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MINORITY PHYSICIAN JOB SATISFACTION: A CONTENT ANALYSIS OF WRITTEN RESPONSES TO OPEN-ENDED SURVEY QUESTIONS ABOUT PROFESSIONAL AND ORGANIZATIONAL DISSATISFACTION

by

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B.A. University of Central Florida, 2002

A thesis submitted in partial fulfillment of the requirements
for the degree of Master of Arts
in the Nicholson School of Communication
in the College of Sciences
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Orlando, Florida

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ABSTRACT

Few interpersonal and organizational communication studies examine the professional and organizational aspects of career satisfaction among minority physicians. Due to the underrepresenation of minority physicians, most studies resort to comparing aggregate groups of minority physicians in juxtaposition to non-minority physicians. These studies fail to uncover possible communication differences, which originate from cultural dissimilarities between disaggregate racial/ethnic groups. Even fewer studies examine physicians' written communication to open-ended survey questions about career satisfaction/dissatisfaction between disaggregate racial/ethnic minority groups and non-minorities. This study specifically examines written responses to two open-ended survey questions about professional and organizational dissatisfaction and compares responses from disaggregate minority physician and non-minority physicians. Participants were divided into five response-driven categories of race/ethnicity as follows: Asian/Pacific Islander, Black/African American, Indian/Pakistani, Hispanic, and White/Non-Hispanic. The population consists of 1849 members of the medical staff roster of a Southeastern, U.S., not-for-profit hospital group. Primary findings indicate the presence of recurrent themes among disaggregate minority physician racial/ethnic groups' responses. Significant variation exists between responses from disaggregate minority physician racial/ethnic groups and non-minority physicians. Results imply that open-ended methods of data collection are essential to gaining knowledge about ways cultural dissimilarities between disaggregate minority racial/ethnic groups affect communication and satisfaction. Understanding more about cultural dissimilarities is necessary for: improving data collection quality; recruiting and retaining minority physicians; and reducing healthcare disparities among minorities.

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To my father, who by powerful example taught me to do everything with pride, determination, and excellence regardless of obstacles. For holding strongly to his belief that one should never to be too proud to reach out and help someone else along the way, I am eternally grateful. To all those who reached out for me along the way, I have the utmost admiration.

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To my mother, your unconditional love and undying belief in me through all life's successes and failures has driven me far beyond where I would be without them. Thank you for a lifetime of priceless gifts like these.

To my husband, your faith in me and your patience throughout this and all my endeavors motivates me to achieve my best. Thank you for all your sacrifices.

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LIST OF ACRONYMS/ABBREVIATIONS

P2P	Physician to Physician Study
P2PS	Physician to Physician: Satisfaction Study
OR	Operating Room
FPs	Family Practioners
GPs	General Practioners
HMO	Healthcare Management Organization
Q30	P2PS Survey Question 30 about career dissatisfaction: *What is the one thing you would change, if you could, to help physicians generally be more satisfied in their work?*
Q31	P2PS Survey Question 31 about organizational dissatisfaction: *What is the single most important thing Zeus Hospital could do to help you personally?*

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INTRODUCTION AND RATIONALE

As the U.S. minority patient population increases and diversifies, the need for racially/ethnically diverse minority physician representation among medical educators, practioners, healthcare leaders/administrators, and policymakers grows rapidly. Cultural diversity, competency, and sensitivity are paramount to efforts aimed at increasing the minority physician workforce as well as reducing healthcare disparities among minorities.

A December 1995 report by The Pew Health Professions Commission about *Healthcare Challenges to be Faced in the Twenty-first Century* states there is "a substantial body of literature which concludes that culturally sensitive care is good care." Medically underserved areas within the U.S., especially those populated by Blacks and Hispanics, are more likely to receive care from physicians who are Blacks and Hispanics. These two groups of minority physicians tend to locate their practices within underserved areas and provide care to poor, uninsured, and Medicaid patients (Reede, 2003). Since minority patients tend to seek out physicians who share with them cultural and communication similarities, endeavors aimed at understanding minority physician communication may bear grave importance in the face of any attempts to diminish health disparities among minorities. Another barrier to minority healthcare is that ethnic minorities exhibit greater variability in their preferences when compared to whites (Blackhall, et al, 1995). Until more evidence can lead toward a better understanding of the relationship between race-concordant visits and the effectiveness of intercultural communication skills programs, the most direct strategy for decreasing health disparities among ethnic minority groups may be to increase ethnic diversity among physicians (Cooper, et al, 2003).

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Dissatisfied minority physicians continue to leave the medical profession for greener financial pastures and are discouraging others from entering the field of medicine altogether (Landon, 2003). Therefore, it is of utmost importance for healthcare administrators and policymakers alike to understand how career and organizational communication differences originating from cultural influences can affect satisfaction among various minority physician racial/ethnic groups. To readily address the dire need for increasing the racial/ethnic diversity of the minority physician workforce, we must first become more aware of what contributors to satisfaction/dissatisfaction exist among these physicians. These factors must be researched in depth despite the presence of some challenges to their discovery, such as the design of measurement tools and the treatment of data.

Often measurement tools in research about minority communication contain predetermined variables or language dissimilar in many ways to the minority populations' communication cultures under study (Houston, 2002). Houston's analysis of African-American career communication studies from 1975 to 2000 revealed that researchers "inadvertently centered Whiteness in African American interpersonal scholarship" through an overrepresentation of the quest for difference. Houston's meta-analysis makes it abundantly clear that analyses of minority communication have historically more often than not been performed from a non-minority standpoint rather than applying the science of response-driven or culturally appropriate data gathering and analyses.

The variables of race/ethnicity are often inadequately collected and often misappropriated once the data are collected. According to a 2004 report from the American Academy of Medical Colleges (AAMC), minority medical student enrollment shows decreases across all racial/ethnic groups from 2003 to 2004, except for Asians (Figure 1). However, more than half of the

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students are categorized as *unknown* in the categories of race/ethnicity (56.2%). This percentage of *unknown* race/ethnicity among the student population is up more than 11% from 2003 (45.1%), just one year prior.

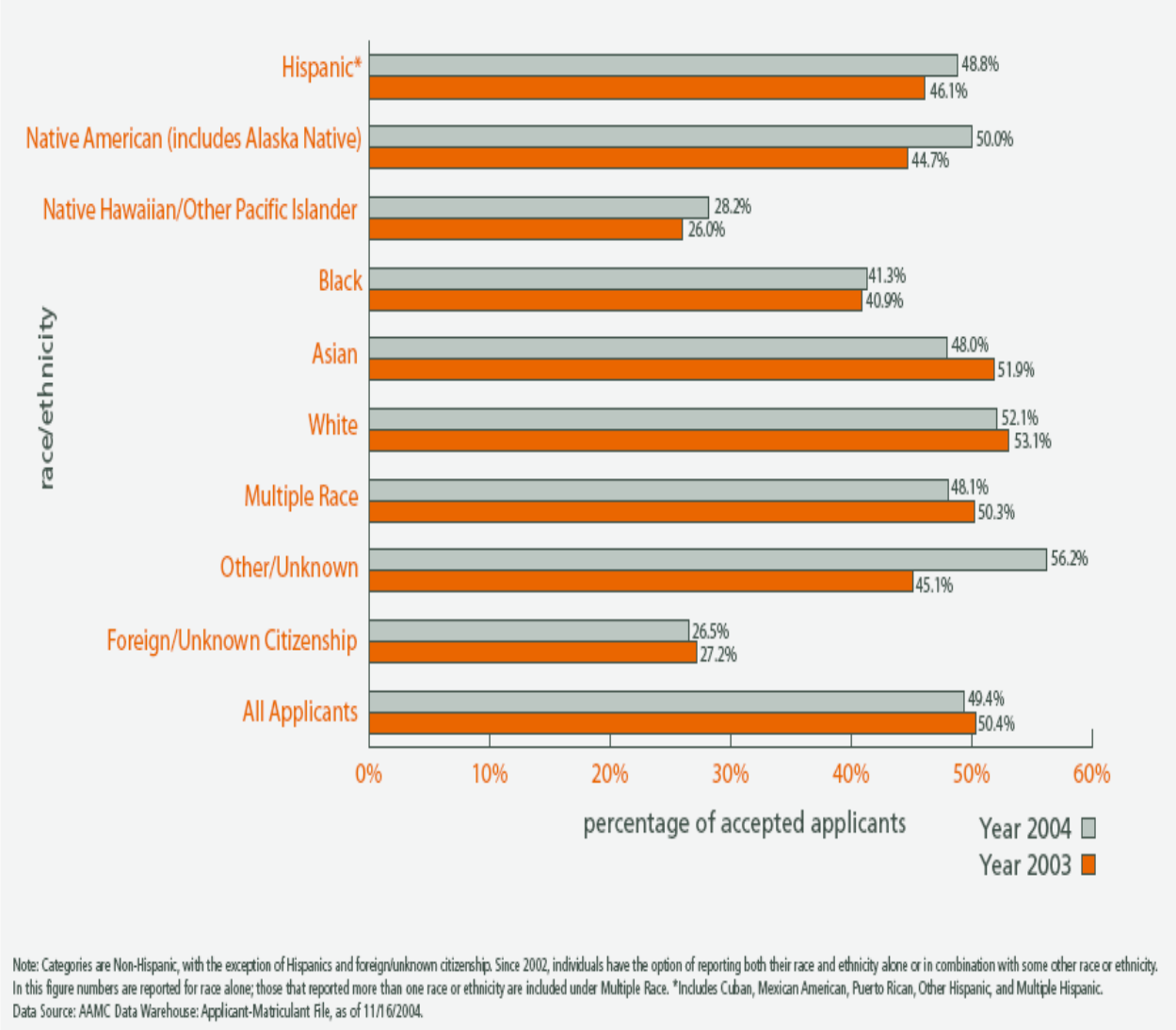

Figure 1: Medical School Accepted Applicants within Race and Ethnicity 2003-2004

In addition to questionable culturally appropriateness in design, most studies about minority physician interpersonal and organizational communication merely aggregate all physicians of underrepresented cultures together and compare them as a whole to non-minority

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physicians. Aggregating all physicians of underrepresented cultures together creates a barrier to discovering any possible cultural differences in communication that might be uncovered by studies which separate minority physicians not just from non-minorities, but disaggregates minority racial/ethnic groups from one another. The primary findings of a recent study regarding organizational communication satisfaction among physicians indicate a substantial variance among disaggregate minority racial/ethnic groups. Focusing primarily on physicians' satisfaction with autonomy, this study reveals no significant variance between aggregated minority physicians and non-minority physicians. Variance only became evident when satisfaction levels were measured by comparing disaggregate minority physician racial/ethnic groups to non-minority physicians (Fletcher, 2005).

This study differs from most previous studies by examining possible thematic differences in written responses from disaggregate minority physician racial/ethnic groups and non-minority physicians rather than comparing aggregate minority physician responses to non-minority physician responses. These emergent and/or most frequently recurrent themes within disaggregate racial/ethnic groups are explored through a content analysis of the written responses to open-ended survey questions. These questions focus on: 1) dissatisfaction with the practice of medicine in general (professional) and 2) dissatisfaction with the hospital group with which the physicians most closely associate (organizational). This study is intended to help pave the way toward a better understanding how disaggregate minority physician racial/ethnic groups and their non-minority colleagues differ in their communication about factors that influence their job satisfaction/dissatisfaction.

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LITERATURE REVIEW

Minority Physician Underrepresentation

The quality of minority patient care, satisfaction, and access are greatly impacted by minority physician underrepresentation. Minority physician underrepresentation often leaves physicians with no choice but to do their best to communicate with patients who are culturally dissimilar from them in many ways. This becomes a great source of frustration for both physicians and patients. Race-concordant visits in one recent study were reported as being characterized by more patient positive affect and as being longer than visits which were not race-concordant. Patients who visited race-concordant physicians also rated their physicians as more participatory (Cooper, et al, 2003). Although guidelines exist for cultural proficiency, there are very few resources accessible to physicians which outline ways to apply these guidelines to direct patient care. As a result, many physicians find themselves unfamiliar with common cultural differences regarding patient-physician communication and medical decision making, as well as attitudes about topics with high levels of emotional and interpersonal intensity, such as end-of-life planning (Searight & Gafford, 2005). These cultural dissimilarities and the lack of diverse cultural proficiency among most physicians contribute substantially to health disparities among minorities.

Poor, minority, and underserved populations are experiencing a decrease in access to physicians who are culturally similar to themselves at a time when minority patient populations are growing at a rapid pace. A literature review examining the relationship between opportunities for underrepresented minorities in medical education and the role of minority

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physicians in providing access to health care for underserved populations reports a grossly disproportionate percentage of minority physicians in comparison to minority populations. Underrepresented minorities make up 30.1% of the U.S. population. However, only 10.5% of incoming medical school classes in 2000 were comprised of minority students. Black/African American physicians only represent 3.7% of the population, whereas Black/African Americans as a whole represent 12.1% of the Nation's population (Gartland, 2003). Anti-affirmative efforts have curtailed judicial and legislative actions to resolve these inequities resulting in a reduction of medical education opportunities offered to minority groups. This reduced access for minorities to medical education has resulted in a decrease in the number of minority physicians available to already underserved minority populations (Thrumond & Kirch, 1998).

Since physicians tend to strategically locate their offices in areas more convenient to the patients they seek to serve, usually those who are racially/ethnically similar to themselves, it can be concluded that this geographical factor indeed influences racial/ethnic groups when choosing their physicians (Reede, 2003). Forty-two percent of Hispanics in a nationwide study reported choosing Hispanic physicians because of language similarity (Saha, Taggart, Komaromy, & Bindman, 2000). In a nationwide study of 2720 telephone interview participants including Whites, African Americans, Hispanics, and Asian Americans, each racial/ethnic group of patients was more likely to choose a physician similar to their own race/ethnicity when given a choice. Researchers find that greater patient satisfaction occurs when race concordance between patient and physician exists. Such findings suggest that efforts to increase the number of minority physicians should continue as well as attempts to better equip physicians with the skills needed to communicate with patients of races/ethnicities different from their own (Laveist & Nuru-Jeter, 2002).

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Research has aimed at identifying the challenges perceived by medical educators regarding ethnic diversity as well as facilitating and/or debating the development of teaching cultural competency. Medical educators who participated in the workshops during one study had very little diversity training themselves (Kai, Spencer, & Woodward, 2001). Critical dilemmas about teaching philosophies and practicalities about face-to-face teaching to those of dissimilar cultures were just a few of the concerns raised by participants in the study. Kai's research team posits that medical educators will have to *develop their own* cultural awareness and develop training skills that are sensitive to ethnic diversity if the underrepresentation of minority physicians is to be effectively diminished.

The Pew Commissions recommends that, in an effort to help the U.S. minority population receive good medical care, all health professional schools should "continue their commitment to ensure that the students they train represent the rich ethnic diversity of our society" and further recommends that such a commitment "be continued at each institution until it is no longer an issue." This report stresses that "diversifying the entering class is not sufficient to ensure understanding and appreciation of diversity. Cultural sensitivity must be a part of the educational experience that touches the life of every student," not just minority students. The Pew Commission implies that these same recommendations must be applied not only to health professional schools, but also to practicing physicians, healthcare organizations, and policymakers. Not only does cultural competency and diversity affect patient care, but also physician satisfaction.

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Physician Satisfaction

Physician satisfaction/dissatisfaction has been well-studied from many perspectives in the past few decades. Extant research focuses on factors that make physicians less satisfied, factors that make physicians more satisfied, and ways to improve physician satisfaction, and/or ways to reduce physician dissatisfaction.

Eisenberg and other organizational communication theorists argue that there are three general levels of employee needs:

1) Safe working conditions and sufficient pay, rewards, and equipment

2) Supportive interpersonal relationships with co-workers and supervisors

3) Opportunities for personal growth

This Employee Needs Hierarchy, quite parallel to Clayton Alderfer's ERG (Existence, Relatedness, and Growth) Model, outlines the most basic of needs for employee satisfaction. It concurs with Abraham Maslow's and Frederick Herzberg's models about needs hierarchy and motivation theory, which both explain how a series of human needs similar in language to these must first be met for employees to be satisfied (NetMBA, 2005). When these three general levels of employee needs are met, employees tend to report higher levels of job satisfaction (Eisenberg, 2001). The most important bit of information organizations must bring forth from these theories is that employees have multiple needs that must be satisfied simultaneously if a remarkable level of employee satisfaction is to be realized (NetMBA, 2005). Physicians seek the simultaneous fulfillment of these same needs in their careers.

A 1992 study posits that the prevention of physician dissatisfaction specifically related to patient demand and workload can be promulgated through the maintenance of professional

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values and a professional work environment even in the process of bureaucratizing medical practice in hospitals. Stevens and his associates found work environment to be the most prevalent predictor of other dimensions of physician satisfaction. Results from this study show that, within the work environment, behavior formalization, professional autonomy, and time spent with patients are positive predictors of satisfaction. Professional attitudes about *traditional* service provider tasks, such as craftsmanship in medicine and client services, were the best predictors of satisfaction levels related to patient demand (Stevens, Diederiks, & Philpsen).

Research about physician career satisfaction across specialties has revealed that those specialties considered to be very satisfying when compared to family medicine include: neonatal-perinatal medicine, dermatology, and pediatrics. Those specialties found to be less satisfying when compared to family medicine include: ophthalmology, orthopedics, and internal medicine. When consideration was given to geographical location as a factor of satisfaction, results revealed that physicians in the west north Central and New England states are reportedly more satisfied while physicians in the south Atlantic, west south Central, Mountain, and Pacific states are less satisfied (Leigh, Kravitz, Schembri, Samuels, & Mobley, 2002). Findings such as these may greatly affect medical students' choices for medical specialty and practice location as well as the recruitment strategies of medical administrators and educators.

Older physicians and pediatricians have been shown by research to be more satisfied in their careers and more committed to their work and the HMO organization with which they were most closely associated (Freeborn, 2001). Autonomy, perceived work demands, social support from colleagues, and satisfaction with resources were shown in this study by Freeborn to be predictors of satisfaction. In a 2002 study, common areas of dissatisfaction included patient load and time with patients (Freeborn, Hooker, & Pope).

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Equitable distribution of resources, trust and/or communication with the department head predict good satisfaction among physicians according to a study of 105 non-management and non-emeritus physicians who had been hired by or left the University of Missouri Columbia School of Medicine between 1991 and 1998 (Demmy, Kivlahan, Stone, Teague, & Sapienza, 2002). Regardless of overall satisfaction, the most important priority for the faculty of University of Missouri Columbia School of Medicine was protected time for research or personal use.

The top two most prevalent factors underlying physician dissatisfaction with managed care are: (1) autonomy in the form of interference with physicians' abilities to make decisions related to patient care, and (2) the increased administrative burden imposed by managed care organizations in the form of paperwork, pre-authorizations for referrals and diagnostics (Lepore and Tooker, 2000). HMO physicians were reportedly less satisfied overall. More specifically, they were less satisfied with: current and future earnings; skill enhancement opportunities; time to spend with patients; patient appreciation; specialty referral systems; overall quality of practice; and the opportunity to practice as desired (Ahern, 1999).

Research by Murray and Landon shows that physician dissatisfaction has been on the rise for at least the last decade (2003). Factors believed to heavily influence this increase include: restricted choice of hospitals; influence on practice by managed care; inadequate reimbursement; and low financial incentives of managed care (Landon, 2002). Rather than a reduction in income, threats to the following areas of practice have the most influence on negative changes in physicians' satisfaction: their perceived autonomy, their ability to manage day-to-day patient interactions, their ability to manage time, and their ability to provide high-quality care (Landon, 2003).

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Even though a large body of past and extant research addresses patient satisfaction with culturally dissimilar physicians, research which addresses physician satisfaction with encounters of culturally dissimilar patients has only recently been brought to the forefront. When delivering preventive care, chronic disease management in particular, patients' ethnicity affects physician satisfaction with clinical encounters. Most of the marked dissatisfactions with ethnically dissimilar patients in this study were related less specifically to communication and cultural beliefs/practices, but were more related to issues of patient compliance (Kamath, O'Fallan, Offord, Yawn, & Bowen, 2003). Findings from Chen's study about U.S. Americans' initial encounters with persons of international descent point to three main factors as reasons for dissatisfaction in communication: synchrony, difficulty, and common ground (2002). The results from Chen's study are not that different from those reported among physician experiences with ethnically dissimilar patients, regardless of whether or not the physicians themselves were ethnic minorities.

Minority Physician Satisfaction

In Fletcher's study, Physicians of Asian/Pacific Islander origin (n = 66) reported significantly more overall satisfaction (M = 6.40, SD = 1.15) than Black/African Americans, Hispanic, and White/Non-Hispanic physicians, respectively. Interestingly, Black/African American physicians (n = 24) were significantly less satisfied *overall* (M = 5.38, SD = 1.31), when compared to any of the other disaggregated racial/ethnic subgroups in the data set. The archival data set used by this study comes from the 2004 Physician to Physician Satisfaction Study (Bogue), which determined the overall satisfaction of responding physicians with 17

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Likert-type survey items. The results of the overall satisfaction of respondents to the 2004 P2PS Study compared by race/ethnicity are shown below (Figure 2).

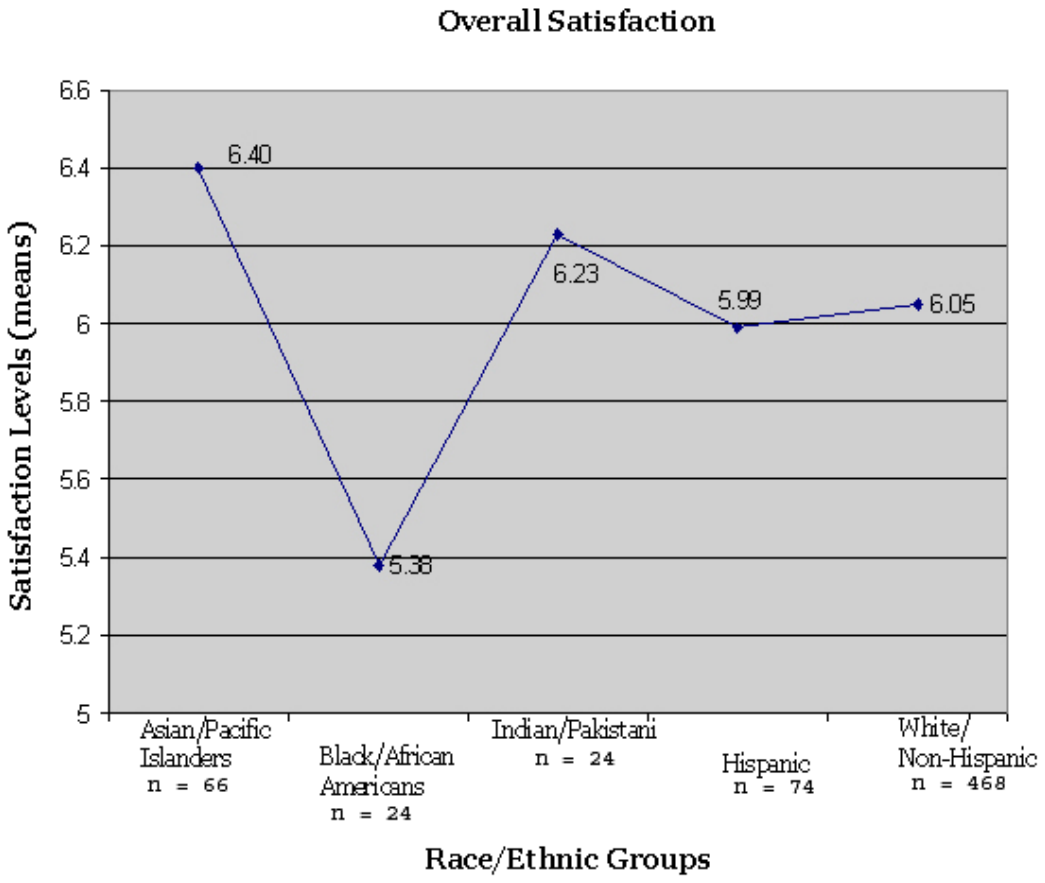

Figure 2: Minority Physician Satisfaction

Another study from 2004 also disaggregates minority physicians by race/ethnicity, compared minority physicians' professional satisfaction and job stress. Among a national sample drawn from the AMA Physician Master File, physician respondents (n=2217) to the Physicians' Worklife Survey (PWS), a career satisfaction survey of physicians, varied in race/ethnicity as follows: 57 black, 134 Hispanic, 400 Asian or Pacific Islander, and 1,626 white. Scales measuring Likert-type response items were constructed to survey overall job and career

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satisfaction and work-related stress. The association between physician ethnicity and each of these scales was examined. In general, minority physicians reportedly provided care to a more demanding patient base than white physicians. When compared to white physicians, Hispanic physicians reported significantly higher job ($p=0.05$) and career ($p=0.03$) satisfaction. However, no significant difference between these groups was found in relation to stress. When compared to white physicians, Asian/Pacific Islander physicians averaged higher stress ($p<0.01$) and lower job satisfaction (p=001). Black physicians and white physicians did not differ significantly from one another on any of the three career satisfaction measures. Significant variance was found relevant to the following satisfaction indicators: autonomy; patient care issues; relations with staff; relations with the community; pay rates; and resources (Glymour, 2004).

Research shows that African-American medical students when compared to Caucasian medical students report greater dissatisfaction with personal relationships/communication with medical school faculty and administrators as well as with the medical school social environment (Gartland, Hojat, Christian, Callahan, & Nasca, 2003). This study about medical college graduate satisfaction from Thomas Jefferson University Medical School shows that African-Americans when compared to Whites are less likely to recommend medical education to younger members of their race/ethnic community. The sense of dissatisfaction with the social environment among African American respondents in this study reportedly carries over into their professional lives. Minority physician dissatisfaction with relationships in both medical school and professional environments contributes to minority physician workforce underrepresentation.

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Themes in Physician Communication

To better understand minority physician communication and increase cultural diversity/ proficiency among physicians, we must first understand the recurrent *themes* (ideas, thoughts or concepts) shared by minority physician communication. A variety of studies focusing on *themes* in medical communication have been conducted. This important body of research focuses mainly on audio communication, which is usually recorded by researchers serving as participant-observers. Operating room (OR) and/or team communication was the target of one recent study, which attempted to understand what tensions influence the functions of these groups and whether or not institutional context makes a difference in these types of interpersonal communication (Lingard, Garwood, & Peonard, 2004). Focus groups and observations of medical surgical teams were conducted in both larger, urban hospitals and smaller, academic hospitals. Thematic codes established by previous research were applied and a *grounded theory* process was engaged to reveal additional, emergent *themes* through the use of trained coders. Tension catalysts observed by the researchers were consistent with previous results from research by Lingard and his associates. The observation sessions revealed that consistent themes emerged from all OR settings and included: roles, situational control, resources, safety/sterility, and time. The post-observation interviews yielded two main themes: role perception and attribution of motivation. *Higher tension* events were observed in 70% of the OR procedures at smaller institutions compared to at least one high tension event in each of the procedures in the larger, urban hospital setting. These results strongly imply that institutional context does make a difference in OR medical team communication.

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Research into decision-making skills among young medical students posits that community-based education and communication skills training are essential for improving these skills (Thistlethwaite & Storr, 2004). Semi-structured interviews were conducted with GPs in practice for 1.5 to 20 years, who have been teaching students from 1 to 10 years, and who teach second-, third-, and fourth-year medical students in their practices. The main themes and their subsidiary themes from this study are shown below in Figure 3.

Themes from the Interviews (Thistlethwaite & Storr, 2004)

- The experience of teaching
  - motivation
  - predominantly a positive experience
  - tendency to learn to teach 'on the job'
  - keen to improve skills
- Students' communication and consultation skills
  - have improved over the years
  - lack of knowledge a problem
- Learning and teaching about management and shared decision making
  - GPs learn this by experience themselves
  - GPs describe themselves as using the shared decision model
  - a key skill is deciding how much information to give patients
  - students know the model strategies for helping students

Figure 3: Themes from Thistlethwaite and Storr Interviews

Research into interpersonal communication between physicians and patients has also investigated themes in these types of communication. A 2001 study, which gathered data from 72 clinical patient interactions with one HMO family physician, the following five themes emerged from the data: 1) control; 2) role negotiation; 3) healthcare commitment; 4) trust; and 5) time and money. The later three of these are believed by Walker and his associates to be unique in medical communication research observations into patient-physician relationships, but the first two do appear in previous health literature. Although patients and physicians often place little importance on developing communication skills within the context of developing these

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professional-personal relationships, researchers are learning about how to share that constructive information in a way that can help increase the quality of patient care (Walker, Arnold, Miller, & Webb).

Sixty-one medical educators from 42 organizations participated in a study about cultural diversity (Kai, Spencer, & Woodward, 2001). Workshops were conducted in three different locations with populations varying in minority race/ethnicity. The qualitative data gathered from the workshops included: flip chart notes made by facilitators and participants; participant observations recorded during and after the workshops; written records of group discussions and work made during the workshops; feedback from participants on the workshops; and the reflections of and discussions by facilitators recorded as field notes following the workshops. The *themes* listed as broad challenges to training in ethnic diversity in healthcare included:

- Uncertainty about central aims and philosophy of training
- Lack of awareness, experience, and understanding about the field and issues for training
- Not a perceived priority of institutions, teachers and lecturers
- Anxiety and prevarication
- Challenges of interface between institutions and the community

The challenges, concerns and barriers for educators included main *themes* such as:

- Teachers' lack of confidence and apprehension
- Lack of experience and resources
- Current training approaches
- Face to face teaching

One researcher recently conducted in-depth, semi-structured interviews with 26 highly satisfied physicians to learn more about the *life practices* that help them remain motivated to stay in medical practice despite the many challenges they face as modern physicians (Bogue, 2004). Interview candidates were systematically and intentionally selected to represent a cross-section of survey respondents in terms of gender, race/ethnicity, medical specialty, and career stage.

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Responses to interview questions were video/audio taped and transcribed. The recurrent *themes* emergent from this data were identified and categorized post concordance. The top ten most frequently recurrent themes are shown below (Figure 4).

P2PS Life Practice Category	***Definition***
Designing a Satisfying Medical Practice	Implementing choices about how to organize and operate the practice of medicine itself
Engaging with Patients	Taking steps to connect with, understand, and create positive sentiments within patients and their families
Regulating Thoughts and Feelings	Observing how one is responding to stress and taking steps to overcome it
Seeking Balance in Life	Making a point of having other interests and activities to help balance the challenges of being a physician
Engaging with Family Members	Setting boundaries around family time, protecting those boundaries, and making the most of family time
Connecting to a Larger Purpose	Practices that imbue one's life with a larger purpose, such as meditation, prayer, or taking good care of one's employees
Enjoying Creativity in the Art of Medicine	Finding the opportunities in medical practice to stimulate one's creative and artistic potential
Exercising the Body	Physical exercise, good nutrition and adequate rest are bulwarks against stress and depression
Engaging with Community	Establishing manageable ways to meet and accomplish things with neighbors and other community members
Conducting Research and Training	Finding the opportunities in medical practice to stimulate one's intellectual curiosity

Figure 4: P2PS Life Practices

Purpose

The purpose of this study is to examine whether or not recurrent *themes* exist within written responses to open-ended survey questions about professional and organizational dissatisfaction between disaggregate minority physician racial/ethnic groups and non-minority physicians. In addition, this study investigates whether or not there is variance between the thematic responses from disaggregate minority physician racial/ethnic groups and non-minority physicians.

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RESEARCH QUESTIONS

The current study examines a body of archival data for recurrent *themes.* Voluntarily written responses to open-ended survey questions by disaggregate minority physician ethnic/racial groups and non-minority physicians are investigated. More specifically, special attention is given to the possible differences between disaggregate minority physician racial/ethnic groups' responses to open-ended survey questions about professional and organizational dissatisfaction in comparison to responses from their non-minority peers. The following research questions were formulated based on recent research, which focuses on 1) themes in medical communication, as well as 2) the lack of extant research literature about disaggregate minority physicians' professional and organizational communication satisfaction/dissatisfaction:

RQ_1: Do recurrent themes emerge within written responses to open-ended survey questions about professional and organizational dissatisfaction from disaggregate minority physician racial/ethnic groups? And if so, what are those recurrent themes?

RQ_2: Do recurrent themes in written responses to open-ended survey questions about professional and organizational dissatisfaction differ significantly between responses from disaggregate minority physician racial/ethnic groups and responses from non-minority physicians?

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RESEARCH DESIGN AND METHODOLOGY

Participants

All data in the archival source were collected from voluntarily completed surveys mailed to all physicians (N = 1,849) on the roster of a Southeastern U.S. not-for-profit hospital group. The original study made no exclusions on the basis of physician age, gender, race/ethnicity, location, or type of practice. No protected populations were included in the data collection procedures that produced the archival data. No data other than voluntarily supplied survey data were included in the archival data set. All those physicians who completed and returned surveys for the archival data source were considered eligible participants for this study (n = 704). The data elements from the original study did not contain any personally identifying information for the participants. Demographic data in Appendix B show a comparison of the participants for the original P2P Satisfaction Study (Bogue, 2004) compare to the national and state populations.

Independent Variables

The P2PS survey instrument used by the original study to construct the archival data set asked physicians to self-report their demographic information, including race/ethnicity. Recent research shows that administrative data may represent only about a 60% agreement rate between data sources and self-reports. Most of the mismatch of data are a direct result from the race/ethnicity category usually identified as *unknown*, with the least agreement between self-reports and data base are those of Native American, Asian and/or Pacific Islander descent

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(Kressin, 2003). Race/ethnicity were collected through self-report, open-ended methods for the P2PS study (Bogue, 2004). Racial/ethnic categories (independent variables) were assigned nominal codes and extracted from the archival data set for comparison to the emergent themes (dependent variables).

Dependent Variables

The dependent variables for this study are the recurrent themes which emerged from the data through content analysis, grounded theory, and Q-sort methods. No predetermined dependent variables were established. A content analysis was conducted of two open-ended survey questions focusing on professional (Q30) and organizational (Q31) contributors to dissatisfaction. The resultant thematic categories serve as the dependent variables. For responses about professional dissatisfaction, the emergent thematic categories include: *Medical/Legal Concerns; Financial Concerns; Autonomy, Respect, & Recognition; Workload; Collegiality & Unity; Resource Availability; Attitude, Approach, & Balance; Patient-Physician Relationships;* and *Insurance/Third Party Challenges*. Responses about organizational dissatisfaction include the following thematic categories: *Provide Access & Support Staff; Improve Physician Relations; Improve Patient Care; Increase Income; Reduce Workload;* and *Reduce Medical/Legal Concerns*.

Procedure

The following three variables from participants' responses were extracted from the archival data set for examination and comparison: 1) self-reported racial/ethnic categories; 2) an

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open-ended question concerning professional dissatisfaction (Q30), and 3) an open-ended question concerning organizational dissatisfaction (Q31). No other variables were extracted from the archival data set for the purposes of this study.

The disaggregate categories for race/ethnicity extracted from the archival data set were created according to the number of self-described, voluntary responses for each racial/ethnic category. These categories were assigned nominal codes post concordance. The response-driven categories for race/ethnicity created during the original study were: Asian/Pacific Islander (9.5%), Hispanic (10.6%), Black/African American (3.4%), Indian/Pakistani (3.4%), and White/Non-Hispanic (67%). Appendix B provides more statistical data concerning participant demographics as well as how the participants compare to state and national populations of physicians.

Content analysis offers researchers the ability to generalize research findings to the public by sharing patterns in the content with which the study population and/or the public have high exposure. In this case those patterns are the recurrent themes which emerge from within the open-ended responses to Q30 and Q31. Grounded theory, founded by Glaser and Strauss' in 1967, allows researchers to encounter the data set(s) with less bias and gives them the freedom to evaluate the data on its own merit rather than trying to make it fit into an existing theory. Intersubjectively constructed *norm-based* coding, also known as *most frequently concordant* coding, allows multiple coders from various social backgrounds to rely on their existing coding schema to interpret content based on social norms and their own perceptions (Potter & Levine-Donnerstein, 1999). For these reasons, the participants' responses to the open-ended questions Q30 and Q31 were subjected to content analyses by use of grounded theory and Q-sort methods.

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The data for each of the two questions were managed and examined separately and independently. After the emergent themes for the two open-ended questions were categorized and assigned nominal codes, they were compared by cross tabulation to the self-reported racial/ethnic categories described above. Due to the potential subjectivity and ambiguity of the participants' written, open-ended responses to those questions intended for analyses in the study, multiple, independent coders were used during each phase of the Q-sort process to ensure the highest possible interrater reliability. The coders for both the pre Q-sort phase and the actual Q-sort phase were trained by using researcher-created examples of responses very similar to the survey responses coders might encounter from the actual data.

In a pre Q-sort phase, lists of responses for Q30 and Q31 were delivered to three coders for each of the two questions. During this phase, the coders determined which of the responses, if any, were to be treated as separate and individual ideas during the Q-sort process. The results from the pre Q-sort phase were then used post concordance to create the individual cards to be used during the actual Q-sort phase: 652 cards for Q30, and 442 cards for Q31.

During the actual Q-sort phase, unforced, or naturalistic, Q-sort methods were performed by 6 independent coders, 3 for each of the 2 questions, who individually grouped the cards into categories they felt were similar and created names for these categories. Final category names were negotiated among the coders post concordance, and all responses were then placed in one of the post-concordant, or forced, categories. The categories were then assigned nominal codes for use during statistical analyses. This combination of *unforced* and *forced* Q-sort methodology is highly recommended to help reduce subjectivity among coders (Block, 1961). A flow chart showing the entire Pre Q-sort and Q-sort processes used during this study can be seen below (Figure 5).

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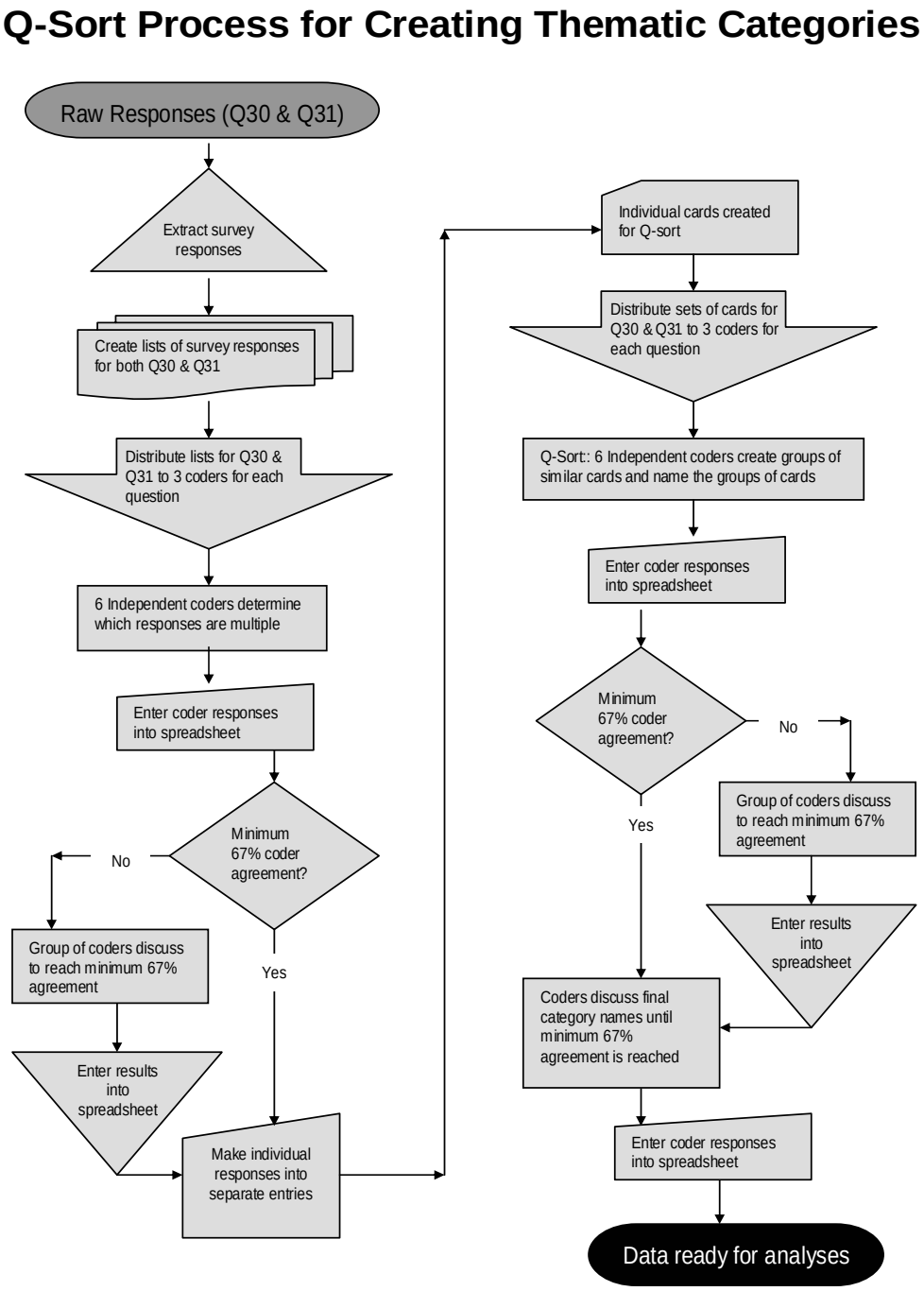

Figure 5: Q-Sort Flow Chart

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Each coder's categorical placement for each Q-sort card was recorded in a Microsoft Excel spreadsheet. Since Cohen's Kappa (1960) accounts for the percentage of agreements between coders, over and above the agreements that should occur if the judgments were strictly independent and occurred due to chance (Hays, 1981), SPSS was used to calculate Kappa for the percentages of agreement between the coders for this study. All results were calculated using a 95% confidence interval. For Q30, the interrater reliability between coders A & B, coders A & C, and coders B & C was excellent (k=0.90, 0.89, and 0.90 respectively). The interrater reliability for Q31 between coders D & E, coders D & F, and coders E & F was also quite good (k=0.83, 0.83, and 0.81 respectively).

The emergent, recurrent themes were compared between responses from disaggregate minority physician racial/ethnic groups and responses from non-minority physicians for both Q30 and Q31. The data for the two survey questions were managed and analyzed separately and independently from one another. Frequency percentages for each recurrent theme in comparison to physician participants' race/ethnicity were calculated. Cross tabulations were conducted to further validate the findings for those groups with large enough cell frequencies (at least 5) to accomplish statistical evaluations.

Responses to Q30 & Q31 not included in the analyses of these data are those which did not qualify for use due one or more of the following reasons: 1) no information about race/ethnicity was included, 2) questions of specific interest to this study were left blank, or 3) answers to the questions of interest to this study were deemed unusable through coder concordance (e.g. "I don't know," "none," "nothing," or any response closely similar to these examples). The responses to categories labeled "other" for both Q30 & Q31 are too small in

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number to qualify these for any statistical analyses. These eliminations left 652 responses about professional dissatisfaction (Q30) and 442 responses about organizational dissatisfaction (Q31).

Measurement Tool

The P2PS survey instrument which created the archival data for the original study contains questions about: participants' personal demographics; participants' medical practice characteristics; 17 Likert-type scale items about various job satisfaction contributors; and finally open-ended questions about stress, professional, and organizational factors of satisfaction/dissatisfaction. However, for the purposes of this study only three variables (shown below, 1-3) were extracted from the archival data source:

(1) Race/ethnicity

Open-ended responses to the following two survey questions:

(2) Q30: *What is the one thing you would change, if you could, to help physicians generally be more satisfied in their work?*

(3) Q31: *What is the single most important thing Zeus Hospital could do to help you personally?*

Response Rate

Survey responses were voluntarily completed and returned by 704 of the 1849 physicians included in the original survey mailings and serve as the archival data set for this study. This return represents a 38% response rate to Bogue's original P2PS Study from which the archival data were extracted (2004). Potential participants in the original study were not offered any

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incentives, but were informed that the aggregate results from the study would be mailed to them in a final report. Also communicated to all physicians solicited for participation were the potential benefits the results from the P2PS Study would yield to them, their fellow physicians, as well as and medical leaders.

Data Quality Check

Thorough data quality checks were performed on the archival data set by the original research team for the P2PS Study in 2004, prior to extraction of the data used for this study. Data entry from the current study consists of two separate Microsoft Excel spreadsheets, one for each of the two questions: Q30 and Q31. There were a combined total of 8521 possible errors for the data related to these two questions. Since much of the qualitative data from the original study was transformed into nominal data for statistical analyses by this study, there was a considerably high risk for errors. Therefore, a two step data quality check was conducted for each data cell. The first quality check located 54 errors (.0062, approx. 6 errors per thousand). After those errors were corrected, a second quality check was conducted, which located two errors (.0002, < 1 error per thousand). All errors located were either blank cells that should have contained data or cells containing data that actually belonged in other cells. Prior to any statistical analyses, corrections were made to all errors detected during the data quality checks

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FINDINGS

The two research questions to be answered by the findings from analyses of the responses to both survey questions are restated below:

RQ_1: Do recurrent themes emerge within written responses to open-ended survey questions about professional and organizational dissatisfaction from disaggregate minority physician racial/ethnic groups? And if so, what are those recurrent themes?

RQ_2: Do recurrent themes in written responses to open-ended survey questions about professional and organizational dissatisfaction differ significantly between responses from disaggregate minority physician racial/ethnic groups and responses from non-minority physicians?

Recurrent Themes

In response to the first research question about whether or not recurrent themes emerge from the physicians' responses, recurrent responses to survey questions about professional and organizational dissatisfaction did reveal recurrent themes. A list of the nine emergent thematic categories from the written responses about professional dissatisfaction are shown below in descending order, from most frequent to least frequent among all responses received (Table 1).

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Table 1: Professional Dissatisfaction Themes

PROFESSIONAL DISSATISFACTION THEMES Category Names and Descriptions	Overall (n = 652)
Medical/Legal Concerns: Malpractice, Tort Reform, Lawyers, etc.	31.88%
Financial Concerns: Pay, Fair Compensation, Cost of Practicing Medicine, Reimbursement Rates, Insurance Issues, Malpractice Costs	21.78%
Autonomy, Respect, & Recognition: authorizations/referrals, restrictions from managed care, HMOs, hospital administration, regulations, formularies, referrals	19.34%
Workload: Patient Volume, No free time, Paperwork, Non-Financial Office Practice Concerns, Efficiency	16.72%
Collegiality & Unity: Relationships with colleagues, hospital, nurses, teamwork	10.98%
Resource Availability: Access to equipment, facilities, patient records, & support staff; organizational issues, policies/procedures of organization	6.97%
Attitude, Approach, & Balance: pace, time with family, time away from medicine, attitude/approach to medicine, more time off, etc.	6.62%
Patient-Physician Relationships: Specifically stated or implied (e.g. more time with patient, quality of patient care, etc.)	5.92%
Insurance/Third Party Challenges: (General/Not Specified as Financial) hassles, Hospitalists, HMOs, Health Care System	5.75%

The three most frequently mentioned themes in response to the survey question Q30 about the professional dissatisfaction were (1) *Medical/Legal Concerns;* (2) *Financial Concerns; and* (3) *Autonomy, Respect, & Recognition.*

A list of the emergent thematic categories from the written responses about organizational dissatisfaction are displayed below in descending order, from most frequent to least frequent among all responses received (Table 2).

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Table 2: Organizational Dissatisfaction Themes

ORGANIZATIONAL DISSATISFACTION THEMES Category Names and Descriptions	Overall (n = 442)
Provide Access & Support Staff: Resources, Qualified Staff, Privileges, Policies/Procedures (Separate from Patient Records), General support, CME, teaching, & other opportunities for education, office staff training	27.30%
Improve Physician Relations: Autonomy, Hospital Regulations, Provide More Benefits & Perks, Promote Collegiality, Give More Respect/Recognition	26.05%
Improve Patient Care: Accessibility of Services, Upgrade equipment and/or facility, Improve Technology, Hospital Expansion, Bed Availability, Physician Access to patient records	24.07%
Increase Income: Fair compensation, Pay for ER Call, Reimbursement Rates, Expedite Org. Claims Processing, Practice Growth, Reduce Practice/Insurance Costs	13.90%
Reduce Workload: Patient Volume, Paperwork, Hospital Efficiency, ER Call	9.93%
Reduce Medical-Legal Concerns: Malpractice, Tort Reform, Lawyers, etc.	8.44%

The three most frequently mentioned themes in response to the survey question Q31 about organizational dissatisfaction overall are (1) *Provide Access & Support Staff;* (2) *Improve Physician Relations; and* (3) *Improve Patient Care.*

Comparison of Recurrent Themes by Race/Ethnicity

In response to the research question about whether or not the themes found in physicians' responses differ when disaggregate minority physician racial/ethnic groups are compared to non-minorities, the data reveal significant variance between these groups. Not only is variance found between disaggregate minority groups and non-minorities, but also between the disaggregate groups of minorities.

A comparison by race/ethnicity of the most frequently mentioned themes about professional dissatisfaction (Q30) coded from the physicians' written responses was conducted, and the results of this analysis can be seen below (Table 3).

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Table 3: Professional Dissatisfaction Theme Frequency

PROFESSIONAL DISSATISFACITON FREQUENCY OF RESPONSES IN EACH THEMATIC CATEGORY BY RACE/ETHNICITY					
	RACE/ETHNICITY (n = 652)				
THEMATIC CATEGORY	Asian/Pacific Islander Responses (n = 60)	Hispanic Responses (n = 73)	Black/African American Responses (n = 21)	Indian/ Pakistani Responses (n = 21)	White/ Non Hispanic Responses (n = 477)
Medical/Legal Concerns	**29.82%**	**20.90%**	**23.81%**	**27.78%**	**34.89%**
Financial Concerns	19.30%	**22.39%**	**19.01%**	5.56%	**23.10%**
Autonomy, Respect, & Recognition	**21.05%**	14.93%	**23.81%**	**38.89%**	**18.92%**
Workload	**22.81%**	**28.36%**	9.52%	**22.22%**	14.25%
Collegiality & Unity	5.26%	16.42%	**14.29%**	5.56%	11.06%
Resource Availability	10.53%	13.43%	9.52%	5.56%	5.41%
Attitude, Approach, & Balance	5.26%	2.99%	9.52%	16.67%	6.88%
Patient-Physician Relationships	5.26%	7.46%	4.76%	16.67%	5.41%
Insurance/Third Party Challenges	8.77%	2.99%	4.76%	5.56%	5.90%
KEY:	**Most Frequent**		**2nd Most Frequent**		**3rd Most Frequent**

Medical/Legal Concerns was the most frequently recurrent theme among White/Non-Hispanics (34.89%), Asian/Pacific Islanders (29.82%), and Black/African Americans (23.81%) but occurred much less frequently with Hispanics (20.90%) than the other groups. The most frequent theme among responses by Hispanics was *Workload* (28.36%). In contrast, Black/African Americans mentioned this theme least frequently (9.52%) of all the groups. *Autonomy, Respect, & Recognition* was the most frequent recurrent theme among Indian/Pakistanis (38.89%) and Black/African Americans (23.81%), but among Hispanics was

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mentioned least frequently (14.93%). White/Non-Hispanics mentioned *Financial Concerns* much more frequently (23.10%) when compared to all other racial/ethnic groups, especially in contrast to Indian/Pakistanis (5.56%). The theme of *Collegiality and Unity* occurred much more frequently among Hispanics (16.42%) and Black/African Americans (14.29%) than it did among all other groups. However, among Asian/Pacific Islanders and Indian/Pakistanis this theme occurred quite infrequently (5.26% and 5.56%, respectively). *Attitude, Approach, & Balance* was mentioned much more frequently by Indian/Pakistanis (16.67%) than by other groups, especially in comparison to Hispanics (2.99%).

To further validate the above findings, and as a means of demonstrating correlations between variables, Chi square/cross tab analyses were conducted in SPSS on those data with large enough cell frequencies (5 or more) to be evaluated using these statistical means. Since the data were not perfectly dependent to one another, phi coefficients (Cramer's V) were used to compare data to the ideal situations. Cramer's V is often used to measure the strength of association, or dependency, between the nominal/categorical variables in the contingency table, and is equal to the absolute value of the phi coefficient in a 2 x 2 table (Heiman, 2001; Lowry, 2005). Thematic responses about professional dissatisfaction compared by race/ethnicity are shown below (Table 4).

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Table 4: Professional Dissatisfaction Cross Tabs

PROFESSIONAL DISSATISFACTION THEME CROSS TABS			
	RACE/ETHNICITY		
THEMATIC CATEGORY	**Asian/Pacific Islander vs. White/Non Hispanic**	**Hispanic vs. White/Non Hispanic**	**Asian/Pacific Islander vs. Hispanic**
Medical/Legal Concerns	Asian/Pacific Islander = 29.8% White/Non Hispanic = 34.9% Phi (Cramer's V) = .035 **Approx. Sig. = .450**	Hispanic = 20.9% White/Non Hispanic = 34.9% Phi (Cramer's V) = .104 Approx. Sig. = .024	Asian/Pacific Islander = 29.8% Hispanic = 20.9% Phi (Cramer's V) = .103 **Approx. Sig. = .252**
Financial Concerns	Asian/Pacific Islander = 19.3% White/Non Hispanic = 23.1% Phi (Cramer's V) = .030 **Approx. Sig. = .521**	Hispanic = 22.4% White/Non Hispanic = 23.1% Phi (Cramer's V) = .006 **Approx. Sig. = .898**	Asian/Pacific Islander = 19.3% Hispanic = 22.4% Phi (Cramer's V) = .038 **Approx. Sig. = .674**
Autonomy, Respect, & Recognition	Asian/Pacific Islander = 21.1% White/Non Hispanic = 18.9% Phi (Cramer's V) = .018 **Approx. Sig. = .702**	Hispanic = 14.9% White/Non Hispanic = 18.9% Phi (Cramer's V) = .036 **Approx. Sig. = .434**	Asian/Pacific Islander = 21.1% Hispanic = 14.9% Phi (Cramer's V) = .080 **Approx. Sig. = .373**
Workload	Asian/Pacific Islander = 22.8% White/Non Hispanic = 14.3% Phi (Cramer's V) = .078 Approx. Sig. = .093	Hispanic = 28.4% White/Non Hispanic = 14.3% Phi (Cramer's V) = .133 Approx. Sig. = .004	Asian/Pacific Islander = 22.8% Hispanic = 28.4% Phi (Cramer's V) = .063 Approx. Sig. = .481
Collegiality & Unity	N/A	Hispanic = 7.5% White/Non Hispanic = 11.1% Phi (Cramer's V) = .041 Approx. Sig. = .375	N/A
Resource Availability	Asian/Pacific Islander = 10.5% White/Non Hispanic = 5.4% Phi (Cramer's V) = .071 Approx. Sig. = .128	Hispanic = 13.4% White/Non Hispanic = 5.4% Phi (Cramer's V) = .113 Approx. Sig. = .014	Asian/Pacific Islander = 10.5% Hispanic = 13.4% Phi (Cramer's V) = .044 Approx. Sig. = .621
Attitude, Approach, & Balance	N/A	Hispanic = 16.4% White/Non Hispanic = 6.9% Phi (Cramer's V) = .121 Approx. Sig. = .008	N/A
Patient-Physician Relationships	Asian/Pacific Islander = 8.8% White/Non Hispanic = 5.4% Phi (Cramer's V) = .047 Approx. Sig. = .309	N/A	N/A

All percentages shown in this table are within group percentages.

The most significant variance exists between Hispanic physicians and White/Non-Hispanic physicians. *Workload* has the most variance between these two groups, with Hispanics mentioning this theme nearly twice as often as White/Non-Hispanics (28.4% and 14.3%

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respectively, Approx. Sig. = .004, $p < .05$). *Attitude, Approach, & Balance* also showed a statistically significant difference between these two racial/ethnic groups, with Hispanics mentioning this theme much more frequently than White/Non-Hispanics (16.4% and 6.9% respectively, Approx. Sig. = .008). There is a significant variance between these two racial/ethnic groups when comparing how frequently each racial/ethnic group mentioned *Resource Availability*. Hispanic physicians mentioned this theme more than twice as often as White/Non-Hispanic physicians (13.4% and 5.4% respectively, Approx. Sig. = .014). Considering the theme of *Medical/Legal Concerns*, there is also a noticeable variance between these two groups, with White/Non-Hispanics mentioning this theme much more frequently than Hispanics (34% and 20.9% respectively, Approx. Sig. = .024).

Themes about organizational satisfaction (Q31) were also compared to race/ethnicity. The percentages of the most frequently reoccurring themes for this survey question are shown below (Table 5).

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Table 5: Organizational Dissatisfaction Theme Frequency

ORGANIZATIONAL DISSATISFACTION FREQUENCY OF RESPONSES IN EACH THEMATIC CATEGORY BY RACE/ETHNICITY					
	RACE/ETHNICITY (n = 442)				
THEMATIC CATEGORY	Asian/Pacific Islander Responses (n = 45)	Hispanic Responses (n = 50)	Black/African American Responses (n = 16)	Indian/ Pakistani Responses (n = 16)	White/ Non Hispanic Responses (n = 315)
Provide Access & Support Staff	30.95%	29.55%	14.29%	28.57%	26.99%
Improve Physician Relations	23.81%	31.82%	28.57%	21.43%	25.61%
Improve Patient Care	9.52%	36.36%	21.43%	14.29%	24.91%
Increase Income	14.29%	4.55%	21.43%	28.57%	14.19%
Reduce Workload	11.90%	6.82%	14.29%	7.14%	10.03%
Reduce Medical Legal Concerns	14.29%	2.27%	7.14%	7.14%	8.65%
KEY:	Most Frequent		2nd Most Frequent		3rd Most Frequent

Provide Access & Support Staff is the most frequently mentioned theme among Asian/Pacific Islanders (30.95%), White/Non-Hispanics (26.99), and Indian/Pakistanis (28.57%). However, this theme is mentioned much less frequently by Black/African American physicians (14.29%). The most frequently recurrent theme among Hispanics was *Improve Patient Care* (36.36%) in large contrast to Asian/Pacific Islanders (9.52%). Among Black/African American physicians, the most frequent theme was *Improve Physician Relations* (28.57%). However, Indian/Pakistani physicians mentioned this theme less frequently than all other groups (21.43%). *Increase Income* and *Provide Access & Support Staff* (28.57%) were the two most frequent themes among Indian/Pakistanis. On the contrary, *Increase Income* is mentioned least frequently by Hispanics (4.55%) in comparison to all other physician racial/ethnic groups. The theme of

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Provide Access & Support Staff is mentioned much less frequently among Black/African American physicians (14.29%) in comparison to other groups. Black/African Americans mentioned *Reduce Workload* much more frequently (14.29%) than others, especially in comparison to Hispanic physicians (6.82%). Asian/Pacific Islander physicians mentioned *Reduce Medical/Legal Concerns* much more frequently than do all other groups (14.29%). In fact, they mention this theme more than twice as often as Black/African American physicians and Indian/Pakistani physicians and six times more often than Hispanics (2.27%).

To further validate the above findings for the most frequently recurrent themes about organizational dissatisfaction (Q31), Chi Square/cross tab analyses were conducted using SPSS and the Phi coefficient (Cramer's V) was calculated as is described above for Q30. The results from these statistical analyses are shown below (Table 6).

These results confirm differences in the frequencies of responses about organizational dissatisfaction between disaggregate minority physician racial/ethnic groups in comparison to non-minority physicians, and in some cases between minority racial/ethnic groups. Hispanics mentioned the theme of *Improve Patient Care* 11.5% more frequently than White/Non-Hispanics. Hispanics also mentioned the theme of Improve Physician Relations more frequently than two other racial/ethnic groups: 8.0% more frequently than Asian Pacific Islanders, and 6.2% more frequently than White/Non-Hispanics. The theme of Provide Access & Support Staff was more frequently mentioned by Asian Pacific Islanders in comparison to White/Non-Hispanics (4.0% more frequently). Even though differences in percentages of frequently reoccurring themes between disaggregate racial/ethnic groups are evident, the approximate significances show no significant variance between Asian/Pacific Islanders, Hispanics, and White/Non-Hispanics.

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Table 6: Organizational Dissatisfaction Cross Tabs

ORGANIZATIONAL DISSATISFACTION CROSS TABS			
	RACE/ETHNICITY		
THEMATIC CATEGORY	**Asian/Pacific Islander vs. White/Non Hispanic**	**Hispanic vs. White/Non Hispanic**	**Asian/Pacific Islander vs. Hispanic**
Provide Access & Support Staff	Asian/Pacific Islander = 31.0% White/Non Hispanic = 27.0% Phi (Cramer's V) = .030 Approx. Sig. = .591	Hispanic = 29.5% White/Non Hispanic = 27.0% Phi (Cramer's V) = .019 Approx. Sig. = .723	Asian/Pacific Islander = 31.0% Hispanic = 29.5% Phi (Cramer's V) = .015 Approx. Sig. = .887
Improve Physician Relations	Asian/Pacific Islander = 23.8% White/Non Hispanic = 25.6% Phi (Cramer's V) = .014 Approx. Sig. = .803	Hispanic = 31.8% White/Non Hispanic = 25.6% Phi (Cramer's V) = .048 Approx. Sig. = .384	Asian/Pacific Islander = 23.8% Hispanic = 31.8% Phi (Cramer's V) = .089 Approx. Sig. = .408
Improve Patient Care	N/A	Hispanic = 36.4% White/Non Hispanic = 24.9% Phi (Cramer's V) = .088 Approx. Sig. = .109	N/A
Increase Income	Asian/Pacific Islander = 14.3% White/Non Hispanic = 14.2% Phi (Cramer's V) = .001 Approx. Sig. = .986	N/A	N/A
Reduce Workload	Asian/Pacific Islander = 11.9% White/Non Hispanic = 10.0% Phi (Cramer's V) = .021 Approx. Sig. = .709	N/A	N/A
Reduce Medical/Legal Concerns	Asian/Pacific Islander = 14.3% White/Non Hispanic = 8.7% Phi (Cramer's V) = .064 Approx. Sig. = .241	N/A	N/A
All percentages shown in this table are within group percentages.			

It is possible that these findings are due in part to the lower numbers of available and qualified responses from Hispanics and Asian/Pacific Islanders in comparison to White/Non-Hispanics. Unfortunately, these three were the only disaggregate racial/ethnic groups which had large enough cell frequencies (at least 5) to perform these statistical analyses.

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CONCLUSION

Professional Dissatisfaction

White/Non-Hispanic physicians were more inclined to present themes about *Medical/Legal Concerns* and *Finance* than were all other groups in regard to professional dissatisfaction. This difference between White/Non-Hispanic physicians and the other racial/ethnic groups may be due to tendencies within White/Non-Hispanic culture toward individualism in comparison to the collectivistic tendencies of the racial/ethnic minority groups represented by the participants in this study. Collectivists are not as prone to lawsuits as are individualists due in part to their common belief that such behavior is repulsive and humiliating to one's own family, business, and/or community. Research shows that White/Non-Hispanic physicians generally see more patients who are White/Non-Hispanic, and who also live in more financially advantaged areas (Reede, 2003). These patients may have the resources necessary to bring about lawsuits much more easily than do minorities. Research also shows that White/Non-Hispanic physicians experience more culturally dissimilar patients, which could result in more frequent misunderstandings about care and patient compliance (Cooper et al, 2003, & Kamath, O'Fallan, Offord, Yawn, & Bowen, 2003). More frequent misunderstandings potentially lead to more frequent lawsuits.

The theme of *Workload* among Hispanics, Asian/Pacific Islanders, and Indian/Pakistanis is mentioned approximately twice as frequently when compared to Black/African Americans and White/Non-Hispanics. Cultural differences in interpersonal communication styles offer a likely explanation for this variance. Included in those communication style conflicts are: high-context

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versus low-context; collectivism versus individualism; and associative versus abstract. Most White/Non-Hispanics and Black/African Americans have been members of American culture and/or have spoken English as a first language for multiple generations. This means that they communicate within a high-context infrastructure, one of strict social boundaries and intersecting networks of relationships with an understanding of the nonverbal cues within those networks. However, Hispanics, Asian/Pacific Islanders and Indian/Pakistanis, may have ancestors who came here only this or a single generation ago. In fact, many of them are the first generation in their families to come to America or speak American English (Beer, 2003). In many of their homes and networks of relationships, English is a second, maybe even a third, language. These three minority racial/ethnic groups operate within a low-context infrastructure where social boundaries are more uncertain and relationships are either short-term or compartmentalized. This means that the non-verbal signals and presumptions/implications made by long-term members of White/Non-Hispanic, American culture may feel quite unfamiliar. This not only would cause uncertainty, but also would make task completion without explicit verbal direction much more challenging for them. Asking for this kind of individual guidance and direction might prove extremely humiliating for members of their cultures. As members of collectivistic cultures, Hispanics, Asian/Pacific Islanders, and Indian/Pakistanis may feel that the workload should be more of a shared affair than one in which a single individual is assigned high levels of responsibility and large quantities of work (Alder & Elmhorst, 1999; Beer, 2003). It is also possible that they identify work itself as being highly defining of worth due to pressures within their own cultures. Most likely they or their immediate ancestors came to the United States expecting to gain success and cultural respect through hard work, and it is, therefore, their focus. Associative cultures, like that of American culture, imply meanings and share knowledge in

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relatively small groups through spontaneous personal experience and individual feelings. Hispanics, Asian/Pacific Islanders, and Indian/Pakistanis, tend to be members of more abstract cultures where thinking is based on ideas with precise meanings that can easily and often be stated in explicit, verbal terms, which can then be shared across larger groups (Folger, Poole, & Stutman, 2001). The challenges of now living and working within a more associate culture where meanings are often implied and not as explicit, coupled with the challenges of learning to communicate in a language other than their native tongue would in part explain why the work environment or workload would carry this much dissatisfaction for these groups.

In regard to professional dissatisfaction among Indian/Pakistanis, the theme of *Autonomy, Respect, & Recognition* is mentioned much more frequently than any other theme among any other racial/ethnic group, 15.08% to 23.96% more frequently. It is possible that non-verbal cues and language barriers between this racial/ethnic group and others frequently lead to misunderstandings and difficulties in finding a common ground, especially during physician-patient encounters (Chen, 2002; Kamath, O'Fallan, Offord, Yawn, & Bowen, 2003). These mismatched communications might leave Indian/Pakistani physicians feeling insulted and lacking the autonomy, respect, and recognition they deserve as medical professionals. Research implies that, since Black/African American physicians self-report as being highly dissatisfied in their communications with administrators during medical education and in professional relationships, these interpersonal and organizational communication disparities likely contribute to the most frequently recurrent theme as being *Autonomy, Respect, & Recognition* among responses from Black/African Americans about professional dissatisfaction (Gartland, Hojat, Christian, Callahan, & Nasca, 2003). Feelings among Black/African Americans of not belonging or feelings that the right or privilege to make decisions as members of a predominately

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White/Non-Hispanic profession is not theirs to execute are also likely contributors to the frequent appearance of this theme among Black/African American physicians (Fletcher, 2005). These perceptions and lack of communication satisfaction among Black/African Americans are also thought to be closely linked to the frequently recurrent theme of *Collegiality & Unity* among their responses about professional dissatisfaction. When an individual experiences an interaction that does not leave him/her feeling autonomous, respected, or recognized in his/her identity claims, that individual tends to feel publicly humiliated and is said to have *lost face* (Folger, Poole, & Stutman, 2001). The strong need for any individual to maintain a favorable image when trying to *save face* or overcome humiliation at such a basic level of validation often leads to retaliation and sacrifice of rewards at great costs (Brown, 1977). This type of behavior often causes others to view the victim's attempts to *save face* as overly defensive, inflexible, and maybe even volatile. The individual committing the offense is often perceived by the victim as hateful or intentionally malicious. These negative perceptions of one another by both the victim and perpetrator have the power to cause much damage, often irreparable, to interpersonal relationships and/or *Collegiality and Unity* within organizations (Folger, Poole, & Stutman, 2001).

Organizational Dissatisfaction

The theme of *Provide Access & Support Staff* appears much more frequently among Asian/Pacific Islander physicians (30.95%) than Black/African American physicians (14.29%). The difficulty Asian/Pacific Islanders experience in communicating with primarily English-speaking Americans can also explain the large gap in how these two groups perceive access to

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resources (Chen, 2002). Cultural beliefs, values, and social norms may also play a role in whether or not members of collectivistic Asian/Pacific Islander cultures, perceive others as being non-compliant in making resources/services available the same way that difficult interpersonal communication affects patient-physician relationships by manifesting itself through patient non-compliance (Kamath, O'Fallan, Offord, Yawn, & Bowen, 2003). Collectivistic Asian cultures typically share more joint access to work resources than do more individualistic cultures who believe an individual is more personally responsible for attaining the career position that earns the right or privilege to access currently unavailable resources.

Asian/Pacific Islanders mention dissatisfaction with organizational efforts to *Reduce Medical/Legal Concerns* at a much greater frequency (14.29%) than do Hispanics (2.27%). Asian/Pacific Islanders may view the organization as being more responsible for this area of concern, since this racial/ethnic minority group typically originates from slightly more collectivistic cultures than do Hispanics. Collectivists recognize and accept an external locus of control and tend to see external forces as being in control of their destiny while having little power defend against outside forces, especially ones as large as a law firms, hospital organizations, and policymakers (Ramisetty-Mikler, 1993). Hispanics may feel a somewhat more internal locus of control about medical/legal issues, since they have typically been more deeply acculturated through multiple generations in American culture than have Asian/Pacific Islanders, most of whom are born outside the United States (Cantore, 2005). Organizations in Asian countries tend to protect their employees from individual lawsuits against their actions as employees in order to avoid bringing public shame to the organizations themselves. This certainly must contribute to Asian/Pacific Islanders' perceptions about the organization's responsibility for medical/legal issues.

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The theme of *Improve Patient Care* appears least frequently among Asian/Pacific Islanders (9.52%), but most frequently among Hispanics (36.36%). This vast difference may have several explanations. Results from a 2001 study by Hargraves strongly suggest that disparities among minorities are not only limited to minority patients' access to health care, but also extend into other areas of the healthcare delivery system, including the physician workforce. Hispanic physicians participating in Hargraves' study were more likely to report problems in obtaining referrals to specialists when compared to white physicians. Hispanic physicians also tend to spend more hours per week involved in direct patient care and are more likely to have a primary care specialty (Fryer, 2001). The tendency of Hispanic physicians to spend extensive hours giving direct patient care and carry higher patient loads as primary care physicians offers an explanation for the frequent mention of this theme among this group. Hispanics may also feel that the community, hospital groups included, has more of a responsibility to make healthcare more available to indigent/underinsured populations the same way Hispanic physicians themselves tend to do (Reede, 2003). More Asians are foreign-born than are Hispanics, and tend to hold on to the cultural beliefs from their native lands. Many Asian cultures view Westernized medicine as being *too strong* and something not to be taken long-term for fear it might cause damage one's liver and kidneys. This organs are believed by many Asian cultures to be the dominate organs in control of all bodily functions (Cantore, 2005). Among Asian/Pacific Islanders the less frequently mentioned theme of *Improve Patient Care* may be a reflection of how this racial/ethnic group feels in keeping with their cultural traditions and about Westernized medicine in general.

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Professional Dissatisfaction vs. Organizational Dissatisfaction

Several differences became evident while comparing similarly-named categories between responses about professional dissatisfaction (Q30) to responses about organizational dissatisfaction (Q31). For responses about professional dissatisfaction, *Medical/Legal Concerns* was the most frequently recurrent theme overall. In bold contrast, among responses about organizational dissatisfaction, the similar theme of *Reduce Medical/Legal Concerns* was least frequently recurrent overall. This finding implies that physicians as an aggregate whole are very concerned about how medical/legal concerns affect their practices, but do not feel the organization is ultimately responsible for their plight surrounding medical/legal concerns. However, these results may also imply that physicians feel issues about *Medical/Legal Concerns* are so large the organization has neither any influence over the situation nor any plans to advocate for change on their behalf.

Black/African Americans show the least amount of concern for *Workload* when responding to the question of professional dissatisfaction in comparison to other racial/ethnic groups. However, when responding to the question of organizational dissatisfaction, Black/African Americans mention *Reduce Workload* as their most salient theme. Research suggests that the difference in responses to these two questions among Black/African Americans can be attributed to their perceptions of autonomy. Since autonomy is a known indicator of job satisfaction/dissatisfaction among Black/African Americans, and as findings from Fletcher's study (2005) imply, Black/African Americans feel they have autonomy over intrinsically controlled factors; in this case, their individual practices and personal lives. However, Black/African Americans also report feelings of little autonomy over extrinsically controlled

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factors; in this situation, relationships with the hospital administrators or the hospital organization itself.

With approximately 33% fewer responses to Q31 about organizational satisfaction (n = 442) than Q30 about professional satisfaction (n = 652), a few smaller, very similar categories were combined to create large enough categories of responses to qualify for statistical analyses. It is not known how, if at all, combining these smaller categories may have affected the results of this study. Future interpersonal and organizational communication research among disaggregate minority physicians should be aimed at larger sample sizes than those made available for this study by the archival data set. Since physicians of all minority races/ethnicities are currently underrepresented in all populations within the U.S., this goal presents quite a challenge to researchers (AAMC, 2005; Gartland, 2003).

Concerns for Organizations and Institutions

The exploration of open-ended responses and more knowledge about what ideas, or themes, or concerns, are more salient among disaggregate minority physician racial/ethnic groups, are key to the design of more culturally appropriate measurement tools. As a result of collecting and maintaining data more truly reflective of minority racial/ethnic groups, policymakers, educators, and institutions will be more adequately equipped to find better ways to educate, recruit, and retain a more diverse minority physician workforce. An increase in cultural competency among culturally dissimilar physicians may help address this need to some degree, but lasting solutions to reducing health disparities among minorities must include aggressive solutions to workforce disparities among minority physicians.

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Currently, hospital organizations often neither ask race/ethnicity as a part of their data-collecting nor do they keep records about the race/ethnicity of physicians associated with their organization. These *don't ask, don't tell* policies may be earnest attempts to convey cultural competency/sensitivity or political correctness, not to mention necessary measures to protect certain racial/ethnic groups. However, attempts to accomplish cultural sensitivity in this way may be negligent to the needs of the very same racial/ethnic minority groups being protected by these policies. Organizations and educational institutions who do seek information about physicians' race/ethnicity most often do not allow physicians to self-report this information using open-ended methods. Instead choices are limited to a small list of predetermined, often inadequate, categories. Many organizations have added the category of *multiracial*, which most likely appeases cultural competency policies within those organizations. However, adding the category of *multiracial* alone results in larger numbers of *unknowns* or *others.* In most cases, the racial/ethnic groups with which respondents most closely identify are still not data being collected. AAMC, like many other organizations has added a category for *multiracial* responses without any specifics as to which racial/ethnic group these respondents most closely identify as their own. However, students responding to the AAMC questionnaire are offered the option of selecting more than one category for race/ethnicity, rather than selecting *multiracial* alone as the category with which they most closely identify (2005). Data about race/ethnicity would best be collected through self-report and/or open-ended methods. If this is not feasible, the predetermined categories should be expanded to include more choices (Kressin, Chang, & Hendricks, 2003). Of course, there still exists the challenge of collecting these data in our modern age of information access/sharing while unequivocally ensuring complete confidentiality and privacy to all who respond.

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Regardless of challenges to obtaining these data, an organization's lack of information about its own racial/ethnic make-up debilitates that organization from being able to adequately provide for the needs of the very persons they are attempting to protect. While it is certainly necessary to protect the privacy and safety of an organization's members, the decision to *not* collect data about their race/ethnicity strips an organization of its ability to accurately measure the outcomes of its own cultural competency, diversity, and sensitivity programs. For any organization, this delicate balance between adequately protecting and effectively serving will no doubt be difficult to achieve. However, given the variance between responses from disaggregate minority racial/ethnic groups in this study and Fletcher's (2005), organizations should consider revisiting their *don't ask, don't tell* policies despite these challenges.

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APPENDIX A: P2P SATISFACTION STUDY PARTICIPANT DEMOGRAPHICS

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P2P: SATISFACTION STUDY PARTICIPANT DEMOGRAPHICS 2004				
	U.S. (N=853,187)	Florida (N=48,706)	Zeus Hosp (N=1849)	Zeus [1] (N=704)
GENDER				
Male	**74.8%**	**81.0%**	**81.4%**	**80.2%**
Female	**25.2%**	**19.0%**	**18.6%**	**19.8%**
RACE/ETHNICITY				
Asian	**8.6%**	**6.7%**	**N/A**	**9.5%**
Black	**2.4%**	**2.5%**	**N/A**	**3.4%**
Hispanic[2]	**3.3%**	**11.1%**	**N/A**	**10.6%**
White	**50.6%**	**44.4%**	**N/A**	**67.0%**
American Indian/Alaskan Native	**.1%**	**0%**	**N/A**	**.4%**
Indian Continent (Indian/Pakistani)[3]	**N/R**	**N/R**	**N/A**	**3.4%**
Other	**2.4%**	**2.6%**	**N/A**	**2.0%**
Unknown[4]	**32.5%**	**32.6%**	**N/A**	**14.2%**
AGE				
<35	**16.3%**	**9.8%**	**8.3%**	**8.9%**
35-44	**24.6%**	**22.7%**	**35.3%**	**32.1%**
45-54	**24.9%**	**25.0%**	**36.3%**	**37.7%**
55-64	**15.8%**	**16.1%**	**16.0%**	**15.3%**
65+	**18.3%**	**25.3%**	**4.1%**	**3.0%**
SPECIALTY				
Primary Care[5]	**33.6%**	**29.8%**	**42.9%**	**45.5%**
Other	**66.4%**	**70.2%**	**57.1%**	**54.5%**

[1] For the P2P data, the percentage of valid, non-missing values is reported. Binomial (for gender and specialty categories) and chi-square tests were conducted to assess the fit of the P2P sample with the Zeus Hospital population. No significant difference was found for gender or age. The P2P study had a marginally higher proportion of primary care specialties when compared to the total Zeus Hospital medical staff ($p = .041$). Zeus Hospital data do not include the race or/ethnicity of medical staff members (N/A = Not Available).
[2] Race and ethnicity categories for the Physician to Physician Study (P2P) were adopted from the standards established by the federal Office of Management and Budget. These standards are currently in use by federal and state agencies, and many private sector organizations. U.S. and Florida data from the AMA, however, recorded Hispanic as a racial category. Current practice is to treat Hispanic as an ethnicity and not a race. Hispanics may be of any race. Thus, when comparing race and ethnicity to the way in which the AMA reported race, the P2P study sample totals to more than 100%.
[3] The number of Indian Continent survey respondents is reported here due to the frequency at which they occurred, while the US and Florida sources did not report this subgroup (N/R = Not Reported).
[4] For the P2P data, the percentage of "Unknown" reported is specific to Race, and not to Ethnicity, to allow better comparison with the US and Florida data for which Ethnicity was not separately gathered.
[5] Consistent with national and state level data collection, primary care specialties have been defined as General practice, Family practice, Obstetrics/Gynecology, Pediatrics, and Internal Medicine.

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APPENDIX B: P2PS SURVEY INSTRUMENT

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Physician to Physician: Satisfaction Survey

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

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

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

A. Physician Characteristics

1. What is your age? _____ 2. Are you: Male____ Female____
3. Are you: Single___ Married___ Separated___ Divorced___ Widowed___
4. How many children do you have living at home? ____
5. How would you describe your race/ethnicity?_____
6. What is your medical specialty?_____
7. How many years have you been practicing medicine? _____
8. Of all your patients, about what percentage is covered by:
   a. Commercial managed care plans? _____
   b. Medicaid? _____
   c. Medicare? _____
9. Check any or all of the following if they are characteristics of your practice:
   Solo Practice___ Single Specialty Group___ Multi Specialty Group___ Hospital-Based Practice___ Management Responsibilities___ Equity Stake___
   Contracted Office/Practice Management___
10. About how many hours do you work in a typical week? ____
11. How would you rate your overall stress level? (*Place one X in a box above a number to indicate your response)*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(PLEASE CONTINUE TO THE LAST PAGE)

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C. Areas for Action

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

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

32. What are your favorite hobbies or leisure activities?

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

Yes _____ Maybe _____ No _____

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

Name _____Preferred Phone #_____

Mailing Address Street/PO Box _____

Mailing Address Suite/Additional_____

Mailing Address City, State, ZIP_____

THANK YOU!

PLEASE RETURN THE COMPLETED SURVEY
(*via the self-addressed envelope provided*)

NO LATER THAN _____.

TO: PHYSICIAN TO PHYSICIAN
Zeus Hospital
321 Grecian Ave.
South Eastern City, U.S. 3xx00

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APPENDIX C: PRE Q-SORT INSTRUCTIONS

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Pre Q-Sort Instructions

Please read these instructions entirely before beginning.

Enclosed please find 4-6 pages of actual physician responses to a survey question about satisfaction.

Your Goal as a Pre-Sorter
Your goal is to ***identify separate and different ideas within individual response if there are any to be found.***

The Procedure
The entire process with this list, including your responses, should take approximately 1 hour. Move quickly. It does not have to be done all in one sitting. As far as the rhythm of work goes, this activity should feel like brainstorming through a list of ideas others have sent you to read for a party your are planning. In other words, there are no "right" answers, only the ones right for YOU in the time you give this activity.

No special training or material is required. You do not need an Internet search, or even a dictionary (unless you just need to look up an unfamiliar word). All you need is: (1) the list of responses, (2) a flat work space (a table or the floor) and the enclosed colored pen for writing your responses. The pen is yours to keep as a thank you for your participation.

1. Ignore the first three columns; they are codes for the researcher's use only.

2. Using the enclosed colored pen/pencil, please draw a dividing mark between responses where you feel one idea ends and a separate one begins, for example:

   Bureaucratic indifference / Nurses treated us with more respect

3. In the last column, circle the number of separate ideas you feel are contained in the corresponding response, for example:

Survey	A5b	A5c	RESPONSE	CIRCLE ONLY ONE
9452	77	17	Bureaucratic indifference / Nurses treated us with more respect	1 (2) 3 4 5+
9476	24	99	Get rid of malpractice mess, reduce malpractice insurance rates	(1) 2 3 4 5+

4. GET YOUR LIST BACK TO THE RESEARCHER BY WEDNESDAY NIGHT, OCTOBER 12, IF AT ALL POSSIBLE.

What's Next
The researcher will record the results from each pre-sorter and check for the level of agreement between coders. A quantitatively verified highly concordant solution across sorters will result. In other words, by finding the similarities in how 4-5 persons identified separate and individual ideas in the response list, we'll discover which responses would be best created as separate cards (responses) for a Q-sort, which is a next step in the process where sorters will place responses into categories. The way we will have carried out these procedures, with your help, will meet the standards for scientific inquiry.

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APPENDIX D: SAMPLE PRE Q-SORT PAGE

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SAMPLE PRE Q-SORT PAGE

Survey Number	A5b	A5c	RESPONSE (C30a)	CIRCLE ONLY ONE TO SHOW NUMBER OF IDEAS FOR EACH RESPONSE				
1015	24	99	Improving reimbursement would have a trick-down effect of improving patient contact and care because we would not have to work so fast, would make all the paperwork easier, and less time consuming because of less patients, more time for administrative issues, etc.	1	2	3	4	5+
1016	77	17	less paperwork, better reimbursement from insurance	1	2	3	4	5+
1023	77	88	The hospital to provide universal fair compensation for emergency work @ FL Hospital, lighten the load on forced volunteerism, not play favorites with neurosurgeons and/or hospitalist, etc…See FMA Quarterly Journal, July, 2003.	1	2	3	4	5+
1032	22	99	Increase number of nurses in ED, Put nurses on performance based compensation.	1	2	3	4	5+
1038	24	99	Increase the amount of time allowed with patients without amount reimbursement.	1	2	3	4	5+
1050	24	99	Reduce liability, Reduce HMO Procedures	1	2	3	4	5+
1071	24	99	Reduce interference from managed care companies, regulators	1	2	3	4	5+
1076	24	99	Reduce work hours, increase income/reimbursements, decrease managed care.	1	2	3	4	5+
1082	24	88	Maybe teaching, helping doctors running their practices, network of coverage for doctors, form a large pool of good available employees.	1	2	3	4	5+
1094	24	99	Less exposure to bureaucracy and decreased reimbursements from managed care	1	2	3	4	5+
1095	24	99	Eliminate the administrative/insurance/malpractice burdens. Go to single payor system.	1	2	3	4	5+
1097	77	17	The workload can be extremely stressful. The demands can lead to errors. A more balanced work week, avoidance of unnecessary consults, patient visits, more physician extras	1	2	3	4	5+
1124	23	99	Third-party payor system, tort reform	1	2	3	4	5+
1125	77	17	Remove burden of malpractice, insurance companies telling us how to handle a patient by denying or shifting money.	1	2	3	4	5+
1129	24	99	better payment for services - less discounted care. Payment above not below Medicare rates.	1	2	3	4	5+
1164	24	99	To be able to practice medicine without the threat of malpractice and reimbursement issues	1	2	3	4	5+
1174	24	99	Return to the roots of medical care by treating root issues not just symptom management, not letting insurance / drug companies, etc., dictate what care should entail	1	2	3	4	5+

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APPENDIX E: Q-SORT INSTRUCTIONS

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Q-Sort Instructions

Please read these instructions entirely before beginning.

Please find enclosed a deck of cards. These cards contain words or phrases, which are responses extracted from the all the responses to a single survey question about physician satisfaction. They also contain a series of numbers, which you are to ignore. The numbers are tracking codes for the researcher, who will need the numbers for data entry of the results when you are finished with the cards.

Your Goal as a Q-Sorter
Your goal is to ***find the common sense in this deck of cards***.

You will help us find the common sense through a simple procedure called a Q-Sort that a few others will also do.

The Procedure
The entire Q-Sort process with this deck of cards, including preparing your results, should take approximately 2 hours. Move quickly. It does not have to be done all in one sitting. As far as the rhythm of work goes, this activity should feel like racing through a jig-saw puzzle with many large pieces, none of which are hard to put in "just the right place." In other words, there is NO single best solution to this puzzle, just the best solution YOU can happily make in the time you spend with it.

No special training or material is required. You do not need an Internet search, or even a dictionary (unless you just need to look up an unfamiliar word). To begin, you'll need: (1) the deck of cards, and (2) plenty of flat space (a table or the floor). To prepare your results, you'll need the enclosed: note pad, pencil, and rubber bands. The remaining notepad, extra rubber bands and pencil are yours to keep as a thank you for your participation.

1. Thoroughly Shuffle the Deck of cards.
2. Read the first card and lay it down, face up, in front of you. *Do this step only the very first time through these steps*.
3. Read the next card and ask yourself: Is this suggestion similar to one(s) already on the table?
    a. If your answer is "**Yes**" then lay the next card down just above or below the card already on the table. This is a **Category** because more than one card holds a "similar" suggestion. Categories will "stack up" taller as you add more cards.
    b. If your answer is "**No**" then lay the next card down to the left or right of the one(s) already on the table.
    c. *Take only a few seconds to answer question 3. Procedures are built into this process to ensure thoughtfulness and the opportunity to validate, but also let you move through the cards quickly.*
4. Continue this process for every card in the Deck.
    a. You will find after awhile that a number of cards seem to be all alone in their own Categories. Once there are more than 5 cards total left all alone from the others, you may put them in an "Other" group, which holds all the cards that don't seem to group with other card categories. This Other group will help you keep moving forward quickly.
    b. Do not stop to reorganize cards. Do not spend more than a few seconds on any one card. Just do one of the following with each card…

        1. Add the card to an existing Category
        2. Start a new Category
        3. Put the card in the Other group

5. If at the end of this cycle of sorting, the Other group contains more than 37 cards, return the Other group to your Deck and return to step 1.

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6. Once your Other category contains 37 or fewer cards, count the number of cards in each of the Categories you have created. If any category has fewer than 19 cards, it cannot be treated as a Category.
    a. Check to make sure there are not cards in the Other Group that are similar to the Category with fewer than 19 cards. If there are, add them and check again to see if there are 19 or more cards.
    b. If a Category cannot be brought up to 19 cards with cards from the Other group, check to see if this Category is similar enough to some or all cards in another Category. *Sometimes people discover new ways of organizing Categories or groups of cards that will get the Other group below 37 cards AND result in every Category containing at least 19 cards.*
    c. If a Category still does not have at least 19 cards, add its cards to the Other group and return to Step 1.
7. FINALLY! You should have:
    a. Fewer than 37 cards in the Other group
    b. No Category with fewer than 19 cards
    c. **You're DONE. BUT WAIT!** Keep the cards right where they are until you've prepared your results.

Preparing Your Results

8. Invent a name for each Category
    a. The name should be brief: a word or two, or a brief phrase.
    b. The name should reflect how you see the cards in that Category fitting together. Why did YOU put all those cards together in one category? What common factor or thought or question or feeling made these cards seem similar to you?
9. Write each of your Category names on a separate piece of paper using the note pad provided.
10. Bind the cards for each Category to the piece of paper with its name on it and keep it separate from the other Categories using the enclosed rubber bands.
11. GET YOUR ORGANIZED CARDS BACK TO THE RESEARCHER BY MONDAY NIGHT, OCTOBER 17, IF AT ALL POSSIBLE.

What's Next?

The researcher will organize the results of the Q-Sorts of each of the sorters. Then she will check for concordance (how much agreement between sorters there is) for each Category and card. A quantitatively verified highly concordant solution across sorters will result. In other words, by finding the similarities in how three different people sort the cards into categories, we'll discover the best "fit" of this set of suggestions, the common sense in the cards. And the way we will have done it will meet the standards for scientific inquiry.

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APPENDIX F: SAMPLE Q-SORT CARDS

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SAMPLE Q-SORT CARDS

Malpractice 1103-22-99	Scheduled time off 4048-24-99
Make a larger Emergency Department 6296-77-17	No managed care insurance 6284-24-99
Require doctors to do their own rounds 9395-24-99	Less hospital call 4048-24-99

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