DOCTORS UNDER PRESSURE:
AN EXPLORATORY LOOK AT PROFESSIONAL SATISFACTION

by

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ABSTRACT

The British Columbia Medical Association (BCMA) is a not-for-profit organization whose stated goal is to achieve fair economic reward and maximum professional satisfaction for British Columbia physicians. It is not the intent of this paper to examine the structure, business processes, efficiency or economic prospects of the BCMA. The intent is to develop a series of suggestions that target areas of physician dissatisfaction and assist the BCMA in fulfilling its mandate.

The Professional Satisfaction Index (PSI) survey instrument was developed and sent to BC physicians. The PSI survey was designed as an aid to the BCMA and is exploratory in nature. The results have not been tested for reliability and validity. While preliminary results suggest that physician dissatisfaction is real, any conclusions drawn from the survey should be judged according to its unproven status. Any use of this instrument in its current form outside its stated context is not recommended.
DEDICATION

To my wonderful wife Michele and my two darling daughters, Amberlie and Alaina, who continue to indulge me in all my foolishness.
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INTRODUCTION

The most fundamental question this paper attempts to address is ‘Does professional satisfaction matter?’ The British Columbia Medical Association (hereinafter referred to as the Association) is a not-for-profit organization that represents the interests of British Columbia (BC) physicians. The Association’s mission statement is:

To promote a social, economic, and political climate in which members can provide the citizens of British Columbia with the highest standard of health care while achieving maximum professional satisfaction and fair economic reward.

If professional satisfaction does not matter then this is nothing more than an idle, feel-good addendum to the Association’s mission. This paper will argue that professional satisfaction does indeed matter and that it matters more now than ever before. Failure to address issues of professional satisfaction threatens not only the legitimacy of the Association but also that of the medical profession as a whole.

This paper introduces the Professional Satisfaction Index (PSI). The PSI is calculated from an exploratory survey instrument that seeks quantitative input from BC physicians on their perceptions of their own professional satisfaction. It also seeks qualitative input on the Association’s role in supporting their professional satisfaction. The PSI survey will both highlight areas of concern and
create a baseline for ongoing evaluation of the Association’s success in supporting professional satisfaction for BC doctors.

The PSI survey was designed as an aid to the Association in identifying ways to fulfil its mandate. It is entirely exploratory and as such, does not put forward a particular hypothesis to be tested. At this point, the results have not been tested statistically for reliability or validity. Even if the instrument will not be reused, some statistical analysis should be conducted (see Chapter 9, Survey Limitations) to verify that the survey questions do indeed probe the facets they purport to explore. Particularly where patterns of variance between groups in the survey suggest a conclusion, analysis is required to determine whether those variances are statistically significant. To date, time, resource and political constraints have prevented taking the survey beyond this developmental stage. If the instrument is to be reused and particularly if it is to be used outside of its current context, it will require one or more additional iterations with some additional analysis to verify its validity.

The output of this exploratory process is a series of suggestions that are within the power of the Association to either enact or influence. These suggestions are based on apparent patterns in the survey results and will, if validated, improve deficiencies in professional satisfaction as identified by the PSI survey. They should also cement the role of the Association as a representative body and help reverse some recent, unfortunate trends in public perception of the medical profession in BC.
It is important to note that this paper is not a strategic analysis of the role, structure, operations or economic prospects of the Association. The purpose of this paper is to articulate the need for measures of professional satisfaction, to develop an instrument for measurement and to identify the achievable advantages of addressing areas of professional dissatisfaction amongst BC physicians.

The Process

The path to the PSI presents several challenges. The need for measures of professional satisfaction as opposed to job satisfaction is not necessarily clear. Support for evaluation of subjective measures like happiness and satisfaction is far from universal. Why is professional satisfaction more relevant today than 50 years ago? These questions and concerns are addressed in the following manner.

Chapter 1 explores professionalism and introduces a definition of a medical professional. The intent is to clarify that evaluating professional satisfaction involves measuring criteria that are distinct from other occupations. Chapter 2 provides some historical context concerning the ascendancy of the medical profession and the development of physician expectations concerning the practice of medicine. Chapter 3 explores the progressive uncertainty that has developed in the last 30 years and highlights why professional satisfaction has particular relevance now. Chapter 4 examines the credibility of subjective measures like satisfaction and Chapter 5 proposes a definition of professional satisfaction that flows from the earlier discussion.
Chapters 6 and 7 introduce the PSI survey, its structure, methodology and rationale. The quantitative and qualitative results are analysed and the impact on the Association and the profession are explored. The final chapter suggests opportunities for the Association to address issues of professional dissatisfaction and the benefits that could flow from action.

The remainder of this introduction will provide some brief background on the societal and professional context for the practice of medicine in BC and identify the roles of the representative bodies.

The Practice of Medicine in British Columbia

The College of Physicians and Surgeons of British Columbia (College) has responsibility for the regulation of medical practice in BC. Formed in 1886, this not-for-profit organization derives its authority from the Medical Practitioners Act, which defines its role and responsibilities. The principal role of the College is to safeguard the public interest by establishing and maintaining high technical and ethical standards for the practice of medicine in BC. The College has the responsibility to license, monitor and evaluate physicians. The Medical Practitioners Act grants the College powers of self-regulation, which includes both the right and the responsibility to discipline members as necessary. The College takes its responsibilities seriously, stating on its website:

"The College recognizes that self-regulation of the profession is a privilege granted in the public interest and for the public good, and that the College has a responsibility to merit the retention of this privilege."
Once licensed by the College, physicians may choose to practice medicine in a variety of settings. The most popular of these is the Fee for Service model wherein physicians bill the provincial Medical Services Plan (MSP) for their services using a negotiated fee guide that defines both the billable services and the appropriate fees. Under Canadian law, it is illegal to charge patients a fee in excess of the fee guide for medically necessary insured services. Physicians may also take salaried positions or operate under individual service contracts. In all cases though, they are subject to the standards of practice established by the College.

The Role of the BC Medical Association

Unlike the College, whose principal responsibility is to the public, the British Columbia Medical Association represents the interest of physicians. The Association is a not-for-profit organization that advocates on behalf of physicians in the areas of compensation, working conditions and public policy. The Association also advocates on public health policy issues that affect all BC citizens (infant car seat legislation, bicycle helmet legislation, etc.)

Membership in the Association is voluntary and renews annually. Depending on how you count, anywhere from 75 percent to 90 percent of eligible physicians typically join the Association every year. Membership numbers vary with the success of negotiations and the degree of current political turmoil but in general, the Association's membership has been increasing steadily as the number of physicians in the province grows.
Economic Reward

The Association devotes considerable effort to this aspect of its mission. The Association’s Negotiations Department has six full time staff and they enjoy a good reputation for delivering ever-improving compensation and benefits to the membership. While it is true that ‘fair economic reward’ is somewhat subjective, relative success in this area is tangible. Fee increases and individual benefit payments are measurable and they have been increasing. However, tension exists between various membership constituencies over perceived disparities in fee allocations and it is plain that increasing economic rewards do not of themselves, make doctors happy.

Professional Satisfaction

While economic rewards are measurable, professional satisfaction is much more slippery. Not only is it entirely subjective but almost no attempts have been made to measure professional satisfaction. National surveys exist but are not specific to the BC medical community and focus on job satisfaction measures. Professions have a unique role in society and that role has been the subject of much sociological discourse over the last 60 years (Parsons, 1951; Freidson, 1970, 1985, 1986, 1996; Haskell, 1984, Krause, 1996). Professional motivations are a large part of that discussion; particularly how they differ from the motivation of laypeople.

The Association has six employees who deal exclusively with the member’s fair economic reward but there are no staff tasked with pursuing the other half of the organization’s mission. This is likely because economic issues
are tangible, highly visible and ever-present. There is also a temptation to assume that better compensation leads to greater satisfaction. The evidence, however, suggests that beyond a certain baseline of economic well-being, the correlation between money and satisfaction is weak at best. A study by Sheldon et al (2001), while not specific to physicians, found that of 10 personal needs, money was the least positively associated with satisfaction.

How then would one measure professional satisfaction and how would we account for personal preferences? This paper proposes a survey instrument that starts from the assumption that people are satisfied when their experience meets or exceeds their expectations. This approach is consistent with ‘matching’ theories of satisfaction put forward by Oishi, Diener, Suh and Lucas (1999). The PSI survey (see Appendix 1) has the potential to create a benchmark against which the Association can measure its activities. In order to achieve this goal, professional satisfaction must first be defined. The next several chapters move progressively towards that definition.
CHAPTER 1: PROFESSIONALISM

A professional is a person who can do his best at a time when he doesn't particularly feel like it.

Alastair Cooke

What is a professional and how do we identify them? In driving towards a definition of professional satisfaction as distinct from job satisfaction, it is necessary to first look at how professions differ from other occupations. What is it that makes a doctor a professional and his/her calling a profession while a professional athlete is a professional – rather than an amateur - purely as a by-product of being paid?

Is a profession an organization or social entity that confers professionalism on its members by virtue of their association? Alternately, are people professionals because of some personal attribute, aspect of their character or their role in society? In the latter case, a profession is simply an association of professionals who band together for social, political or economic reasons.

The first step is to look at the classic or idealized view of professionals and professions put forward by Talcott Parsons (1951). Parson’s view places significant focus on the motivations of individuals. The PSI survey contends that satisfaction is, at least partially, a function of expectations so it is probably useful
to look at some of the factors that draw people to a profession. This chapter will close with a definition of a medical professional.

**Hallmarks of Professions**

From an organizational perspective, it would be easy to create a checklist of criteria that, if present, would define a profession. Formal education, self-regulation, control of training and licensing, and other similar characteristics would all be hallmarks of a profession. While it is likely true that all professions share these characteristics it may not be equally true that possessing these characteristics automatically confers professionalism. This approach is mechanistic and suggests that professionals are a function of a profession. Their professionalism stems only from association with a certain occupational group.

The individual perspective on professionalism is most often associated with the work of Talcott Parsons, one of the most distinguished sociologists of the last century. Parsons first became interested in the subject of professionalism when translating Max Weber's sociological work from the original German (Latham, 2002). Weber was writing on the subject of authority and viewed it as the likelihood that people would obey commands. He identified three types of legitimate authority, legal (the law compels me), traditional (we have always done it that way), and charismatic (something about you makes me want to obey). Parsons felt that there was a fourth category, which he called expert authority (Latham, 2002). Expert authority derives from the confidence that someone else knows more than you do. Parsons directly associated expert authority with professionals.
Parsons viewed professionals as mediators between individuals and society. He contended that professionalism is marked by five “pattern variables”. In order of precedence they are achievement, universalism, functional specificity, affective neutrality and collectivity-orientation (Parsons, 1951).

In his view, professionals were primarily motivated by social status and respect (achievement) as opposed to economic considerations. In addition, the primary obligation of the professionals was towards a duty of care. Writing of the medical profession, Parsons said:

The “ideology” of the profession lays great emphasis on the obligation of the physician to put the “welfare of the patient” above his personal interests, and regards “commercialism” as the most serious and insidious evil with which it has to contend... The “profit motive” is supposed to be drastically excluded from the medical world. (Parsons, 1951:435)

This primary obligation to exercise a duty of care towards their clients or patients allows professionals to resist any excessive orientation towards money and power and to gain the trust and respect of individuals, peers and society (Latham, 2002).

‘a profession is an occupation that uses its legitimate expert authority to mediate between individuals and society... A profession’s members are characteristically peer-oriented and status hungry, but not profit-motivated and not motivated by desire for political power. Their professional institutions socialize them for proper service in their interstitial role, and give them the opportunity for acts of profession before one another and society at large. These acts of profession both socialize the professionals and inspire trust from the public, facilitating the safe exercise of professional authority.’ (Latham, 2002:365)

In essence, professionalism is marked by the exercise of legitimate knowledge-based expert authority by dispassionate individuals in pursuit of the
best interests of the client to the exclusion of other short-term considerations. It is easy to see how a definition like this would exclude many occupations that sometimes attract a professional appellation. The service orientation associated with a duty of care tends to exclude the likes of professional basketball players and professional software designers who utilize a specific technical competence primarily for their own ends.

**Professional Motivation**

What attracts people to a profession? Every profession will confer some benefits on its members and, therefore, attract individuals seeking those benefits. Parson’s view notwithstanding, the medical profession clearly presents benefits beyond social status and respect and it’s likely that these other benefits have some influence on people choosing the profession.

Parson’s perspective has been widely criticized. Freidson (1970) points out that the collective action of professional associations to secure monopoly power and exert political influence tends to suggest motivators beyond social status. These opposing views are not necessarily irreconcilable. Freidson’s interest is primarily organizational while Parsons is looking at the orientations of individuals. It is reasonable to imagine professional individuals banding together into groups to acquire some collective economic or political advantage that, at the same time, cannot be allowed to intrude into the individual practitioner/client relationship. Put in the context of medical practice in BC, it is reasonable that doctors, through their Association will advocate for increased fees. A failure of
this process, however, would not influence a doctor to substitute a more remunerative but less appropriate service in dealing with a patient.

The following motivating factors, financial reward, societal status, autonomy, intellectual growth and desire to help are neither exhaustive nor unique to the professions. They are, however, all commonly cited motivations for joining the medical profession. They are also intuitive, which aids their use in the PSI survey. They are all “pull” oriented, meaning they draw an individual towards a profession as opposed to something like family pressure which might “push” someone towards a profession or occupation.

**Financial Reward**

Professions by their nature tend to limit supply. Standards for entrance to a profession tend to be high. It usually takes about nine years of training to become a doctor and can take up to 12 years or more depending on specialization. Medical school slots in Canada are severely constrained and the selection process is time-consuming and arduous. Successful candidates will typically have one or more undergraduate degrees and often hold graduate degrees as well.

Autonomous credentialing bodies like the College typically establish entrance criteria to a profession. These same bodies will control educational content and by combining both will create a knowledge monopoly that will, if the standards of technical competence are high enough, give rise to a claim of legitimate expert authority. Public trust in the legitimate expert authority of a
profession is used to resist infringement on the professionally maintained body of knowledge. The same credentialing bodies will exercise a disciplinary role that protects the technical standards of the profession and promotes public trust. Taken together, these facets of a profession will limit supply, safeguard quality and ensure a predictable financial reward.

**Societal Status**

Substantial financial rewards typically convey a certain social status but professions accrue social status in other ways as well. Public acceptance of expert authority is based on an understanding that the professional possesses valuable and beneficial knowledge that cannot be obtained elsewhere. The professional, therefore accrues status through their possession of a unique and valuable asset. The social status of the professional is enhanced further when that expert knowledge is used in service of societal goals. The service orientation of the professional, to the exclusion of their own short term interests, reflects a type of altruism that confers social status.

**Autonomy**

One of the most common privileges of the professions is self-regulation. The ability to set standards for entrance to the profession and for professional practice is incredibly powerful because many of the benefits of professional membership flow directly from self-regulation. In the Parsonian view, self-regulation combined with a disinterest in money or power, is what insulates professionals from undue influence on the part of public or private interests.
The professional autonomy that is associated with self-regulation, however, can be fragile. It is a measure of the diminished respect for the teaching profession in BC that the government has interfered with the governance of the BC College of Teachers and mandated the makeup of the board to include government representatives and members of the public. Despite entrance requirements that can, at the higher levels, rival those of medicine, the Teachers’ claim to legitimate expert authority is not as clear in the eyes of the public. The parents of elementary and high school age children have their own long history of exposure to the education system and familiarity typically breeds contempt. For those who have not actually tried it, the complexities of teaching appear to have lost their mystery.

Sensational media reports indicating that BC children are falling behind in education combined with the familiarity as contempt principle have resulted in a general lack of certainty surrounding the legitimate expert authority of teachers. In addition, strike action by teachers eroded public confidence in the duty of care orientation of the profession. A loss of legitimacy in the eyes of the public can be catastrophic for a profession. The legitimacy of BC teachers has been damaged but not destroyed. For a more compelling view of the effect of lost legitimacy, one need only look to the firing of striking air traffic controllers by Ronald Reagan in 1981.

The expert authority of the medical profession is more resilient than that of teachers. Particularly with respect to family physicians, doctor-patient interactions are more relationship-based, longitudinal and episodic. Still, the doctors of BC
faced a similar threat a few years ago when the government proposed changes to the Health Professions Act that would interfere with the regulatory authority of the College of Physicians and Surgeons. The Association and the College successfully lobbied to strike down the amendments but the threat to the profession was significant.

The College of Physicians and Surgeons of BC is certainly aware of the double-edged sword of self-regulation when they identify it as a privilege that exists to further the public good. Any profession that loses the legitimizing opinion of the public and through it, the government, may lose its privilege of self-regulation and potentially, its standing as a profession.

With autonomy, there comes a certain freedom; one associated with a duty or burden of responsibility. Society expects professionals to take personal responsibility for the consequences of their action or inaction. In a professional capacity, the buck always stops here. Accountants at Arthur Anderson were not able to shield themselves during the Enron fiasco by claiming they were doing as ordered. The purpose of an audit and the duties of a professional auditor are to safeguard the interests of the shareholders. In the Enron case, that primary duty was ignored in favour of corporate interests and the fallout destroyed one of the world’s largest accounting firms.

It is not possible to sidestep responsibility for failures in standards of practice and judgment by professionals. A nurse cannot abdicate responsibility for violating the duty of care demanded by the profession because he or she was
acting under doctors orders. Similarly, a pharmacist cannot ignore potential hazards to a patient simply because a doctor has provided a prescription.

Intellectual Growth

Public acceptance of expert knowledge is one of the foundations of a profession. That knowledge is challenging to acquire and maintain. Knowledge, however, is only the beginning. The challenge derives from developing the wisdom that is born of training, experience and judgment. This wisdom enables appropriate application of that knowledge. This process takes time and commitment. In many professions, the advancement of technology has created a situation where the base of expert knowledge is growing exponentially. To complicate matters, the new or emerging knowledge is not evenly distributed across the profession. This can create a conflict between the need for steady controlled growth of time-tested, peer-reviewed knowledge which forms the traditional basis of legitimate expert authority and the rapid accumulation of new information which, when not immediately embraced by the profession can lead the public to question their expert authority. Regardless, for many, the attraction of a profession like medicine is the requirement for, and challenge of, continuous intellectual growth.

Desire to Help

Personal gain, whether expressed in terms of financial reward, status or freedom is not the only source of motivation. Many professions, medicine in particular, are characterized by the concept of public service. Medicine is about
healing and healing is about setting things right. The desire to heal expresses a motivation to help others. Those seeking clinical practice may be motivated by the desire to help individuals while those pursuing medical research are motivated by a desire to serve society as a whole.

The Medical Professional

Every profession has its unique characteristics and society has unique expectations of each profession. In the case of the medical profession, the inevitability of death is a given. The societal expectation is that doctors will ensure that neither accident nor disease will unnecessarily hasten that inevitability. An evaluative framework for measuring professionalism developed by the American Association of Medical Colleges uses Swick's (2000) definition of Medical Professionalism. In framing his definition Swick states:

medical professionalism consists of those behaviours by which we—as physicians—demonstrate that we are worthy of the trust bestowed upon us by our patients and the public, because we are working for the patients' and the public's good. Failure to demonstrate that we deserve that trust will result in its loss, and, hence, loss of medicine's status as a profession. (Swick, 2000:614)

Swick defines medical professionalism as exhibiting the following behaviours:

- Physicians subordinate their interests to the interests of others.
- Physicians adhere to high moral and ethical standards.
- Physicians respond to societal needs, and their behaviours reflect a social contract with the communities served.
• Physicians evince core humanistic values, including honesty and integrity, caring and compassion, altruism and empathy, respect for others, and trustworthiness.
• Physicians exercise accountability for themselves and for their colleagues.
• Physicians demonstrate a continuing commitment to excellence.
• Physicians exhibit a commitment to scholarship and to advancing their field.
• Physicians deal with high levels of complexity and uncertainty.
• Physicians reflect upon their actions and decisions.

This definition of medical professionalism recognizes the social contract that exists between the profession and society and reinforces the idea that the profession exists to serve the public good.

We now have a definition of professionalism both generally and in relation to the practice of medicine. We have also looked at some of the factors that draw people to the medical profession, particularly autonomy. The freedom that physicians enjoy through their professional autonomy, however, is not absolute. It is clear that physicians are aware of this when barely half (54.6%) of PSI survey respondents felt that they were able to practice medicine in the manner that 'works best' for them and their patients (see appendix 1, section 3, q 15).

The doctor-patient relationship suffers when financial pressures drive physicians towards a more transactional model of medicine. When, as is happening in BC, physicians allow their financially motivated internal bickering to spill over into the public view, public confidence in the motives of the profession is strained. Finally, when doctors curtail or withhold services for financial reasons, their collective obligation of a duty of care to the public will be
questioned. All of these things threaten the legitimizing public opinion on which the autonomy of the profession rests.
CHAPTER 2: THE RISE OF THE MEDICAL PROFESSION

Doctors are the same as lawyers; the only difference is that lawyers merely rob you, whereas doctors rob you and kill you too.

Anton Chekhov (attributed)

Prior to the start of the twentieth century, medicine enjoyed a mixed reputation at best. Expensive and painful treatment of questionable efficacy was the norm. Public confidence in the profession was not high. In the period from the middle of the 19th century through to the middle of the 20th century, medicine enjoyed a renaissance. Buoyed by advances in technology, the profession moved from a professional dark age into an age of enlightenment that peaked in the 1960’s. Physicians of this era were the most respected, most successful and the most powerful of any professional group.

The vast majority of doctors practicing today either entered practice during this period or grew up and formed their early opinion of the desirability of the medical profession during this golden age. If professional satisfaction is a function of expectations, then the degree to which the history of the profession affected the expectations of today’s doctors is relevant to a discussion of professional satisfaction.
From Quackery to Expertise

The dominant school of medical thought during the middle of the 19th century was the ‘heroic’ approach that subscribed to the curative powers of bleeding and purging. With little or no use of antiseptics or anaesthetics, surgery was more likely to kill than cure you. Organized medicine did little to further the image of the profession. Grave robbing to obtain dissection specimens for medical schools was widespread and extremely unpopular with the public (Tward, 2002).

There was little cohesion amongst medical professionals. Many subscribed to radical new concepts like germ theory, many more still continued to embrace the popular (with physicians) heroic medicine. A lack of public confidence combined with the general populist movement of the time led to most American states abolishing physician-licensing requirements during the 1840’s (Haskell, 1984). Quackery was omnipresent in America with the public gobbling up patent medicines containing everything from cocaine to mercury. Public perception was that common sense had a cure for the ills that the medical community was clearly unable to address.

By the early 1890’s, however, medical views had begun to shift. The growing acceptance of germ theory and the related reliance on antiseptic practices was starting to show concrete results. Surgery was now more life saving than life threatening (Cartwright, 1967). The introduction of successful vaccines for cholera, typhoid and the plague reinforced a growing public confidence in medical expertise (Krause, 1996). By the beginning of World War I,
a much more cohesive medical profession was demonstrating a proficiency that was practical, tangible and accessible.

Medical expertise was now seen as a distinct asset to society and an even greater asset to the medical profession. The first half of the 20th century saw the medical profession “dominate both policy and lay perceptions of health problems” (Freidson, 1994:31).

**Professional Dominance**

The professional dominance view, most commonly associated with Eliot Freidson (1970), suggests that the medical profession dominates the healthcare field primarily through control of the production of medical knowledge and control over the division of labour within medicine. This creates an exclusionary environment that grants extraordinary privilege to anyone intelligent, fortunate or connected enough to gain access. Berlant (1975) and others have echoed this perspective and in some cases (Illich, 1976), extended the concept well beyond Freidson’s original theory.

**Production of Medical Knowledge**

If, as Parsons suggests, professions are rooted in their expert knowledge and their authority flows from that knowledge, then control over the production of medical knowledge is key to the creation and maintenance of a monopoly. By securing the support of government in controlling the education and credentialing of physicians and the support of the public who value their services, the medical
profession has cemented a monopoly position. Highlighting the profession’s relationship with government, Freidson writes:

...the most strategic and treasured characteristic of the profession—its autonomy—is therefore owed to its relationship to the sovereign state from which it is not ultimately autonomous. (Freidson, 1970:23-24).

Likewise, in referring to the profession’s relationship with the general public:

...that such a consulting profession as medicine must, in order to win a secure status, make itself attractive to the general public which must support its members by consulting them. The contingency of the lay public was thus critical to the development of medicine as a profession. (Freidson, 1970:188)

Freidson and Parsons may not agree on the underlying motivations of physicians and the nature of the relationship between the profession and the public. They are, however, aligned in the belief that the legitimizing opinion of the public is of paramount importance to the profession.

Control of the Division of Labour

The medical profession parlayed its position of expert knowledge into a position of dominance over other health-related professions. Freidson argues that professions such as Nursing and Pharmacy were subservient to the medical profession and obliged to work under the supervision of doctors.

Institutional changes in the delivery of healthcare affected the nature of the profession during the first half of the 20th century. Advancing technology required larger and larger capital investment in equipment that was beyond the
reach of individual physicians. As physicians became somewhat dependant on hospitals for equipment, beds and paramedical services their reliance on institutions increased. Freidson describes the pre-WWII medical profession as:

...a cottage industry composed of self-employed physicians working primarily in their own offices and sometimes sending their patients to hospitals where nurses and members of a few other health care occupations cared for the patients according to the doctors’ orders. (Freidson, 1985:11)

The growing reliance on hospitals and other acute or long term care facilities brought doctors under the influence of business interests in the form of accountants and hospital administrators. Even when those administrators were also physicians their dual role compromised them in the eyes of practicing physicians. As physicians moved more into institutional settings, their relationships with patients, hospital administrators and governments also altered. While public acceptance of their expert authority was still strong, at least some doctors no longer enjoyed the free-wheeling sort of individual professional autonomy that was common in the first half of the 20th century. As with doctors, many other healthcare workers were also answering to other interests and the dominance of the medical profession in controlling the division of labour may have peaked by the middle of the century.

Medical Dominance in Canada

In many respects, the Canadian medical community at the turn of the century was better organized than their American colleagues. The latter part of the 19th century saw several attempts to assert influence over associated health
professionals. The medical profession in Canada conducted pitched battles with pharmacists, nurses and midwives until by the early 20th century, pharmacists struck a deal to eliminate counter-prescribing in favour of exclusive control of dispensing, nursing accepted a subordinate role and midwifery effectively vanished (Coburn et al, 1983).

The passage of the Canada Medical Act in 1912 standardized licensing procedures across the country. At the same time, the release of the Flexner report on medical education in the US and Canada stimulated the continued association of proprietary medical schools with accredited universities and worked to standardize medical education (Coburn, Torrance & Kaufert, 1983).

In the period following the First World War and leading up to the close of the Second World War, the Canadian Medical Association (CMA) worked to expand the influence of the medical profession in Canada. Ultimately, the profession achieved a prominent role, not only as a self-regulating profession but also as a political pressure group and as an administrator of public programs (Taylor, 1960).

...no effort is spared to make certain that if a government programme is introduced, the profession will occupy strong strategic positions from which to influence and control its direction (Taylor, 1960:114-115).

The efforts of the CMA were both pervasive and self-sustaining. Representatives of the profession were well placed both in government and in public administration to assist the medical profession (Coburn et al, 1983).
By the 1960s medical dominance was thus institutionalized, embedded in law, administrative statute, organizational forms, and relationships and custom (Coburn et al, 1983:417).

By the middle of the 20th century, medicine was the most prominent of all professions in Canada, enjoying greater political influence, social status and higher incomes than any other group. At the same time, they had almost completely subordinated associated healthcare professionals within the healthcare delivery hierarchy.

By the time this golden age of the medical profession peaked in the late 1960s and early 1970s, anyone contemplating a career in medicine in Canada was assured of a privileged position in society. Any prospective doctor could anticipate a rosy and stable financial future and an unparalleled position of social prestige and respect. Minor annoyances of dealing with hospital administrators aside, a doctor could expect to exercise his or her professional judgment relatively unhindered by political or bureaucratic interference. Many doctors practicing medicine today were practicing during this period. Almost all of the remainder grew up during this period and their earliest impressions of the medical profession were formed during this golden age.

The social position of doctors is still high in absolute terms. Relative to their position in the 1960s, however, the gap is large. Seventy-eight percent of PSI survey respondents agreed that ‘Society valued doctors more thirty years ago than they are valued today’ (see appendix 1, section 3, q 8). This gap between the practical realities of medicine today and the expectations of those who entered the profession or grew up during this period of power and
prominence is a source of dissatisfaction for physicians. It is not the role of the Association to handle expectation management for disgruntled doctors. It is the role of the Association to identify sources of dissatisfaction, their impact on the profession and to seek solutions that unify the profession.
CHAPTER 3: THE AGE OF UNCERTAINTY

If you trust Google more than your doctor then maybe it’s time to switch doctors.

Jadelr and Cristina Cordova (attributed)

The medical profession in Canada has undergone significant changes in the last 30 years. The increasing socialization of healthcare, the power of information technology, the growth of medical consumerism and the shift in public perceptions of the role and motivations of the medical profession have all had an impact. Dozens of authors have examined and documented the declining influence of the medical profession relative to its prominent position in the 1960s. This process has undoubtedly had an impact on doctors’ attitudes, perceptions and professional satisfaction. The most important question though is whether the collective actions of professional bodies have been effective in managing or slowing the decline. In trying to reinvent the past, it is possible that professional bodies are actually accelerating the process of decline.

Diminishing Authority

While looking at the decline of professions in general, Elliot Krause concluded ‘no profession in our sample has flown quite as high in guild power and control as American medicine, and few have fallen as fast’ (Krause, 1996:31). American public opinion surveys (NORC, Gallup, Harris) covering more than 30 years have asked questions regarding public confidence in the
health care system and in health care leaders. Although the reference to professional authority of doctors is not specific, the results are widely used as a proxy for medical authority (Schlesinger, 2002). While the results across the three surveys are not uniform, there is one significant and compelling correlation; they are all going down. In the Harris poll, for example, those respondents indicating 'a great deal of confidence' in the people 'in charge of running American medicine' plummeted from 80 percent to 40 percent between 1975 and 1999 (Schlesinger, 2002).

Schlesinger identifies three main factors that may be at the root of this perceived decline in medical authority. The first calls the professional efficacy of doctors into question. Growing awareness of both the frequency and impact of medical errors has shaken public confidence. This is partly a function of growing public access to information. Information technology certainly plays a role but Freedom of Information legislation has also allowed access to information that might otherwise have been inaccessible.

The notion that lifestyle issues have a profound impact on healthcare has raised the question of whether healthcare resources should be allocated with a greater emphasis on prevention than cure. The medical profession has traditionally adopted a remedial role in healthcare. People get sick and doctors cure them. The current economic climate serves only to entrench this view. In BC there are no defined billable services that relate to health promotion. As public interest in preventative measures grows and doctors are unable or unwilling to
meet the need, confidence in the role of doctors as the arbiters of all things health-related diminishes.

The second factor is that of professional agency. While many of Schlesinger’s examples are specific to the American model of healthcare, he makes the point that physicians have failed in their Parsonian role as mediators between individuals and society. The perceived influence of pharmaceutical companies on physicians is a source of concern. The Thalidomide situation in the 1950s and 1960s is a good case in point. The drug, prescribed to pregnant women to ease some of their uncomfortable symptoms was inadequately tested and caused birth defects. While the majority of blame was laid at the feet of the manufacturer, the failure of the physician’s duty of care was a black mark on the profession.

Physician integrity is questioned when the government views physicians as a drain on challenged healthcare budgets and when the public views physicians as being financially motivated. In a typical action/reaction scenario, the BC Ministry of Health (MOH) changed billing protocols so that physicians could only bill 50 percent of the fee guide for multiple services during a single visit. Physicians responded by limiting patients to a single issue per visit. The MOH did not achieve the cost reductions they anticipated and physicians suffered a public relations setback. Another excellent example of financial interests overriding a duty of care is the rise of internet pharmacies dispensing medicines under the authority of physicians who receive a fee from the dispensary but have never met the patient. Physician authority is eroded when
physician actions appear to be divergent from appropriate professional motivation.

The third factor is that of countervailing authority. Principally this rests in both the rise of socialized medicine with greatly increased governmental influence in the management and delivery of healthcare and in the growth of medical consumerism. Certainly, as doctors become more subject to government regulation and more answerable to healthcare employers, their influence diminishes in the eyes of the public.

A growing public focus on self-help and prevention, harkening back to the days of patent medicines, has allowed medical consumerism to reach new heights. One need only browse through the nearest bookstore or count the number of nutritional supplement/wellness retail outlets in the local mall to get a sense of the spread of the phenomenon. Pharmaceutical companies enter the picture once again with direct-to-consumer marketing. These advertisements contain only a peripheral nod to the authority of the physician. The tag line 'ask your doctor if X, Y or Z is right for you' has become ubiquitous. Perhaps the ultimate expression of medical consumerism is medical tourism. Individuals not wanting to face high costs in the US or long waits in Canada can fly to India or Cuba and receive care that in many cases rivals that available in North America.

Two schools of thought have emerged during the last 30 years to explain the declining influence of the medical profession. The deprofessionalization theory espoused by Haug (1988) and others looks to an erosion of the medical profession’s knowledge monopoly. The proletarianization theory of the
professions (McKinlay, 1988; Navarro, 1988) contends that doctors are losing control over the object, tools and means of their labour. Both camps and even the unrepentant professional dominance thinkers agree that the medical profession is changing. Regulation is increasing, autonomy and work satisfaction are decreasing, incomes are levelling off, and medical consumerism is on the rise. There is, however, little agreement on the root causes of these things or their impact on the profession (Hafferty, 1988).

**Deprofessionalization**

The deprofessionalization hypothesis is rooted in the notion that professions are being challenged by threats to their knowledge monopoly, authority and autonomy. While diminished autonomy and authority feature in the proletarianization and professional dominance schools of thought, the erosion of the knowledge monopoly is central to the deprofessionalization concept (Haug, 1988).

Haug argues that the growth of information technology has closed the gap between the layperson and the professional. Speaking of medicine, she also makes the point that as the volume and complexity of medical knowledge grows it is very likely that within narrow fields at least, a layperson may be better informed and be able to exercise better judgment than a doctor.

Some of the challenges to the knowledge monopoly of the physician have already been touched upon. The Internet, however, poses a particularly interesting challenge. The Internet is a repository of remarkable volumes of
readily accessible historical information. It is also where the newest information, credible or not, can be found. The obligation to a duty of care requires a physician to engage in only proven medical practices as expressed by published clinical practice guidelines (CPGs). CPGs are peer-reviewed and extensively tested to ensure their efficacy. This process is, of course, time consuming. Physicians are constantly encountering patients clutching reams of internet printouts who want to know why their doctor is not aware of the latest developments in diagnosis and treatment. More than half of the PSI respondents (55.8%) felt that many of their patients relied on alternative therapies as much as on medical advice (see appendix 1, section 3, q 9). Ironically, the mechanism intended to protect both the best interests of the patient and the knowledge monopoly of the profession is acting to diminish the public view of the profession’s expert authority.

When the value of the information is absolute and its effective application requires little in the way of judgment, a knowledge monopoly can be shattered irretrievably. Considering nuclear physics, it is reasonable to assume that the methods for constructing a nuclear weapon were once a closely guarded secret. Now that information is available such that any reasonably competent machinist could construct one. Fortunately, weapons grade plutonium is still hard to come by.

Physician expert authority is also being eroded by scope of practice agitation by formerly subservient healthcare professionals. In projecting their dominance over other allied healthcare workers in the first half of the 20th
century, doctors may have overreached themselves (Schlesinger, 2002). The pendulum appears to be swinging back. The introduction of the Nurse Practitioner role allows nurses to substitute for physicians in a way that would never have been contemplated 30 years ago. The success of pharmacists in regaining some prescribing powers in Alberta (contemplated in BC) is another sign of the growing power of other healthcare disciplines at the expense of the medical profession.

As technology advances and the tools of medical diagnosis and treatment become more expensive, more rarefied and more complex, the medical profession sacrifices some of its apparent expert authority to a growing cadre of medical technologists. Consider that an appointment with a GP (if you have one) can usually be made within a few days. Scheduling an MRI, however, can take months. Increasingly, the physician acts as a gatekeeper and facilitator, exercising their judgment on where and when specialized services are required but delivering very few of those services personally.

Proletarianization

The proletarianization theory holds that physicians are losing control of their work as their authority diminishes. Over the last century, doctors have seen an erosion of their control over entrance criteria, training content, terms of work, remuneration and the object, tools and means of labour (McKinlay, 1988). There is some support for this theory. As regulation increases, doctors opt out of fee for service payment models in favour of salaries, and new classes of non-doctor
administrators crop up to manage healthcare delivery and the activities of physicians.

In British Columbia, the predominant power of the Ministry of Health as a payer through the fee for service model means that physicians have lost control over their ability to determine remuneration for their services. In the past, physicians would have exercised their social responsibility by utilizing sliding scales of fees that took into account a patient's ability to pay. This process was discretionary to the physician and a facet of their autonomy. The medical profession in BC has lost all discretion in this area.

Consequences of Diminishing Authority

The accepted expert authority of a profession and its claim to professional autonomy are linked and to some degree mutually dependant. Both of these are cornerstones of a profession and both are vulnerable to external factors. If the expert authority of a profession is diminished, through any of the mechanisms discussed, its claim to autonomy may be challenged. If the profession loses the legitimizing opinion of the public through an apparent failure to fulfil its perceived societal role, its ability to maintain its knowledge monopoly and protect it from infringement will be severely curtailed.

In these uncertain times doctors face challenges to their authority and autonomy. They are often financially pressed and their role in society is changing. The challenge for the Association is to identify those areas where it can effect change and unify the profession to achieve positive outcomes for
doctors. This can be difficult when the immediate concerns of physicians may be at odds with the long-term interests of the profession. The ease with which this can occur in the current climate is clear when less than half (44.9%) of PSI survey respondents agreed that they ‘would continue to practice medicine the way I currently do even if I made less money’ (see appendix 1, section 3, q 24).

There is broad academic agreement that the legitimizing opinion of the public is vital to the viability of a profession. Short-term concerns of physicians, no matter how acute, cannot be successfully addressed with solutions that threaten the legitimacy of the profession. Latham expresses this succinctly:

It follows that patients and society are deeply threatened when physicians’ professional institutions lose their way, and instead of attending to the issues they should be attending to... they waste the “status-capital” of the profession by lobbying for pocketbook issues, training physicians to concentrate on money, and battling for political clout. (Latham, 2002:368)

Effective change is achieved through collective action. Collective action for professional organizations depends on professional unity. Professional unity in a community that has a tradition of personal and professional independence can be hard to achieve. The PSI survey gave respondents an opportunity to identify those areas in which the Association could impact their professional satisfaction. The overwhelming majority of those comments centered on the topic of internal discord and professional unity. It was also clear from many of the comments that much of the blame, rightly or wrongly, is laid directly at the doorstep of the Association. It will be very difficult for the Association to effect any useful
collective action when members of the profession are investing so much of their energy fighting amongst themselves.

The challenge to the Association is particularly acute when it is seen as contributing, actively or passively, to the growing internal unrest. The Association must identify the critical points of dissatisfaction as they relate to professional disharmony and act decisively to address those issues.

The PSI survey is intended to identify areas of professional dissatisfaction but can a subjective measure like this be reliable? Although instinctively distrusted by those who prefer to measure observable behaviours, there is significant academic and practical support for measures of satisfaction.
CHAPTER 4: MEASURING SATISFACTION

Say you don’t need no diamond ring and I’ll be satisfied
Tell me that you want the kind of thing that money just can’t buy

P McCartney/J Lennon, Can’t Buy Me Love, 1964

The Association is at risk if it allows professional dissatisfaction to create internal disharmony or any other situation that hampers collective action. Is it practical to measure satisfaction or dissatisfaction? How is satisfaction measured and what factors are important to individuals in evaluating their satisfaction? Life satisfaction surveys have been around for decades and are widely used at the national and international level. Opinions vary on the usefulness of subjective evaluations of satisfaction or happiness but they are gaining popularity as tools to guide public policy decisions.

Subjective Well-Being

The term subjective well-being (SWB) is widely used in the social science literature as a more precise definition of what we might otherwise call ‘happiness’ (Kahneman and Krueger, 2006). Interest in the subject of SWB has been growing over the last two decades and significant effort has been directed towards developing measures of SWB as well as towards defining the income-equivalent effects of SWB and its contribution to social capital. The Kingdom of Bhutan, for example, is determined to produce an index of Gross National Happiness. Other
governments (UK, Australia) are considering national measures of subjective well-being. (Kahneman and Krueguer, 2006).

**Measuring Subjective Well-Being**

Life satisfaction is the most popular measure of subjective well-being. Survey instruments like the World Values Survey, Eurobarometer and the General Social Survey are used to score life satisfaction. However, the whole notion of measuring something as subjective as happiness is challenging. Economists, for example, are traditionally opposed to the notion of subjective measures. They prefer to rely on observable data. The view is that while people might declare a belief or a preference, the way they behave exposes their actual beliefs and preferences. Nevertheless, there is some credible evidence to support the validity of life satisfaction scores. Life satisfaction test-retest scores conducted over a four-week period have shown correlations as high as .79. While this suggests that subjective measures like this are prone to short term fluctuation, they are, on balance, probably an effective indicator (Kahneman and Krueger, 2006).

**Life Satisfaction and Remembered Utility**

Life satisfaction scores depend on the concept of remembered utility. Not only are respondents asked about their feelings, they are asked to remember their feelings about an event or situation in the past. Helliwell refers to studies indicating that subjects tend to evaluate past experiences based on some average of the peak moment of the experience combined with their feeling at the
end of the experience (Helliwell, 2005). This presents a double challenge to those more interested in objective evaluation. Helliwell suggests that remembered utility is effective as a predictor of future behaviour because people make decisions about future action based on their remembered utility. Consequently, as a policy tool, life satisfaction based on remembered utility is credible (Helliwell, 2005). Helliwell bolsters his argument for the credibility of life satisfaction scores by pointing to the negative correlation between life satisfaction scores and national suicide rates (Helliwell, 2005).

**Experienced Utility and the U-Index**

Experienced utility is the moment-by-moment evaluation of an experience as it occurs. The strength of this concept is that it removes another variable, memory, from the process. Presumably, this would lead to more accurate measures and stronger predictive reliability. The primary difficulty, however, is that experienced utility is very difficult to measure effectively outside of the lab and almost impossible to manage on a large scale. Kahneman and Krueger proposed an alternate approach called the Day Reconstruction Method that had subjects evaluating their emotional states by reconstructing their feelings from the prior day. The researchers hoped that by working with the very recent past they could mitigate the impact of memory and produce results close to those produced by real-time sampling (Kahneman and Krueger, 2006). The researchers concluded that the Day Reconstruction Method produced similar results to real-time sampling but did so much more efficiently.
As an attempt to define a more objective measure of subjective well-being, Kahneman and Krueger proposed an indicator called the U-Index. The U-Index provides a complement to life satisfaction scores (a misery index). It scores the amount of time per day that individuals spend in activities that give rise to negative feelings. Kahneman and Krueger (2006) contend that by using time spent in an unpleasant activity instead of the strength of the feeling, they can control for personal characteristics such as optimism and pessimism and develop a useful cross-cultural measure of unhappiness. Finally, the authors conclude that the U-Index is a more useful than life satisfaction scores at the national policy level.

‘Lastly, we suspect that many policymakers are more comfortable with the idea of minimizing a specific concept of misery than maximizing a nebulous concept of happiness.’ (Kahneman and Krueger, 2006:22)

**Life Satisfaction and Psychological Needs**

A 2001 study by Sheldon et al, correlated the occurrence of positive and negative feelings with 10 psychological needs. The 10 needs included, amongst others, self-esteem, autonomy, competence, relatedness (social connection), popularity, and money. In various samples, the four psychological needs most strongly correlated with satisfaction were self-esteem, competence, autonomy and relatedness. In all samples the need least associated with satisfaction was money. Money’s correlation with positive feelings was only .05. However, money’s correlation with negative feelings was .21 (Sheldon et al, 2001). This suggests that money is more powerful in its ability to generate dissatisfaction than it is in promoting satisfaction.
Relative vs. Absolute Measures

While absolute income tends to have little impact on life satisfaction, relative income within a peer group can have a significant impact (Kahneman and Krueger, 2005). The choice of reference group may be entirely subjective and lead to differential dissatisfaction. The doctor who compares himself with doctors in another province may be content while a doctor who compares himself against other medical sub groups may be very unhappy. This is particularly important for the medical profession where large income disparities can exist between general practitioners and specialists and between individual specialist groups. Achieving substantial across-the-board income increases for doctors is likely to have a very transitory effect if perceived income disparity issues remain.

Of the 245 anecdotal responses alluding to professional disharmony, 83 spoke directly of income disparity. A weakness of the PSI survey is that no question specifically addresses this issue. There is, however, some evidence of perceived disparity in the overall Financial Reward scores between GPs and specialists. GP satisfaction with Financial Reward was 11 percent lower than that of specialists (2.263 vs. 2.532). In addition, 76.7 percent of GPs regarded the profession as 'less rewarding than it was 30 years ago' (see appendix 1, section 3, q 4) while only 62.7 percent of specialists felt the same. There is no objective evidence from the survey of the degree of income disparity and associated dissatisfaction amongst specialists but many of the income disparity comments were from specialists complaining of cross-specialization differences.
Money may have modest power to create satisfaction but it has significant capacity to create dissatisfaction. That dissatisfaction is particularly acute when physicians feel financially marginalized in comparison to their reference group. Depending on the moment, that reference group might be other specialists, doctors in other provinces or different professions.

**Validity of Satisfaction Measures**

There is ample support, both academic and practical, for the validity of satisfaction measures. In testing the satisfaction of BC physicians, it is tempting to proceed with a U-Index approach as defined by Kahneman and Krueger. This approach is more objective, controls for some elements of personal perspective and mitigates the effect of memory on satisfaction. It would also be more closely aligned with the objective, evidence-based orientation of the profession. This approach should also be particularly attractive to the Association given that the focus is on identifying target areas of dissatisfaction and the U-Index measures misery. Unfortunately, the prospect of engaging overworked doctors in a Day Reconstruction methodology is not promising. A primary requirement of the PSI survey is that it be quick and easily accessible to as many physicians as choose to participate. The rigour of the Day Reconstruction Method requires an investment in time that would be effectively impossible to achieve in a community of hard-pressed physicians.

If satisfaction can be measured in a credible and practical way then it only remains to establish a definition of professional satisfaction that ensures the results of the PSI survey will provide useful guidance to the Association.
CHAPTER 5: PROFESSIONAL SATISFACTION

No one is useless in this world who lightens the burdens of another.

Charles Dickens (attributed)

Job satisfaction and workplace satisfaction measures have been around for decades but are they relevant to a discussion of professional satisfaction? As discussed, professions fill a unique role in society and their members achieve different benefits and carry different obligations than other occupations. Typical job satisfaction instruments focus on workplace issues, which tend to be more about how, when and with whom work is done without much reference to why. In addition, many instruments focus on specific elements of satisfaction such as work/life balance. If the golden age of medicine in the last century formed the expectations of current and prospective doctors and if those reasonable expectations attracted individuals with a particular set of personal values, a more values-oriented approach is necessary for measuring professional satisfaction.

Values as a Driver of Professional Satisfaction

Personal preferences or characteristics can have a significant impact on the strength or degree of positive or negative emotion attached to an event or situation. Optimistic people may find an event only mildly dissatisfying while a pessimist may regard the identical situation as profoundly dissatisfying. In addition, personal outlook can affect the outward expression of satisfaction. A
subdued individual may describe their reaction to a satisfying situation as ‘not displeased’ while a more expressive person could categorize the identical situation as ‘incredibly satisfying’ (Bailey et al, 2007).

Oishi et al, proposed the value-as-a-moderator concept. This concept suggests that individual satisfaction is dependent on underlying values. Consequently, someone who holds benevolence as a value is likely to find volunteer activities more satisfying than someone who holds hedonism as a value. The model utilizes 10 values: power, achievement, hedonism, stimulation, self-direction, universalism, benevolence, tradition, conformity and security. The study found evidence that degree of satisfaction is value dependant. The authors conclude, “The present findings suggest that it is value-congruent activities that provide a sense of satisfaction” (Oishi et al, 1999, 178).

The difficulty with applying the value-as-moderator approach to a professional satisfaction study is that it first requires significant analysis to determine the value orientations of individuals. The professional satisfaction survey takes a simpler approach. The significance that prospective doctors attach to the perceived benefits of the medical profession is assumed to be rooted in their underlying values. The five ‘motivators’ identified earlier, financial reward/stability, social status/respect, intellectual growth, autonomy and desire to help are all commonly cited reasons for becoming a doctor. The five motivators also tend to map roughly to several of the 10 values. Desire to help is associated with benevolence and universalism. Financial reward and stability is associated with security. Autonomy and freedom are associated with self-direction. Social
status and respect is associated with achievement and conformity, while intellectual challenge is associated with stimulation.

For this analysis, the following definition of professional satisfaction is proposed:

‘Professional satisfaction is achieved when the realization of professional practice consistently delivers the benefits anticipated by the individual when first contemplating entering the profession.’

Time and experience will moderate expectations and some might argue that relying on an idealistic baseline that can be decades old is neither practical nor realistic. On the other hand, while expectations do change, underlying values rarely shift significantly. By using the reported significance of the five motivators to weight the outcome, it should be possible to produce a more balanced professional satisfaction score that accounts, at least somewhat, for differing personal orientations.

The PSI survey weights category responses by the relative importance of the associated motivating factor. Physicians reporting that financial reward was not a factor in pursuing a career in medicine (relative to other factors) will have their response to financial category questions weighted less heavily than other categories in the final score. It is not the absolute score but the relationship with other motivating criteria that matters. Physicians who record a 1 (not important) for all criteria equally will show no weighting effects. Likewise physicians who score 4 (very important) for all five criteria equally will also show no weighting effects.
Prior Views of Professional Satisfaction

Past studies have attempted to rate the professional satisfaction of physicians. Two in particular are interesting. The Canadian Institute for Health Information (CIHI) periodically conducts a National Physician Survey that contains a section on professional satisfaction (CIHI, 2006). The Society of General Internal Medicine (SGIM) Career Study Group in the US developed a Physician Worklife Survey that was piloted in 1999 (Konrad et al, 1999).

National Physician Survey

Last completed in 2004, the National Physician Survey contains nine questions on the subject of professional satisfaction amongst Canadian physicians. Physicians were asked to rate their degree of satisfaction (5 point scale) with each of the following:

- Relationship with patients
- Relationship with Family Physicians
- Relationship with Specialists
- Relationship with non-physician healthcare workers
- Relationship with hospitals
- Current professional life
- Availability of Continuing Medical Education (CME)
- Balance between personal and professional commitments
- Ability to find a locum

The overwhelming strength of this survey is its broad distribution and high response rate. Delivered to over 60,000 doctors, the 2004 survey received 21296 responses. The survey was conducted over a five month period in 2004 and
included an advance awareness campaign in the media, three separate mailings
and telephone follow up. The majority of questions focus on relationships. The
remaining four questions touch on intellectual enrichment, general satisfaction
and work/life balance.

The primary difficulty with this survey is that ‘satisfaction’ is not defined.
Referring again to personal orientations, it is likely that some respondents would
view satisfaction as ‘meeting a minimally acceptable standard’ while others would
view it as ‘fulfilling a specific desire or need’. The survey also mixes very general,
subjective questions (satisfaction with current professional life) with much more
specific questions (ability to find locums).

Even with these problems the results are useful if not completely
surprising. Province by province comparison highlights jurisdictional differences
with Ontario doctors being the least happy (see Table 1).

<table>
<thead>
<tr>
<th>Province</th>
<th>Family Physicians</th>
<th>Specialists</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newfoundland/Labrador</td>
<td>73.8</td>
<td>72.6</td>
</tr>
<tr>
<td>Prince Edward Island</td>
<td>71.7</td>
<td>82.4</td>
</tr>
<tr>
<td>Nova Scotia</td>
<td>73.7</td>
<td>79.5</td>
</tr>
<tr>
<td>New Brunswick</td>
<td>77.4</td>
<td>79.5</td>
</tr>
<tr>
<td>Quebec</td>
<td>75.5</td>
<td>83.4</td>
</tr>
<tr>
<td>Ontario</td>
<td>61.1</td>
<td>73.2</td>
</tr>
<tr>
<td>Manitoba</td>
<td>72.1</td>
<td>79.0</td>
</tr>
<tr>
<td>Saskatchewan</td>
<td>77.4</td>
<td>77.6</td>
</tr>
<tr>
<td>Alberta</td>
<td>69.9</td>
<td>78.5</td>
</tr>
<tr>
<td>British Columbia</td>
<td>70.3</td>
<td>77.4</td>
</tr>
<tr>
<td>Yukon/NWT/Nunavut</td>
<td>77.3</td>
<td>69.2</td>
</tr>
</tbody>
</table>

In general, family physicians are less satisfied than are specialists. One interesting characteristic is that the two provinces (New Brunswick, Saskatchewan) reporting the smallest gap between family physicians and specialists also report higher satisfaction overall. Another interesting result from the survey is that, particularly for family physicians, as dependence on fee for service remuneration increases, satisfaction decreases (see Table 2).

### Table 2: Percentage of Physicians Satisfied with Professional Life by Income Mix

<table>
<thead>
<tr>
<th>FFS Income as a Percent of Total</th>
<th>Family Physicians</th>
<th>Specialists</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>76.5</td>
<td>79.7</td>
</tr>
<tr>
<td>1-24%</td>
<td>77.1</td>
<td>79.8</td>
</tr>
<tr>
<td>25-49%</td>
<td>69.5</td>
<td>81.8</td>
</tr>
<tr>
<td>50-74%</td>
<td>72.4</td>
<td>79.6</td>
</tr>
<tr>
<td>75-99%</td>
<td>68.3</td>
<td>75.1</td>
</tr>
<tr>
<td>100%</td>
<td>62.6</td>
<td>75.8</td>
</tr>
</tbody>
</table>


This outcome suggests that specialist physicians tend to feel better served by a fee for service model than their family physician colleagues.

Despite concerns over the lack of a definition of satisfaction, this survey produces some useful comparative results. Ultimately, however, this survey is more about the job than about what physicians get out of the job.

**The Physician Worklife Survey (PWS)**

The SGIM study (Konrad et al, 1999) was developed by a large team of researchers working in conjunction with an American physician expert panel. The team originally identified 15 facets of physician satisfaction, three of which (autonomy, pay, status) are directly comparable with the motivators identified for
the PSI survey. Working from an original base of 150 questions, the survey was whittled down to 70 questions representing 10 facets of satisfaction and 19 questions covering global indicators (Konrad, et al, 1999). The PWS survey went to 5,704 American physicians and drew 2,325 responses. The researchers conducted four mailings with an individualized cover letter from the researchers and the SGIM. A telephone follow up campaign for non-respondents was carried out prior to the close of the survey.

The primary strengths of this survey are its careful development methodology and its use of neutrally framed agree/disagree questions that do not depend on a mutually agreed definition of satisfaction.

There are several difficulties with this survey. The first is that the authors’ intent was not to actually to assess physician job satisfaction but rather to assess a tool for measuring physician satisfaction. The entire study was focused on refining the survey rather than on whether or not physicians were satisfied in their jobs. The second is that once again, the questions and facets of satisfaction used are very job-oriented (relationships with hospitals, relationships with other healthcare workers, etc.). The third problem is that this study is designed to measure job satisfaction of American physicians who operate in a different environment than Canadian physicians. While it might be reasonable to expect a values-based satisfaction index to cross borders, a job-specific satisfaction survey would have more trouble.
The Professional Satisfaction Index (PSI)

The structure of the PSI survey developed by the author is similar to the SGIM survey (multiple facets of satisfaction, global indicators, etc.). Like the PWS, the nature of the questions in the PSI does not specifically depend on a mutually agreed definition of satisfaction. Care has been taken, however, to steer away from job-specific issues (relationships with allied health professionals, etc.). The purpose of the professional satisfaction index is to examine not what doctors put into the profession but rather what they get out of the profession. It is not likely that many prospective physicians entered the profession because they would enjoy good relationships with nurses or physiotherapists. It is likely that those things were simply assumed. If they have not materialized, it probably has more to do with the character of the physician than it does with the nature of the profession.

Reliance on the stated definition of professional satisfaction tends to narrow the focus somewhat. It would be ridiculous, of course, to suggest that the obstacles and constraints of the workplace do not affect one’s satisfaction. However, by taking a values-oriented approach, it is possible to determine not just what satisfies or dissatisfies but the relevance of that issue to doctors. Where there is agreement amongst the profession, at least on symptoms if not root causes, there is an opportunity for the Association to act.

Facets of Motivation

A significant problem in the development of the five facets of motivation is that a literature review revealed no studies that clearly identified or ranked the
reasons why people choose to become doctors. Some studies touch on individual elements and others approach the topic peripherally. One US study from the early 1990s was targeted at discovering why undergraduate students, particularly those with acceptable MCAT scores were not choosing medicine as a career (Barondess and Glaser, 1993). A separate South American study targeted at determining if personality differences would explain gender bias in medical school acceptance did ask respondents their motivation for entering the profession but probed only the primary reason (Millan et al, 2005). Altruism and intellectual growth figured prominently but recognition and money also surfaced as primary motivators. It is not clear that the results of this research are fully cross-cultural. The general lack of comprehensive resources left a more subjective process that looked for clues in the existing literature.

Financial Reward was chosen for a variety of reasons. Relatively speaking, doctors do enjoy very good incomes. It is a defining characteristic of the profession. The Canadian Federation of Medical Students (CFMS) identifies on its website that two of the most common questions asked by prospective students are ‘How much does it cost to become a doctor?’ and ‘How much money will I make?’ (CFMS, 2007). The power of money to dissatisfy (Sheldon et al, 2001) suggests that it has influence as a motivator. The disagreement between Parsons and Freidson over the influence of money on the profession also made this facet worth exploring.

The history of the development of the medical profession in Canada identifies that substantial social standing and recognition were accorded to
physicians in the glory days during the late middle of the last century. This too
was a defining characteristic of the profession and likely figured in the
expectations of those joining the profession. The Millan (2005) study identified
recognition as a motivator for prospective medical students. The Parsonian view
as well suggests that doctors are ‘characteristically peer-oriented and status
hungry’ (Latham, 2002).

Intellectual growth was the second most commonly cited primary reason
for pursuing medicine in the Millan (2005) study. Competence showed
consistently in the top four factors that correlated positively with satisfaction in
the Sheldon (2001) study. Parsons (1951) ranked achievement as the most
important pattern variable identified with the medical profession. Parson’s view of
achievement in this context related directly to achieving a high degree of
technical competence in a challenging field. The Swick (2000) definition of a
medical professional specifies a continuous commitment to the advancement of
medical knowledge. In addition, the very high intellectual entrance requirements
for the medical profession suggest that it is attractive to those who have not only
the capacity for but also the interest in, intellectual growth.

Autonomy has been discussed as a defining characteristic of professions
in general. Freidson described autonomy as a profession’s most strategic and
treasured characteristic. It is also had the second-highest correlation with

A Desire to Help is probably the most prominent of the five motivational
facets. This was the most often cited reason for pursuing medicine in the Millan
(2005) study. The Swick (2000) definition of a medical professional focuses strongly on the responsibility of the physician to society. Collectivity orientation is one of Parson’s five pattern variables that distinguish the medical profession. He identifies that the physician’s ability to put the welfare of the patient above all other concerns is a core characteristic of the profession.

Clearly, this is not an exhaustive list. For example, one often-cited motivator for joining the profession is the influence of a third party (Millan et al, 2005). That motivator was not included here because it does not relate to an expectation of benefit from the profession.

**Constraints on the PSI Survey**

The Association is keenly aware of the presence of survey fatigue amongst doctors. Doctors are surveyed on compensation and benefits. They are surveyed on technology. They are surveyed on policy issues. They are even surveyed on their opinion of the Association’s annual report. In light of this, Association management placed several constraints on the PSI survey.

The survey had to be brief. Average time to finish the survey had to be less than 10 minutes and shorter was better. There could be only one contact. No follow up would be allowed. The survey had no budget and no staff time would be allowed for support. The survey was delayed to accommodate two other Association surveys and was approved at the end of June 2006. The survey, therefore, was only open for 15 days until the middle of July.
CHAPTER 6: PROFESSIONAL SATISFACTION INDEX

Happiness is nothing more than good health and a bad memory.

Albert Schweitzer.

The intent of the PSI survey is to measure the professional satisfaction of physicians. Unlike other job satisfaction instruments the PSI survey uses values-based motivational factors to weight the responses. This approach seeks to identify not just sources of dissatisfaction but their relative importance to physicians. As a tool for the Association, the PSI provides an opportunity to target specific areas of dissatisfaction that lend themselves to collective counter measures. This is particularly relevant if issues of dissatisfaction are fragmenting the profession and challenging the role of the Association as a cohesive representative body.

This is a period of uncertainty for physicians. The history of the profession tells them what their role should be but social, economic and political forces are creating obstacles to the fulfilment of that perceived role. The challenge for the Association is to ensure that collective efforts to redress concerns in one area do not exacerbate problems in another. As illustrated, this is exactly what can happen when reactionary economic tactics create a social backlash.
PSI Survey

The survey sample was developed using the Association member database. This database contains up-to-date contact information for all BC physicians. For cost and efficiency reasons the survey was web-based and invitations were distributed via email. The web-based approach allowed for anonymity although physicians were given the option to self-identify by providing their MSP billing number.

This exploratory survey was developed as an aid to the Association in identifying areas of professional dissatisfaction. As such, the survey sample and distribution method are appropriate to the established pattern of practice for the Association. The Association is not in the habit of conducting statistical analysis of the reliability of its opinion surveys and regularly makes judgments based on surveys with relatively small response rates (6-8%). Although exploratory, the theoretical nature of the PSI requires that some statistical analysis of the quantitative results be conducted before any conclusions based purely on quantitative results can be verified. No statistical basis for the reliability and validity of the results of this survey has been established. In its current form, the survey has numerous limitations (see Chapter 9) Until some analysis of validity has been conducted any conclusions based on apparent patterns in the data should be judged accordingly.

Survey Sample

The survey sample was developed based on the following criteria:
- Resident in BC
- Licensed by the BC College of Physicians and Surgeons
- Either salaried or with earnings greater than $30,000 in 2006
- No residents
- Have a contact email address

The Association database does not record earnings data for salaried physicians. Salaried physicians must self-report their status. All other physicians were selected based on earnings information reported to the Association by the Medical Services Plan of BC or by the various health authorities throughout the province. These criteria yielded a survey sample of 6,369 physicians. This was not a random sample. Every BC physician who met the sample criteria received an invitation to complete the survey. The need for email distribution did eliminate some potential candidates from the sample but the selection bias is probably not significant given that within this group, 88 percent of all candidates have an email address. The Association regularly relies on email surveys for opinion data.

**Survey Response**

The survey was open for a two-week period and received 712 completed responses for an overall response rate of 11.2 percent. The Association regularly conducts opinion surveys of the membership with typical response rates of 6-7 percent. Demographic comparisons between the sample and the respondents showed very similar profiles.
The age distribution comparison is very uniform with the exception of an unexplained spike in the 55-59 age category. Doctors in this category made up 14 percent of the sample but 17 percent of the respondents. This differential may or may not be indicative of a bias in the response set (see Chapter 9).
Comparisons of gender, practice type and practice location also showed a very similar distribution between the sample and the respondents. The similarity in distributions suggests that the respondent group is representative of the sample as a whole.

**Survey Format**

The survey contained four sections (see appendix 1 for full text of the survey questions). Section one of the survey was limited to demographic data (age, gender, practice type, etc.). Section two asked the degree to which each of the five motivating factors (financial reward, social status, etc.) influenced the decision to enter the profession. Section three contained 28 agree/disagree statements scored on a five-point scale (Strongly Disagree, Somewhat Disagree, Neither Agree nor Disagree, Somewhat Agree, Strongly Agree). Some of the
questions were negatively phrased and the numerical scoring for those was reversed so that higher scores inferred higher degrees of satisfaction. There were between four and six statements associated with each of the five motivating factors as well as four global satisfaction statements. The fourth and final section asked whether the respondent considered that the Association had a role to play in supporting their professional satisfaction and provided two open-ended response opportunities to elaborate.

To calculate the PSI, average raw scores were calculated for each motivation category. The raw score for the category was weighted using a simple mathematical approach that modified the weighting factor up or down from 1.0 based on the variance of the significance score for that motivation factor from the mean of all motivation factors. The cumulative average score for all five sections was modified using the average score for the global satisfaction section. A score of 3.0 was set as the baseline for the global modifier. Scores higher or lower than 3.0 could modify the base score by up to 40 percent (5.0=modifier of 1.4, 1.0=modifier of .6). The combination of the category average and the global modifier produced the final score.

**PSI Survey Results**

The large number of unique interest groups within the profession tends to generate a broad range of responses to many of the survey questions. Standard deviations for individual question responses reached as high as 1.5, which is large considering the maximum range of the response scores is 4.0. Average scores for each category showed much smaller standard deviations (.58 to .9)
but the weighting approach tended to magnify the deviation. The total base score showed the smallest deviation of all at .44.

Some clear patterns did emerge from the data and those patterns were consistent with the CIHI National Physician Survey. Age, practice type (GP vs. specialist) and income source all show similar satisfaction differentials. Like the CIHI survey, Gender and Practice Location (Rural/Urban) showed very little differences (CIHI, 2006).

**Motivation**

The pattern of motivational factor response data was very consistent across all demographic subgroups, particularly in the relationship between the five motivators. The ranking of motivators is indicated in Table 3.

<table>
<thead>
<tr>
<th>Motivational Factor</th>
<th>Score (out of 4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Desire to Help People/Society</td>
<td>3.591</td>
</tr>
<tr>
<td>Intellectual Growth/Challenge</td>
<td>3.576</td>
</tr>
<tr>
<td>Autonomy/Freedom</td>
<td>3.320</td>
</tr>
<tr>
<td>Financial Reward/Stability</td>
<td>2.798</td>
</tr>
<tr>
<td>Social Status/Respect</td>
<td>2.399</td>
</tr>
</tbody>
</table>

The relative positioning of motivational factors was almost universal when looking at the data across various sub groups. The one/two position shifted back and forth but only rarely did the scores for Desire to Help and Intellectual Growth separate by more than .1. Salaried doctors represented the only significant variation in this pattern. Of the 25 identified demographic subgroups (age,
gender, practice type, remuneration, practice location and years practicing), only salaried doctors scored Social Status higher than Financial Reward. Additionally, salaried doctors showed motivation scores for Financial Reward and Autonomy lower than any other group (see Figure 3).

Overall, the motivation scores for social status provide an interesting counterpoint to Parson’s perspective that professionals are peer-oriented and status seeking.

**Calculating the Index**

Scores for each of the five motivator categories, the global modifiers and the final score are shown in Table 4. Raw and weighted scores show that the greatest satisfaction is derived from the top two motivator categories, Intellectual Growth and Desire to Help. Applying the weighting shuffles the remaining three categories. The result is consistent with the ranking of the motivator categories.
Table 4: PSI Calculation

<table>
<thead>
<tr>
<th>Category</th>
<th>Raw Score</th>
<th>Weighted Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial Reward/Stability</td>
<td>2.385</td>
<td>2.091</td>
</tr>
<tr>
<td>Social Status/Respect</td>
<td>2.650</td>
<td>1.988</td>
</tr>
<tr>
<td>Intellectual Growth/Challenge</td>
<td>4.084</td>
<td>4.714</td>
</tr>
<tr>
<td>Autonomy/Freedom</td>
<td>2.223</td>
<td>2.331</td>
</tr>
<tr>
<td>Desire to Help People/Society</td>
<td>3.698</td>
<td>4.309</td>
</tr>
<tr>
<td>Subtotal Categories</td>
<td>3.008</td>
<td>3.087</td>
</tr>
<tr>
<td>Global Satisfaction</td>
<td>3.411</td>
<td></td>
</tr>
</tbody>
</table>

The Professional Satisfaction Index is 3.404.

The fact that the raw and weighted subtotal scores were only .079 apart raises the question of whether the weighting adds value. Only further surveys with other groups would identify whether the weighting is useful for adjusting the overall score or simply helps to clarify the relative importance of each of the individual motivator categories.

There are no current comparisons for the PSI score and statistical analysis to test the validity of the survey is pending. Until validity testing is conducted, the PSI score cannot be considered representative. Regardless, with a mid-point score of 3.0, an index of 3.4 is certainly not stellar. Only the application of global satisfaction modifiers raised the score above the mid-point at all. On the positive side, the two most important motivating factors (Intellectual Growth, Desire to Help) deliver satisfaction scores well above the mid-point. In addition, the global satisfaction scores are comfortably above the mid-point,
which suggests that the more important motivators are still holding their own against other less happy indicators.

On the negative side, social status, one of Parson’s key professional motivators, is scoring well below the mid-point. Autonomy, Freidson’s ‘most strategic and treasured characteristic’, is also failing to live up to expectations. The raw score for Autonomy was the lowest of all five. Autonomy is not only a motivating factor but also a key characteristic of a profession. It was also the third highest ranked motivator next to Intellectual Growth and Desire to Help scoring 0.522 higher than the next lowest motivator, Financial Reward. Whereas Financial Reward dissatisfaction may have short-term consequences for the Association, Autonomy-based dissatisfaction may have much longer-term implications.

Comparing Subgroups

Subgroup comparison offers some insights that the total absolute PSI score cannot. At this point, observations of variance between subgroups are based solely on visible patterns in the data. In many cases these are echoed by the 2004 CIHI survey. The survey sizes, however, are very different and statistical significance cannot be inferred. Highlights are included below.

Practice Type

General Practitioners are somewhat less happy than their specialist colleagues. For example, GPs are more likely to believe they are underpaid (73.9% vs. 58.5%) and more likely to feel they lack timely access to appropriate
resources (19.3% vs. 35.7%). While the satisfaction scores in Figure 4 are patterned identically, GPS score consistently lower in each satisfaction category.

**Figure 4: Professional Satisfaction: GPs vs. Specialists**

Age

Satisfaction tends to be higher with younger doctors and those still practicing after the age of 65. Over 65 doctors report raw scores that are typically about .2 higher than other age bands regardless of category. Over age 65 doctors also have the highest global satisfaction scores of any demographic group and the highest PSI (3.995) of any demographic group.

It is not completely clear why this subgroup should report higher satisfaction scores. One possible explanation may be that at this point in their lives, these doctors are more likely to be practicing medicine because they want to rather than because they must. If that is true, then they will likely be less
concerned about financial issues and more likely to focus on what drew them to the profession in the first place. This explanation is consistent with the results of question 24 'I would continue to practice medicine the way I do, even if I made less money.' Over 65 doctors score 3.911 vs. the next nearest score of 3.284. This gap represents one of the largest single differentials for any question and any subgroup comparison.

**Income Source**

Differences between the various income subgroups are extremely interesting. The small group of salaried doctors (n=20) is particularly salient. Salaried doctors had the lowest Financial Reward and Autonomy motivation scores of any income subgroup (Figure 3). The proletarianization view holds that as employer influence increases, autonomy decreases. Therefore, it would seem reasonable that those physicians attracted to salaried (employer/employee) positions would probably place lower importance on autonomy. The reality is that although they place lower significance on both financial reward and autonomy, salaried physicians show satisfaction scores significantly higher than other groups in both these categories (Table 5).

<table>
<thead>
<tr>
<th>Remuneration Type</th>
<th>Financial Reward</th>
<th>Autonomy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salary</td>
<td>3.138</td>
<td>2.625</td>
</tr>
<tr>
<td>Sessional</td>
<td>2.655</td>
<td>2.446</td>
</tr>
<tr>
<td>Other</td>
<td>2.594</td>
<td>2.333</td>
</tr>
<tr>
<td>Service Contract</td>
<td>2.558</td>
<td>2.445</td>
</tr>
<tr>
<td>Fee for Service</td>
<td>2.309</td>
<td>2.158</td>
</tr>
</tbody>
</table>
The National Physician Survey indicated that as reliance on Fee for Service remuneration goes up, satisfaction goes down (CIHI, 2006). Consequently, a useful approach will be to compare the fee for service doctors against the salaried, sessional and service contract doctors combined.

### Table 6: Professional Satisfaction: FFS vs. Other Income

<table>
<thead>
<tr>
<th>Category</th>
<th>Fee for Service</th>
<th>Salary/Sessional/SC</th>
<th>% Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial Reward/Stability</td>
<td>2.309</td>
<td>2.784</td>
<td>20.6</td>
</tr>
<tr>
<td>Social Status/Respect</td>
<td>2.624</td>
<td>2.758</td>
<td>5.1</td>
</tr>
<tr>
<td>Intellectual Growth/Challenge</td>
<td>4.056</td>
<td>4.099</td>
<td>1.1</td>
</tr>
<tr>
<td>Autonomy/Freedom</td>
<td>2.158</td>
<td>2.505</td>
<td>16.1</td>
</tr>
<tr>
<td>Desire to Help People/Society</td>
<td>3.655</td>
<td>3.805</td>
<td>4.1</td>
</tr>
<tr>
<td>Global Satisfaction</td>
<td>3.338</td>
<td>3.661</td>
<td>9.7</td>
</tr>
<tr>
<td>Net PSI</td>
<td>3.306</td>
<td>3.759</td>
<td>13.7</td>
</tr>
</tbody>
</table>

Fee for Service doctors score lower in every category and in most cases, much lower. This pattern suggests that the fee for service payment model is a significant source of dissatisfaction for physicians. Comparison by practice type suggests that fee for service may be kinder to specialists than GPs (this appeared in CIHI data as well; see Table 2). Given the power of money to generate dissatisfaction, it is possible that rather than other payment models making doctors happy, fee for service just makes doctors very unhappy. That unhappiness may colour their view in other categories as well.

Fear of the gradual loss of autonomy may well be at the root of the pervasiveness of the fee for service model. At one time, when physicians could set their own fees, fee for service would have been supportive of physician autonomy. This has not been true for 30 years but fee for service may still hold
some of its old cachet. The PSI survey indicates however, that doctors on alternate payment models are more satisfied with their autonomy than are those on fee for service. In the past, fee for service doctors have taken action to address financial concerns that cast the profession in a negative light with the public. Given the degree to which professional autonomy rests on legitimizing public opinion, it is likely that the fee for service model is actually more dangerous to physician autonomy than a salaried model.

**Anecdotal Evidence**

Seventy-seven percent of respondents felt that the BC Medical Association had a role to play in supporting their professional satisfaction. There were 475 responses indicating what the Association should do/do more of and 328 responses indicating what the Association should stop doing.

**Internal Conflict**

The vast majority of comments referred to resolving issues of real or perceived internal conflict. The theme of professional unity came up 98 times. Most comments were of the ‘stop fighting amongst ourselves’ variety. Income disparity issues were raised 83 times. There were concerns that GPs are financially disadvantaged compared to specialists and that individual sub specialties were disadvantaged in comparison to their colleagues. Sixty-four respondents commented that the Association favours one group over another. In total, there were 245 comments that touched on dissension and discord. Many
respondents felt the Association was either actively or passively contributing to the disharmony.

Compensation

Eighty-eight respondents spoke out on compensation issues with 53 advocating for better income, benefits and working conditions and 35 calling for less focus on the Fee for Service billing model. Suggestions ranged from opening up more private billing options to putting all doctors on salary.

Autonomy

This topic covered everything from ‘getting out of bed with government’ to reducing bureaucratic overhead and oversight. Eighty-one respondents expressed concern over these issues.

Public Relations

Respondents expressed significant concern over the public image of the profession. Forty-six comments touched on educating the public about the realities of the healthcare system and on redressing negative perceptions of doctors as ‘being only concerned about money’.

CME and Locums

A total of 41 respondents were seeking more support for CME and better access to locums. The locum issue was particularly acute for respondents who felt they were at risk of burnout because the lack of locums restricted their ability to take time off.
CHAPTER 7: LOOKING AT THE ISSUES

But it's all right now, I learned my lesson well.

You see, you can't please everyone, so you've got to please yourself,

Ricky Nelson, Garden Party, 1972

The PSI survey identified several issues of dissatisfaction. Internal discord sparked primarily by income disparity is the first of these. Dissension is fragmenting the membership and the Association appears powerless to address the problem.

The second issue is the fee for service model of payment. Doctors using this model are significantly less happy than are their colleagues. When doctors take precipitate action to address shortcomings of the fee for service model, the outcome is often a negative public perception of the profession and the Association.

The third issue is autonomy. Increasing regulation, the growth in paperwork and bureaucracy that reduces the amount of time physicians spend with patients and widespread suspicion regarding the motives of government are all leading to a general feeling that physicians are losing control over their professional lives. There was substantial anecdotal commentary concerning the degree to which the Association is allowing this problem to grow.
Public relations is the fourth issue. Many physicians are concerned about the negative public image of the profession. Doctors often appear ineffective in securing timely treatment for their patients. Financial issues are spilling over into the public view with increasing frequency and promoting the image of doctors as being primarily financially motivated. The rise of medical consumerism has changed public attitudes towards healthcare and the physician’s role as the manager of society’s physical well-being.

**Internal Discord**

Several past presidents of the Association have made professional unity a goal during their tenure and yet the problem, if possible, is getting worse. More than anything else doctors are fighting about money, particularly about perceived inequities in the distribution of money. Income disparity has a spillover effect when less well off physicians perceive their relatively lower income to be a sign of social marginalization on the part of the government, inattention on the part of the association and peer disrespect on the part of their wealthier colleagues.

The inability to successfully deal with income disparity is a primary source of professional dissatisfaction amongst physicians and of member dissatisfaction with the Association. Several recent initiatives that attempted to deal with some aspects of disparity were either defeated or narrowly passed with much heated debate. The membership is becoming less trusting of the Association’s leadership and if the situation is not corrected soon, the Association’s role as a representative body will be severely compromised.
Allocating Money

The Association represents physicians in negotiations with government on compensation issues. Although negotiations often involve targeted funds that are directed to specific areas of need, the main thrust is always around general fee increases. Once the negotiation process is complete and the agreement ratified by the membership, the trouble starts. The general fee increase must be allocated to the various billing fee codes through a process of Macro Allocation (the split between GPs and specialists) and Micro Allocation (the split between sub specialities). Each participant to the process presents their case using historical prerogative, selective statistics, perceived disparity and raw emotion to bolster their argument. The problem, of course, is that this is a zero-sum game. In order for one group to gain, another must suffer proportionately.

An excellent example of the problem is currently in process. In May 2006, the membership of the association ratified the richest working agreement ever concluded with the government. The agreement received a 94 percent approval; the highest ever in BCMA history. To date, 15 months later, no physician has received any of the negotiated fee increase. Predictably, the GPs and specialists could not agree on the macro allocation and the matter was referred to arbitration. The arbitrator ruled in favour of the GPs and the specialists immediately appealed the decision. The results of the appeal are still pending but even when that is delivered, money cannot flow until the micro allocation is complete. The micro allocation can be even more acrimonious than the macro
process because of the large number of sub specialties individually competing for their portion of a fixed sum of money.

The allocation process is protracted, painful and, as one survey respondent described it, ‘professionally destructive’. Internal strife is guaranteed when physicians are pitted against each other in an unseemly dash for cash and the worst part is that no one wins. Everyone feels tainted by the process and cheated by the outcome.

**Fee for Service Payment**

Seventy-eight percent of respondents reported fee for service (FFS) as their principal source of income. While many physicians have income from other sources as well, FFS is clearly the dominant payment model. Fee for service has its roots in the origins of the profession and is viewed by many as a sacred cow. In the good old days, a physician would provide a service and collect a fee. The physician would establish the fee based on market conditions but the nature of the fee was under the control of the physician. Many physicians still associate this payment model with professional autonomy.

The rise of socialized medicine in the last half of the 20th century has eroded the professional autonomy of physicians and fee for service billing is no exception. Physicians no longer control how much they can charge or which services are chargeable. Advancing technology, rising pharmaceutical costs and an aging population are driving up healthcare costs. Cash-strapped governments respond by restricting services and capping fees. The reality is that fee for
service billing models do not offer any refuge for professional autonomy because the only control doctors can exercise comes at the expense of their colleagues. To the degree that problems in the FFS model lead doctors to actions that damage their credibility as a profession in the eyes of the public, the FFS model may actually be contributing to a decline in professional autonomy.

Despite the proletarianization view that non-FFS doctors sacrifice autonomy, the PSI survey indicates that non-FFS doctors perceive higher satisfaction with their degree of control over the practice of medicine than do their FFS counterparts. Both the CIHI National Physician Survey and the PSI survey concur that non-FFS doctors are happier with their finances than are FFS doctors.

Doctors are suffering under the fee for service model. The system is rife with entrenched inequities. The billable amount for many fee codes is unrepresentative of the time and effort involved in delivering the service. One survey respondent reported that for the first time in 33 years, their monthly overhead cost exceeded their monthly income. Retiring family physicians can no longer even give away their practice, a practice that was once a significant asset with distinct market value. The Ministry of Health and the Association introduced several targeted funding initiatives to offset the problem. The Medical on Call Availability Program (MOCAP) now reimburses physicians for being on call but is not universally available and, therefore, reinforces disparity concerns. Chronic disease management (CDM) initiatives reward doctors for better management of their diabetes and congestive heart failure patients but at the cost of centralized
data gathering that some feel threatens patient privacy. The overwhelming popularity of the recently introduced Practice Support Program (PSP), which helps train doctors to better manage their practices, speaks to the concern in the physician community. Physicians welcome these initiatives but they are not going to solve the problem. The system needs more than a fresh pair of crutches for the walking wounded.

**Autonomy**

For an individual physician, autonomy means freedom, the freedom to manage their practice of medicine in a way that suits their needs, the needs of their patients, and the best interests of the profession. From an organizational perspective, autonomy means self-regulation. Self-regulation allows a profession to set standards of entrance and performance. It allows the profession to protect its knowledge monopoly from infringement and a secure knowledge monopoly means secure professional boundaries.

The profession is fending off attacks on its autonomy, in the form of increased government involvement and diminished public trust. Its publicly acknowledged expert authority is threatened by medical consumerism, scope of practice infringement, information technology and changing public attitudes regarding the role of medicine in healthcare.

Well-meaning attempts by the Association to improve physician income under the FFS model often lead to a decrease in individual physician satisfaction. When programs intended to improve physician income come at the expense of
significantly increased paperwork or bureaucratic oversight there is a trade-off between financial satisfaction and autonomy. The incremental satisfaction achieved by marginal improvements in revenues is usually small and transitory. The lingering effects of increased bureaucracy and reduced autonomy will ultimately lower satisfaction overall.

Public Image

Many survey respondents identified patient education and the public image of the profession to be points of significant concern. At the same time, a few individuals said ‘let the Ministry of Health worry about the public, you worry about me’. This attitude is not surprising given the current distress of many physicians but it ignores the fact that much of what makes the profession independent is self-regulation and that self-regulation is grounded in public trust. William Sullivan points out:

The root of the public’s trust is the confidence that physicians will put patients’ welfare ahead of all other considerations, even the patients’ momentary wishes or the physicians’ monetary gain. It is the function of medicine as a profession to safeguard and promote this trust in the society at large. …medicine must take the lead in a public conversation about the profession’s contract with society. If it does not, that contract is likely to be redefined in terms, and in a language, quite antithetical to the core concerns of medicine (Sullivan, 2000:162).

As physicians perceive a loss of control over various aspects of their professional lives and feel the financial pinch of constrained public resources, the tendency is to become both reactionary and militant on any issues where some control still exists. Public fights over income distribution and internal fights over
association governance that have leaked into the public view have done nothing to cement the reputation of the profession.

The public needs to be engaged to redefine Sullivan’s social contract in light of the current social and economic context. The Association needs to reinforce the public view of the profession’s role in health promotion. The profession’s failure in this area is a threat to its perceived expert authority. Current programs in health promotion are under-funded, under-manned and limited in scope. The Association has a standing Council on Health Promotion (COHP) who’s role is primarily public-facing. This committee is arguably the least appreciated and most marginalized within the Association hierarchy.

Several physicians expressed the point of view that the Association’s role is to represent physicians not the public. Technically, this is true. It is also short-sighted. The Association has the same obligation to the best interests of the profession as individual physicians have to their patients. Just as individual physicians must exercise judgment in balancing immediate patient wants against long-term patient needs, so must the Association focus on the long-term needs of the profession. The profession is not independent of the public. Professional autonomy is at the core of the medical profession. The government grants autonomy, in the form of self-regulation, and the government derives its power from the public. Forty-one doctors voiced concern over the negative public image of the profession and they are right to be worried. Negative public opinion is the number one threat to the profession as a whole.
The Role of the Association

Many of the issues facing the profession are beyond the control of the Association. Growing public interest in health promotion as a substitute for remedial medicine cannot and should not be restrained. The aging population and the pace of change in medical and information technology cannot be controlled. More often than not, the membership of the Association will assume opportunities for control that are beyond the Association’s reach. It is all the more important then, that when control can be exercised, it be exercised with dispatch and authority. Ultimately, the Association will be forgiven for the things beyond its control if it takes concrete, direct, constructive action on the issues that are within its reach. This will often require political courage. Introducing structural change that upsets the status quo will give rise to skepticism, concern and outrage to varying degrees. In most cases, these things will be like the satisfaction effects of monetary increases, larger than life in the moment but ultimately transitory.

There is no miracle cure for the professional unity problems that face the Association. The membership has been growing steadily more segmented and tensions between sub groups are increasing. While there is no simple cure for the overall problem, it is possible to remove a major irritant that is accelerating the growth of internal tension. The current fee for service allocation model is a major irritant and should be restructured.

Positive public image is vitally important for professions and their representative bodies. Reputational capital, however, accumulates slowly and can dissipate very rapidly under the right (or wrong) circumstances. Financial
advisors recommend starting early with small, continuous investments to build a strong retirement portfolio. The Association needs to start investing now to build the reputational capital it might need in the future.

The Association has made positive progress in dealing with some of the problems of the FFS model but a success in one area often exposes multiple weaknesses in another. Many survey respondents called out for a fresh look at alternate payment models. It will be time consuming to make structural changes to something as entrenched as fee for service. Physicians, however, need concrete help now. The Association could take the lead in a program to make salaried locums more freely available to the FFS community. A program like this would create immediate relief for overworked physicians dealing with stress and burnout. It would also start the lengthy process of socializing the profession towards alternate payment models that are clearly more supportive of professional satisfaction.
CHAPTER 8: OPPORTUNITIES FOR ACTION

You can't always get what you want
But if you try sometimes well you just might find
You get what you need

M Jagger/K Richards, You Can’t Always Get What You Want, 1968

The problems facing physicians have been growing and solidifying over several decades and will not be solved overnight. The situation has become so complex, the problems so interdependent, and the environment so emotionally charged that the Association often feels powerless to effect change. The Association certainly lacks the power to return the profession to its golden age of the 1960s. In looking at opportunities for action by the Association there are four questions to consider:

- Will the opportunity directly address one or more issues of professional satisfaction?
- Can the Association implement it independently? (or are there third parties involved?)
- Will the opportunity produce a tangible near-term positive outcome? (or are there more likely to be long-term intangible benefits?)
- Is the opportunity politically feasible?

The four questions, in order, determined the ranking of the following suggestions. First, the Association needs to discard the subjective and demoralizing fee allocation process in favour of an objective, transparent
approach. Second, the Association needs to expand the role of its Council on Health Promotion to more actively engage the public and walk the health promotion talk. Third, the Association needs to advocate for the creation of a salaried locum pool that would provide badly needed relief to overworked physicians.

Fee Allocation

The anecdotal evidence from the PSI survey is clear and compelling. Internal dissent, characterized by accusations of partisan leadership, professional disrespect, income disparity and downright name-calling is the most prominent source of physician dissatisfaction and the most urgent threat to the Association. At the core of this problem is the current fee for service payment model and in particular, the fee allocation process. This is not the only causal factor of internal dissent but it is the most prominent. It is highly visible, directly actionable by the Association and corrective action will yield a current and recurring benefit.

The fee for service model is not going to go away anytime soon. Fee increases must be allocated in a way that does not pit one physician against another. The allocation process needs to equitable, objective and transparent. It also needs to be fast. The current allocation process has been going on for 15 months and there is no end in sight.
Fee Allocation Formula

This paper proposes a simple formula that splits the allocation process into three steps. The primary allocation step is the most important and has the objective of establishing a target net income increase for each fee for service physician in a sub specialty group. The Medical Services Plan establishes a coding structure for FFS physicians called a Practice Type. This code is based on billing patterns and categorizes physicians according to how they practice (General Practitioner, Radiologist, Psychiatrist, etc.). The BCMA Economics Department establishes an Overhead Factor for each type of practice. This is an estimate of the percentage of a physician’s income required to operate their business and is used to calculate physician net income for a variety of benefit programs.

The primary allocation process would use the doctor’s overhead factor to weight the distribution with a target of equalizing the net increase to all physicians. Given an overall negotiated fee increase of $100m, the table below contains a sample primary allocation calculation.

Table 7: Fee Allocation - Primary

<table>
<thead>
<tr>
<th>Practice Type</th>
<th>Overhead</th>
<th>Count</th>
<th>Weight (Count/(1-OH%))</th>
<th>Percent Of Total</th>
<th>Allocation</th>
<th>Gross per Physician</th>
<th>Net per Physician</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor 1</td>
<td>45%</td>
<td>2,000</td>
<td>3636</td>
<td>29.47%</td>
<td>29.47m</td>
<td>14,735</td>
<td>8,104</td>
</tr>
<tr>
<td>Doctor 2</td>
<td>35%</td>
<td>2,500</td>
<td>3846</td>
<td>31.17%</td>
<td>31.17m</td>
<td>12,468</td>
<td>8,104</td>
</tr>
<tr>
<td>Doctor 3</td>
<td>30%</td>
<td>2,000</td>
<td>2857</td>
<td>23.15%</td>
<td>23.15m</td>
<td>11,575</td>
<td>8,102</td>
</tr>
<tr>
<td>Doctor 4</td>
<td>25%</td>
<td>1,500</td>
<td>2000</td>
<td>16.21%</td>
<td>16.21m</td>
<td>10,806</td>
<td>8,104</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>12339</td>
<td>100.00%</td>
<td>100.0m</td>
<td></td>
<td></td>
</tr>
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</table>
The purpose of the primary allocation formula is to determine a target gross amount per physician that will yield a consistent target net amount across all physicians. A key component of this formula is that it targets a net increase in absolute dollars, not in percentage. A major disparity concern is that the application of uniform percentage increases always benefits the individuals whose commonly used fee codes have a higher value.

The secondary allocation process will use the target gross per physician to calculate the actual dollar fee increase for those fee codes that are shared across different practice types. Many fee codes are shared and some are universal. The secondary process will identify the shared codes and also identify the group that depends the most on that code as a percentage of overall billings. The billing profile and target gross increase of the dominant group will be used to calculate the increase for that individual fee code. See Table 8 for an illustrative sample calculation.

<table>
<thead>
<tr>
<th>Practice Type</th>
<th>Fee Code</th>
<th>Percent of Billings</th>
<th>Target Gross</th>
<th>Fee Code</th>
<th>Average Usage</th>
<th>Fee Code Increase</th>
<th>Annual Revenue Increase</th>
<th>Balance Not Allocated</th>
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</thead>
<tbody>
<tr>
<td>Doctor 1</td>
<td>1</td>
<td>60%</td>
<td>14,735</td>
<td>8,841</td>
<td>20,000</td>
<td>0.44</td>
<td>8,800</td>
<td></td>
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<tr>
<td></td>
<td>2</td>
<td>20%</td>
<td>14,735</td>
<td>2,000</td>
<td>0.75</td>
<td>1,500</td>
<td></td>
<td>4,435</td>
</tr>
<tr>
<td>Doctor 2</td>
<td>1</td>
<td>15%</td>
<td>12,468</td>
<td>5,000</td>
<td>0.44</td>
<td>2,200</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>60%</td>
<td>12,468</td>
<td>10,000</td>
<td>0.75</td>
<td>7,500</td>
<td></td>
<td>2,768</td>
</tr>
</tbody>
</table>

This simple example is limited to two practice types and two fee codes. While each practice type uses both codes, Doctor 1 is dominant in Fee Code 1. Therefore, the Doctor 1 billing profile is used to calculate the fee code increase.
for Fee Code 1. Likewise, Doctor 2 is dominant in Fee Code 2 and determines the increase for that code. This secondary allocation process repeats for every shared code.

The tertiary allocation process begins when all shared codes have an assigned increase. At this point, some practice types will have unallocated target monies associated with fee codes that are unique to that group. Doctor 1 above, for example, may use one additional fee code that no other group bills. They also have an unallocated amount of $4,435. If the average annual usage of that fee code were 3,000, the fee code increase would be $1.48 (4,435 / 3,000). In the case of multiple group-specific fee codes, the calculation would proceed as per the secondary allocation.

Benefits of the Fee Allocation Formula

The fee allocation formula is equitable. The primary allocation process targets every physician for the same overall increase in income. Every physician gets one vote on compensation issues and is entitled to equal representation by their association. Entrenched disparity aside, there is no professional justification for one physician to receive disproportionate benefits from a general fee increase.

The fee allocation formula is objective. The formula is based on verifiable data. Practice types are assigned by MSP based on observed billing patterns. Fee code usage by group can easily be calculated from billing data. Overhead percentages are already used in calculating net income for benefit calculation
purposes. The process involves no deal making, judgment calls or subjective interpretation.

The fee allocation formula is transparent. The formula is simple and would be publicly available. Any section of the association would be able verify the outcome.

The fee allocation formula is fast. Physicians voting on a compensation package would know in advance how a general fee increase would affect them and be able to judge its worth more accurately. Fee code increases could be put into effect immediately upon ratification of an agreement.

**Potential Concerns with the Fee Code Formula**

Entrenched disparity exists and this formula will be slow to address the problem. The fee code formula will narrow the gap over time in relative terms but not in absolute terms. A four percent gap now might shrink to a 3 percent gap over several years but a $10,000 absolute advantage in yearly revenues now will still be a $10,000 advantage in the future. Historically marginalized groups may express some frustration that the formula does little to address entrenched disparity. Privileged groups, however, may see the focus on absolute net income increases as eroding their position over time. It would be possible to adapt the formula to close the gap more aggressively but any move to do so will likely be staunchly resisted by the ‘have’ groups.

A target is no guarantee. No two doctors practice in an identical way. The formula is based on averages and individual billing patterns will vary. Overhead
percentages are also averages and doctors whose actual overhead expense varies significantly from the norm will either suffer or profit. Individual doctors will do better or worse than target based on their unique pattern of practice. This is, of course, true under the current model and would be true under any universally applied fee code increase regardless of how it was calculated.

The formula depends for its objectivity on overhead percentages. The calculation of those percentages relies, at least in part, on self-reported data. Any group that could artificially inflate its overhead percentage would secure an advantage relative to other groups. Consequently, there may be some need to introduce some additional analytical rigour, and possibly granularity, to the overhead calculation process.

Effect on Professional Unity

The fee allocation formula will not settle old scores and it will not fix the underlying problems of the fee for service billing model. It will, however, stop the current agonizing debate over allocation and get doctors the fee increases they ratified over a year ago. It will eliminate the fee allocation process as a direct source of physician-to-physician conflict and eliminate a primary cause of the current internecine warfare that colours all association activities.

It is vital that the Association take strong and direct action to minimize the disharmony associated with the fee allocation process. The Association’s inability to interfere in the current destructive process is viewed as a sign of weakness or incompetence by many doctors. Those same doctors then question the value
and relevance of the Association. Strong action by the Association is required if it hopes to retain its status as an effective representative body.

**Enhance Health Promotion**

Public image is a concern for many members. The Association is in a position to address this issue but improvement may be evolutionary rather than revolutionary. Political feasibility presents some challenges as many members regard public health issues as a waste of time and money.

The Association is notoriously weak at public self-promotion. Very few members of the public know of the pivotal role the Association plays in public health issues such as infant car seat and bicycle helmet legislation. The only attempt to engage the public in a serious way is during fee disputes with the government. Arguments about ‘protecting healthcare’ usually ring hollow during these debates as the public views doctors as self-serving and financially motivated. This is similar to the teaching profession, which always categorizes job action as protecting the rights of students. In both these cases, the profession is spending reputational capital it has not earned.

**Community Engagement**

The Association needs to support the activities of the Council on Health promotion by dedicating staff resources to community engagement. The recent Healthy Kids program is an excellent starting point. This program targeted physical activity and healthy eating for elementary school age children and was well conceived but badly promoted. More effort needs to be focused in this
direction. Children do not vote but their parents do and parents react positively to positive influences for their children.

The key to this is active involvement. Active involvement will require money and time. A community events coordinator should be attached to the Association’s Communications Department and that person should work with the COHP committee to present the doctors of BC in a health promotion role. Media-friendly physicians need to be fronting Association-sponsored community events. The Association should be sponsoring community sporting events that provide opportunities for children and promoting that sponsorship. Active sponsorship of healthy lunch programs in elementary schools with physician healthy lifestyle speakers is another option. A minimum of $150,000 per year should be set aside to fund this effort. This budget would support a full-time community events coordinator, 30 days a year of physician honorarium and approximately $50,000 for direct cash sponsorship of various programs. The Association needs to stop investing in low-value exercises such as health promotion pamphlets that fester in physician’s offices and invest instead in getting out into the community to ‘press the flesh and kiss the babies’.

Positive public image is not a ‘nice-to-have’ for a profession. It is a must-have and a potential critical point of failure. This process does not offer a short-term win. It will take time and money to re-engage the public but that time and money will show future dividends in the form of enhanced public respect for the profession.
Salaried Locum Pool

This suggestion addresses several professional satisfaction issues directly (access to CME and Locums) and others indirectly (fee for service problems). In addition, it will assist with some mundane but significant job satisfaction issues like workload, stress and burnout. Physicians are facing increasing difficulty in securing locum coverage for vacations, illness or continuing medical education. The challenge of this program is that the Association cannot directly implement a solution. Government involvement and government funding will be required.

The Association should lobby the government to fund the creation of a salaried locum pool. The locum pool would be created primarily from two types of doctors. One source would be retirement age physicians who enjoy the practice of medicine but are no longer interested in maintaining their own office and patients. The second source would be new doctors just completing their residency. New doctors would be attracted through a program that offsets their education expenses with a forgivable student loan. Student loans would be progressively forgiven based on a three-year commitment to join the locum pool.

Fee for service doctors would be able to access the locum pool for vacations, CME leave and extended sick leave. A five-week maximum draw on the locum pool would be established for full time equivalent physicians. As locum physicians are paid salary, they would not be an expense to the FFS physician. At the same time, their deployment would offset government salary costs because the FFS physician would not be billing services in their absence. The
locum pool would also stipend the FFS physician for an objectively calculated office overhead amount during their absence.

**Benefits of the Locum Pool**

The benefits presented by this opportunity are many and varied. For the new physician who enters the profession with as much as $200,000 in student debt it provides debt relief. It also provides them an opportunity to gain additional practical experience before striking out on their own. For the retirement age physician, it allows them a predictable environment to continue exercising their desire to help people without burdening them with the complexities of a dedicated medical practice. The overworked fee for service physician will be able to plan and book vacations and CME opportunities without sacrificing patient care or suffering substantial financial loss to close their office.

From the government perspective, this program will be close to cost neutral. Salaried locum physicians substitute for FFS physician during their absence. Salary, benefit, debt recovery and office overhead costs will be substantially offset by eliminated FFS billings. Physician burnout will be reduced and continuity of care will be improved.

There is one additional intangible benefit to this program. Over time, physicians, especially new physicians, will become socialized to the notion of alternate payment models. This is not to suggest that salaried physicians are the wave of the future. Other alternate payment models exist and the evidence is clear that alternate payment models are more supportive of professional
satisfaction (particularly financial and autonomy) than the currently predominant fee for service model.

**Conclusion**

Does professional satisfaction matter? Theoretical and practical evidence have been presented to indicate that professional satisfaction does matter, not just to the individual but to the representative bodies of the profession as well. Threats to the Association in terms of professional disharmony are real and urgent. Threats to the profession in terms of reduced public support for its autonomy and expert knowledge are well documented. The Association cannot control the environmental factors behind many of these threats but that does not mean they are powerless. Clear opportunities to address issues of professional dissatisfaction exist. The challenge will be to seize the political courage to balance the wants of the vocal few with the needs of the silent many.
CHAPTER 9: SURVEY LIMITATIONS

The limitations of this survey in its current form are significant. The response rate is low relative to the CIHI National Physician Survey. Despite matching respondents to the sample on demographic characteristics there may be some hidden factors common to the response set that are uncommon in non-respondents. The primary weakness, though, is that the quantitative results have not been analyzed for validity, reliability or statistical significance.

Response Set Size

The CIHI survey achieved a response rate of 35 percent. The PWS survey achieved a response rate of 40 percent. Compared with those numbers the 11 percent response rate for the PSI seems unreasonably low and gives rise to the possibility that hidden factors are affecting the response rate. Both of the national level surveys were conducted over an extended period of time and employed multiple mailings. Both involved telephone follow up for non-respondents. Given the constraints of the PSI survey process (short survey period, no follow up) it is not surprising to see a much smaller response rate. Association sponsored surveys do not normally generate high response rates. Surveys with response rates in the high teens are judged to be extremely successful. Surveys with response rates as low as 6 percent or 400 responses are generally judged to be adequate provided that demographic profiles of sample and respondents are similar.
While it is likely that the primary reason for the comparatively small response rate is due to time and resource constraints of the PSI survey, this cannot be guaranteed. There is no assurance that a more lengthy and comprehensive data gathering strategy would have yielded a higher response rate. Lack of certainty here is a limitation of the survey.

Response Set Characteristics

The Association usually uses population demographics to test the representative nature of survey respondents. This is also the technique that was employed in the much larger CIHI survey. The response set appeared to be normally distributed by age and matched fairly closely with the sample. There was an unexplained over-representation of physicians in the 55-59 age category. Other demographic indicators (gender, rural/urban, gp/specialist) appeared to be representative, typically varying from the sample by less than 3 percent.

Delivering a survey by email always gives rise to the concern that only technology-savvy individuals will respond. Eighty-eight percent of practicing physicians recorded in the Association database have email addresses and the Association regularly relies on opinion data gathered from email surveys. Many security conscious individuals, however, are cautious of following links in email and this has the potential to introduce a bias into the response set. The very short time period that the survey was open may also have an impact. It is possible that individuals who simply like taking surveys are over-represented. The biggest risk though is that physicians who are feeling particularly dissatisfied or frustrated may be more motivated to respond than their colleagues. In that
case the quantitative and qualitative numbers would be skewed towards dissatisfaction. The inability to follow up introduces this factor as a significant limitation of the study.

**Lack of Correlation to Observable Data**

Helliwell (2005) argues that the greatest support for the validity of life satisfaction scores is their negative correlation to national suicide rates. By correlating subjective results with observable objective data, the relevance of a subjective measure can be verified. There is no such opportunity here. This approach requires a time series of data and none exists for professional satisfaction. A time series of PSI data could be useful if it is tested and refined to provide some comfort as to the validity of the instrument. There are a number of possible observable indicators that could be correlated over time. The drop in applicants to Family Practice residency slots has been documented. The Physician Health Program (PHP), a counselling organization that assists doctors with financial, stress or burnout problems is reporting ever larger numbers of physician contacts. This problem is often an issue for subjective measures and is a limitation of the survey.

**Further Research**

In the absence of some statistical analysis to validate the results of the survey any conclusions drawn are speculative at best. There are three primary problems. First, there is no certainty that the individual survey questions actually test the degree of physician satisfaction with the underlying motivational factor.
Second, the relative relationship of motivational factors to high and low satisfaction has not been determined. The self-reported nature of the motivational ranking cannot be verified and may be untrustworthy. Third, the reported variance between subgroups has not been tested and may not be statistically significant. The appearance of a pattern may be due to naturally occurring error.

The data from the PSI response set appears to be normally distributed and so could be analyzed with parametric statistics. Reliability testing using Cronbach’s alpha scores (a measure of internal consistency) would indicate the degree to which individual questions are correlated with the associated motivational factor and the degree to which the underlying motivational factor is correlated with overall satisfaction. For example, it is possible that one question related to autonomy may be more closely correlated with social status. In that case, inclusion in the wrong category would inappropriately affect the relative standing of the two motivational factors. In the case of the PWS survey, the authors discovered during their initial pilot study that three of the four questions they had established for intrinsic satisfaction were either more highly correlated with other satisfaction facets (cross-loaded) or not significant at all. In this particular case, two questions were moved to a different category and one was dropped altogether during the refinement process. Cronbach’s alpha scores are generally considered significant when items correlate at .70 or above. The pilot PWS survey started with 70 questions and was reduced to 38 as a result of factor analysis. An alternative method would be to use the Cronbach’s alpha
reliability test on all the questionnaire items to produce a subset of items with a
Cronbach's alpha level of at least 0.7. Factor analysis could then be used with
the reliable subset of items to produce groupings of items (factors) that could be
compared with the theoretical constructs of interest. The virtue of this approach
would be the ability to assess the relative importance of the professional
satisfaction variables.

Some of the apparently alarming data from the PSI survey is derived from
comparison of subgroups. The disparity between GPs and specialists for
example shows results similar to the CIHI survey. However, the likelihood that a
variance between two groups is statistically significant increases with the survey
size. It is not legitimate to say that a 16 percent variance in satisfaction is
significant in a smaller sample (712 responses, 11% rate) simply because it
matches with a 16 percent variance from a much larger sample (21,000
responses, 35% rate). The smaller the survey size the greater the variance
between groups must be to eliminate the likelihood that a variance is a result of
naturally occurring error.

An analysis of variance (ANOVA) should be conducted on the various
subgroup comparisons to determine whether the observed variance is significant
and can be used as the basis for forming conclusions or recommendations. The
ANOVA test analyzes the variances of the different groups (FFS, Sessional,
Salary, etc.) and compares the in-group variances with the total variances to
isolate the variance due to naturally occurring error and that due to the effect of
the independent variable. This approach yields a value (F) that, if equal to or
close to 1, indicates that independent variable has little or no impact. Large F values tend to indicate that the observed variance is due to the impact of the independent variable. The ANOVA test requires that the data be normally distributed and that the variances in compared groups be similar.

The test of reliability (Cronbach’s alpha) is necessary to determine whether the survey can be relied upon to measure the things it purports to measure. The ANOVA approach is required to determine if any observed variances in the data are worthy of analysis or simply due to naturally occurring error.

The PWS survey went through three separate iterations before the final product was judged worthy of measuring physician job satisfaction. It is likely that the PSI survey would require a very similar approach and it is not clear that the Association will support an iterative development process with adequate survey support to improve response rates that would allow the PSI to mature into a proven instrument. Even in the absence of that support, it is necessary to continue this project at least to the point of analyzing the first round data so that the Association can determine what (if any) of the quantitative data can be relied upon. Until that occurs, it is safer to rely on quantitative data from the larger CIHI survey and analyze that in conjunction with the qualitative feedback from the PSI survey.
APPENDICES

Appendix 1: PSI Survey Questions and Responses

Covering Memo

Dear Doctor,

Part of the BCMA’s mission is to support doctors in achieving maximum professional satisfaction. Unfortunately, it can be hard to tell how we are doing because measurement tools for professional satisfaction don’t really exist. As part of my MBA program, I am conducting some research on professional satisfaction and have developed an experimental survey instrument. Knowing how generally over-surveyed physicians are, I have attempted to make this as quick and painless as possible. It has been tested with a number of physicians and typically takes 5-7 minutes to complete.

It is my hope that the survey results will be beneficial to the work of the association and also to the profession in general (and of course, it will be enormously helpful to me personally). Although it is not necessary to do so, you can choose to identify yourself with your MSP billing number. If you do self-identify you will be entered into a draw for one of three Apple iPod Shuffle MP3 players.

I know that there are many demands on your time but I believe that the results could prove very interesting and would really appreciate your taking a few minutes to complete the survey. The survey will be accessible at the link below for the next two weeks only.

Thank you in advance,

Introduction

Part of the BC Medical Association’s mission is to promote an environment wherein doctors can achieve ‘maximum professional satisfaction.’ There are many survey instruments that examine job or career satisfaction but they tend to focus primarily on workplace issues. The Professional Satisfaction Index is an experimental instrument that seeks to measure professional satisfaction by
evaluating the experience of practicing medicine against the respondent's original motivation to become a doctor.

### Section 1: Demographics

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<thead>
<tr>
<th>Question 3-</th>
<th>Gender</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent</td>
<td></td>
<td>33.0</td>
<td>67.0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Question 4-</th>
<th>Practice Type</th>
<th>GP</th>
<th>Specialist</th>
</tr>
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<tbody>
<tr>
<td>Percent</td>
<td></td>
<td>54.1</td>
<td>45.9</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Question 5-</th>
<th>Location</th>
<th>Rural</th>
<th>Urban</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent</td>
<td></td>
<td>20.9</td>
<td>79.1</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Question 6-</th>
<th>Income Source</th>
<th>FFS</th>
<th>Sessional</th>
<th>Service Contract</th>
<th>Salary</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent</td>
<td></td>
<td>9.1</td>
<td>10.8</td>
<td>10.9</td>
<td>17.1</td>
<td>52.5</td>
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</table>
Section 2: Motivation

Question 1-
Thinking back to when you were first considering medicine as a profession, how important were each of the following factors in your decision to become a doctor?

<table>
<thead>
<tr>
<th>Factor</th>
<th>Not Important</th>
<th>Slightly Important</th>
<th>Fairly Important</th>
<th>Very Important</th>
<th>Average Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial Reward/Stability</td>
<td>7.0</td>
<td>27.5</td>
<td>43.4</td>
<td>22.1</td>
<td>2.81</td>
</tr>
<tr>
<td>Social Status/Respect</td>
<td>17.8</td>
<td>34.5</td>
<td>36.9</td>
<td>10.9</td>
<td>2.41</td>
</tr>
<tr>
<td>Intellectual Growth/Challenge</td>
<td>0.7</td>
<td>5.0</td>
<td>30.8</td>
<td>63.5</td>
<td>3.57</td>
</tr>
<tr>
<td>Autonomy/Freedom</td>
<td>3.4</td>
<td>12.6</td>
<td>31.6</td>
<td>52.4</td>
<td>3.33</td>
</tr>
<tr>
<td>Desire to Help People/Society</td>
<td>0.5</td>
<td>5.3</td>
<td>28.4</td>
<td>65.8</td>
<td>3.59</td>
</tr>
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</table>

Section 3: Satisfaction

<table>
<thead>
<tr>
<th>Statement</th>
<th>Percent Strongly Disagree</th>
<th>Percent Somewhat Disagree</th>
<th>Percent Neither Agree nor Agree</th>
<th>Percent Somewhat Agree</th>
<th>Percent Strongly Agree</th>
<th>Average Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) I don’t worry about my current finances or my financial future.</td>
<td>23.6</td>
<td>30.5</td>
<td>7.4</td>
<td>28.7</td>
<td>9.8</td>
<td>2.70</td>
</tr>
<tr>
<td>2) I expect to be financially able to retire by the time I’m 60 years old.</td>
<td>32.3</td>
<td>19.6</td>
<td>8.2</td>
<td>21.7</td>
<td>18.1</td>
<td>2.74</td>
</tr>
<tr>
<td>3) Although I certainly make a good living, I am underpaid for what I do.</td>
<td>2.9</td>
<td>12.6</td>
<td>17.6</td>
<td>29.4</td>
<td>37.5</td>
<td>2.14</td>
</tr>
<tr>
<td></td>
<td>Percent Strongly Disagree</td>
<td>Percent Somewhat Disagree</td>
<td>Percent Neither Agree nor Disagree</td>
<td>Percent Somewhat Agree</td>
<td>Percent Strongly Agree</td>
<td>Average Rating</td>
</tr>
<tr>
<td>---</td>
<td>---------------------------</td>
<td>---------------------------</td>
<td>-----------------------------------</td>
<td>------------------------</td>
<td>------------------------</td>
<td>----------------</td>
</tr>
<tr>
<td>4) In relative terms, the medical profession is less financially rewarding today than it was 30 years ago.</td>
<td>1.9</td>
<td>8.2</td>
<td>19.5</td>
<td>25.5</td>
<td>44.8</td>
<td>1.97</td>
</tr>
<tr>
<td>5) More and more patients come to me simply seeking confirmation and/or treatment after having researched medical information in advance.</td>
<td>9.5</td>
<td>18.1</td>
<td>20.3</td>
<td>43.0</td>
<td>9.1</td>
<td>2.76</td>
</tr>
<tr>
<td>6) I think that patients often double-check my advice with another healthcare provider, friends or online resources.</td>
<td>5.4</td>
<td>15.4</td>
<td>22.0</td>
<td>46.8</td>
<td>10.4</td>
<td>2.58</td>
</tr>
<tr>
<td>7) Patients are more demanding and intolerant today than they were 30 years ago.</td>
<td>1.4</td>
<td>8.1</td>
<td>24.6</td>
<td>37.8</td>
<td>28.2</td>
<td>2.17</td>
</tr>
<tr>
<td>8) Society valued doctors more thirty years ago than they are valued today.</td>
<td>1.9</td>
<td>8.0</td>
<td>12.2</td>
<td>38.2</td>
<td>39.7</td>
<td>1.94</td>
</tr>
<tr>
<td>9) Many of my patients give as much weight to alternative therapies as they do to my medical advice.</td>
<td>5.8</td>
<td>20.2</td>
<td>18.3</td>
<td>44.1</td>
<td>11.7</td>
<td>2.64</td>
</tr>
<tr>
<td>10) When collaborating with my colleagues on professional issues, they often seek my advice.</td>
<td>1.1</td>
<td>4.8</td>
<td>23.6</td>
<td>53.8</td>
<td>16.9</td>
<td>3.80</td>
</tr>
</tbody>
</table>
11) I enjoy going to work every day because each day presents me with new intellectual challenges.

3.8 11.7 12.2 47.1 25.1 3.78

12) I would seek out continuing medical education opportunities even if they were not required.

0.5 1.0 3.2 33.1 62.2 4.55

13) The advancements in the field of medicine over the last 30 years have been very exciting.

0.3 1.6 3.8 32.0 62.2 4.54

14) I am able to keep up with the rapid pace of change in medical technology.

4.8 21.6 11.5 49.6 12.5 3.43

15) I feel that I am able to practice medicine in the manner that works best for me and my patients.

11.5 24.2 9.6 40.2 14.4 3.22

16) I am able to spend most of my time practicing medicine and not too much time dealing with bureaucracy, paperwork and other non-medical issues.

30.9 33.5 9.5 21.4 4.7 2.35

17) I have reasonably timely access to all the resources my patients need for their diagnosis and treatment.

32.8 30.2 10.2 22.9 3.8 2.35
<table>
<thead>
<tr>
<th></th>
<th>Percent Strongly Disagree</th>
<th>Percent Somewhat Disagree</th>
<th>Percent Neither Agree nor Disagree</th>
<th>Percent Somewhat Agree</th>
<th>Percent Strongly Agree</th>
<th>Average Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>18) The government has too much influence over the medical profession.</td>
<td>1.0</td>
<td>9.3</td>
<td>19.8</td>
<td>36.7</td>
<td>33.2</td>
<td>2.08</td>
</tr>
<tr>
<td>19) Government influence over the medical profession has increased over the last 30 years.</td>
<td>0.4</td>
<td>2.6</td>
<td>17.2</td>
<td>31.5</td>
<td>48.4</td>
<td>1.75</td>
</tr>
<tr>
<td>20) The administrators and bureaucrats responsible for the 'business of healthcare' don't understand how it differs from the practice of medicine.</td>
<td>0.5</td>
<td>2.3</td>
<td>7.8</td>
<td>32.6</td>
<td>56.7</td>
<td>1.57</td>
</tr>
<tr>
<td>21) Patients would get lost or left behind by the system if it weren't for me.</td>
<td>2.6</td>
<td>7.1</td>
<td>26.1</td>
<td>44.2</td>
<td>19.9</td>
<td>3.72</td>
</tr>
<tr>
<td>22) Recognizing that I can't help everybody, I am making a positive difference in my patient's lives.</td>
<td>0.4</td>
<td>1.0</td>
<td>5.2</td>
<td>52.1</td>
<td>41.3</td>
<td>4.33</td>
</tr>
<tr>
<td>23) Even after I have enough money to retire, I plan to continue practicing medicine in some form.</td>
<td>7.0</td>
<td>9.9</td>
<td>13.2</td>
<td>45.6</td>
<td>24.3</td>
<td>3.70</td>
</tr>
<tr>
<td>24) I would continue to practice medicine the way I currently do even if I made less money.</td>
<td>17.7</td>
<td>22.9</td>
<td>14.4</td>
<td>29.5</td>
<td>15.4</td>
<td>3.02</td>
</tr>
<tr>
<td>25) I feel more positive about the medical profession today than I did 10 years ago.</td>
<td>24.6</td>
<td>29.7</td>
<td>30.9</td>
<td>12.1</td>
<td>2.7</td>
<td>2.39</td>
</tr>
</tbody>
</table>
26) Knowing what I now know about practicing medicine, if I had to do it all over again, I would still choose to become a doctor.

<table>
<thead>
<tr>
<th>Percent Strongly Disagree</th>
<th>Percent Somewhat Disagree</th>
<th>Percent Neither Agree nor Disagree</th>
<th>Percent Somewhat Agree</th>
<th>Percent Strongly Agree</th>
<th>Average Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.0</td>
<td>12.8</td>
<td>7.8</td>
<td>25.3</td>
<td>46.2</td>
<td>3.89</td>
</tr>
</tbody>
</table>

27) If the son or daughter of a good friend was considering medical school, I would advise them to go ahead.

<table>
<thead>
<tr>
<th>Percent Strongly Disagree</th>
<th>Percent Somewhat Disagree</th>
<th>Percent Neither Agree nor Disagree</th>
<th>Percent Somewhat Agree</th>
<th>Percent Strongly Agree</th>
<th>Average Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.0</td>
<td>11.4</td>
<td>17.4</td>
<td>33.4</td>
<td>29.8</td>
<td>3.66</td>
</tr>
</tbody>
</table>

28) Thinking back on the things that motivated me to become a doctor, the profession has lived up to my expectations.

<table>
<thead>
<tr>
<th>Percent Strongly Disagree</th>
<th>Percent Somewhat Disagree</th>
<th>Percent Neither Agree nor Disagree</th>
<th>Percent Somewhat Agree</th>
<th>Percent Strongly Agree</th>
<th>Average Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.0</td>
<td>15.4</td>
<td>8.5</td>
<td>43.0</td>
<td>27.1</td>
<td>3.70</td>
</tr>
</tbody>
</table>

Section 4: Comments

1) My professional association has a role to play in supporting and enhancing my professional satisfaction.

<table>
<thead>
<tr>
<th>Percent Strongly Disagree</th>
<th>Percent Somewhat Disagree</th>
<th>Percent Neither Agree nor Disagree</th>
<th>Percent Somewhat Agree</th>
<th>Percent Strongly Agree</th>
<th>Average Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.5</td>
<td>4.4</td>
<td>13.1</td>
<td>46.0</td>
<td>33.0</td>
<td>4.01</td>
</tr>
</tbody>
</table>

2) In order to maximize my professional satisfaction as a doctor, my professional association should do, or do more of, the following:

3) In order to maximize my professional satisfaction as a doctor, my professional association should stop doing, or do less of, the following:
REFERENCE LIST


Millan, L.R., Azevedo, R.S., Rossi, E., Neves De Marco, O.L., Millan, M.P.B., & Vaz de Arruda, P.C. 2005, What is Behind a Student’s Choice for Becoming a Doctor?, Clinics, 60(2):143-150


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