Powerlessness, Control, and Complexity: The Experience of Family Physicians in a Group Model HMO

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ABSTRACT

BACKGROUND I wanted to explore family physicians' perceptions of working in a group model health maintenance organization participating in ongoing quality improvement initiatives.

METHODS I undertook a qualitative study using semistructured interviews with 24 family physicians in which there was specific inquiry about informants' perceptions of organizational and team functionality.

RESULTS Three main themes emerged from the data: lack of control, strategies for coping, and valuing the practice of primary care. More than one half of the physicians interviewed expressed a sense of powerlessness to change or control their working environment. Some physicians managed to retain a sense of control or at least to mitigate the impact of their powerlessness by employing a range of different strategies for coping. Maintaining a sense of specialist skill in the complex art of family practice was important to many of the physicians interviewed. This sense of specialization across the broad and varied canvas of family practice was not always attainable, however.

CONCLUSIONS Retaining the family physician's enthusiasm means both acknowledging what is difficult about family practice and considering how the experience of being a family physician can be improved. To achieve these ends probably means not only finding ways of restoring to family physicians a sense of professional autonomy and control over their immediate working environment but also assigning greater value to the skills in managing clinical and organizational complexity that are particular to family practice.

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INTRODUCTION

Physicians across the developed world are increasingly dissatisfied with their practice environment,[1] and a wide range of personal, professional, practice, and patient care characteristics are associated with dissatisfaction in all primary care specialty groups.[2] Of central concern, however, is the sense of limited freedom to make clinical decisions that meet patients' needs. A recent survey suggested that perceived lack of support, poor working conditions, and lack of control over the practice environment were important factors in the dissatisfaction of family physicians working in a large, group model, health maintenance organizations (HMOs).[3] Recruitment to residency training that leads to careers in primary care continues to decline,[4,5] and family physicians regardless of work setting are reported to be increasingly frustrated.[4] Nevertheless, there is some variability among primary care specialties, with internists reporting more dissatisfaction and pediatricians reporting less dissatisfaction than family physicians.[2]

Recent research has attempted to go beyond larger surveys by using qual-

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itative methods to examine in detail the processes that might cause or alleviate this dissatisfaction.[6] To this end, I explored family physicians' perceptions of working in a group model HMO that were obtained during a larger study of the impact of two quality improvement initiatives within the organization. My objectives were to shed light on the factors that can lead to dissatisfaction in primary care physicians working in organized care settings and to examine strategies that the physicians themselves use to cope with these factors.

METHODS

Study Design

The study was designed to use semistructured interviews with family physicians in a group model HMO that had more than a half-million enrollees and more than 1,000 medical and allied staff; 89% of the primary care practice group was board certified.

Sample

I obtained Human Subjects Review Committee approval to interview family physicians primarily to study the impact of quality improvement initiatives on the care of common disorders in primary care. All family physicians were rank-ordered on the basis of performance indicators for 2 common disorders, depression and diabetes, and then divided into high, medium, and low performers. Physicians were recruited into the study from the following 3 categories: high performance in diabetes, low in depression (total available n = 13); high performance in depression, low in diabetes (n = 14); and high performance in both depression and diabetes (n = 11). The sample was also selected to ensure a wide range of geographic and specialist provider settings. A family physician who declined participation or was not able to be contacted was replaced with (listed in order) an eligible provider from the same clinic, a provider from a clinic close to the original clinic, or the provider with the highest overall ranking.

I approached 29 physicians to recruit 24 successfully. No physician was recruited whose performance was low on both sets of indicators. From the outset of the study, physicians were informed how they were selected for interview to avoid any suggestion of being a poor performer. Characteristics of the physicians interviewed can be found in Table 1.

Table 1. Characteristics of Family Physicians (N = 24)

Characteristics	Percent
Male	62.5
Female	37.5
Full-time employed as family physician	54.2
Mean years in family practice (range)	18.8 (10–30)
Mean years in health maintenance organization (range)	15.7 (4–30)

Interviews

I interviewed in person 24 physicians from 14 different clinics at their place of work. I asked specific questions about number of hours worked, allied professionals in the clinic, size and nature of patient population, years working in the organization and in primary care, previous employment, medical education, specific interests, views of the interface with specialist services, and the success or otherwise of the quality improvement initiatives being evaluated. Interviews were guided by a preset topic guide. Specific to this article, family physicians were asked to respond to the following questions: "What is it like to work in this organization?" and "How well is the primary care team functioning?" Interviews were audiotaped and transcribed for the purposes of analysis.

In addition, I recorded brief field notes of observations of how the clinic functioned, eg, attitudes of staff, the atmosphere and efficiency of the office where the interview took place, and age and number of patients in the waiting room.

Analysis

I read the typed transcripts of the interview for emerging themes, then coded the themes using a standard computer package for qualitative analysis (WinMAX).[7] Codes in each interview were compared with those in other interviews to create broader categories linking codes across interviews (the technique of constant comparison).[8] A sample of transcripts was reviewed by a second researcher; we discussed the emerging themes as a measure of reliability of the analysis and agreed about the ideas developed from the interviews. At the end of the analysis, I presented the results to senior members of the HMO. An early draft of this paper was circulated to all interviewees for comments (as a member check of the data). It was also reviewed by a second research colleague and an academic family physician working in the organization.

Background of Researcher and Theoretical Stance

As a physician visiting from England and with no experience working in the United States, I was able to adopt the role of an outside observer. Additionally, as a practicing psychiatrist, an experienced teacher of family physicians, and primary care researcher, I was aware of achieving a considerable degree of empathy with fellow physicians during interviews. I was also aware of the risk of becoming overly sympathetic to the problems of fellow medical professionals, which I discussed with a fellow researcher from a nursing background. Our conversations enabled me to be more explicit about aspects of the everyday

conduct of primary care. As both a teacher and researcher, my analytic approach was strongly influenced by social learning theory, formulated by Bandura,[9] which proposes that people regulate their actions on the basis of consequences they experience directly, of those they see happening to others, and of those they create for themselves.

RESULTS

Three main themes emerged from the data: lack of control, strategies for coping, and valuing the practice of primary care. It is important to say at the outset that although many things were going wrong, some things were clearly going right for the family physicians who were interviewed.

Lack of Control

More than one half of the physicians interviewed expressed a sense of powerlessness to change or control their working environment, as typified by this response:

"I have no control over my schedule. I have no control over whether I'm triple booked or double booked, for a 15-minute slot. I've no control over how much time I get with [patients]. If I want to have half an hour for a physical 'cause the person's 80 years old and has multiple medical problems, I really don't have any say. And, even if I want 30 minutes, there's a good chance that whoever's doing the scheduling, be it the nurse over there in God knows where or our people here, they'll say 'Oh she's got half an hour for that physical. We'll just squeeze in 1 or 2 other quickies'" (family physician [FP] 11).

A variety of different experiences seemed to contribute to this sense of powerlessness. Examples of these can be found in Table 2.

The family physicians were clearly aware of rising expectations about how many patients they could see in 1 day. They also perceived pressure to increase clinic throughput as coming not simply from patients directly but also from their managers. The family physicians generally acknowledged that as front-line physicians, it was their role to see all comers as part of normal primary care. It seemed essential to their working morale, however, that they retain some sense of control of the patient workflow. When this sense of local control was taken away from them, without acknowledgment that they were already stretched for time, they felt particularly unhappy. The introduction of same-day access in the clinics, for instance, appeared to highlight how differently family physicians experienced and controlled the boundary between themselves and the patient when compared with hospital-based specialists. They pointed out that specialists in the organization appeared to be much more in control of their working day and still able to say that they had no urgent appointments left.

Some of the powerlessness appeared to derive from the corporatization of family medicine, as managers streamlined service delivery, for example, by moving the scheduling of appointments to a central call center. The loss of a team receptionist—to meet what the physicians perceived as new quality criteria simplistically concerned with call pickup times—signified to many the loss of an effectively functioning primary care team.

Table 2. Factors Contributing to Sense of Dissatisfaction and Powerlessness of Family Physicians in this Organization

Category Identified From Interviews	Text Example
Isolation	I come into my cubby-hole at 7 AM. I work all day, and when I finally get out, everyone else here is gone, so meeting docs who work in the same building is sometimes awkward. It's a little embarrassing. I don't know them by sight. (FP 8)
Limited role in decision making	I get the team moving in a certain direction and get the support. I present it before higher ups, and they just veto everything .... (FP 22)
Undervalued	[The manager doesn't] look for feedback or advice ... she's a teamster. She's going to drive those horses, you don't ask the horse for advice. (FP 8)
Long working hours	I put in 12- to 14-hour days sometimes—but I do have Sundays as my day off. Saturdays ... I come back in to do paperwork ... the main thing is just the ongoing long hours—it's tiring. (FP 5)
Increasing accessibility	This is the latest craze ... . Same-day access. Only certain groups are having to do it. Ask a psychiatrist if they're going to have same-day access. (FP 1)
Loss of effective functioning team	Before they decentralized appointments ... the doctor felt like he had a little more control of what he was doing ... the receptionist could identify em' and you know if they needed longer appointments or if they needed an appointment at all ... not this anonymous person putting a name on your schedule ... . (FP 16)
Excessive paperwork	2-4 hours each day just following up on things... (FP 5)
Difficulty accessing specialist support	I called them up one time ... I said you gotta see this patient, this patient's sick, I can't figure out what to do, and he said we don't have appointments left... .(FP 6)
Conflicting demands	The priority is the acute problem ... the diabetic who walks in with a blue leg or chest pain or a stroke, that takes precedence obviously over going to my desk and working on the registries and from my perspective as a provider there's a bit of a disconnect ... it's the important but not urgent that's [also] the issue. (FP 6)
No time to think, talk, reflect	I don't have time to run off and start phoning people, you know, for discussing patients, 'cause the next patient's in the room, angry, "where is he? What's going on here?" (FP 1)

Some physicians clearly saw themselves as little more than a commodity to be balanced up in the equation, working through their patient lists determined by unseen telephone operators, in physical and technical isolation, and with little say in day-to-day decision making within the clinic.

This experience of powerlessness was not universal, however. For some physicians, particularly those in the smaller clinics with closer working relationships and more local control, there was a more collegial atmosphere among the workforce that alleviated these pressures. Additionally, physicians who had previously worked in private practice pointed out that salaried practice had a number of advantages when it came to earning a regular and predictable income and getting paid holidays and study leave:

"I don't have to worry about my paycheck coming. I can sleep most nights. I do put in many hours, like 12 to 14 hours a day … but I can also take a vacation. That V word is not heard by many physicians in private practice; they can't take the time off. I have very good colleagues. We are not in competition, we help each other out" (FP 4).

The family physicians reported that they generally believed they were well rewarded for their job despite their long hours, often dealing with excessive paperwork and e-mails after the rest of the staff, including the managers, had gone home.

Strategies for Coping

Some physicians managed to retain a sense of control over their working lives or at least to mitigate the impact of their powerlessness by using a range of different strategies for coping.

A number of physicians had reduced their working hours, but 9 of the 11 physicians who worked part-time were female. Part-time workers felt sufficiently comfortable financially to be able to reduce their work commitment, though some reported coming into the office to deal with the paperwork on days they were not actually paid. Some found ways of making their workday more interesting by developing expertise in a particular medical problem or by learning another language so they could to treat patients from an ethnic minority group more effectively. A highly important strategy appeared to be the supportive relationship built among clinic team members, which was more easily available to those in smaller clinics, where the atmosphere was markedly more relaxed and supportive.

Others coped by externalizing blame onto the health care system in general rather than the organization that employed them:

"The way things are in America in health care, my panel has gone from 1,800 to 2,600, and that keeps me real busy; and I tell you, these patients, if they stay the same age it would be tough enough, but they've gotten a lot older" (FP 13).

Another approach to coping was to ignore the rules of the organization. For instance, some physicians did not follow the procedures for referral but instead used personal contacts; others did not always follow protocols absolutely. In response to a question about her views on a new and unpopular (among the family physicians) single-point referral system to mental health, 1 physician replied:

"I usually just call the local office, because I will often want to talk with one of the folks there, so I'm not sure I'm using it correctly. I'm not sure I've been instructed in the proper use of the central line…" (FP 14).

An alternative philosophy adopted by some was to just get on with the job. This approach seemed to involve acceptance that what one could do to change one's working life was limited, and it was important not to lose much sleep over it.

"I'm not in a position to say 'no,' and that's my job, so I do my duty. If I don't like it here, what's the option? …that's my profession" (FP 7).

Unless this approach to work was also combined with a willingness to ignore the rules, at least occasionally, it might lead to burnout.

Certain physicians who had worked for the organization for a long time seemed to cope by listening to their own different drummer[10]:

"I've gotten to the point where that doesn't bother me any more. You know I come and see whoever shows up and do whatever I can and go on about my life" (FP 16).

Valuing the Practice of Primary Care

Maintaining a sense of "specialist skill and knowledge in caring for the whole family" was important to many of the physicians who saw themselves as "one of those who specialize in family practice" (FP 24). This meaning of the term "specialization" was different from that in common usage in health care systems. Specialization in the art of family medicine across the broad canvas of many different problems, however, was not always attainable in their HMO. The variety of family practice was a commonly cited reason for entering family medicine, yet variety was far from evident in my observations of the clinics (indistinguishable from outpatient geriatric medicine for most of the physicians) or in the workday or week.

"My practice is maturing, but I still do some obstetrical cases; it enlivens the mix I'm missing sometimes. I'm not doing as much pediatrics, and I miss that" (FP 5).

There was a palpable tension between how family physicians could meet the patients' (and increasingly the managers') demands of faster access and satisfy an

alternative agenda, voiced more often by physicians than patients, of more effectively coordinating and planning care for patients, most of whom were elderly and had multiple chronic illnesses.

A further tension was created by the addition of specialist nurse case managers, which resulted in a sense of deskilling as the physician became less involved in the day-to-day management of particular disorders, such as diabetes.

"I'm not doing the hands-on day-to-day stuff. And, you know, they're better at it than I am by far … then I become less and less skilled as time goes by … so for me, professionally, that's a loss"(FP 23).

Complexity, often perceived as the remit of specialists, develops from the depth of complex and detailed clinical knowledge within one specialty. Family physicians are indeed specialists in coordinating care across body systems and specialties and making sense of complex multisystem signs and symptoms:

"Someone comes in having dizzy spells and lightheadedness, and this horrible back pain, and also 'my marriage is breaking up and I'm depressed and I'm seeing spots and my left eye went blind yesterday for 15 minutes, does that mean anything?'" (FP 1).

There was a feeling that management did not recognize the importance of the family physician's role in being able to systematically tie together and make sense of such complex problems. This role was further eroded as numerous single-disorder disease management systems were created. Although the physicians found these systems helpful, they did not believe such management systems could substitute for the decision-making ability of a physician who can prioritize multiple problems in the consultation. Perhaps more importantly for the physicians, they felt they were no longer always able to carry out the full range of practice for which they had been trained and which had attracted them to family medicine in the first place.

DISCUSSION

The family physicians I interviewed in a single HMO expressed mounting dissatisfaction and, most importantly, a lack of autonomy. More than one half of the physicians interviewed described a lack of power to change or control their working environment. Some physicians managed to retain a semblance of control or at least managed to mitigate the impact of their powerlessness by resorting to a range of different coping strategies. Although maintaining their sense of specialist skill in the complex art of family medicine was important to many of the physicians interviewed, this sense of specialization across the broad spectrum of health care was not always attainable.

As an experienced British primary care researcher, I found that the physicians in this HMO enjoyed a lower status in the system of health care and considerably less autonomy than is experienced by family physicians in the United Kingdom. British family physicians currently assume greater responsibility for managing their practices, and they play a central role in planning and commissioning care.[11] Even so, erosion of autonomy has also been perceived among British family physicians as an important source of dissatisfaction,[12,13] a result of the current trend toward US-style managed models of care.[14]

Ways of coping with the job may be common across settings and cultures, but not all are good for the organization in the long term. For example, physicians who disregard the rules may inadvertently create an atmosphere in which any change may become difficult to achieve. Retaining the family physician's enthusiasm means not only acknowledging what is difficult about primary care, namely, the competing demands that physicians face in their daily work,[15] but also addressing how the experience of being a family physician can be improved. Initiatives to improve the working life of the family physician should probably aim to inject a sense of diversity and personal meaning into the working week, both of which might restore some feeling of professional autonomy. Introducing group clinic visits for patients with particular problems such as diabetes, or holding special interest sessions in a specialty clinic for physicians to develop their expertise in a given area, such as cardiology or rheumatology, are some options.

It is important to acknowledge the methodological limitations of this study. I interviewed family physicians about their role satisfaction as part of a larger study relating to implementation of quality improvement initiatives. The physicians were selected on the basis of their performance on quality indicators, which may have skewed their responses. I did not interview physicians who performed poorly on both sets of indicators because I did not wish to begin my enquiry with any suggestion that I was interviewing poor performers. All the physicians, however, expressed their interest and appreciation in being asked about how they experience their working day, a conversation not usually engaged in with a researcher. Additionally, during the interview process, I did not accept responses at face value; I cross-checked what the physicians were telling me against any observed evidence that might contradict or support what they were saying. The findings, in terms of physicians' levels of satisfaction and sense of autonomy, cannot be generalized outside this HMO, but the insights into understanding the reasons for dissatisfaction and burnout in physicians[16] may be of wider application.

Recently Plsek and Greehalgh[17] have highlighted the importance of recognizing the inherent complexity

in the daily life of a primary care physician. The role of family medicine in managing clinical complexity and negotiating the organizational morass of the health care system is perceived as an essential component of good quality care.[18] Yet it was clear that many physicians did not find this integrative aspect of their professional role, ie, the "ability of a family physician to choose the most important things to focus on, within the context of a longitudinal relationship,"[19] to be valued or supported by the system in which they worked. Integrative skills seemed particularly to be lost in the process of rolling out successive quality improvement initiatives, such as training nurses as case-managers for chronic illness[20] and assigning specific diagnostic groups of patients to disease management programs.[21,22] These changes, along with the absence of home visiting (still routine in European countries) and the introduction of hospitalists,[23] (US primary care physicians have traditionally managed their patients care in hospitals), have contributed to a less varied working week for many US family physicians.

The broader issue that needs to be addressed is how efforts to improve the quality of care and reduce costs can be reconciled with interventions to improve job satisfaction for physicians and the coping strategies physicians use to mitigate their growing dissatisfaction, such as working fewer hours or disregarding the rules. The degree of professional autonomy experienced by physicians may be one mediating factor in achieving successful outcomes in organizational quality improvement initiatives. Physicians who feel disempowered are not only dissatisfied, they may also devise ways of coping with their dissatisfaction that undermine further (well-intentioned) attempts at organizational change and impinge on patient care. Efforts should be focused on increasing a sense of professional autonomy by greater involvement of front-line workers in not just delivering care but also planning and managing initiatives at a local level.

In conclusion, improving the working experience of family physicians in this type of organizational setting will require physicians and their managers together to seek ways of restoring a sense of professional autonomy and control over the immediate working environment of the family physician. It will also require those in key positions of managerial power and influence to be prepared to assign a greater value to the skills in managing clinical and organizational complexity that are particular to family medicine.

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