows tolerance for greater exercise, are now convinced that it has the power to prolong life and are operating on patients who do not have chest pain as a prophylactic measure against heart attacks. This is in spite of the fact that there are no controlled studies which show increased survival or lowered risk of heart attack as a result of surgery. In addition, medical therapy claims that angina (chest pain) can be relieved in 65 to 95 percent of cases without surgical intervention. There are risks to having the surgery including heart muscle damage and possibility of heart attack during the procedure. There is evidence that benefits of the surgery decline after a few years because the disease which produces the symptoms is a progressive one and surgery is not a cure. Despite the controversy about the operation it is being performed at an increasing rate. Surgical teams and surgical suites are proliferating plus the intensive care units necessary to care for the post-operative patient. Some of the reasons for the spread of the bypass surgery are surgeons who need to find "new sources for operations after their old ones began to disappear" and hospitals that are competing for patients and doctors. Profits also go to the medical supply industry and electronic firms that market monitoring equipment. In addition, heart disease is the single greatest cause of death and disability in the United States and with the tendency of the public to believe technology is useful, justified and soundly applied, patients are available.

To be soundly applied the surgeon doing the operation must be experienced. If the surgery is performed in underused facilities by inexperienced teams, the mortality rate is higher. In reports of 100 or fewer operations over a period of time, the mortality rate was 12 percent, in 200 or more cases the rate was 4.5 percent. Inexperienced teams also have a higher surgical complication rate.

Millman feels that patients are misled about the surgery by doctors who give the most promising statistics and who do not tell of the limitations and risks of the surgery. She feels, also, that the media dramatizes the effects of the surgery which make it more desirable to the public. One research cardiologist expressed the opinion that 80 percent of the by-pass operations were "worthless" apart from relieving symptoms. He explained that it was impolitic to make such a strong statement publicly because other physicians would respond angrily.

This operation has developed in the United States under the laissez-faire structure of medicine. There is no restriction on how experimental surgical procedures can be used in the United States. Any cardiac surgeon can perform it, whether he is experienced or not, and this is the philosophy typical of surgery as a whole. Regulation of surgical procedures is resisted but does have precedents. Mechanic (1972: 293) points out abortions were commonly regulated in earlier years.

This unregulated expansion of surgery represents a trend in the United States health care toward "engineering" rather than a preventive approach to disease, using expensive technology yielding large profits to giant corporations. Establishing these techniques involve large amounts of public money (in research facilities and educational grants) and "selected (usually affluent) patients, at the expense of basic health

care for large portions of the population." Ironically, it is not clear that these "selected" patients are getting good medical care. Millman feels that more careful regulation would eliminate some questionable surgical practices and that industries profits should be disallowed in health care.

EXCESSIVE AND INAPPROPRIATE DRUG USE

The overuse, abuse, and misuse of drugs constitutes a major health problem in the United States. Landers (1974: 51) says that drugs are used as a substitute for personal relationships. They are used in place of personal support and reassurance by the physician while at the same time the physician validates his power by writing the prescription. By the mid-seventies, three-fourths of the visits to a general practitioner or internist concluded with the physician prescribing at least one drug (Landers, 1974: 44).

The drug arsenal is impressively large. In 1972, American physicians had 6,780 single drug entities from which to choose, as well as 3,300 combination products with almost half of the drugs having been introduced since 1950. This puts great pressure on the physician to keep abreast of applicability and adverse reactions to new drugs and the risks involved in patients receiving multiple medications. Unless the physician has access to reliable information from non-commercial sources, he is influenced by drug advertisements and salesmen. The problem is particularly acute for physicians who practice alone and cannot benefit from the experience of colleagues. The protection of the public from harm from the use of physician prescriptions is not always successful. The drug chloramphenicol, an antibiotic, continued to be used by physicians and manufactured by industry even after there had been ample documentation

that it could cause aplastic anemia, a condition which is usually fatal. The drug company which manufactured the drug received one-third of its profits in 1960 (after the problem was known) from this drug (Illich, 1976: 65). Neither self-control of the medical profession nor the drug industry gave warning of this problem. Congressional hearings finally required that a warning of the consequences of the use of the drug be put in the brochure that accompanies the packaged drug.

Drug retail markup is typically about 40 to 50 percent of the selling price. Differences of as much as 500 percent between prices charged pharmacies and the price charged hospitals or between domestic and export prices have been noted. Such conduct suggests that drug manufacturers possess and use monopoly powers (Fuchs, 1974: 108). Fuchs says the organization of drug dispensing would best be handled by integrating them with the broader area of overall organization of medical care by giving physicians a financial stake in keeping down the cost of drugs. He feels the capitation pre-payment system would accomplish this end.

THE COST OF IMPERSONAL CARE

Fuchs says it is critical to understand that the physician has always filled a "caring" as well as a "curing" function. People who are troubled or who are in pain want someone to share their troubles. "As much as a "cure", they want sympathy, reassurance and encouragement."

The caring aspect of medicine seems to recede as the relationship between physician and patient becomes more commercialized and treatment is a commodity purchased in the market-place. The language used shows a change in the perception of society about medical care (Landers, 1978: 95). Industrial terminology is increasingly used in the health

professions, health care becomes an industry with physicians, nurses and others as providers and the patient becoming a consumer. The use of such labels removes the sense of personal involvement between patient and doctor and may lead to less satisfaction and trust between the two. Landers continues that the doctor-patient relationship is further damaged by the physician who becomes a high-priced consultant (specialist) similar to those in the commercial world. He keeps a five or four and one-half day week, charges standardized prices and is spared, through insurance, from having to consider the individual circumstances of his patients. He transforms himself into a professional corporation with tax free benefits and increasingly asks his "customers" to pay at the time of their office visit and is protected from the public by use of an answering service. Specialization increases the splintering of care and the patient finds himself "strung out" among many practitioners while their connection to any one is not strong enough to provide "caring". The result is that though a patient may be cured of disease, he may be "wounded in other parts of his personhood" and in addition, his attitude toward the physician may be one of anger.

Illich (1976: 7) sees the health care system as a "major institutional endeavor turned counter-productive" for these three reasons. It produces clinical damage that outweighs its benefits. It enhances and at the same time obscures political conditions that render society unhealthy. It "mystifies" and takes the power of the individual to heal himself and shape his own environment. On the individual level he believes the system undermines the personal characteristics of self-sufficiency and individualism. The public has acquired a "lifelong therapeutic dependence" on such things as health counseling, health education, medical testing and maintenance. This illustrates the

"imperialistic" character of the medical system. Illich feels it undermines social patterns by making biology and the medical-model the legitimate arbiters for what is healthy. He cites delivery of the newborn in hospitals as evidence of a former social event which has been made a technological one. He feels medicine has created a desire for technology and "megamachines." He believes that the professional organization of medicine functions as a domineering moral enterprise that is opposed to all suffering. Suffering, healing and dying have been taken over by technology rather than by people. The result is that this situation has, "undermined the ability of the individual to face their reality." Illich sees the need for autonomy of the individual rather than the industrial mode of production at the center of life and that the recovery of personal autonomy depends on political action. He sees medical services as a public utility and that reform can be had by setting two sets of limits. First, treatment needs to be rationed so that all may have an opportunity for care. Second, there should be a limit on the total output of treatment and modes of health production so that the health care system takes its proper place in the society rather than dominating it.

CHAPTER IV

Long Range Planning of a Local Medical Association

This report has looked closely at the power and structural approaches to the study of professions. It has looked at the historical growth of the medical profession and at abuses in the health system. It will now focus on a community situation to see whether or not examples of such approaches and problems can be identified.

These are some of the community background statistics. There are 41 medical doctors in the community (listed in Nov. 1980 telephone directory). Of the 41, 17 are internists, family practitioners and pediatricians (by self-definition in telephone listing). Seven serve other doctors rather than patients as pathologists and radiologists. There are two hospitals in the area with a combined 169 beds. Hospital A has 63 beds and an occupancy rate of 56%, according to their administration. Hospital B has 106 beds and an occupancy rate of 65%, according to their administration. The size of the area from which patients are drawn is estimated, for planning purposes of this community, to cover parts of nine contiguous counties. The population estimate of this area in 1977 is 173,500 and the population projection for year 2,000 is 214,000.

HISTORY

There have been two hospitals in the area since 1954. After some efforts in the early 70's to combine meetings and efforts to find mutual ways of saving money, there were talks of consolidation of services. In 1978 pediatrics and obstetric-gynecology services moved to hospital A and emergency-room and the intensive care unit moved to hospital B.

Hospital B was offered for sale and with hopes of combining the two under one management there were shared nutritional and physical therapy services. The offer to sell was rescinded. Both hospitals experienced financial difficulty but the political climate did not allow them to cooperate as they might have.

PLANNING COMMITTEE REPORT

Before the offer to sell, in Feb. of 1980, a Health Planning Committee of the local medical association presented a report to the association members which focused on five areas: the hospital facilities issue, physician supply-demand trends, the impact of technology on high quality medicine, trends of growth in Topeka, 60 miles distant, and trends of growth in the community.

The committee pointed out that there are national trends to "cut" small hospitals due to financial failure as well as trends to consolidate and share services. Recent considerations and potential consolidation in this community were mentioned. The report goes on, nationally the supply of physicians has risen sharply in the last 10 years. Locally there has been a gradual growth in supply. "Without documentation, there is a feeling that demand for primary care is not much greater than supply, in the last year." There is a "probable demand for specialized services in many areas but documentation is not available." The population of the area continues to increase, so demand will remain high for services. The report included the following: "Technology leads to specialization for more accurate and dependable use of such technology. Technology leads to costly methods." Technology, in the public mind, denotes quality.

The report continues, there are other areas with which this area competes for providing medical services. In the last five to ten years, Topeka has become a major referral center with a large number and wide spectrum of specialists, with hospitals which have "overproduced in size" and developed "outreach programs" for such areas as Wamego and Westmoreland. The Shawnee County Medical Foundation provides educational outreach, and formal training conferences for residents and students. The question was raised as to the desirability of Topeka becoming a "commercialized" medical center, that is a center not established around a medical school.

The local community has experienced growth in a regional sense with additional surgical sub-specialties, a level II nursery and outreach programs that were offered through Kansas University.

The report included the results of a survey of local physicians, taken earlier, which showed that: 1) the physicians of the society do not want to own a hospital (this was considered as an option to the present situation), 2) two-thirds of the members feel there should be a staff physician as a regular member of the hospital boards, aside from the member who represents the staff, to give the physicians insight and input to the board, 3) surgery and specialty services feel the city is an adequate referral center, non-specialty members do not feel so. An interpretation of the answer, by the committee, suggests the physicians might have a "too inflated" view of their present position as a regional referral center, 4) the society desires to become a regional referral area, 5) there are differences in views on the territory outside of the county which should be reached but a population of 150,000 should be included, 6) practitioners of specialties and sub-specialties tend

to feel Topeka and Salina do not offer advantages over local care, but sub-specialties in internal medicine see a deficiency locally, 7) there is a general consensus that most major medical care should be available to the region around the city and that care should be equally as good as Topeka's care. The major benefit would be closeness for family members during the period of care.

As a result of the survey, five proposals were made to the society.

1) More information be gathered to further assess needs for a regional referral center. 2) Needed physicians be recruited. 3) Physicians promote needed facilities and technology. 4) A regional educational program be developed. 5) Promotion of local physicians involvement in important areas such as HSA (Health Systems Agency) boards.

This report to the membership indicates the physicians are frustrated by the hospital situation and want the situation resolved in order that they may pursue their plans for a referral center. They want political influence (as opposed to expert influence) on hospital boards and state agencies. "Without documentation" they feel that there is enough primary care in the area and more specialists are needed if the community is to become a referral center to rival Topeka. Mechanic's preferred ratio is one specialist to each 4 general practitioners, the community ratio is 23 specialists to 17 primary care practitioners (one is unclassified). There is no discussion of overlapping or duplicated services with an area only 60 miles away. Such duplication increases costs. The public is described as believing technology equates with quality. Physicians are encouraged in efforts to influence the public to its view. Each of these views seems to support narrow self-interest of the profession rather than public interest. Such behavior is illustrative of the power approach to the profession.

INTERIM

One result of the meeting was a questionnaire that was developed, to be filled out in doctor's offices, to determine information about patients referred to acute facilities outside of the city. Information was wanted as to whether there were enough referrals outside to warrant having other specialists here (especially a heart specialist), and to educate physicians here about what could have been taken care of locally. Results of the study from June 1980 to March 1981 show:

<u>Service transferred to:</u>		<u>Special procedure referred for:</u>
Medicine	Surgery	
<u> </u> Neonatology	<u> </u> Throacic-lung	<u>14</u> Cardiac catheterization
<u> 3</u> Pediatric	<u> 2</u> Thoracic-heart	<u>39</u> CT scan
<u> 9</u> Pulmonary	<u> </u> Neurology	<u> 6</u> EEG
<u>28</u> Cardiology	<u>11</u> Orthopedic	<u> 2</u> Arteriogram, not coronary
<u> </u> Nephrology	<u> 2</u> Ob-GYN	<u>14</u> Radiation therapy
<u> 7</u> Gastrointestinal	<u> </u> Proctology	<u> </u> Pacemaker
<u> 2</u> Hematology	<u> 1</u> Urology	<u> </u> Acute dialysis
<u>21</u> Oncology	<u>44</u> ENT	<u> </u> Allergy testing
<u> 6</u> Rheumatology	<u> 4</u> Ophthalmology-Laser	<u> </u> Endoscopy
<u>93</u> Neurology	<u> 1</u> Vascular	<u> </u> Other
<u> 1</u> Psychiatric-alcohol	<u> 2</u> General Surgery	<u> 1</u> Electromyography
<u> 1</u> Psychiatric-psychotic	<u> 2</u> Plastic	<u> 1</u> Angiogram
<u>20</u> Allergy-Immunology	<u> 1</u> Radiology	<u> 2</u> Cardiac scan
<u> 1</u> General Int. Med.		<u> 2</u> Echo cardiograph
<u> </u> Family Practice		
<u> 4</u> Endocrinology		

Neurology, ear nose and throat, and cardiac cases (diagnostic referrals and procedures) are those most often referred out, however, the number of cases would not seem to indicate support for such apecial-ists and special procedures in the area.

A REPORT TO THE HOSPITAL BOARDS AND COUNTY COMMISSIONERS

After the report to the society and later in 1980 the following presentation was made by the Health Planning Committee of the Medical Society to members of the two hospital boards, members of the County Commission, and others who were invited. The concern was the possible status of hospital care in the area in the future. Three possibilities were presented. First, the hospitals in the area could remain the same with no sharing of local problems. This would lead to some of the sub-specialists leaving the area and Riley County would then have the same health "advantages and problems" as Wamego and Clay Center. Second, the two local hospitals could consolidate or a new large hospital could be built. This would attract more physicians in sub-specialties and be more convenient for citizens as well as an economic advantage to the region. Services offered now from Topeka would be cheaper offered locally. The third possibility presented was that of a Regional Non-Profit Corporation being formed by the Medical Association. The board of the corporation would include elements of the Medical Societies from the nine county area, medical staff from all the hospitals, board of directors of hospitals and nursing homes and other politically appointed members. This organization would provide these things: certain equipment such as CT scanner, a physician director of education, nursing service, respiratory therapy, physician services (such as emergency room care), and administrative services. Small hospitals could buy services, such as billing, from the organization. There would be an administrator and staff to carry out the policies of the organization. The advantages to this scheme would be that progress could be made now where the division of power presently inhibits progress. "Problems which are similar in the

region can be solved by pooling resources, and such an organization will make it more likely that the area would be able to become a level II medical center." Administrative services of hospitals could be purchased from the corporation but separate boards and administrations could be maintained if this were advisable. In summary: If an effective method of solving the problems isn't found, one can expect an unhealthy medical climate in the area.

EVALUATION

Milton Roemer (1978) has developed a theoretical "ideal health care system" which defines a regional hospital as serving a population of 500,000 with one hospital bed per 1,000 people, or 500 beds. Procedures at the regional hospital would include complex diagnostic work-ups, chest surgery and complicated abdominal surgery. There would be training programs for nurses and technicians, a research program would function and courses for continuing education would be provided. Using this criteria, the catchment area the local physicians envision is too small for the proposed regional center. The combined hospitals are not adequate for a regional facility in Roemer's overall system, but are about the right size (120-150 beds) for a district hospital which Roemer defines as taking care of less complicated cases.

It is possible that the Regional Corporation was proposed to dramatize the need for action by the two local hospitals. Taken on its merit, however, the effect of the Regional Corporation would seem to eliminate the hospital administrator as a source of competition for influence in the local health care system (Freidson, 1970: 168). It would give physicians the greater influence on the corporation board. The plan would have the corporation rent space from the hospital but the corporation

would control the services and equipment as well as the people providing the services. The physicians would be in greater control of health care in the area and in a position to work toward the idea of a referral center in close geographic proximity to an already established referral center.

CONCLUSIONS

Looked at through the power approach the committee has harnessed the historically proven power and prestige of the American Medical Association and the county Medical Association and assumed (their opinion was not solicited) the right to make suggestions for the community. When looked at closely, the suggestions benefit the individual physician rather than their patients or the health system as a whole. The physicians want hospital facilities and equipment but do not want to have to own them. They assert, "without documentation", that locally there are enough primary physicians, there is public demand for more specialists and that advanced technology means quality to the public mind. All of these statements have been shown to be in doubt. The purpose seems to be to get what they want from the community despite the fact that such a program, while increasing the number of patients for the physician and providing them with inexpensive work places, would increase costs in individuals' bills and in local taxes. It would also promote overlapping and duplication in the larger health care system. The program, as presented by the Medical Association, would increase the power and economic position of those in the Society at the expense of those served. This illustrates the power advocates' theory that the professions tend to increase their power and maintain and improve their

position by encouraging and using public belief that the professional is able to make better decisions than the public and therefore what the physicians suggest is desirable.

At the time of May 1981 there had been no apparent movement on the problem by the physicians and little by the community.

Summary and Prospects for the Future

In the situation described in the local community the physicians are proceeding under the assumption that the professional physician should control the area of health care, a functionalist view of professions. In view of the profession-centered suggestions made by the physicians the power approach to professions would be a more fruitful community approach. The citizens of the community would serve themselves best by recognizing that the claims made by the profession of medicine for itself are idealized and in matters of fact do not work for the benefit of the consumer. As power advocates point out, control by the physicians was acquired by them by convincing the public that they could and would do a superior job in providing health care without interference from the public. When the public is convinced this is not so, control can be contested. Professional authority can also be contested for the reason that the community believes physicians should work with the community rather than assume a position of superiority. More economical health care could become available if the community would recognize their legitimate power and responsibilities and make decisions together with the physicians. Community decisions would be better based on the resources and needs of the community as a whole viewed in the wider context of the resources of the region in which they live.

Political control of medical care, now well established by the medical profession, has proven difficult to change. The power advocates, however, see the power of professions as exaggerated and likely to decline in the future. In the overall, long range view of the power approach to the study of professions it sees change as a necessary and inevitable process in society. At the present time the professions are

threatened with social change from without and internal technical change and conflicts among segments of the profession from within. Johnson says the major tension stems from the relationship between occupational authority and the consumer. Marie Haug ("The Profession and Their Prospects," 1973), a power advocate, sees de-professionalization in the future. She sees the public rejecting the authority of professionals in a client revolt where clients are more likely to question the professional and less likely to bow to expert power. She sees professionals losing their monopoly on knowledge as the public becomes more educated and less mystified by professional experts. Also new technology, the computer, makes it possible to store large amounts of information and it will be less needful to know the information than to know how to retrieve it from the computer. She believes the public is losing confidence in the professionals statement about human concern. One result is that para-professionals are creating new occupations which incorporate the social-emotional skills in which the professional is found wanting. Importantly, she believes professionals are being checked on more closely, called to accountability, and that clients insist on proofs, explanations and justifications for decisions of the professional. This gives the client more control. In the future, Haug sees new occupations being established, new divisions of human service work, and new methods of applying knowledge to service problems.

Martin Oppenheimer ("Proletarianization of the Professional," 1973: 213) has proposed that the future will bring "proletarianization" to the professions. He believes that white collar workers will replace the autonomous professional types in the upper strata of a coming professional-technical society. He believes that working conditions

of the professional will deteriorate, as consumers make demands, and the professional will be forced to find different solutions to providing his services. Economically, income increases will be harder to come by and an educated public will be more difficult to please. Oppenheimer believes the professional response will be to choose to change work places, to choose to work in an organization (bureaucracy) where there will be less professionalism.

In these views, by power advocates, the future is in the direction of greater control by the consumer and a change in the nature of hierarchy with bureaucracies becoming a more dominant social structure in the medical delivery system.

How can changes be brought about at the community level at the present time? The entrenched position of the medical society suggests it will not be done without conflict and stress. However, recognition by the members of the community of their need and obligation to participate in monitoring and planning medical services is one necessary step.

BIBLIOGRAPHY

- Alford, Robert R.
1975 HEALTH CARE POLITICS. Chicago: University of Chicago.
- Becker, Howard.
1961 BOYS IN WHITE. Chicago: University of Chicago.
- Blau, Peter, Marshall Meyers.
1971 BUREAUCRACY IN MODERN SOCIETY. 2nd ed. New York: Basic Books.
- Coe, Rodney M.
1970 SOCIOLOGY OF MEDICINE. New York: McGraw-Hill.
- Cockerham, Wm.
1978 MEDICAL SOCIOLOGY. New Jersey: Prentice Hall.
- Duke, James.
1976 CONFLICT AND POWER IN SOCIAL LIFE. Utah, Provo: Brigham Young Press.
- Freeman, Howard, Sol Levine and Leo Reeder.
1979 HANDBOOK OF MEDICAL SOCIOLOGY. 3rd ed. New Jersey: Prentice-Hall.
- Freidson, Eliot.
1975 DOCTORING TOGETHER: A STUDY OF PROFESSIONAL SOCIAL CONTROL. New York: Elsevier.
1971 PROFESSION OF MEDICINE: A STUDY OF THE SOC. OF APPLIED KNOWLEDGE. New York: Dodd, Mead Co.
1970 PROFESSIONAL DOMINANCE: THE SOCIAL STRUCTURE OF MEDICAL CARE. New York: Atherton.
- Fuchs, Victor R.
1974 WHO SHALL LIVE? Health, Economics, and Social Choice. New York: Basic Books.
- Ginzberg, Eli.
1978 HEALTH MANPOWER AND HEALTH POLICY. New York: Universe.
1969 and Miriam Ostow. MEN, MONEY AND MEDICINE. New York: Columbia Univ.
- Hastings, Arthur, James Fadiman, James Gordon.
1980 HEALTH FOR THE WHOLE PERSON. Boulder, Colo.: Westview Press.
- Haug, Marie, and Marvin Sussman.
1973 "Growing Industrialization of the Professions," Eliot Freidson, ed., THE PROFESSIONS AND THEIR PROSPECTS. Beverly Hills: Sage Publications.
- Hiestand, Dale, Miriam Ostow.
1976 HEALTH MANPOWER INFORMATION FOR POLICY GUIDANCE. Massachusetts: Ballinger.

- Hughes, et al.
1978 HOSPITAL COST CONTAINMENT PROGRAMS. Massachusetts: Ballinger.
- Illich, Ivan.
1976 MEDICAL NEMESIS. New York: Pantheon Books/Random House.
- "Institute of Medicine: Assessing Quality in Health Care."
1976 Washington, D.C.: National Academy of Science.
- Johnson, Terence J.
1972 PROFESSIONS AND POWER. Great Britain, Essex: Anchor Press.
- Kornhauser, Wm.
1962 SCIENTISTS IN INDUSTRY. California: Berkeley Press.
- Lander, Louise.
1978 DEFECTIVE MEDICINE. New York: Farrar, Straus and Giroux.
- Mechanic, David.
1979 FUTURE ISSUED IN HEALTH CARE. New York: Free Press.
1978 MEDICAL SOCIOLOGY. 2nd ed. New York: The Free Press.
1976 THE GROWTH OF BUREAUCRATIC MEDICINE. New York: John Wiley and Sons.
1974 POLITICS, MEDICINE, AND SOCIAL SCIENCE. New York: Wiley.
1972 PUBLIC EXPECTATIONS AND HEALTH CARE. New York: Wiley-Interscience.
- Oppenheimer, M.
1973 "The Proletarianization of the Professional," P. Halmos, ed. PROFESSIONALIZATION AND SOCIAL CHANGE. Keele, Staffordshire: University of Keele.
- Millman, Marcia.
1977 THE UNKINDEST CUT. New York: William Morrow and Co.
- Ritzer, George.
1977 WORKING: CONFLICT AND CHANGE. New Jersey: Prentice-Hall.
- Roemer, Milton I.
1978 SOCIAL MEDICINE. New York: Springer.
- Stevens, Rosemary.
1981 "The Nation's Health," THE MANHATTAN MERCURY. Kansas: Manhattan.
1971 AMERICAN MEDICINE AND THE PUBLIC INTEREST. New Haven: Yale Univ. Press.

THE EFFECT OF THE MEDICAL REFERRAL
SYSTEM ON MANPOWER DISTRIBUTION AND COST

by

G. JO LINDLY

B. S. NS., Washington University, St. Louis, 1951

AN ABSTRACT OF A MASTER'S REPORT

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ABSTRACT

The purpose of this study is to discuss the effects of one organizational structure of the medical profession, the referral system, in terms of cost, availability of care, and quality of professional medical care to the public. The social-structural and power approaches to professions are discussed to provide a basis with which to compare. The present entrepreneurial system of organization has resulted in increased autonomy of the medical profession, lack of accountability and discontent among patients and the public.

A prominent aspect of current medical organization is the division of physicians into specialties and sub-specialties. This has had important effects on the number and type of physicians available to the public and also on the standard of care given. This division of labor has affected the public's perception of medical care.

The referral system and the current method of payment, fee-for-service, are structural components of the system which have logical alternatives. The bureaucratic type of organization is one such alternative.

The recent inflation of costs in the medical health care system have brought increasing awareness of the need to understand the way the system is organized and the consequences and alternatives to such organization.