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MINORITY PHYSICIAN JOB SATISFACTION: AN ANALYSIS OF
EXTRINSICALLY-CONTROLLED ORGANIZATIONAL FACTORS

by

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B.S. San Jose State University, 2003

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ABSTRACT

Few organizational communication studies examine the organizational aspects influencing career satisfaction specifically among non-white cultures in the medical physician population. This study examines minority physicians' perceptions of extrinsically controlled work environment factors in comparison to their white counterparts. Three research questions were analyzed from a 17-question survey tool to measure: physician satisfaction levels with autonomy over medical decision-making; autonomy over non-medical workplace decisions; and hospital cost containment efforts. These organizational variables have served as major points of discourse within the healthcare arena and they relate to the enigmatic nature of career satisfaction. Determined by the volume of respondents representing each race and ethnicity, five categories were selected for comparison: Asian/Pacific Islander, Indian/Pakistani, White/Non-Hispanic, Hispanic, and Black/African American. Participants that were surveyed included all physicians listed on the medical staff roster of a Southeastern, not-for-profit hospital group, regardless of status and medical specialty. The primary findings indicate that substantial variance exists among racial and ethnic subgroups regarding satisfaction with the dependent measures. Due to low numbers of minority health care physicians, previous studies have commonly measured physician job satisfaction aggregately, failing to differentiate cultural groups. Interestingly, when minority and non-minority groups were aggregately juxtaposed, no significant differences were reported in the data. However, when satisfaction was measured contrasting minority subgroupings with that of non-minority physicians, significant variations emerged from the data set. This study contributes to understanding better the organizational experiences of minority physicians in healthcare and the body of knowledge concerning minority health research as a whole.

To the resilient souls behind the disparate statistics and those who seek the knowledge to bring

about change. I admire you all…

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To begin, I would like to give honor to my Lord and Savior who blessed me with the compassion and humility to realize that the change I desire to see in society must begin with me.

To my family, for recognizing my aspirations and responding with unconditional love and support. You all give me strength beyond your understanding. Thank you…

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INTRODUCTION AND RATIONALE

There is compelling evidence for the need to increase diversity within the physician workforce. Many segments of the U.S. population, particularly minority groups, reside in medically underserved areas and suffer disparate disease burden and negative health outcomes. Reports show that Black and Hispanic physicians are more likely to provide health care to Black and Hispanic patients; serve poor, uninsured or Medicaid-insured patients; and locate their practices in underserved areas (Reede, 2003).

During an October 2003 hearing before the Sullivan Commission on Diversity in the Health care Workforce, National Medical Association President Randall W. Maxey, testified regarding the urgent need to increase minority health care professionals. Maxey noted that many minorities do not have access to quality, affordable health care, largely due to "the absence of health care professionals who look like them, are committed to serving them, or who are culturally competent to meet their health care needs" (National Medical Association Press Release, Oct. 2003). Dr. Maxey also urged the committee to adopt several recommendations aimed at expanding the number of minority physicians including; collecting and reporting data on race and ethnicity related to admissions, matriculation, graduation and placement of graduates of medical schools; and to provide increased funding for medical schools that have an historic mission to train African-American physicians as well as physicians from other minority groups. He supplemented his testimony by citing the conclusions published by the Pew Commission, which affirmed that "today's generation of health professionals does not fully represent the diversity of the nation, and as a result, significant numbers of people are not receiving the most effective care."

In recent years, the problem of under-representation has become even more dire. Among the recommendations that Dr. Maxey made to the 15-member Sullivan Commission, the need for additional financial support for programs, initiatives and medical schools that have an expressed purpose of increasing the number of minority physicians predominated his testimony. This approach to achieving racial uniformity among health care physicians appears to be of widespread consensus among health researchers; however, little research has been conducted to address the organizational factors within health care that may represent a key ingredient to the lack of enticement among minority scholars to pursue medical careers.

During the latter portion of his deposition, Dr. Maxey interestingly called for the Sullivan Commission to "set forth a planned approach through which future and practicing physicians actively participate in the effort to achieve parity of diversity in the health care workforce." This recommendation differed from the others in that it introduced new post-medical school factors into the equation. This proposal suggests utilizing present and future physicians in a joint effort to promote initiatives that would help bridge the racial gap among physicians. Intriguingly, this approach presumes at least two outcomes to be true; first, practicing minority physicians possess moderate-to-high levels of job satisfaction, and secondly, that minority physicians would fervently endorse a career in medicine to potential minority medical school candidates. If a highly qualified minority college student, undecided about attending medical school, sought the counsel of a practicing minority physician to possibly sway opinion, what advice might that physician offer? More importantly, how can the health care system, from an organizational bureaucratic standpoint, assure that the majority of such conversations conclude with the practice of medicine being presented in a favorable light?

Isolated cases similar to the aforementioned are commonly dismissed; however, when examined on a comprehensive level, they can produce influential word-of-mouth effects that can permeate a society and culture bringing forth positive or negative opinions of medical careers. If minority physicians are called upon to influence students to pursue medical careers, and their advice can be assumed to emanate from their own levels of job satisfaction, then it is imperative to study the organizational factors that influence job satisfaction among practicing minority physicians.

REVIEW OF LITERATURE

Review of Physician Satisfaction Research

The level of career satisfaction derived by physicians from their work is a basic yet essential element in the functioning of the health care system. The contributing factors affecting physician satisfaction have been studied and outlined in the extant body of literature. Stoddard, Hargraves, Reed, and Vratil conducted a study entitled "Managed Care, Professional Autonomy, and Income in which they examined the degree to which *professional autonomy*, *compensation*, and *managed care* are determinants of career satisfaction among physicians. A nationally representative sample of 12,385 direct patient care physicians was surveyed in the study. The level of satisfaction with one's overall career in medicine served as the dependent measure. The main finding was that physicians with low managed care revenues are significantly more likely to be "very satisfied" than are physicians with high managed care revenue, and that physicians with low managed care revenues are significantly more likely to report higher levels of clinical freedom than are physicians with high managed care revenue. Among the measures,

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traditional core professional values and autonomy were the most important determinants of career satisfaction after controlling for all other factors. Relative income is also an important independent predictor. Managed care illustrated its greatest effects on satisfaction through its impact on *professional autonomy*, not through income reduction. The researchers' main conclusion was that when managed care erodes professional autonomy, the result is a highly negative impact on physician career satisfaction.

Another such study of physician satisfaction (Landon, Reschovsky, & Blumenthal, 2003) sought to measure the changes in satisfaction levels longitudinally from 1997 to 2001. The results showed a decline in overall satisfaction between 1997 and 2001, but not dramatically. However, four individual factors were reported as significant contributors to career dissatisfaction over that time period – a longer work week, decreasing income, barriers to referral, and the degree of managed care penetration. Findings differed among primary care physicians and specialists concerning the contributing factors of career dissatisfaction, yet, results showed a steady parallel in low satisfaction levels regarding certain organizational factors - the decrease in control over one's practice and difficulty getting needed outpatient services for their patients.

One of the most often cited articles in terms of the effect of organizational setting on physician satisfaction was Mechanic's 1975 study in which the major objective was to determine how a prepaid setting affected physicians. Data on a variety of characteristics were presented, including sociodemographic attributes, size of community, income, and workload, among others, for both prepaid and nonprepaid settings. In this study satisfaction was considered to be a dependent variable, and the nature of the organization was considered to be the independent variable. The level of satisfaction of physicians was found to be less in the more highly structured organizations. The past data on

physician satisfaction establishes a profound need to study, not only, intrinsic factors that affect satisfaction levels, but also the perceived organizational constraints that affect physicians abilities to amply function within the health care system.

<p align="center">Implications for Lack of Physician Satisfaction</p>

As more physicians practice in organized settings, such as group practices, health maintenance organizations (HMOs), and hospitals, the manner in which these physicians cope with higher levels of organization and bureaucracy in their practice settings will become increasingly important. For instance, low physician job satisfaction may pose serious costs to organized health delivery settings in the form of low morale, high turnover, and perhaps, low productivity and quality of care.

Job satisfaction can be conceptualized as the difference between what a worker experiences on the job and what he or she wants or expects to find. Locke hypothesized that job satisfaction is an affective response or feeling "…associated with a perceived difference between what is expected as a fair and reasonable return…and what is experienced, in relation to the alternatives available in a given situation." Job satisfaction is not a single concept. Rather, it has multiple dimensions or facets that correspond to different aspects of the work environment.

Theoretically, physician job satisfaction would be related to such instrumental concerns as pay and perquisites, staffing adequacy, and equipment availability, as well as to such matters as the physician's degree of autonomy, relationships with colleagues and patients, status and prestige, time pressures, range and complexity of cases seen, quality of care rendered, and the quality of the overall practice setting.

Understanding trends in physician career satisfaction and how changes in the practice environments of physicians affect their career satisfaction is important for several reasons. First, physician satisfaction is associated with quality of care, particularly as measured by patient satisfaction. Second, dissatisfied physicians are more likely to leave the profession and discourage others from entering (Landon, 2003). This is disruptive to patient-physician relationships, costly to physician practices, and could ultimately diminish overall quality of care if potentially outstanding physicians are dissuaded from choosing this career. Finally, career dissatisfaction might be one manifestation of physician's perceptions of problems in delivering high-quality care to their patients.

In an attempt to understand organizational climates, researchers as well as practitioners have begun to closely measure job satisfaction. This focus on employee satisfaction originated in the human relations and human resources approaches to organizations and communication. Douglas McGregor, Frederick Herzberg, and Abraham Maslow have argued, in different but related ways, that a satisfied employee is one whose needs are being met. Employees have general levels of needs that correlate with degrees of job satisfaction.

- Level 1 needs include safe working conditions and sufficient pay, rewards, and equipment.
- Level 2 needs, which include supportive interpersonal relationships with co-workers and supervisors, contribute to employee morale and motivation.
- Level 3 needs include opportunities for personal growth, such as those provided by challenging work tasks, greater responsibility, *greater independence*, and a clear career path for the future.

When the three levels of employee needs are satisfied, higher levels of job satisfaction are likely to result (Eisenberg, 2001).

Effects of Perceived Autonomy on Satisfaction

As early as 1973, beginning with the J.B. McKinlay studies, there has been extensive debate about the issue of autonomy. The principle of autonomy is related to professionalism at several levels. Autonomy at the collective level relates to the ability of a profession to control the standards of entry as well as set the terms of work. On another level, individual autonomy can encompass altruistic motivations as well as self-interest. Through a commitment to professional values and in exchange for honoring the needs of the patient in a sacred trust, physicians earn unique societal stature. This in turn conveys a high degree of individual autonomy to control the terms and content of their work. Professional autonomy on an individual level encompasses not only those aspects of work derived from one's medical expertise, such as clinical decision-making and the ability to obtain needed medical services for patients (clinical or technical autonomy), but also other prerogatives pertaining to control over work (such as the autonomy to structure one's schedule). Autonomy in this latter aspect of practice, although not directly related to patient care, remains a highly valued privilege among physicians (Stoddard, 2001).

Physician satisfaction is a critical topic not only for physicians but also for patients and health care administrators. When physicians are satisfied, they are significantly more likely to stay in a given practice and as a result, plan administrators are saved the financial costs associated with high turnover, as well as the decline in patient satisfaction that often accompanies high turnover. Researchers have found a strong correlation between physician satisfaction and patient satisfaction. As a result, when

patients are satisfied, they are less likely to leave a plan, which is obviously a benefit for any health care administrator (Warren, 1998).

Physician satisfaction or dissatisfaction has implications for workforce policy. A dissatisfied physician workforce can negatively affect the future supply of physicians. According to the Association of American Medical Colleges (1999) (Lepore, Tooker, 2000), medical schools reported a decrease in applicants and cited "the perceived loss of physician autonomy due to recent changes in health care marketplace" as one reason for the decline.

Consistent with The Job Characteristics Model of Work Motivation (Hackman & Suttle, 1977), autonomy is defined as the degree of freedom or control employees have in scheduling and performing their work. Autonomy is perhaps the most important factor in reducing job stress and improving quality of work life because it encourages employees to feel effective, resourceful, responsible, and trusted by others in the organization (Jackson, 1983; Karasek, 1979; Luhman & Albrecht, 1990) (Eisenberg, 2001).

Loss of autonomy is an issue with managed care and fiscal reform. Traditionally, physicians have had considerable autonomy, and other caregivers such as nurses, pharmacists, and therapists have had limited input about treatment decisions. With managed care, even doctors are likely to have supervisors, and their decisions are subject to administrative review and financial oversight. Research suggests that about two thirds of doctors feel they have lost autonomy in recent years, mostly as a result of managed care (Schulz, 1997). The loss of autonomy may explain, in part, why HMO doctors are typically less satisfied with their jobs than physicians who work on a fee-for-service basis (Schulz, Scheckler, Moberg, & Johnson, 1997). Specialists are particularly sensitive to

the effects of managed care since they must rely on referrals from primary care physicians.

Caregivers may also feel constrained by economic pressures. They must answer, not only to their employers, but also to funding agencies and patients who have strong, often conflicting, interests in medical decisions.

Health communication may suffer if doctors become discouraged by institutional demands. An Israeli study suggests that salaried physicians (like those employed by hospitals and some HMOs) are more apathetic than others. Salaried physicians surveyed were less likely than other doctors to instigate talk about patients' lives and emotions (Ben-Sira, 1990). The physicians said their outlook would turn around if the organizations for which they worked allowed them adequate time for patient visits, reduced administrative demands, and gave them more authority to make decisions about patient care.

Professional autonomy is typically lessened by participation in managed care organizations. Doctors accustomed to making their own decisions may be required to follow new guidelines, cut spending, and justify their actions.

Some people are optimistic that caregivers and managed care organizations will work out a pleasing compromise between professional authority and financial considerations. Val Dean, a physician and managed care executive, asserts in a (1997) editorial that HMOs are becoming more sensitive to doctors' concerns at the same time doctors are becoming more comfortable with group practice. Sharing administrative responsibilities and patient care is a prospect that appeals to some doctors, Dean says, especially new doctors, who may not expect the same autonomy as doctors did in the past.

The Role of Utilization Management on Satisfaction

In recent years, the practice of medicine has been undergoing substantial change. Because of prohibitive health-care costs, employers and other purchasers have been pressuring health providers to contain costs. Almost all health plans, even those offered by traditional insurers, have instituted some form of management initiative to control costs. *Utilization management* (UM) represents a broad array of techniques designed to influence the consumption of health care services, usually with the objective of promoting cost containment. UM has become a prominent fixture of the U.S. health care system and managed care plans, public and private payers of health care services, insurance carriers, and hospitals have used UM in one form or another to control health care utilization and contain costs. Evaluations of UM have generated mixed findings, with some studies showing reductions in utilization and costs and others showing little effect.

Despite its widespread use, UM has engendered debate and controversy. Physicians have been outspoken critics of utilization management because it has limited their clinical autonomy and has contributed to an unendurable administrative burden (Wickizer & Lessler, 2002). Insurance carriers, third-party payers, and health plans have defended the use of UM as an imperfect, but necessary, practice that is needed to reduce consumption of unnecessary or inappropriate health care services and thereby contain health care costs.

The most common cost-saving initiatives across most types of plans are *utilization review* controls, *gatekeeping*, and changes in physician *payment mechanisms*.

Utilization review typically involves preauthorization, second opinion reviews, prospective procedure reviews, concurrent reviews, and case management. Physicians

also have an increased administrative burden from utilization review. Because there is no uniformity among utilization review firms which perform the service, the kind of treatment a patient receives depends on the particular consultant used.

Gatekeeping involves using primary care physicians to provide as much care as possible and to limit access to high-cost specialists. To the extent that primary care physicians are penalized for referrals and are improperly prepared for their expanded gatekeeper role, quality of care may suffer.

Changes in physician *payment mechanisms*, especially capitated payment, have also been instituted to help control costs. Payment, too, can impact quality. Quality is of particular concern in managed care settings, such as HMOs, where incentives to underproduce are more common than in looser plan configurations (Ahern, 1993).

Utilization review, which is arguably the most controversial and invasive feature of UM, typically focuses on hospital care but is also used to review and authorize outpatient care. The intent of UR is to constrain health care costs by reducing unnecessary or inappropriate medical care. These two terms generally indicate care that (a) provides no significant clinical benefit, or (b) could be rendered in a less costly setting. Utilization review is performed on a case-by-case basis, usually by an external review agency, and is offered by health plans and insurance carriers as a benefit design feature (Wickizer & Lessler, 2002).

There is increasing focus on and concern about, the equality of medical care; financial constraints are being applied more frequently and stringently; and the practice and management of medical care has become increasingly centralized and dominated by managed care and physician organizations. Whereas physicians once practiced primarily alone or in small autonomous groups, they now are more likely to practice in large groups

and are increasingly subjected to profiling, utilization review, and preapproval for procedures and treatments (Wilkes, 2000). In addition, most physicians are now expected to follow prescribed guidelines and to use decision tools supplied by outside sources, which further compounds the issues that physicians already face in daily practice, leading to higher levels of dissatisfaction. One of the main ideas of this study will be to examine physicians' satisfaction concerning the utilization management procedures of a Southeastern United States health care system.

<u>Implications of Minority Physician Underrepresentation</u>

Given the disparity between proportions of minority's in the general population and in the physician workforce and the projected increase in the minority population, it is crucial and timely to examine factors that contribute to satisfaction of minority physicians. The likelihood that all U.S. citizens will be able to obtain quality health care in this country during the 21st century will depend to a great extent on how well diversified the U.S. physician workforce becomes in the near future! According to the 2000 U.S. Census, underrepresented minorities, African Americans, Mexican Americans, mainland Puerto Ricans, and Native Americans now comprise 30.1% of this country's population but only constitute 10.5% of the incoming medical school classes in 2000. African Americans presently account for approx. 12.1% of the U.S population but account for only 3.7% of the physician workforce (Gartland, 2003). African American and Hispanic physicians currently account for less that 10% of the physician workforce yet provides care for more than 20% of the minority population (Saha, Taggart, Komaromy, Bindman, 2000). This should be of concern to every U.S. citizen when it is

realized that the minority population of the United States is projected to increase by 60% by the year 2010 (Association of Medical Colleges, 1998).

Multiple studies have detailed select aspects of physician job satisfaction, but little has been done to systematically identify variables that influence career satisfaction. In addition, important physician subgroups, such as women, minorities, and inner-city physicians have been underrepresented in the literature on this subject (McMurray, 1997).

In some areas, the disparity is even more striking. In the Boston area, only 3.2% of physicians are African American or Hispanic American although those groups comprise 13% of the state's population (du Pré, 2003). And the numbers are not improving. In Boston, cancer death rates are 45% higher among African Americans than European Americans (du Pré, 2003). This is not to say that White doctors intentionally let people of color die. A more reasonable explanation is that the social conditions and discrimination that make minorities at risk for health concerns also create disadvantages in medical settings and limit their opportunities to become medical professionals.

The odds are that minority patients in the United States will be cared for by doctor's whose race and cultures are different from their own. This is not necessarily a problem, but it can be. Levy (1985) observed that physicians may be more critical and less comfortable with patients of another race, or they may be overly paternal or condescending. Caregivers may also under- or overestimate cultural differences. As a result, they may consider behavior abnormal because it does not conform to their expectations or may perceive unhealthy irregularities as mere cultural differences (Daly, Jennings, Beckett, & Leashore, 1995).

Reports on Minority Physician Satisfaction

The vast majority of the research data concerning physician satisfaction is presented in aggregate form and does not account for the varied racial and ethnical demographics of the field. As a result of this insufficiency, it is plausible that the specific opinions and satisfaction levels of minority physicians are not being distinctly recorded outside of the non-minority majority. Out of nearly 800,000 U.S. physicians, minority's account for approximately 14.3%, which appears relatively invisible when compared to the 50.6 % that accounts for non-minorities (Plasko & Smart, 2003). [1]

In 2003, The Gallup organization conducted a survey for the National Medical Association (NMA), which reported that nearly 70% of the black physicians who participated were dissatisfied with the medical profession. The data also suggested that a large number of black physicians are dissatisfied with their decision to practice medicine and are *unlikely* to recommend being a doctor to a young friend or associate. Given the low satisfaction levels, the number of black physicians isn't likely to increase, and could possibly decrease (Blizzard, 2003). The results of the Gallup poll were based on mail interviews with 479 past and present NMA members, administered in July and August 2003. This data speaks to the urgent need to rigorously analyze the factors that are significantly affecting minority physician satisfaction levels.

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[1] According to national data collection measures, 35.1% of U.S. physicians have been categorized as unknown/other in the data set.

RESEARCH QUESTIONS

The current study examines how minority physicians perceive extrinsically controlled work environment factors compared to non-minorities. Due to a lack of past and extant literature concerning this issue, the following research questions were formulated:

1) Do minority physicians report significantly different satisfaction regarding autonomy over medical decision-making than their non-minority counterparts?

2) Do minority physicians report significantly different satisfaction regarding autonomy over non-medical workplace decisions than their non-minority counterparts?

3) Do minority physicians report significantly different satisfaction with hospital cost containment efforts than their non-minority counterparts?

METHODOLOGY

Purpose

The purpose of this study is to provide valid information into how minority physicians perceive extrinsically controlled work environment factors compared to non-minority physicians.

Participants

All 1849 physicians listed on the medical staff roster of a Southeastern, not-for-profit hospital group were included in the population surveyed, regardless of status and medical specialty. Of the solicited participants, 38.1% completed and returned surveys.

Independent Variables

The survey tool asked physicians to complete several demographical fields, one of which being race and ethnicity. The race and ethnicity item was extracted to make comparisons between the perceptions of minority physicians versus those of non-minority respondents with regards to the organizational factors that were labeled as the dependent variables.

Dependent Variables

The research literature suggests that variations in physicians' perceptions of job satisfaction are linked to features of the practice or work setting (Freeborn, et al., 2001). The dependent variable was the level of reported satisfaction with three organization-specific variables. Those items being measured were; the level of physician satisfaction with perceived autonomy over medical decision-making, autonomy over non-medical

workplace decisions, and satisfaction with the cost containment efforts at the hospital. The self-report measures required participants to identify their levels of satisfaction with items using a 9-point Likert-type polarized scale (Very Dissatisfied at 1 and Very Satisfied at 9, with no intermediate descriptors).

Procedure

From May through June in 2004, the survey was mailed with pre-paid return envelopes, in three waves, to the 1,849 physicians on the active medical staff list of a seven-hospital, not-for-profit, faith-based health system serving a three-county region in Florida. The surveys for each of the seven hospital campuses were mailed with a letter signed by the Medical Chief of Staff specific to that potential participant's hospital campus. The elected President of the Medical Staff signed a cover letter for those doctors who could not be associated with one or another hospital due to practice or referral patterns (the seven hospitals within the system operate under a single license; thus, it is formally one medical staff). About 1,200 physicians received the survey under the cover of the elected President during the first wave of surveying. Three waves of mailings were accomplished beginning the first week of April 2004. A second mailing labeled "2nd Notice" went out the first week of May 2004. The third and final mailing labeled "Final Opportunity", which went out the first week of June 2004.

The promise of confidentiality was made to all participants. None of their personal information or individual responses would be shared with hospital personnel other than the research team in such a way that their personal identification could be associated with their individual responses. The potential benefits that physicians and medical leaders of the Hospital System, as well as the medical community as a whole

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might gain from the results of the study were expressed to potential participants and used to encourage them to complete and return the surveys.

Measurement Tool

The study utilized a survey instrument that was designed to maximize validity and reliability. The survey format consisted of 17, 9-point Likert-type polarized items (Very Dissatisfied at 1 and Very Satisfied at 9, with no intermediate descriptors). The items were derivatives of commonly used measurement items that were employed and validated in past studies. The layout, design, and ordering of questions for the survey were carefully formulated, encompassing intrinsic, as well as extrinsically related questions that were deemed as highly relevant to physician satisfaction by past researchers via previous surveys and focus groups. According to these focus group results, the issues related to satisfaction for physicians were, from most to less often mentioned, (1) day-to-day practice, (2) relationships, (3) administrative issues, (4) autonomy, (5) income, (6) personal and family issues, (7) quality of care, and (8) government concerns.

A rigorous review of physician satisfaction research literature aided in the decision of inclusion and frequency of question types that were used in the survey instrument. Three studies were used as principal sources during development of the survey tool; Ahern, (1993), Konrad, Williams, & Linzer, (1999), and McMurray, Williams, & Schwartz, (1997).

To insure lucidity, a group of physicians and medical leaders within the hospital system were organized to serve as a "Physician Advisory Group", who shared their insights and advice with the research team during several workshops throughout the study

design process. Their active participation and support were also expressed to participants, which further increased the *credibility* of the study and improved the chances for a greater response rate.

Other specific steps were taken to maximize the response rate. The survey was designed to be brief and to the point, taking less than four minutes to complete. Per the request of the Advisory Group, several survey items were altered or omitted to increase cultural sensitivity. Cronbach's Alpha Scale Reliability on the 17 survey items was .874 (N = 586), providing strong evidence of internal reliability.

The survey instrument also gathered demographic and background information, including gender, age, race/ethnicity, marital status, the number of children living at home, medical specialties, years in practice, proportion of patients by payor, practice setting, participation in practice ownership or management, and hours worked in a typical week. The final item in Section A was a 9-point Likert-type polarized scale on stress (Not At All Stressed at 1 and Very Stressed at 9, with no intermediate descriptors). Section B was the 17 satisfaction items. Section C included open-ended questions about how the system of health could be improved for physicians; the one thing the Hospital system could do to improve the respondent's satisfaction; hobbies and interests; and whether or not the respondent would be willing to participate in a follow-up interview.

Response Rate

The study experienced an overall response rate of 38.13 percent: 705 out of 1849 solicited participants completed and returned surveys. Based on methods proven successful by other researchers, several measures were taken to maximize the overall survey response rate for the study. The survey was brief by design. Participants were not

only asked questions about themselves, outside of their affiliation with the hospital group, but also about personal and/or familial relationships. Questions about the hospital group were few. An Advisory Group, who shared their insights and advice with the research team during several workshops throughout the study design process, was organized from a group of esteemed medical leaders. A cover letter signed by the Medical Chief of Staff for each campus accompanied the surveys specific to that campus. Postage-paid, self-addressed, return envelopes were supplied to participants. The survey was distanced in time from other surveys to the same population. A promise of confidentiality was made to all participants. The potential benefits to physicians and medical leaders from the results of the study were expressed to potential participants.

<div align="center">Data Entry and Quality Check</div>

The data was entered into a Microsoft Excel Spreadsheet, which was later transported into SPSS for statistical analysis. To allow for statistical analyses, each variable was assigned a column, and a numerical value was assigned to most text and open-ended responses such as: gender, marital status, race, ethnicity, and medical specialty.

In the first of two quality checks, 10% of the surveys were randomly selected through a function available in Microsoft Excel: =INT(RAND()*10). This function randomly assigns values to each line of data entry. Values range from 0-9. All "0's" were chosen to be those included as the 10% quality check. Those survey numbers to which Microsoft Excel randomly assigned the value "0" included the following:

> 1010, 1023, 1039, 11080, 1122, 1125, 1157, 1158, 1174, 1187, 2002,
> 2007, 3029, 3042, 3052, 3064, 4010, 4084, 4094, 4110, 6015, 6022,
> 6082, 6107, 6146, 6174, 6176, 6186, 6187, 6188, 6215, 6269, 6275,
> 6298, 6356, 6359, 6392, 7020, 7030, 7058, 7078, 7110, 8040, 9113,

3122, 9145, 9151, 9161, 9164, 9167, 9179, 9220, 9267, 9270, 9284,
9313, 9349, 9372, 9448, 9514, 9523, 9526, 9532, 9534, 9598, 9645,
9662, 9702, 9718, 9759, X004, Y005

A second quality check was also conducted due to the high risk of multiple

sequenced or serial items containing errors. For instance, Q6 is a 4-part answer and if not

entered correctly could affect Q7. Questions 13-29 are a series that one incorrect entry

could compromise the validity of the answers in those that follow in the series.

The study contains the possibility of 28,905 errors. During quality check

processes, 142 errors were found, 41 of which resulted from the oversight of one entire

survey's data not being entered. The percentage of errors in data entry was .005 (five

tenths or 5 per 1,000 entries). Among those surveys selected for the quality checks and

listed above, the errors were identified and corrected (see Appendix A, tables 1 & 2).

RESULTS

Test of Research Questions

One-way analyses of variance were conducted on the research questions to assess the satisfaction levels of minority physicians versus non-minority physicians with relation to the three dependent measures; autonomy over medical decision-making, autonomy over non-medical workplace decisions, and satisfaction with cost containment efforts of the hospital. The pattern of means in Table 1 illustrates that there were no significant differences in satisfaction levels when comparing minority and non-minority physician groups for any of the dependent variables. The participants' responses based on three, 9 point Likert-type scale items are summarized in Table 1 below.

Table 1

Means for Measures of Satisfaction across Variables

Satisfaction with	Minority				Non Minority			
	N	Mean	F	*p*	N	Mean	F	*p*
Cost containment efforts	181	5.07	.002	<.05	425	5.06	.002	<.05
Autonomy over medical decision-making	189	5.98	.216	<.05	453	6.07	.216	<.05
Autonomy over non medical decision-making	189	5.43	.262	<.05	446	5.53	.262	<.05

A subsequent ANOVA and post-hoc Tukey test was conducted to more extensively analyze physicians' satisfaction with the dependent measures across racial and ethnical subgroupings. Determined by the volume of respondents representing each race and ethnicity, five categories were selected for comparison; Asian/Pacific Islander, Indian/Pakistani, White/Non-Hispanic, Hispanic, and Black/African American. Also of note, the Indian/Pakistani group among this study's respondents was large enough to raise the notion that it may be time to consider this as a distinct group in survey studies. With increasing reliance on foreign medical graduates in the U.S. and the cultural uniqueness of that region of the world, systematic influences on how U.S. medicine will evolve may be underway and understudied.

The pattern of means in Table 2 illustrates that significant variation in satisfaction levels exist concerning the dependent measures. Black/African American physicians reported significantly lower satisfaction levels on several of the dependent measures when compared to other minority, as well as, non-minority physicians.

Table 2

Means for Measures of Satisfaction across Racial/Ethnical Subgroups

Means v. Contrasts

Satisfaction with	Asian/Pacific Islander	Indian/ Pakistani	White Non-Hispanic	Hispanic	Black/African American	Overall ANOVA		
	n=66	n=23	n=446	n=74	n=24	df	F	Sig.
Cost containment efforts	5.60*a*	5.14*ab*	5.06*b*	4.94*b*	3.86*c*	4,598	3.665	.006
Autonomy over medical decision-making	6.43*a*	5.57b	6.07*a*	6.07*a*	4.91b	4,634	2.452	.045
Autonomy over non-medical workplace decisions	5.82*a*	5.87*a*	5.53*a*	5.27*ab*	4.57b	4,627	1.871	.114
Overall Satisfaction	6.40*a*	6.23*a*	6.05*b*	5.99b	5.38*c*	4,642	3.851	.004

* Groups with common subscripts do not differ from each other, at p < .05 (Post-hoc tests).

As illustrated in Figure 1 (below), physicians classified as Asian/Pacific Islanders (n = 66) reported significantly higher levels of satisfaction with cost containment efforts at the hospital (M = 5.60, SD = 2.01) than did Black/African American, Hispanic, and White/Non-Hispanic physicians, respectively. In contrast, Black/African American physicians reported significantly less satisfaction with the cost containment efforts at the hospital than any other group of physicians (M = 3.86, SD = 1.64), including non-minorities. There were no other significant differences reported.
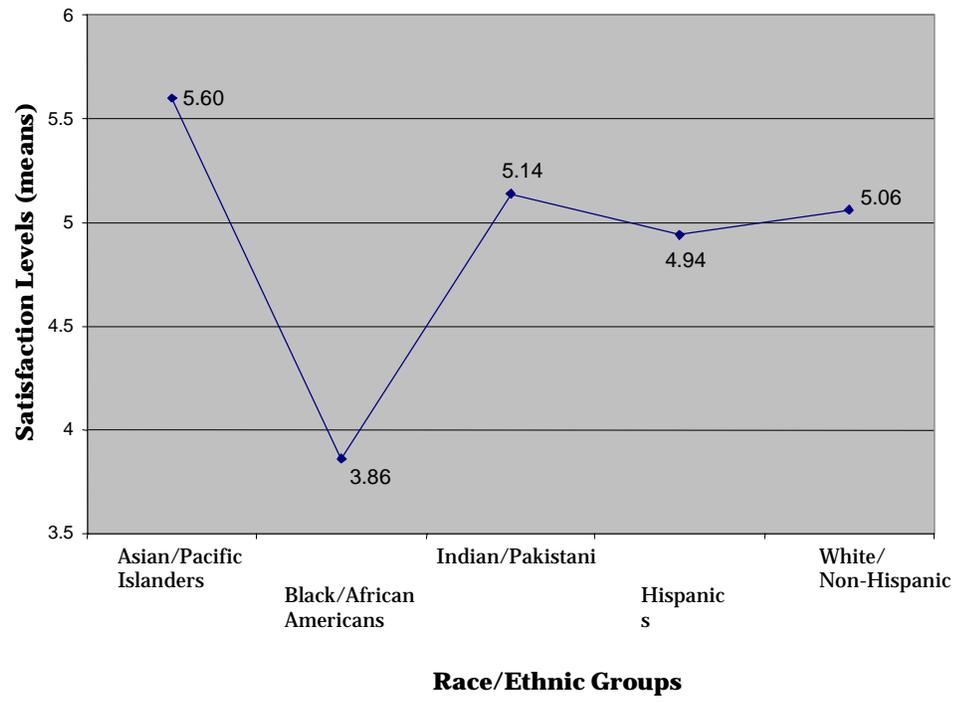
Figure 1: Satisfaction with Cost Containment Efforts

Additionally, Black/African American physicians reported significantly less satisfaction with autonomy over medical decision-making (M = 4.91, SD = 2.58), when compared to each of the other racial subgroupings, with the exception of Indian/Pakistani physicians (M = 5.57, SD = 2.56). Also of note, Black/African American physicians were the only group to report a significant mean difference for satisfaction with autonomy over medical decision-making when analyzed across racial subgroupings. No other groups reported significant differences for this variable.
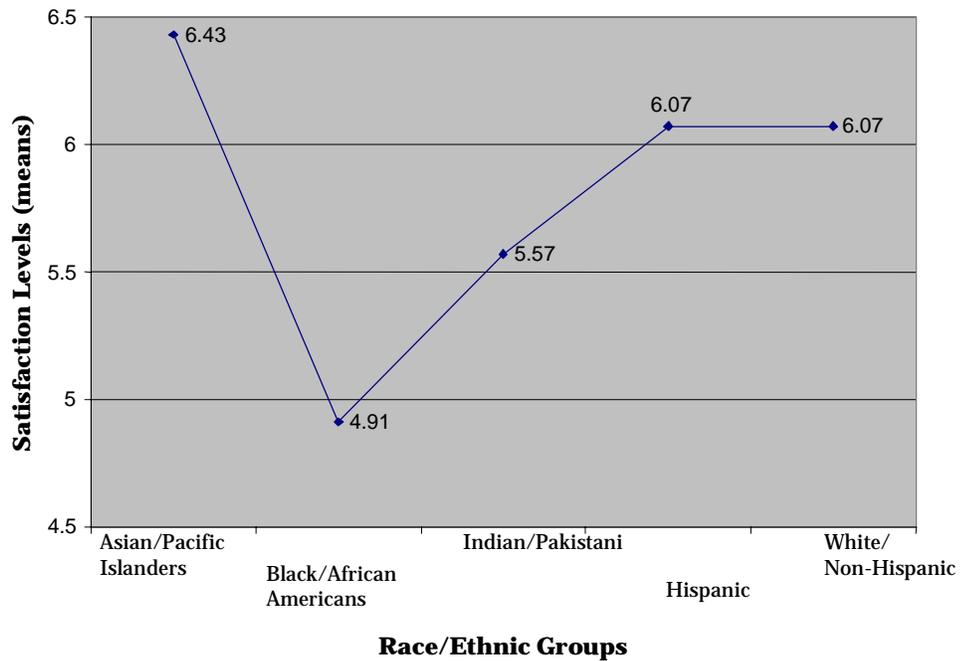

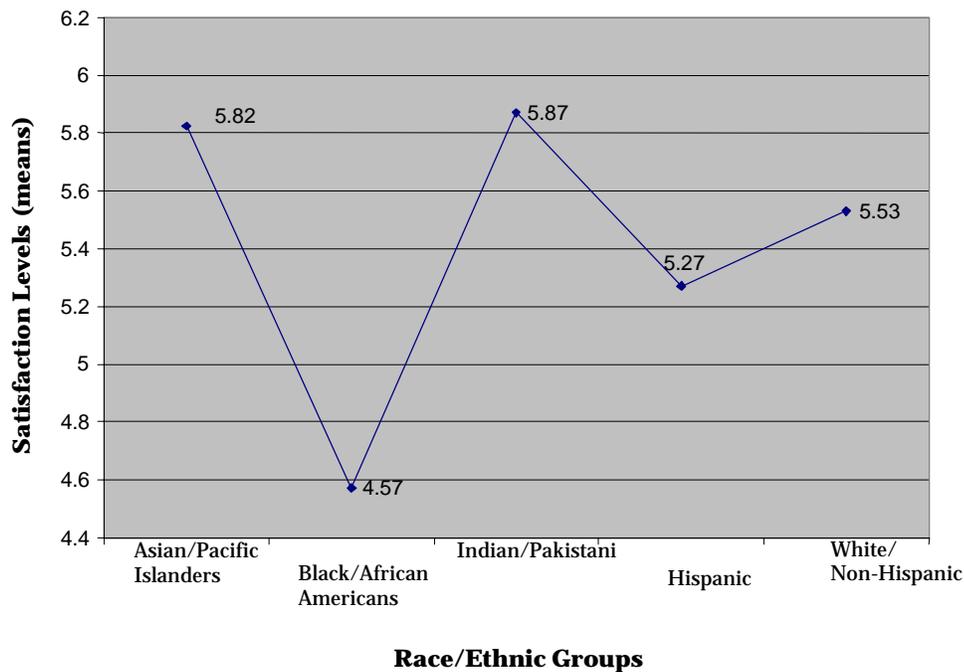Figure 2: Satisfaction with Autonomy over Medical Decision-Making

Figure 3: Satisfaction with Autonomy over Non-Medical Workplace Decisions

As evident in Figure 3, Black/African American physicians were significantly less satisfied with their autonomy over non-medical workplace decisions (M = 4.57, SD = 2.39), when compared with all other racial categories except for Hispanics (M = 5.27, SD = 2.19). No other cultural group reported significant differences for this measure in the data set.
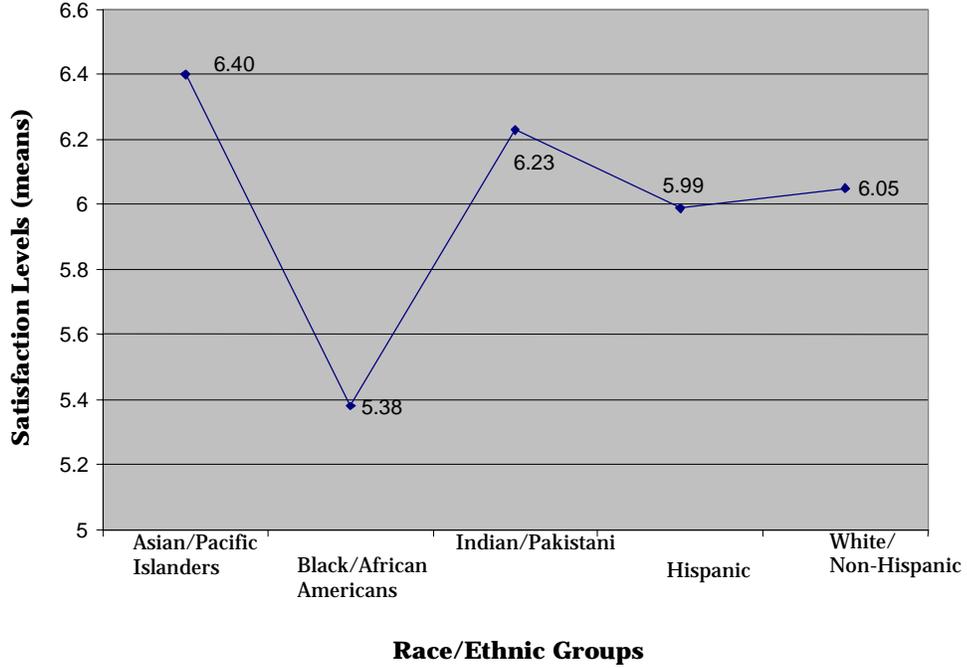
Figure 4: Overall Satisfaction

To provide further context to the dependent measures, a fourth item was computed to measure the overall satisfaction of physicians with all 17 survey items (see Appendix A). Physicians of Asian/Pacific Islander origin (n = 66) reported significantly more overall satisfaction (M = 6.40, SD = 1.15) than Black/African Americans, Hispanic, and White/Non-Hispanic physicians, respectively. Interestingly, Black/African American physicians (n = 24) were significantly less satisfied *overall* (M = 5.38, SD = 1.31), when compared to any other cultural group in the data set.

DISCUSSION

The primary motivation for this study was to identify key disparities in satisfaction levels between minority and non-minority physicians, and to obtain a clearer understanding of what certain cultural subgroups deem to be central in maintaining satisfaction in the workplace. Moreover, this research study sought to deviate from the extant literature in its attempt to restore the voice that speaks to the nuances that separate cultures and their unique perceptions of health care organizational bureaucracy. Given the austere disparity in numbers, these perceptive contrasts have remained relatively hidden by the often-used aggregated form of data collection and analyses.

Research questions were formulated to measure physician satisfaction levels with (1) autonomy over medical decision-making, (2) autonomy over non-medical workplace decisions, and (3) hospital cost containment efforts. These extrinsically-controlled organizational variables have served as major points of discourse within the health care arena as they relate to the enigmatic nature of career satisfaction. The analyses of physician satisfaction concerning these dependent variables offer generalizable data, in that these continue to be very pertinent issues on arguably the majority of hospital campuses nationwide.

The data were collected with no favored preconceptions of how physicians' attitudes toward these variables would be culturally organized; therefore, research questions were selected to provide this insight, as opposed to establishing a set of hypotheses.

The primary findings indicate that substantial variance exists among racial and ethnic subgroups with regards to satisfaction with the dependent measures. Interestingly,

Black/African American physicians reported significantly lower satisfaction levels with each of the dependent measures when compared to other minority, as well as, non-minority physicians. In contrast, physicians of Asian/Pacific Islander origin reported higher levels of satisfaction with cost containment efforts at the hospital and with their perceived autonomy over medical decision making.

To supplement these dependent measures, a fourth item was computed to measure the overall satisfaction of physicians with all 17 survey items (see Appendix A). Again, physicians of Asian/Pacific Islander origin reported more overall satisfaction than any other racial and ethnic group. Conversely, consistent with the 3 initial dependent measures, the results showed that Black/African American physicians were significantly less satisfied overall, than any other cultural group. Overwhelmingly, Black/African American physicians were experiencing lower levels of satisfaction with these key organizational variables than any other ethnic group.

Researchers have yet to adequately clarify the nature and consequences of discouraging barriers that persistently frustrate achievement strivings of African Americans in valued organizational roles, such as physicians. Nor have the cultural conflicts which make it difficult for African Americans and other people of color to function in mainstream organizations been extensively examined.

Past scientific literature has cautioned organizations against embracing multicultural trends and suggests that advancement in mainstream organizations is better served by assimilation and Anglo-conformity (Jones, 1991). Perhaps the inherent pressure to conform to the dominant organizational culture is a plausible explanatory theory as to the dissatisfaction of certain African Americans holding key organizational roles. Studies have also documented the adverse effects of double consciousness, dual

identity or bi-culturality in organizations on the performance of African Americans in predominantly white workgroups (Jones, 1991).

Helman (2000) claims that the Western health care system is, to some extent, a miniature model of the values and social structure of the society from which it arises. Critics of the medical systems in the Western world have expressed how the internal organization of the professional sector reflects some of the inequalities in those societies, especially in relation to gender, social class, and ethnic background. Also, the personnel within the medical sector are arranged in hierarchies similar to the social strata of the wider society were white males usually occupy the more powerful and prestigious positions. It is conceivable that many of the underlying prejudices of society are being reproduced in Western health care organizations and having adverse affects on the career satisfaction of minority physicians.

Optimistically, Triandis (1984) purports that *additive pluralism* may best bridge the cultural gaps in organizations by utilizing intercultural training where both groups add new dimensions to their experience without feeling less identified with their own culture. Similar to the ideology of additive pluralism, effective organizational strategies must be driven by research that aims to increase the meaningful participation and achievements among African Americans in mainstream organizations.

Additionally, in the present study, when minority and non-minority groups were aggregately juxtaposed, no significant differences were reported in the data. However, when satisfaction levels were measured contrasting minority *subgroupings* with that of non-minority physicians, significant variations emerged from the data set. Due to the low numbers of minority health care physicians, it is common practice for researchers to aggregately measure physician job satisfaction levels, failing to account for influential

cultural differences between racial/ethnic minorities. This failure to address the unique multicultural factors that influence career satisfaction among minority groups versus non-minorities may be a result of a form of *transubstantiative error*. Transubstantiative error occurs when researchers convert the symbols and behavior of others into those consistent with their own epistemology (Wells, 1985). Many differences exist between mainstream white culture and minority cultures with respect to values, attitudes toward authority, self-disclosure, class, caste, and freedom. Therefore, hypotheses generated and inferences predicated on transubstantiative errors limit the efficacy of behavioral science theory and its practice (Wells, 1985).

This study has far reaching implications for understanding the cultural differences that exists among a diverse physician workforce, and how they influence career satisfaction. The long range results may impact such entities as employer-employee relationships, physician-patient relationships, attrition of the minority physician population, and the matriculation of minority students into medical school programs. Health care administrators and policymakers alike may be better able to understand the nuances affecting career satisfaction among its physician population and predict the ramifications of their policy decisions if they gain a better understanding of the cultural differences that influence physician job satisfaction. Ultimately, health care administrators may be better equipped to productively interact with a diverse workforce of physicians, which may significantly affect the satisfaction and growth of the minority physician workforce. This may prove to have vital implications on minority health as a whole.

This study examined factors affecting minority physician satisfaction from an organizational communication perspective only. Further research should focus on (1)

examining and refining organizational communication methodology as it relates to studying diverse populations; (2) examining the impact of communication networks in various cultures and how they affect the career selection of the cultures youth; (2) exploring obstacles to acculturation perceived by minority physicians who are currently functioning in a predominately white health care system; and (4) examining the role of social support systems in minority cultures versus non-minority communities as it relates to career and goal selection.

Additionally, organizational researchers who seek to study the career satisfaction of minority physicians should explore methods to enhance the limitations of the current study. The findings of this study were limited to the satisfaction levels of physicians operating within a faith-based health care system. Also, the scope of this study did not control for age, gender, or medical specialty, which may impact the data. Although literature helps to substantiate the data from this study, researchers should seek to increase the sample sizes of the cultural subgroups to further enhance generalizability.

A well respected pioneer in holistic medicine expressed to a group of medical school educators that, "a more hidden and profound crisis is the deep alienation and loss of meaning felt by many physicians….many of these burned out physicians are advising students against entering a profession that they believe is diminished by the constraints of managed care and unreasonable expectations (Mangan, 2004)." The speaker went on to pose the question of how young physicians can be stress-proofed to do this work and find the satisfaction that generations of physicians have found before them. It can be surmised that, to date, we are only a few decades removed from the civil rights movement, whereby, minorities began filtering into the medical profession in small numbers. The physician population has yet to witness an overwhelming rise in minority

practitioners that are representative of the vast numbers of minority citizens in the U.S. population. Reflective of the data presented in this study, and the enduring under-representation of minority physicians in health care, perhaps this "generational satisfaction" with the medical profession does not, and has not, held true with all cultures.

A call for cultural diversity among health care physicians must first begin with a call for cultural competency among health care administrators and policymakers. Research that allows for cultural differences to manifest illustrates that there is significant variation in satisfaction among physicians concerning key organizational policies and procedures. Interestingly, further analysis demonstrates that there are significant differences in satisfaction levels across particular subcultures as well. Undoubtedly, this speaks to the need for widespread competency, as it relates to a myriad of cultures.

In order to work toward the riddance of the problem of diversity amongst physicians in health care, health care administrators and policy-makers must do their parts to assure that the organizational culture is attune to the needs of a diverse workforce. This includes rigorously analyzing the communication constructs of their respective organizations. Administrators must constantly work to incorporate the viewpoints of its physician workforce into the establishment of policy and procedure. No longer can cultural uniqueness be overshadowed by aggregate, thus inaccurate, physician satisfaction reports. Equally, no longer can *access* to gainful employment be the sole topic on the workforce diversity agenda, but *treatment* of culturally diverse persons in key organizational positions must finds its way to the forefront of bureaucratic discourse.

Word-of-mouth is an extremely powerful marketing tool, thus the delineation of the health care profession by practicing physicians can prove to sway potential minority

medical students for, or against pursuing a career in health care. From an organizational perspective, it is imperative that health care systems become increasingly sensitive to cultural diversity within their workforce and heed the voices of an underrepresented population of physicians.

APPENDIX A

PHYSICIAN SATISFACTION SURVEY

Today's doctors face many tough challenges. In collaboration with Aspire Hospital's Physician Support Services and with support from Aspire Memorial Hospital and the Aspire Health Foundation, a research team at the Center for Health Futures and the University of South United States is conducting **a study called Physician To Physician**. This study will interview physicians in order to identify "life practices" that help them feel more satisfied with their work. These "physician life practices" will then be shared with other physicians. This Survey serves two main purposes: (1) to provide quantitative background on physician characteristics and satisfaction and (2) to select physicians for participation in the Interview Phase of the study.

This survey must be completed by the physician. It takes about four minutes to complete.

Physician To Physician focuses on the physician as a person, not only as a clinician or medical business person, and we therefore ask for some personal information. All responses to this survey will be kept **strictly confidential**. Your responses will **not** be shared with anyone else in Aspire Hospital, USUS, or anywhere else. We will **only** report results in aggregate form so that no one's response can be identified. Results will become available by the winter of 2004. If you have any questions, please contact XXX.

A. Physician Characteristics

1. What is your age? _____   2.   Are you: Male_____   Female_____

3. Are you: Single____ Married____ Separated____ Divorced____ Widowed____

4. How many children do you have living at home? _____

5. How would you describe your race/ethnicity?   _____

6. What is your medical specialty? _____

7. How many years have you been practicing medicine?   _____

8. Of all your patients, about what percentage is covered by:

     a.   Commercial managed care plans? _____

     b.   Medicaid? _____

     c.   Medicare? _____

9. Check any or all of the following if they are characteristics of your practice:

     Solo Practice____   Single Specialty Group____ Multi Specialty Group____   Hospital-Based Practice____

     Management Responsibilities____ Equity Stake____ Contracted Office/Practice Management____

10. About how many hours do you work in a typical week? _____

11. How would you rate your overall stress level? (*Place one X in a box above a number to indicate your response*)

| Very Low | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | Very High |

12. What are the most important contributors to stress in your life?

B. Areas of Satisfaction (*For each item, place one X in a box above a number to indicate your response*).

13. How satisfied are you overall with your **workload**?

Very Dissatisfied 1 2 3 4 5 6 7 8 9 Very Satisfied

14. How satisfied are you overall with the **availability of office and hospital resources**?

Very Dissatisfied 1 2 3 4 5 6 7 8 9 Very Satisfied

15. How satisfied are you overall with your **opportunities for research and teaching**?

Very Dissatisfied 1 2 3 4 5 6 7 8 9 Very Satisfied

16. ***How satisfied are you with your*** relationships ***with your patients?***

Very Dissatisfied 1 2 3 4 5 6 7 8 9 Very Satisfied

17. ***How satisfied are you with your*** relationships ***with your colleagues?***

Very Dissatisfied 1 2 3 4 5 6 7 8 9 Very Satisfied

18. *How satisfied are you with the **level of administrative responsibilities** in your work?*

Very Dissatisfied 1 2 3 4 5 6 7 8 9 Very Satisfied

19. *How satisfied are you with **cost containment** efforts at Aspire Hospital?*

Very Dissatisfied 1 2 3 4 5 6 7 8 9 Very Satisfied

20. How satisfied are you with approaches to **utilization review** at Aspire Hospital?

Very Dissatisfied 1 2 3 4 5 6 7 8 9 Very Satisfied

21. *How satisfied are you with how it **feels** to work with Aspire Hospital, that is, the "**organizational climate**" or "**culture**" of Aspire Hospital?*

Very Dissatisfied 1 2 3 4 5 6 7 8 9 Very Satisfied

22. *How satisfied are you with your **autonomy over medical decision-making**?*

Very Dissatisfied 1 2 3 4 5 6 7 8 9 Very Satisfied

23. *How satisfied are you with your **autonomy over nonmedical workplace decisions**?*

Very Dissatisfied 1 2 3 4 5 6 7 8 9 Very Satisfied

24. How satisfied are you with your **income**?

Very | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | Very
Dissatisfied   1   2   3   4   5   6   7   8   9   Satisfied

25. How satisfied are you with the **prestige** you receive for your role as a physician?

Very
Dissatisfied   1   2   3   4   5   6   7   8   9   Very Satisfied

26. How satisfied are you with **family issues**?

Very
Dissatisfied   1   2   3   4   5   6   7   8   9   Very Satisfied

27. How satisfied are you with **your personal growth**?

Very
Dissatisfied   1   2   3   4   5   6   7   8   9   Very Satisfied

28. How satisfied are you with the **amount and quality of your personal time**?

Very
Dissatisfied   1   2   3   4   5   6   7   8   9   Very Satisfied

29. How satisfied are you with your ability to **provide quality care**, given all the competing barriers to quality that you face?

Very
Dissatisfied   1   2   3   4   5   6   7   8   9   Very Satisfied

(PLEASE CONTINUE TO THE LAST PAGE)

C. Areas for Action

30. What is the **one thing you would change**, if you could, to help **physicians generally** be more satisfied in their work?

31. What is the **single most important thing** Aspire Hospital could do to help **you personally**?

32. What are your favorite hobbies or leisure activities?

33. Are you willing to participate in a 30 minute videotaped interview, at the time and location of your choice, on what keeps you enthused about being a physician?

Yes _____ Maybe _____ No _____

34. If you answered **YES** or **MAYBE** above, please provide the following information so we may contact you about participating in an interview. *Only some of those physicians who complete this information will be contacted for an interview.* This information will **not** be used for any other purpose.

Name _____   Preferred Phone #_____

Mailing Address Street/PO Box   _____

Mailing Address Suite/Additional   _____

Mailing Address City, State, ZIP   _____

THANK YOU!

PLEASE RETURN THE COMPLETED SURVEY
(*via the self-addressed envelope provided*)
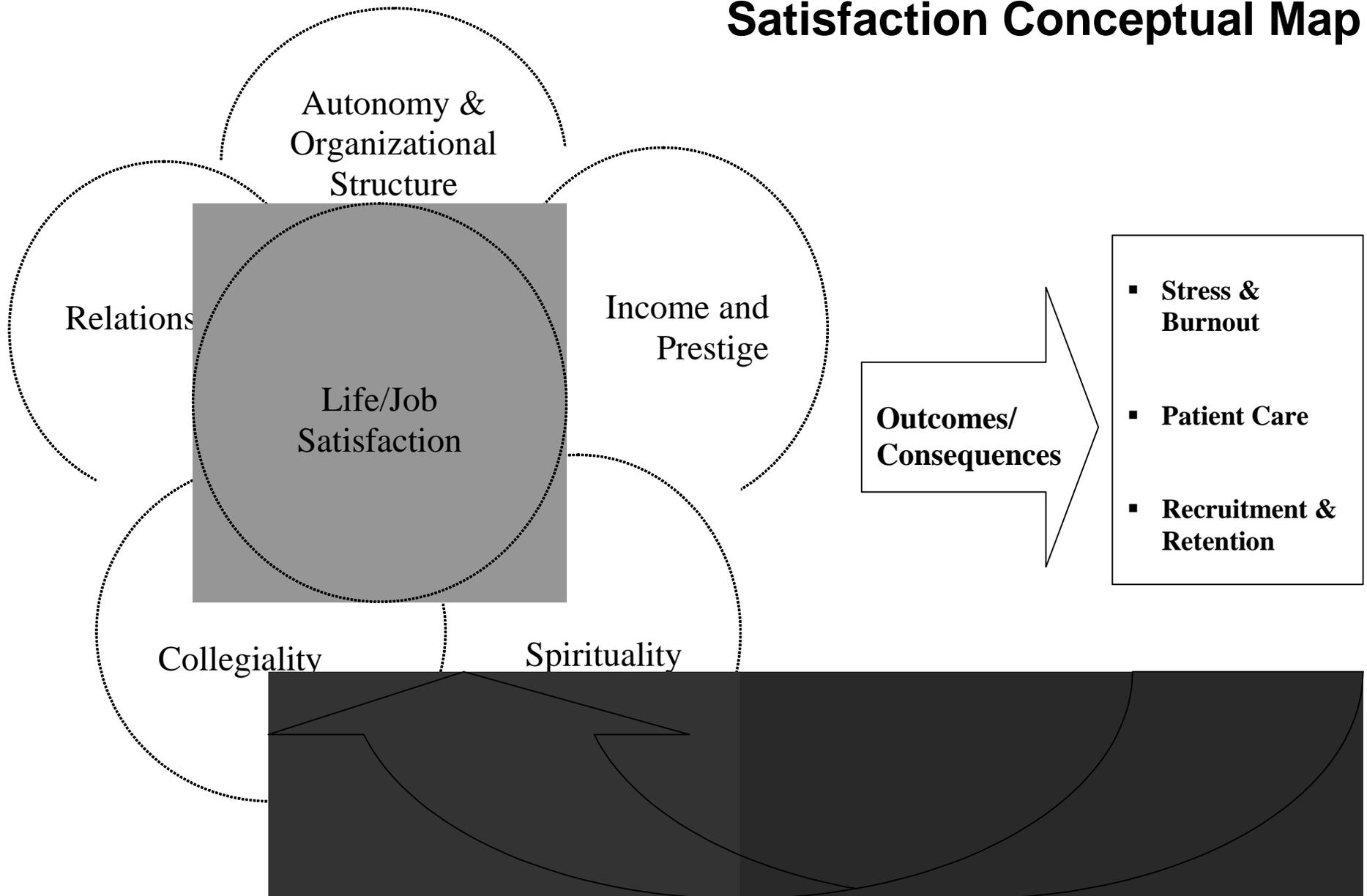NO LATER THAN _____.

TO: PHYSICIAN TO PHYSICIAN
Aspire Hospital
2005 Ambition Ave.
South, U.S. 12345

APPENDIX B

PHYSICIAN SATISFACTION CONCEPTUAL MAP

Physician To Physician:
Satisfaction Conceptual Map

Autonomy &
Organizational
Structure

Relations

Income and
Prestige

Life/Job
Satisfaction

Collegiality

Spirituality

**Outcomes/
Consequences**

- **Stress &
  Burnout**

- **Patient Care**

- **Recruitment &
  Retention**

APPENDIX C

DATA QUALITY CHECKS

Quality Check #1

DOC. #	ERROR (S) FOUND
1080	31. $1,000,000 entered as $91,000
1122	32. theatre entered as heatre
1174	32. church functions left out
2002	30. Duplicated #12. Should be "less difficulty having medications/ treatments authorized from insurances 31. Entered as #30 – should be "more patient beds to aid with admissions
3029	15. Entered as 5, should have been 3; 16 entered as 7, should have been 5; 17 entered as 5, should have been 7
4110	On spreadsheet A6b entered as 19 Orthopaedics, should be 2 Family Med.
6107	6. Pediatric omitted on spreadsheet
6269	15. Entered as 2, should be 1
7020	A6b entered as 22 on spreadsheet, should be 5
7030	32. forest, nature omitted
9145	9a entered on spreadsheet instead of 9b
9161	30. Pre-authorization spelled pre-quthorization
9164	30. Less fear of lawsuit and/or malpractice cost should have been Less fear of lawsuit and lower malpractice cost
9372	23. Entered 9, should be 7 24. Entered 7, should be 9
9759	<u>A2 entered as 1 instead of 2</u> A7 entered as 40 instead of 11 A10 entered as 5 instead of 40 B13 entered as 4 instead of 5 <u>B14 entered as 9 instead of 4</u>
9759	<u>B15 entered as 7 instead of 9</u> <u>B24 entered as 4 instead of 7</u> B17 entered as 6 instead of 7 B25 entered as 5 instead of 4 B18 entered as 4 instead of 6 B26 entered as 3 instead of 5 B20 entered as 5 instead of 4 B27 entered as 4 instead of 3 B21 entered as 6 instead of 5 B28 entered as 5 instead of 4 B23 entered as 7 instead of 6 B29 no entry instead of 5
Y005	<u>12. familities entered instead of families</u>

Quality Check #2

DOC. #	ERROR (S) FOUND
1058	6a. No entry on spreadsheet. Should be Family Practice 6b. No entry on spreadsheet. Should be 2.
1064	6c. Left blank, should be 4.
1081	6a. Foot & Ankle Surgery omitted from description. 6b. Entered as 23 instead of 11. 6c. Left blank, should be 23.
1164	6c. Left blank, should be 3.
3043	15. Entered as 3 instead of 6.
3055	7. Entered as 80 instead of 7.
3059	29. Entered as 7 instead of 8.
3060	7. Entered as 4 instead of 7. (See last page of survey for sample numbers.)
3069	7. Entered as 64 instead of 6 yr.
3070	7. Entered as 16 instead of 15.
3092	15. Entered as 8 instead of 7.
4036	6. Emergency spelled emergeny – Ran spellcheck now
4040	7. Entered as 4 instead of 25.
4048	15. Entered as 9 instead of 4. 20. Entered as 4 instead of 5. 25. Entered as 8 instead of 4. 29. No entry instead of 4. Corrected 13-29; entire series off by one digit.
6006	15. Blank on survey, 9 entered on spreadsheet.
6023	6. Added Pediatric (9) but not Cardiology (4) .
6031	20. Entered as 8 instead of 7.
6040	6c. Left blank instead of 11.
6055	7. No answer recorded because response is unclear.
6067	6. Answer is Pediatric Cardiology; 6a entered as 4 instead of 9; 6b left blank instead of 4.
6147	6. Answer is Pediatric Endocrinology; 6a. entered as 6 instead of 9; 6b. left blank instead of 6.
6149	6. Answer is Peds Oncology; 6a entered as 13 instead of 9; 6b. left blank instead of 13

(Continued)

DOC. #	ERROR FOUND
6235	6c. Left blank instead of 11.
6258	6c. Left blank instead of 28.
6265	6b entered as 11 instead of 9; 6c left blank instead of 11. 25. Entered as 8 instead of 7.
6282	6c. Left blank instead of 28.
6308	6. Internal Medicine omitted; 6c left blank instead of 3.
6324	6. Entered Colon & Rectal Surgery instead of Cardiology. 6b. Entered as 11 instead of 4. 7. Entered as 25 instead of 24.
6331	6. Entered as Cardiology instead of Colon & Rectal Surgery. 6b. Entered as 4 instead of 11.
6369	6. Entered as Pediatric Neurosurgery; 6b. entered as 11 instead of 9; 6c. left blank instead of 11.
7011	No answers were entered on spreadsheet for 13-29, 30, 31, and 33. I put them in.
7013	6b. Entered as 11 instead of 19. 6c. Left blank instead of 11.
7019	7. Entered as 30 instead of 3. 15. Entered as 5 instead of 6. 25. Entered as 9 instead of 3. 29. Entered as 7 instead of 6.
7020	6b. Entered as 22 instead of 5.
7084	6b. Entered as 17 instead of 9. 6c. Left blank instead of 17.
7093	6b. Entered as 17 instead of 9. 6c. Left blank instead of 17.
9004	25. Entered as 8 instead of 3.
9037	6. Entered as Pediatrics instead of Periodontics. 6b. Entered as 9 instead of 17.
9066	6b. Entered as 17 instead of 9. 6c. Left blank instead of 17.
9156	Omitted from spreadsheet.
9159	6b. Entered as 11 instead of 17. 6c. Left blank instead of 11.
9219	6c. Left blank instead of 14.
9340	7. Entered as 3 instead of 18.
9375	6b. Entered as 5 instead of 9. 6c. Left blank instead of 5.
9495	6. Entered as neurology instead of neuropsychology. 6b. Entered as 5 instead of 28.

(Continued)

DOC. #	ERROR FOUND
9551	6. Prostohodontics entered instead of Prosthodontics Dentistry. 6b. 28 entered instead of 17.
9632	7. Entered as 100 instead of 1. 8a. Left blank instead of 100.
9705	7. Entered as 2 instead of 20.
9744	15. Entered as 1 instead of 2. 25. Entered as 6 instead of 7. 29. Entered as 6 instead of 3.
9779	29. Entered as 4 instead of 5.

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    primary care providers in managed care. *Evaluation of Health Professionals*, *25*,
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    professional careers, and research activities. *Teaching and Learning in Medicine, 15*,
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    and non-primary care physicians: a longitudinal study of their similarities,
    differences, and correlates before, during, and after medical school. *Academy
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    Health & Social Behavior*, *39*, 152-67.

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    changing workplace and a challenging environment. *Medical Care*, *37*, 1174-82.

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