The Routinization of Health Care and the Professional Calling

by Megan H. Johnson

Through the years, the "culture of work" has been altered in many occupations. One clear illustration of a type of work that has faced transitions over time is that done by workers in the health care industry, specifically doctors and nurses. Recent changes in the health care industry have greatly impacted the work of health care professionals. Two of the most pressing issues currently affecting the work of doctors and nurses are 1) the role of the HMO (Health Maintenance Organization) in health care, and 2) the impact of the present nursing shortage. In the article "Finding Oneself," Robert N. Bellah shares his views on the role of the individual in society, specifically making pertinent connections between individuals and the work they do, making classifications according to "job," "career" and "calling" that can be applied to the work of doctors and nurses. In the article, Bellah defines a calling in the following terms:

In the strongest sense of a "calling," work constitutes a practical ideal of activity and character that makes a person's work morally inseparable from his or her life. It subsumes the self into a community of disciplined practice and sound judgment whose activity has meaning and value in itself, not just the output or profit that results from it. But a calling not only links a person to his or her fellow workers. A calling links a person to a larger community, a whole in which the calling of each is a contribution

to the good of all. (66)

In this description of qualities that characterize work as a calling, Robert Bellah stresses the importance of one's work being a connection with people outside the workplace. In this sense, work should involve a "give and take" between workers and those they serve. Beyond that, Bellah asserts that in order to truly practice a calling, one must morally integrate work into one's life, investing it with one's own values and a sense of purpose. This moral connection of work to a person's sense of self will then serve as a driving force, urging the practitioner of a calling to perfect his or her craft and take pride in it. Doctors and nurses do a type of work that many people might consider characteristic of a calling, as the word is defined by Robert Bellah, but changes in the industry may be modifying this designation by impeding personalized human interaction between health care providers and patients. By examining their current work roles in terms of Bellah's definition, one can gain insight into how the routinization of medical care is challenging doctors' and nurses' ability to experience their work as a "calling" in the present day.

Health maintenance organizations are undoubtedly driving forces behind many changes in the health care industry, most notably its economic transformation. The fiscal reform of health care has played a key role in altering the work performed by doctors and nurses, as it has forced them to consider costs when delivering care to patients. The controversial system of managed care arose in the 1980s, as insurance companies noticed trends of medical excess. Researchers conducted studies on how many "inappropriate" surgeries were being performed each year,

and insurance companies decided something had to be done to hold down costs (Anders 23). Whereas physicians could once charge unchecked "fees for service" on any treatments deemed appropriate, companies began placing doctors on the capitation system of flat monthly salaries. Many hospitals were subject to similar plans involving "case rates" for treatment of specific illnesses, an approach that rewards providers for keeping patients out of costly intensive care units and internists' offices. The sickest patients, once viewed as lucrative sources of revenue, became the biggest financial drain on hospitals' fixed capitation checks (Anders 26). As a result of these changes, doctors can no longer order unnecessary tests to increase revenue, hospitals must control services or absorb the costs, and patients are forced to leave hospitals sooner. These HMO-instituted compromises have changed not only how health care providers are paid, but also how they are able to interact with patients.

The influence of the HMO in health care and the current nursing shortage have greatly impacted the health care provider-patient relationship on a variety of levels, usually dimming the connection between the two. In "Finding Oneself," Robert Bellah stresses the importance of a person's work connecting him or her to the greater community, stating that a calling (the optimum plateau of work, in Bellah's view) is "a crucial link between the individual and the public world" (66). In Robert Bellah's terms, doctors' and nurses' connection with the "public world" is embodied by interactions with their patients, and therefore, the better the relationship between health care provider and patient, the closer their work is to Bellah's view of a calling. In her article "Systems of Health Care

Delivery: Their Diversification and Decentralization," nurse and author Connie Curran discusses some of the current pressures that are weakening the link between health care professionals and the greater community. Curran notes that in many hospital settings, nurses' responsibilities have increased in recent years in response to what she calls the "diversification and decentralization" of the health care system. Curran writes:

Prospective reimbursement and increased regulation by insurers have created greater financial pressures for health care delivery systems. Because nursing is usually one of the larger expenses within the hospital, nurse managers and executives must have sophisticated financial management skills. Titles have changed from "director of nursing" to "vice president for nursing" and today, many nurse executives hold the title "executive administrator of patient services."(362-363)

The very language Curran uses to describe these prevalent trends in the nursing field hints at the direction in which health care is moving: away from a service-based orientation and nearer to that of a business concerned with the bottom line. The jargon suggests an industry full of "managers," "executives" and "vice presidents," and downplays the humanistic aspect of the field, in which patients would prefer concerned caregivers to disconnected "administrators" who have to juggle patient care and financial bureaucracy. The "greater financial pressures" that these health care "executives" must consider only weaken their ability to genuinely experience their work as a "crucial link between the individual and the public world" (Bellah 66). Marie Cowart expands upon the negative impact of the

nursing shortage on the larger community in *Nurses in the Workplace*, discussing the results of a major 1985 study founded by the Robert Wood Johnson Foundation, whereby nurse staffing shortages in fifteen nationwide general hospitals were gauged. Cowart writes:

> Working short" (i.e. where there are too few or the wrong kind of staff to adequately care for the number or type of patients) changed the way nurses did their jobs. They were more rushed, had to set work priorities between jobs, and even had to decide whether or not to do certain parts of their work. Also, when units were understaffed, monitoring of patients conditions decreased. As a result, many physicians were not notified soon enough about patients who were experiencing problems. In addition, patients did not receive treatments on time or as often as ordered. (11)

Marie Cowart's observations reflect the various manifestations of the impact of the nursing shortage. This account suggests that not only does patient care suffer, but communication between physicians and nurses in the workplace is negatively affected. Expanded responsibilities add stress to nurses and doctors, who in turn cannot give the highest quality of care to the "greater community" they serve. An unfortunate consequence of the nursing shortage is this necessity for currently employed nurses to take on projects beyond patient care. When nurses are "rushed" and forced to decide "whether or not to do certain parts of their work" due to new responsibilities, their ability to connect with their patients is tarnished, and they can no longer view their work as a "crucial link" between themselves and the "public world" they serve. These added responsibilities only diminish the nurse-patient relationship, and evidently lead

to a lower quality of care for the community.

This growing divide between health care providers and their patients, and in a larger sense, the divide between these workers and the "greater community" of which they are a part, commonly occurs in other spheres of the health care industry, as doctors are also faced with the reality of spending less time with patients as a result of the influence of HMOs on their work. In his article entitled "The Single-Doctor HMO," Steve Lopez conveys the experience faced by disgruntled patients everywhere, as he describes a typical visit to a doctor's office in post-HMO society:

> If you've visited a doctor anytime recently, you know the routine. You wait an hour for a 10-minute once-over, and you can't get an aspirin tablet or a Band-Aid-- let alone a referral -- without six bean counters and a dozen paper pushers eyeballing your entire medical history. (8)

This patient's experience is probably becoming more and more common in the wake of HMO intervention in health care, as doctor-patient interactions are limited in a variety of ways. This scenario illustrates the frustration many people feel when they are faced with the constraints brought about by HMOs, such as having less time to develop a trusting rapport with their doctor, and being forced to spend more time dealing with bureaucracy and paperwork. This particular patient actually characterizes modern doctor visits as "routines" instead of spontaneous interactions, reflecting the trend towards lackluster, disconnected physician-patient relationships. Lopez' conveyance of the current prototypical relationship between doctors and their patients as a "routine" in which anonymous "bean counters

and…paper pushers" interfere, describes the limits HMOs place on doctors' attempts to reach out to the "larger community" in a manner befitting Bellah's description of a calling. This new reality is also extending beyond traditional doctor-patient relationships, as recent studies suggest a troubling trend related to the percentage of doctors who provide charity care in their communities. The numbers of physicians who do so dropped four percent between 1997 and 1999, with experts tying the decrease to "changes in the medical marketplace, including an increase in managed care and the trend away from physician ownership of practices during the 1990s" (Romano 12). In "Managed Care: Business as Usual," Eva Havas suggests that the best way to appraise the effect of managed care is to gauge the sense of alienation that currently pervades medicine and affects the quality of care that people receive. Havas addresses the dangers of weakening the doctor-patient relationship, stating that:

> To the extent that the relationship between patient and provider becomes adversarial, the cooperation that is key for compliance with "doctor's orders" is lacking, as is the discourse necessary for accurate diagnosis. Moreover, an adversarial relationship - or no real relationship at all - adds stress to the patient despite our knowledge of the negative role of stress in both causing and exacerbating illness. (81)

While changes in health care may bring emotional stress to both health care providers and their patients, this quote raises the notion that the consequences could reach even farther, affecting the actual physical health of the greater community. When the interaction between doctor and

patient is strained, Havas suggests that the patient's willingness to adhere to the doctor's orders declines, and that the possibility for even an accurate patient diagnosis is diminished. So while the regulations and resultant "routines" imposed by HMOs may be good for business, they don't appear to benefit the health of the community. This newly "adversarial relationship" between physicians and their patients apparently only "adds stress to the patient" and decreases the ability of the doctor to get involved with patients' lives, possibly clouding his or her view of work being a calling, a "crucial link between the individual and the public world" (Bellah 66). The onset of a nursing shortage and the influence of health maintenance organizations are evidently a part of a trend in which work's connection to society is decreased, as these changes in the health care industry are diminishing the relationship that doctors and nurses have with the greater community.

Related to Robert Bellah's concept of work as a calling is author Robin Leidner's opinion on the so-called "routinization of work," an idea vividly illustrated in Steve Lopez' depiction of a modern-day doctor's office visit. Leidner addresses this current trend in Fast Food, Fast Talk: Service Work and the Routinization of Everyday Life: The routinization of human interactions by corporations and other large bureaucracies can be seen as a disturbing trend, one that epitomizes the kind of depersonalization, dehumanization, manipulativeness, and superficiality that critics of late-twentieth century United States culture deplore. (178) Leidner's description of "routinization" paints it in an extremely unfavorable light, stating that it can't help but lead to "depersonalization, dehumanization, manipulation and superficiality." These terms mirror some

of the issues facing doctors and nurses in the workplace today, as challenges brought about by HMOs and the nursing shortage limit the amount of personalized, individual attention that health care professionals can grant their patients. Time constraints often force doctors and nurses to resort to strict routines which bring about "depersonalization" in the manner that Leidner addresses. Steve Lopez describes the medical industry "routine" in "The Single-Doctor HMO," by partitioning a modern-day doctor's office visit, which seems to involve an hour-long wait, a "ten-minute once-over" and an examination of your "entire medical history" by an anonymous office staff of "bean counters" and "paper pushers" (8). Implied in Lopez's description of this "routinization" of health care is that the process is like that of an assembly line, in which the goal is to spend as little time as necessary in the completion of a specific, uniform task, with little concern for tailoring the process to any individual needs. Lopez doesn't even describe his visit as including a thorough examination, only a "once-over." Robin Leidner would view Steve Lopez's account of the doctor's office "routine" as exemplary of the current trend to routinize work through "depersonalization" and "dehumanization," resulting in more and more "superficiality," as is evidenced by Lopez's "once-over." Eva Havas touches on the dangers of routinizing the interactions between doctors and nurses and their patients in "Managed Care: Business as Usual," stating:

As the nature of medical care, which is increasingly a misnomer, becomes bureaucratized and "managed," one very real danger is that both providers and consumers may accept the impersonal nature of medicine and expect nothing more. There is undoubtedly

a day-to-day wearing down of providers and patients that managed care can count on to limit the kind of patient care patients will seek or physicians will provide. (81)

Havas' appraisal suggests that over time, physicians, nurses and patients may all lower their expectations of health care, "accept the impersonal nature of medicine" and demand less of HMOs and the health care system in general. Beyond that, Havas implies that HMOs have a specific objective that routinizing health care can achieve, which is the "limiting of the kind of care patients will seek or physicians will provide." Implied in this conclusion is the fact that routinization and the limiting of care will also limit costs for HMOs, reflecting the concern that health care systems are currently more interested in the bottom line than in providing exceptional patient care. The routinization of health care is yet another negative factor hindering doctors' and nurses' ability to experience their work as a "calling."

Another important component of the culture of work in the health care industry is the extent to which health care providers can connect what they "do" with who they "are." In "Finding Oneself," Robert Bellah asserts his belief that work as a "calling" must "constitute a practical ideal of activity and character that makes a person's work morally inseparable from his or her life" (66). Bellah elaborates on the importance of a moral connection to work by stating that, in a calling, "one gives oneself to learning and practicing activities that in turn define the self and enter into the shape of its character"(69). According to Bellah's standards, those engaged in a calling would view their work as an extension of their very personality and value system, an arena in which to display their finest human

characteristics. In turn, the work done on behalf of the calling would enrich that person's life. Traditionally, the work performed by nurses and doctors has been viewed in this light, in that their work has a mutually beneficial nature, with patients rewarding good service and concern with respect and loyalty that "give back" to the health care provider and boost morale. Nurse Madeleine Leininger reflects on the value of what she calls "humanism" in health care in her article "Humanism, Health and Cultural Values," observing that "...man's quest for reciprocal humanistic expressions toward life, towards other men, and towards being himself has been an important means for his self-growth, self-fulfillment and life aspirations" (38). Following this train of thought, people would be more likely to emotionally grow and fulfill themselves through pursuit of goals and activities that permit them to express their morals and values, and encourage positive interaction with others. Leininger further elaborates on the importance of a moral center in the work of health care providers, writing:

> Traditionally, there has been an implicit normative societal expectation that health care professionals should be sensitive, warm, understanding, and compassionate persons who would be able to respond effectively to the health needs of people...[they] are generally expected to be compassionate towards people who are in a helpless position, empathetic towards those suffering from an acute or chronic illness, and supportive of those facing life crises...it is this attribute of "human compassion for others" that is generally perceived as the ideal and key reason why most health professionals enter the health field. (39)

While society has historically encouraged these ideals of

sensitivity, warmth, understanding and compassion in health care providers, the current trends in the health care field seem to mitigate their usefulness, favoring protocol and cost-effective efficiency over empathy. While "human compassion for others" is a quality still desired by the community in its health care providers, the post-HMO workplace doesn't seem to foster its practice, leaving doctors and nurses to reduce involving their personal value systems in the work they do. In today's healthcare workplace, the doctors' or nurses' desires to be compassionate and concerned are often tempered by the logistics of their work: outside demands of paperwork, time constraints, and limits placed by HMOs on the type of care patients can receive. In the past, while the moral qualities of empathy, support and compassion that Leininger discusses have helped characterize the work of nurses and doctors as befitting of "callings," the bureaucratic influence of HMOs and the constraints of the nursing shortage have helped hinder doctors' and nurses' ability to morally connect with their work. Robert Bellah suggests using work to "define the self" by "practicing activities that...enter into the shape of [the self's] character," yet when a health care professional's inclination to be a "sensitive, warm, understanding and compassionate [person]" is mitigated by HMO protocol or burdensome responsibilities, doing so can be a daunting task. In Nurses in the Workplace, Marie Cowart discusses the impact of the industry-wide shortage on nurses' sense of moral connection to their work. Cowart writes that "providing less than optimal care for their patients caused nurses to have negative feelings and suffer from low morale. They were " 'dissatisfied,' 'disillusioned,' 'angry,' 'discouraged,' and 'burned out.' Nurses were able to develop

less rapport with their patients" (11). In this way, the nurses' work was no longer an extension of themselves or something from which to take pride, as control over how they performed their job was taken out of their hands. These changes challenge the profession's very nature, as "a nurse's values often have a profound effect on the quality of care given to a client and the type of interaction that occurs" (Arnold 309). When a nurse's value system isn't nurtured, and his or her desires to be "compassionate..., empathetic...and supportive" (Leininger 39) aren't fully encouraged, the nurse can no longer view work as something "that defines the self and enters into the shape of its character" (Bellah 69). The type of person the nurse would like to be, and the type of person that he or she is forced to be in the workplace become two different personas. Limiting health care providers' ability to integrate their value systems into their work will ultimately limit their ability to establish a moral connection with it.

The presence of the HMO in the health care industry has led to similar situations for doctors, whose moral connections to their work are increasingly challenged. Doctors are faced with ethical dilemmas related to patient care, as Jacqueline Eastman discusses
in her article, "The Relationship between Ethical Ideology and Ethical Behavior Intentions: An Exploratory Look at Physicians' Responses to Managed Care Dilemmas." Eastman writes of several ethical issues faced by physicians involved with health maintenance organizations, including the problem of under-treatment:

In the traditional fee-for-service system, a physician who provides more services for a patient receives more income because a fee is

charged for each service. Managed care plans may save money not only by squeezing inefficiencies out of the system, but also by refusing needed care (e.g. by limiting needed referrals, nor ordering needed tests, or refusing emergency room claims)...Nearly one third of physicians had to withhold medical services at the request of a health care management organization. (11)

In scenarios like these, doctors are urged by HMOs into pursuing courses of treatment that are financially preferable, despite objections that they may have based on their sense of morality. The doctors' ability to integrate their personal value systems into their work is diminished when they are forced into "limiting needed referrals, not ordering tests or refusing emergency room claims." As a result, physicians end up distancing themselves from the work they do, and are prevented from keeping their work "morally inseparable from their lives" (Bellah 66). As suggested by the estimate that "nearly one third of physicians had to withhold medical service," doctors can no longer simply do what they morally feel is best for their patients; rather, they must prescribe care with the wishes of cost-concerned HMOs in mind, and are sometimes forced to divert from their personal moral code in the name of business.

Efforts to cope with the often negative realities brought about by the onset of HMO intervention and the nursing shortage tend to move the health care professions even further from their roots as "callings." Related to this issue is the third criterion that Robert Bellah uses to qualify work as a calling: the drive of the individual to perfect his or her craft and "[master] a discipline" (67). In some instances, though, the proposed solutions to current problems in the health care industry

discourage this ideal. Donald E. L. Johnson makes some suggestions for ways to counter the understaffing of nurses in his article, "Hospitalists May Help Relieve Nurse Shortage," asserting that the solution is to lower standards in the profession, rather than raise them. Johnson believes that while pay increases will help draw some people to the field, more comprehensive changes must be made, and recommends a "re-engineering of the nursing and nursing management professions" (2). His proposals include "rewriting nursing job descriptions to fit the available talent, dumbing down nurse training programs to make them less daunting and expensive, easier to complete and easier to teach...[and] relaxing licensure requirements"(3). The words Johnson uses to illustrate his ideas clearly suggest lowering standards instead of raising them, and any recommendations that urge "dumbing down" and "relaxing" programs so that they are "easier" will certainly not foster an environment of professional excellence, even if they allow for a short-term fix. While these ideas could conceivably put more people in nursing positions, they clearly don't seem to be ideal long-term solutions to the nursing shortage. Johnson observes that "the smart, dedicated young women who used to flock to nursing schools are being warned away by frustrated nurses and attracted by more appealing lifestyles offered by business, the law and medicine," yet his proposed solutions do little to change this reality in a positive manner, and would only mire the profession in deeper problems (3). These "smart, dedicated young women" (and men) would only be driven further from the profession if standards and job prestige drop in the manner that Donald Johnson recommends, and dedicated nurses currently in the field would likely be

frustrated by less-qualified new recruits. In light of these probable repercussions, Johnson's requests to "dumb down" and "relax" nursing programs and licensure requirements would do nothing to foster the ideal of "mastery of a discipline" that Robert Bellah encourages (67). The related current practice of using low-skilled auxiliary workers as nurse substitutes or "nurse extenders" has helped the plight of overworked nurses very little, as Marie Cowart notes in Nurses in the Workplace:

> At first, nurses welcomed the extra help in the understaffed ICU. Problems soon arose, however, as nurses found themselves spending an increasing amount of time checking the work of technicians. While doing routine tasks, the nurse simultaneously provides other forms of care that cannot be provided by technicians -- such as giving emotional support, teaching, explaining procedures, and making assessments that affect the outcome of care. (21)

Evidently, what the nursing field needs is more bright, compassionate professionals who endeavor to "master their discipline" while lending this "emotional support" as they continue "teaching, explaining procedures and making assessments" - not more haphazardly trained technicians, as Donald Johnson suggests. Some additional positive suggestions for improving the nursing profession, both in numbers and in quality, include making a baccalaureate degree in nursing the minimum preparation for professional nursing, as well as making an associate's degree the minimum preparation for lower-level technical nursing. To facilitate these goals, non-college diploma programs would be closed, and LPN and associate degree programs

would be merged, with a focus on doubling the output of B.S.N. programs (Cowart 26). Reforms like these would lead to "mastery of a discipline" by encouraging brighter, more ambitious and more conscientious young men and women to enter into the field. Furthermore, when these stronger recruits would graduate nursing school, these reforms would ensure that they would be better educated and better prepared for the demands of the nursing profession. While Donald Johnson's suggestions for "dumbing down" nursing programs in an effort to make them "easier to complete" would hardly foster an environment in which Bellah's ideal of "mastery of a discipline" could be encouraged, these latter proposals do more to revitalize dedication and pride in the nursing profession, bolstering its historical identity as a calling.

Twenty-first century nurses and doctors face professional challenges that penetrate to the very core of the work they do, in which involvement in patients' lives can make a profound impression. The impact of HMOs and the nursing shortage is far reaching, affecting communication between health care providers and the greater community they serve. As a result, not only can the relationship between the two falter, but the actual health and well-being of the community can be put at risk, with doctors and nurses bound by limitations they encounter in the workplace. Methods of coping with HMO management and the nursing shortage differ for each profession. To attract more nurses to the labor force, hospitals presently concentrate on financial incentives for recruitment, the use of temporary and foreign nurses in conjunction with "auxiliary personnel," and increased autonomy in the workplace, which has been shown to "promote decision

making, creativity and higher job satisfaction" (Cowart 24). Future positive changes in the nursing profession therefore seem possible, if not revolutionary. Health maintenance organizations, however, appear to be more permanent fixtures in the industry. As Eva Havas notes, "reforming health care is a complex task, and the political process that prefers simple solutions at the same time it favors vested interests mitigates against meaningful reform" (76). Insurance companies and HMOs are clearly two examples of these "vested interests," and these industries' enormous power, coupled with the reluctance of the government to take on such a complex, heated issue dictate that sweeping reforms are not likely in the near future. Some doctors, embittered at the loss of autonomy they have suffered at the hands of HMOs, have broken away from managed care group practices. So-called "white glove service" is growing in certain locales, whereby physicians set up pricey, specialized groups for wealthy patients with money to spare. Such patients pay a yearly fee around $1500, as well as per-visit fees between $50 and $75, in exchange for same-day or next-day appointments, special phone numbers and other high-end services (Pascual 10). Physicians may find the freedom and personalized atmosphere they crave, but fiscally-challenged members of the community are excluded from such a service. Other doctors with great concern for their communities have left health care systems, as was the case with Dr. Bill Davis of Winters, California. After abandoning Sutter West Medical Group, Davis banded together with supportive townspeople and opened a small office out of an abandoned shoe-repair shop with money earned at fundraisers. While a happy ending would be encouraging in such a situation, there isn't one guaranteed.

Davis has yet to take home a real salary, and townspeople are unsure of how long they can pay via food, services, IOUs and cash (Lopez 8). While hopefully anticipating changes in the health care system, physicians currently seem to have few realistic options outside of practicing in a managed care workplace. In the meantime, though, the by-products of HMO management and the nursing shortage are forcing society to view doctors and nurses in a different light, and are requiring health care professionals to go to great lengths if they wish to invest their work with the type of moral connection that Robert Bellah would encourage.

Works Cited

Anders, George. Health Against Wealth: HMOs and the Breakdown of Medical Trust. Boston: Houghton Mifflin, 1996.

Arnold, Elizabeth and Kathleen Boggs. Interpersonal Relationships: Professional Communication Skills for Nurses. Philadelphia: W.B. Saunders, 1989.

Bellah, Robert N., et al. "Finding Oneself." Habits of the Heart: Individualism and Commitment in American Life. New York: Harper and Row, 1985. 55-84.

Cowart, Marie E. and William J. Serow. Nurses in the Workplace. Newbury Park, CA: Sage Publications, 1992.

Curran, Connie R. "Systems of Health Care Delivery: Their Diversification and Decentralization." Perspectives in Nursing: The Impacts on the Nurse, the Consumer and Society. Eds. Clinton E. Lambert, Jr. and Vickie A. Lambert. Englewood Cliffs, NJ: Prentice Hall, 1989. 355-367.

Eastman, Jacqueline K., et al. "The Relationship Between Ethical Ideology and Ethical Behavior Intentions: An Exploratory Look at Physicians' Responses to Managed Care Dilemmas." Journal of Business Ethics June 2001: 209-224.

Havas, Eva. "Managed Care: Business as Usual." Humane Managed Care? Eds. Gerald Schamess and Anita Lightburn. Washington, D.C.: NASW, 1998. 75-83.

Johnson, Donald E.L. "Hospitalists May Relieve Nurse Shortage." Health Care Strategic Management May 2001: 2-3.

Leidner, Robin. "Meaning of Routinized Work: Authenticity, Identity and Gender." FastFood, Fast Talk: Service Work and the Routinization of Everyday Life. Berkeley: U of California P, 1993. 178-213.

Leininger, Madeleine. "Humanism, Health and Cultural Values." Health Care Issues. Eds. Madeleine Leininger and Gary Buck. Philadelphia: F.A. Davis, 1974. 37-60.

Lopez, Steve. "The Single-Doctor HMO." Time 26 Feb. 2001: 8-9.

Pascual, Aixa and Sheridan Prasso. “The Doctor Will Really See You Now.” Business Week 9 July 2001: 10.

Romano, Michael. “Charity Care Drops, Study Shows.” Modern Healthcare 27 Aug. 2001: 12-13.