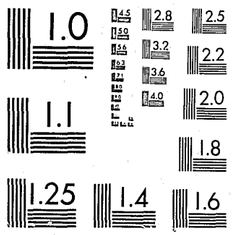
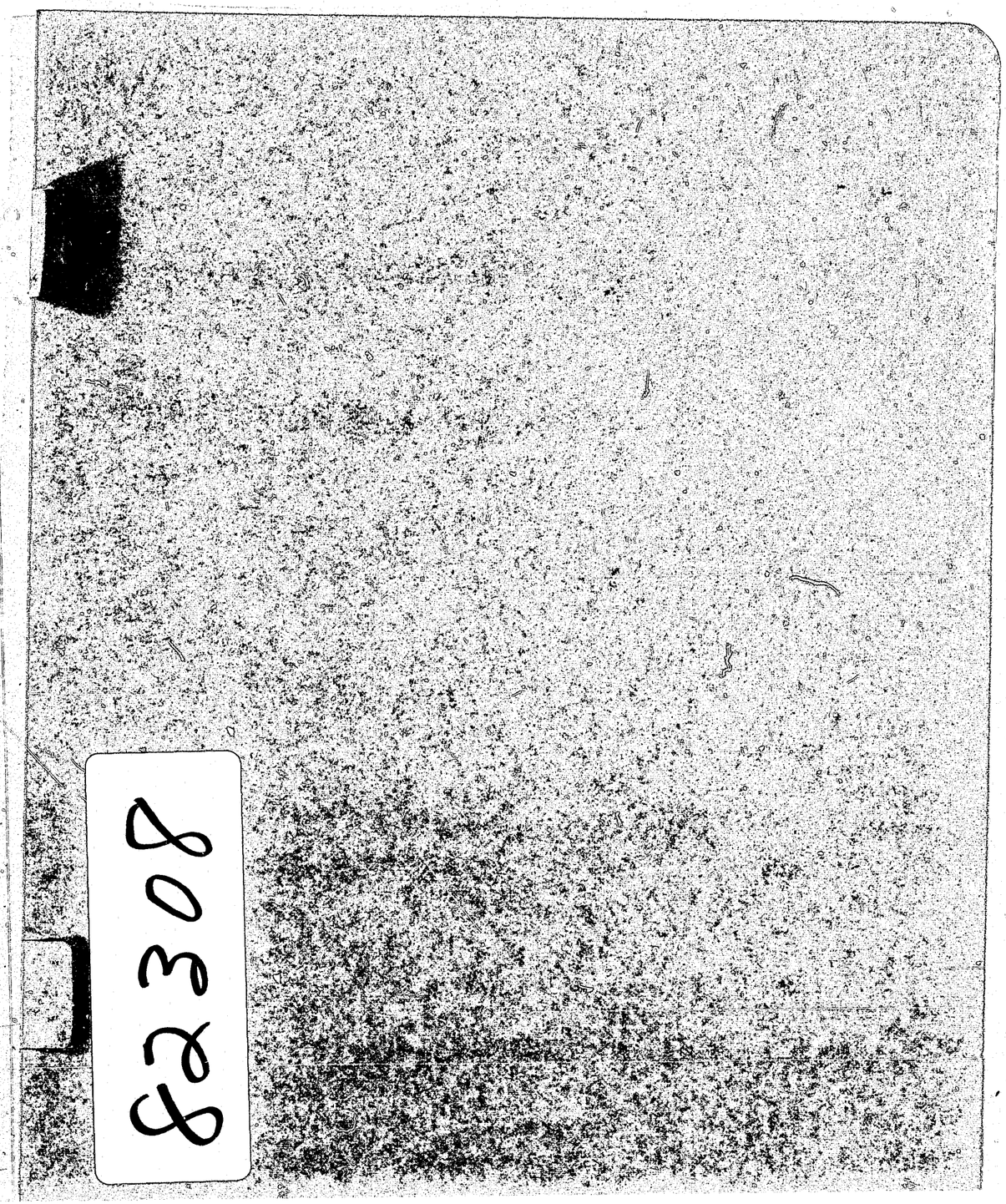


7/27/82

National Institute of Justice
United States Department of Justice
Washington, D.C. 20531



Grant No. HS 04127

PHYSICIAN JOB SATISFACTION AND RETENTION IN CORRECTIONAL HEALTH PROGRAM

RICHARD LICHTENSTEIN

EXECUTIVE SUMMARY

In recent years there has been a growing interest in and awareness of the problems associated with the delivery of health services to inmates of correctional institutions. This increased attention to correctional health care results in part from recent court decisions declaring that inmates have a right to receive medical care[1] and partly from the recognition that recent clinical and administrative advances in health care delivery have largely bypassed correctional health programs. Corrections officials, national health groups, prisoners' rights groups and various state and federal executive, judicial, and legislative bodies have all begun to explore various means for upgrading the level and quality of health services provided to inmates. Several states (e.g., Michigan and North Carolina) initiated efforts to improve their correctional health programs in the mid-1970s, and the federal government, through the Department of Justice's Law Enforcement Assistance Administration (LEAA) and the Department of Health and Human Services' Prison Health Initiative, has already directed funds toward this end. A 1978 report by the General Accounting Office, however, still found correctional health services in the states and the U.S. Bureau of Prisons to be deficient and called for a "federal strategy" to further improve health services to inmates.

One of the major problems faced by correctional health programs is

[1]One such decision was rendered in Estelle v. Gamble . . . U.S. . . ., 97.S.C.T. 285, (1976).

the inability to maintain a sufficient supply of physicians within the institutional setting to meet inmates' needs. Although the full-time presence of a physician is not warranted in smaller institutions, all correctional institutions need at least part-time physicians to provide supervision and back-up services to on-site, non-physician personnel. Recently drafted American Medical Association Standards for Medical and Health Services in Prisons (1979) stipulate that all institutions should have a designated medical authority (a physician) in charge of their health care program. Criteria established by the U.S. Public Health Service designate any correctional facility housing over 250 inmates and maintaining a ratio of available physicians to inmates of more than 1000:1 to be a "health manpower shortage area," eligible for federal health manpower assistance and other federal help.[2]

Maintaining an adequate supply of physicians involves two interrelated organizational activities: first, attracting physicians into the setting--recruitment--and, second, maintaining physicians' interest in the setting as a location of practice--retention. Correctional health administrators report serious problems with both of these activities: most physicians are apparently not interested in practicing in a prison, and those who venture into such settings soon leave. Yet, many physicians do work in the correctional setting and many have worked in the setting for prolonged periods of time. However, the literature identifies neither the types of physicians who are likely to be attracted to the correctional setting nor the organizational features of correctional health programs that would be likely to prove

[2]These criteria were first issued in The Federal Register, 1978, 43(6), 1589.

satisfying to physicians. The purpose of this study was to analyze the personal and organizational factors associated with physician termination behavior in the prison setting. The study focused on the termination of physicians rather than on their recruitment because the former problem enabled a more efficient study design and created a study population of respondents who actually had worked in the corrections setting, rather than one composed of all physicians in the U.S. who could potentially have been employed by a prison.

Another major focus of this study was physician job satisfaction. Job satisfaction has been strongly related to turnover among industrial workers, and also appears to be strongly related to physician turnover. It was therefore critical to measure physician job satisfaction in a study of physician termination behavior. However, previous efforts to measure physician job satisfaction, as evidenced by the medical care literature, did not appear to have been well conceived or constructed and, hence, probably failed to provide adequate measurement of this attitude. It was, then, a further objective of this research to develop a measure of physician job satisfaction that accurately characterized physicians' feelings about their jobs and that thus enabled a better understanding of the job satisfaction-termination behavior relationship.

The study population included all licensed physicians who worked at least 12 hours per month, seeing non-psychiatric patients, on a regularly scheduled basis, inside of an adult or adolescent prison. The entire population of such physicians was studied, rather than a sample of these physicians, since no data was available upon which to design a sampling frame, and since it was believed that the 600 or so eligible physicians could be surveyed satisfactorily within the program's budget.

Data for the study were collected through the use of the two self-administered questionnaires. One questionnaire was sent to all eligible physicians and included questions on personal characteristics, job satisfaction, content of practice, and intentions of staying on or leaving the job. After six contacts, the physician response rate was 65% (352 out of 588 eligible respondents). No systematic bias was identified or is believed to exist in the non-respondent population.

A second set of questionnaires was sent to the chief health official in the correctional systems of all 50 states, the U.S. Bureau of Prisons, and the District of Columbia. This questionnaire sought information on the size, scope and bureaucratic structure of the various correctional systems, and on the specific characteristics of correctional institutions which employed responding physicians. Completed responses were returned for 51 of the 52 systems and 219 out of 220 eligible institutions. Data from the system and institutional questionnaires were then merged with those of individual physicians to yield a data set appropriate to the study's purposes.

Considerable attention was paid to the development of a new measure of physician job satisfaction. Relying more on previous work done on measuring job satisfaction in the industrial sector (notably, the Cornell Job Descriptive Index) than on the literature from the medical care sector, both facet-specific measures of physician satisfaction and a global measure were constructed. The facet-specific measures were based on the discrepancy between characteristics of the physician's current job and what he/she would expect in a "best alternative job." Such discrepancy measures were deemed to be preferable to the more usual direct questions regarding satisfaction. Seven facets of satisfaction

were measured using this methodology, including satisfaction with: resources; self-directed autonomy; externally directed autonomy; relationships with patients; relationships with other physicians; status; and pay. A global measure of satisfaction, which measured a more abstract type of job satisfaction, was also included in the study.

Analysis of the data was accomplished using multiple linear regression techniques. Thirty-three personal and organizational variables[3] were included as predictor variables, while the eight measures of satisfaction and a single measure of physicians' intended termination behavior were included (separately) as dependent variables. Thus nine analyses were performed. In the analysis of intended termination behavior, the satisfaction variables were included, together with the personal and organizational variables, as predictors.

Results of the several analyses indicated that a few factors were rather persistently associated with the various satisfaction areas. Physician age was the single most strongly associated independent variable, showing a fairly strong direct relationship to six of the eight satisfaction variables (age was not found to be related only to satisfaction with pay and relationships with patients). The physician's pay was also a strong correlate of satisfaction as it too emerged as consequential (but less so than age) in six areas of satisfaction (not being related only to satisfaction with relationships with patients and satisfaction with status).

Other variables also were found to be related to several facets of

[3]Among the predictor variables were: age, sex, specialty status, FMG U.S. grad, full or part-time employment, pay and reasons for taking the position of the physicians; and size, degree of bureaucratization, age of building, security designation, geographical location, and degree of overcrowding of the correctional organizations.

satisfaction; however the effects of these variables were not as pervasive as those of age or pay. For instance, the age of the institution's housing facilities was found to be associated with three facets of satisfaction (other-directed autonomy, relationships with patients, and global satisfaction), indicating that older buildings, and the environment that they promote, are associated with physician dissatisfaction. The percentage of his/her working hours that a physician works in corrections was also a consequential variable in three areas of satisfaction. However, the direction of the relationship between the percentage of hours worked and the level of satisfaction was not the same for all three variables. Thus, physicians who worked a high percentage of their time in corrections were more satisfied with the resources available and with their pay than those spending a lower percentage of their time in corrections. In contrast, low percentage timers were more satisfied than high percentage timers with their status in the community.

Foreign medical graduates (FMG's) are frequently mentioned as being more likely to work in the correctional setting than U.S. graduates. Although this study indicated that they are not too disproportionately represented in the prison physician population (the figures are: 24 percent of correctional physicians are FMG's while 20 percent of all U.S. physicians are FMG's), FMG's were found to be more dissatisfied with their jobs than their American counterparts. Being an FMG emerged as a consequential factor in three areas of job (dis)satisfaction (other-directed autonomy, relationships with patients, and global satisfaction).

The final factor which appeared in more than one area of

satisfaction was the existence of a separate official, responsible exclusively for the health subsystem, in the overall correctional system's structure. Physicians working in such systems were more likely to be satisfied (with self-directed autonomy and relationships with patients) than those working in systems in which an official responsible for other matters handled the health area as well. Furthermore, physicians were even more satisfied if their system's health authority was a physician or a professional (master's level) administrator. The establishment of a professional department, whose hierarchical structure is somewhat separate from the general corrections hierarchy, appears to have a salutary effect.

The analysis of physician termination behavior provided support for a number of hypothesized relationships. First, the set of satisfaction variables was found to be quite prominent in relation to termination behavior. Six of the eight satisfaction variables were of some consequence in predicting whether or not the physician was planning to leave the setting. Global satisfaction was by far the strongest predictor of termination behavior, accounting for 32 percent of the variance in that variable. Global satisfaction and three of the other satisfaction variables (satisfaction with: relationships with other professionals, other-directed autonomy, and status) were related to termination behavior in the hypothesized direction: as satisfaction increased, the likelihood of leaving decreased. Surprisingly, two of the satisfaction variables (satisfaction with relationships with patients, and with self-directed autonomy) were found to have a relationship to termination behavior in a direction opposite to the hypothesized one. Physicians who got along well with their patients or

who were satisfied with their self-directed autonomy were more likely to be considering terminating. These relationships were explained by either an "entrepreneurial explanation"--physicians with such traits are likely to leave the setting to initiate private practices or other organized programs--or a "burnout explanation"--physicians with these traits are likely to become emotionally drained by the extreme pressure attendant to working in such a setting.

The physician's age was found to be quite strongly associated with termination behavior, a finding consistent with previous research and the study's hypotheses. A physician's ages increased, they were increasingly unlikely to consider leaving the setting (except for retirement). It was also found that physicians who initially began working in corrections for monetary reasons (for supplemental income, to earn a salary while considering future plans, etc.) were more likely to be considering leaving the setting than those who began working for reasons of job security, humanitarian concern, or limited alternatives. Apparently these physicians' monetary needs had been met, or they had determined that the job was not worth the pay, and therefore they contemplated resigning.

Two characteristics of the specific institution in which the physician worked were also found to be related to physicians' termination behavior. As the occupancy percentage (or degree of overcrowding) of the institution increased, and as the percentage of beds classified as maximum security increased, physicians were more likely to consider termination. Both of these variables were classified as ecological in nature, and both are though to be related to the level of stress, physical control, and work overload the physician is likely

to encounter.

The conclusion reached in the study is that the factors associated with physician termination, and its inverse, retention, are such that a strategy aimed at maximizing physician retention in prisons does not seem appropriate. The factors associated with physician termination either: fall out of the control of prison health administrators (prison overcrowding, maximum security designation of institutions, or old age of facilities housing inmates); would make recruitment difficult (don't hire FMGs or physicians with financial reasons for taking the job); or potentially conflict within other correctional health goals (hiring older physicians would increase retention rates but probably would decrease efficiency, productivity and quality of care).

The argument is made that physician retention should become a secondary goal of correctional health administrators (with quality and efficiency of care being primary goals) and that administrators should seek to accomplish the goal of continuity of care through the use of ancillary personnel, record systems, etc. and through the organization of their medical programs with moderate physician turnover as a built-in constraint.

END