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7 *The upside of bureaucracy: unintended benefits for professional careers*

FORREST BRISCOE

Introduction

There is a frequent refrain from scholars and practitioners alike that the professions are becoming ever more bureaucratized. If true, what does this trend imply for professional careers? Several volumes have been devoted to the implications of bureaucratization in general, nearly all of which see it negatively from the point of view of professional workers themselves (e.g. Derber, 1982; Leicht and Fennell, 2001; Freidson, 2001). In this chapter I advance another, perhaps less obvious, interpretation: that bureaucracy offers those in professional careers the kind of career flexibility that today is welcomed. I argue that bureaucratization is (largely unintentionally) creating a range of flexible career options that were previously unavailable – and that are increasingly valued by professional workers themselves. I advance this argument using data from a multi-method study of primary care physicians.

A review of the historical and current trends in professional organizations (e.g. law firms, medical practices) in the research literature shows that they are indeed becoming more bureaucratic. This process entails a greater use of formalized rules and procedures (Gerth and Mills, 1946), and more centralized control of professional activities and client relationships (Pugh *et al.*, 1968). Some of the resulting effects on careers are straightforward. For example, bureaucracy tends to increase the demand for professionals to take on managerial roles (see Rothman and Perrucci, 1970, and Raelin, 1985).

The link between bureaucratization and career flexibility follows a different logic, however: bureaucracy tends to standardize professionals' client-related activities, and in so doing makes it easier for professional workers to hand off clients amongst one another. That ability to make

client handoffs, in turn, helps to guarantee windows of time for professional workers to plan activities *other* than being available to clients, including work or non-work career activities that would otherwise be infeasible. In effect, bureaucratization allows schedule control, which in turn permits workers to pursue more flexible career options.

The chapter proceeds as follows. I first define and identify professional service workers, and then review the literature on trends in professional occupations and careers, including both historical and contemporary developments. This is followed by a summary of my own studies of primary care physicians (PCPs), focusing on details of the career options and career flexibility found among PCPs in different organizational settings. I introduce the elements of a model used to understand why PCP career flexibility is greatest within the most heavily bureaucratized medical practice organizations, and consider the extent to which this model can be extended to other types of professional service workers.

Who are professional service workers?

Professional service workers represent an important and growing segment of the economy. According to Andrew Abbott (1988), professional services are provided by "exclusive occupational groups that apply somewhat abstract knowledge to particular cases." Those cases usually originate with clients outside the profession (whether individuals or organizations), and the abstract knowledge applied to them is usually codified and regulated to some degree by the profession. Expert services provided to clients commonly require customization to fit each situation (Greenwood *et al.*, 2005; Lowendahl, 2000; von Nordenflycht, 2006). Because expert services are usually difficult to evaluate for non-professionals, an information and power asymmetry arises that favors the professional worker (Sharma, 1997). This power relationship gives rise to the claim for a special fiduciary duty that professional workers have toward clients and society (Freidson, 1970; Nanda, 2003). Part of that duty involves responding to client issues in a timely and thorough fashion – a factor that can place considerable burden on professionals themselves (Zerubavel, 1979).

Though some controversy surrounds the exact scope of the professional service occupations, they generally include the "classic" professions, such as doctors, lawyers, accountants, architects, and scientists

(Freidson, 1970; Abbott, 1988), as well as the (partly overlapping) "professional service firm" professionals, such as management consultants, technical consultants, advertising and design professionals, bankers, and financial advisors (Greenwood, Hinings, and Brown, 1990; Mills *et al.*, 1983; Empson, 2007). The growing ranks of technical workers, whose expertise is typically rooted in understanding particular technologies, share many characteristics with professionals, in that they apply occupationally specified expertise to address issues presented to them by clients and others (see Zabusky and Barley, 1996).[1]

Depending on the definition used, professional services constitute or directly influence between 15 and 25 percent of the US gross domestic product (GDP). Following Joseph Broschak (2004), I used the 2004 US Service Annual Survey to estimate that the combination of professional, scientific, and technical services, health services (ambulatory care, hospitals, and nursing facilities), and securities and brokerage services amount to 23.7 percent of US GDP. Daniel Bell (1999) comes up with similar figures, and Stephen Barley and Julian Orr (1997) present comparable figures to suggest that professional and technical workers may constitute one of the most important and fastest-growing sectors of the modern US economy. These trends in the size and growth of professional services are found in other advanced economies as well (Empson, 2007).

Historical approach to professions and careers

A substantial literature on professionals has developed over the decades, particularly in sociology. In this section I review some of the general literature on professional organizations, the pattern of professional careers, and the links between professional organizations and professional careers. Though much of this research focuses on the US context, there are parallel traditions in other country contexts (Brock, Powell, and Hinings, 1999; Ackroyd, Muzio, and Chanlet, 2007).

[1] Professions that are not directly engaged in the economic sphere, such as soldiers and priests, are often excluded. Teachers, nurses, and social workers are often omitted or treated as cases of partial professionalization (Etzioni, 1969). Other traditional professions, such as academics and engineers, do not fit the client-driven theme in professional service work as easily.

Historically, studies of professionals have emphasized the uniqueness of professional occupations in comparison to other occupations. An orientation toward individual autonomy, rooted in occupational culture, gave rise to an observed tension between professionals and bureaucratic organizations. American and British sociologists, including W. Richard Scott (1965) and Richard Hall (1968), studied the co-occurrence of professionals and bureaucratic organizations, finding that traditional bureaucratic techniques fared poorly with key segments of the professional workforce. Henry Mintzberg (1979) suggested that the professional bureaucracy could do little to intervene in the work of the professionals, instead limiting the scope of organizational activities to providing administrative support. Gloria Engel (1970) and others soon modified the basic negative association between autonomy and bureaucratic intensity, but the general ideas persisted. Debates also developed as to whether this need for autonomy was a functional necessity in order to produce high-quality work or simply a privileged outcome of professional power (Larson, 1977; Abbott, 1988; Freidson, 1984).

The structure of professional careers was also thought to be unique, driven less by the needs of organizations than by the unique character of professional work. The career pattern was marked by lengthy apprenticeship-style training and socialization into occupational norms (Hall, 1948; Goode, 1957). Howard Becker, Blanche Geer, Everett Hughes, and Anselm Strauss (1961) studied the institutional socialization of physicians during medical school and medical residency, characterizing the key function of that career phase as one in which career values and expectations were crystallized and transmitted between generations. Chief among those career values was a primary commitment to the profession, placing employers or other work organizations second (see Wallace, 1995). That pattern of commitment led to careers in which professional success depended on relationships with clients and institutions, rather than on demonstrating commitment to an organization (see Gunz and Gunz, 1994). These are the "careers of achievement" that Stacia Zabusky and Stephen Barley (1996) contrast with the more traditional "careers of advancement" in non-professional occupations, in which organizational attachment and commitment were key elements in career success.

Careers within professional service organizations were characterized by minimal integration with the rest of the organization. For example, physicians maintained arm's-length relationships with hospitals by

acquiring admitting privileges, a position that allowed them a considerable amount of control without ever becoming employees or managers (Starr, 1982). Lawyers, accountants, architects, and others were typically organized into professional partnerships of varying sizes, in which the partners enjoyed being owners with relatively high individual autonomy and minimal imposed structure. Indeed, partnerships have been seen as a way for accomplished professionals to pool certain risks and resources while maintaining their independence (Gilson and Mnookin, 1985). They also allow partners to leverage their knowledge, skills, and social capital by hiring junior professionals in apprentice-style positions, in which they are motivated to work hard with the possibility of one day becoming partners themselves (Galanter and Palay, 1991; Greenwood and Empson, 2003; see also chapter 6 in this volume). These junior positions, in turn, formed a key career phase for professional workers in occupations in which partnership is the norm.

Contemporary developments in professions and careers

The current portrait of professional organizations and careers contrasts with the historical image of exceptionalism. Some aspects of the current portrait were predicted by earlier scholars, who argued that professionals would, essentially, be transformed into ordinary workers through the successful bureaucratizing efforts driven by clients and various other forces external to the professions (Haug, 1973; Derber, 1982; McKinlay, 1982).[2] The theoretical literature on this issue is

[2] At the same time, others suggested that increasing expertise and knowledge content could lead many other types of workers to manifest increasingly profession-like qualities (Bell, 1976; Wilensky, 1964). Knowledge content in non-professional work may indeed be increasing, creating the need for more profession-like autonomy and discretion in a wide range of settings (National Research Council, 1999, pp. 105–63; see also Ichniowski *et al.*, 1996, and Blair and Kochan, 2000). In terms of careers, too, the generic worker literature is also increasingly emphasizing professional career concepts such as socialization (Van Maanen and Barley, 1984), mentoring and networking (Higgins and Kram, 2001), and participation in communities of practice (Lave and Wenger, 1991). Profession-like career patterns, such as project-based careers (Bielby and Bielby, 1999; Jones, 1996), independent contracting (Kunda, Barley, and Evans, 2002; see also chapter 5 in this volume), and organizationally detached careers, are gaining scrutiny (Cappelli, 1999). Anecdotally, even the *term* "professional" seems to be incorporated nowadays into an ever-expanding set of job titles from a wide range of occupations.

extensive (and beyond the scope of this chapter). For present purposes, I will summarize the key empirical trends in professional organizations and the professional workforce that have in fact transpired in recent years.

Changes in professional organizations

Professional organizations are changing in response to a wide range of external factors, such as deregulation, competition, globalization, the use of information technology and managerial practices taken from other sectors of the economy, and changes in the composition and demands of the clients whom professionals serve (Brock, Powell, and Hinings, 1999; Fennell and Alexander, 1993; Abel, 1989). In response to these forces, the organizational form for professionals is changing. For example, Laura Empson and Chris Chapman (2006) marshal evidence that the professional partnership, the traditional organizational form among many professional service occupations, is giving way to incorporation and even public ownership. Andrew von Nordenflycht (2007) documents a trend toward public ownership among advertising agencies, and explores the impact of this trend on professionals employed in those organizations. Royston Greenwood and Roy Suddaby (2006) describe the emergence of new professional organizations that combine multiple professions, such as accounting, consulting, and law. Shah (2005) shows how certain widespread hiring norms in law firms (only hiring associates at entry level, only creating partners through internal promotion) have given way to a more varied set of hiring practices; these practices, in turn, have come to be viewed more as strategic choices and less as taken-for-granted organizational norms (Malos and Campion, 2000).

Internal changes are also taking place in professional organizations, many of which entail increasing bureaucracy. For example, lawyers and professional consultants are using standardized knowledge management systems to encode and share insights across clients and projects (Davenport and Prusak, 1998; Hansen and Haas, 2001; Morris, 2001), and physicians increasingly use electronic medical records for some similar reasons (Weber, 2005). In addition, we are seeing within organizations the increased adoption of rules and procedures that standardize core professional work despite the

long-recognized difficulties and dangers perceived in doing so (Laffel and Blumenthal, 1989). Professionals are also being asked to develop a more standardized and organizationally generic relationship with clients, away from the individual and idiosyncratic bonds linking professionals and clients in the traditional approach (Michelson, Laumann, and Heinz, 2000; Briscoe, 2006). Because many of these changes entail more administrative control and bureaucratic intensity from the perspective of professionals, they strike many scholars and practitioners as the fruition of earlier predictions that the professions would eventually succumb to bureaucratic control (Leicht and Fennell, 2001; Hafferty and Light, 1995; McKinlay and Marceau, 2002).

The implications for professional careers as traditionally conceived, then, could be quite negative. As a result, one might expect professionals to avoid these bureaucracies or to join them with reluctance, leading to greater conflict within organizations. In fact, some evidence exists to support this perspective. For example, some seasoned partners appear to be leaving professional service firms rather than give up personal autonomy and individualized client relationships (Hillman, 2001). In addition, some occupation-wide surveys of particular professional occupations suggest declining career satisfaction (Linzer *et al.*, 2000; Ranalli, 2003), though others do not (NALP [National Association for Law Placement] Foundation, 2004; Landau, 2003).

Concurrent changes in the professional workforce

One reason the trend toward greater bureaucratization may not produce the anticipated negative response is that the professional workers of today are not the professional workers of yesterday. Neither the demographic makeup nor the attitudes of young professionals appear to mirror those of earlier generations. Demographically, women have entered professions in large numbers, including medicine, law, academia, and accounting (see figure 7.1). Reflecting this trend, the division of household labor among workers in these occupations is shifting from one dominated by male breadwinners (with female homemakers supporting them at home) toward a diversity of family structures, including large numbers of dual-career families (Waite and Nielson, 2001). Racial and ethnic diversity are also increasing across the

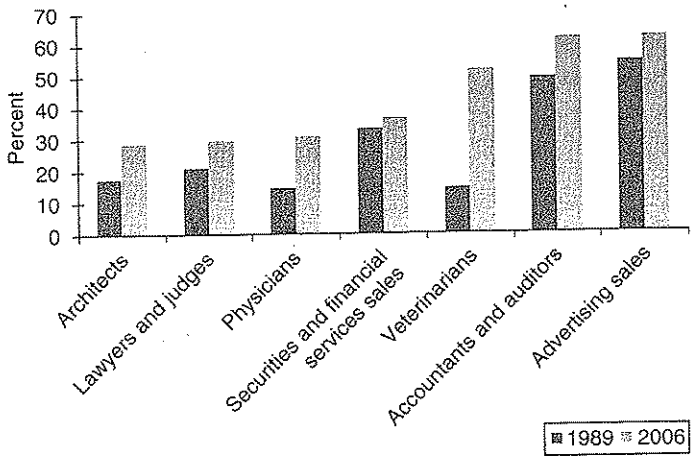

Figure 7.1 Rise in the percentage of women in professional occupations, 1989 and 2006
Source: Author's tabulation of Current Population Survey data (available from www.bls.gov).

professions, though at a generally slower pace (Wilkins and Gulati, 1996; Nickens, Ready, and Petersdorf, 1994).[3]

These demographic trends are bringing a range of new values and, in particular, a range of new career interests into the professional workforce that go beyond traditional conceptions of stratification (based on income, status, and autonomy). The old, homogeneous model of a professional committed fully to his or her work and clients – representing the

[3] Given these changes, many scholars have focused on understanding the degree to which increasing demographic diversity in the overall professional workforce is being translated into differential career attainment and stratification within the professions (Hull and Nelson, 2000; Sasser, 2005). For example, Lisa Cohen, Joseph Broschak, and Heather Haveman (1998) find that female bank managers were promoted only under certain conditions based on the gender composition of their work context, and Christine Beckman and Damon Phillips (2005) find that more women attorneys were promoted to partner in firms in which more of the clients were also women. Forrest Briscoe and Thomas Konrad (2006) find that black physicians were more likely to obtain practice positions as health maintenance organization (HMO) employees during the early 1990s, leading them to greater subsequent career disruption and dissatisfaction. Fiona Kay and John Hagan (1999) find that, even when female attorneys develop the necessary skills and relationships within law firms, they still do not achieve partnership status when compared with similar male attorneys.

"ideal-type" professional in many accounts – is no longer seen as feasible or desirable for many in this new professional workforce (Bailyn, 1993; Williams, 2000). Some professional workers who shoulder family responsibilities are seeking career options during certain phases of their life that accommodate more flexible work arrangements. This may include part-time work or extended leaves of absence followed by a resumption of their professional work roles. These career options represent, to some degree, curtailed commitment to professional work (see Valcour, Bailyn, and Quijada, 2007). Even beyond these work–life considerations, growing diversity within the workforce is increasing the range of career interests in younger generations of professionals (Hull and Nelson, 2000; Families and Work Institute, 2005).

Linking organizational bureaucratization and workforce changes through the career

In the preceding sections I have outlined two major trends at work in the professions: (1) professional organizations are becoming more bureaucratic in response to various pressures, especially the need to streamline client service; and (2) there is increasing diversity in the professional workforce, particularly with regard to the gender and family structure of professionals. The question is, how will these trends affect professional careers? To answer this question I present findings from an in-depth study of one occupational setting.

Field study: primary care physicians

From June 2001 to May 2005 I studied the work practices and careers of PCPs across a range of organizational settings in the United States. In essence, the findings show that *more* organizational bureaucracy was providing *more* personal schedule and career flexibility – while at the same time coming at some cost to the worker in terms of traditional career values such as autonomy and income.

I chose to study physicians in part because they lie at the extreme end of the spectrum in terms of the temporal demands placed on them by their patients. PCP work entails responding to unpredictably timed patient illnesses, and it involves a high level of "specificity" between physicians and their patients, creating a kind of sequential dependency

in which the physician who treated a patient at one point in time often needs to be the one who treats him or her in subsequent episodes. This creates a context in which temporal flexibility is hard to achieve for any PCP. Within this context, I focused on aspects of work related to patients, seeing them as both the focus of PCP work and the root cause of PCP flexibility problems. My overarching aim was not just to understand this context better but also to make a contribution to theory that could be generalized to other client-based professional settings.

Despite a historical tradition of autonomy, the US medical profession experienced an expansion of bureaucratic practice organizations from the 1970s onward that diverged from the past tradition of private partnership (Starr, 1982; Robinson, 1999) – a trend witnessed in other professional occupations and country contexts as well (Leicht and Fennell, 1997; Brock, Powell, and Hinings, 1999). As a result, the current landscape includes physicians practicing in a range of settings, from solo independent practitioners (traditionally the norm), to medium-sized group practices, to large, bureaucratic medical practice organizations, and health care systems in which physicians practice as salaried employees.

At nearly the same time that these organizational changes were taking place, the PCP workforce was also radically shifting. The proportion of women among medical school graduates grew from 7 percent in 1970 to 24 percent in 2000 (American Medical Association, 2002), and among practicing physicians it rose from 9 percent to 44 percent (Barzansky, Jonas, and Etzel, 2000).[4] The division of household labor also moved away from a male breadwinner/female homemaker model. Lee Powers, Rexford Parmelle, and Harry Wiesenfelder (1969) find that, of male physicians who had graduated in the 1930s through the 1950s, 83 percent had wives who were not employed. By 2000 young physicians were more likely to marry or partner with individuals who also had demanding careers. In fact, Nancy Sobecks and colleagues (1999) find that 44 percent of female physicians and 22 percent of male physicians have married other physicians. These changes are bringing new career interests, including a growing interest in schedule flexibility, non-traditional career options, and personal quality of life (Moody, 2002).

[4] At the same time, the occupation itself expanded, from 156 physicians per 100,000 population in 1970 to 261 per 100,000 population in 2000.

Methods

To examine these issues, I conducted multi-method research combining both qualitative and quantitative data. The qualitative data was collected over the course of an eighteen-month field study including interviews, documents, and meeting observations from primary care physicians and administrators in a major US metropolitan region. The study followed an inductive approach, evolving over time from a generative process using semi-structured interviews to a confirmatory process using systematic survey data to evaluate the propositions generated earlier (Strauss, 1987; Eisenhardt, 1989).

I conducted over forty interviews, in six relatively formalized medical practice organizations and seventeen smaller and less formalized practice organizations. I focused the most effort on one of the formalized organizations, referred to here as HCO, where I conducted physician interviews, observed administrative meetings, and collected archival data relevant to the organization's rules and procedures governing physician work life. HCO is one of two large-sized medical practice organizations in its geographic region, the approximately 500 salaried physicians it employs representing approximately 5 to 10 percent of those practicing in the region. The non-formalized settings included solo practices and small-group practices. Most interviews lasted for approximately one hour and were conducted in person. The interviews were guided by a semi-structured protocol that sought to address individuals' personal flexibility and career activities, as well as their understanding of organizational processes and work coordination mechanisms.

The survey data comes from two parallel surveys of PCPs. The first survey was collected from a random sample of PCPs in the region, representing a range of different organizational arrangements. The second survey targeted HCO PCPs. Survey questions covered schedule and career activities, control at work, and other aspects of the physician's organizational context and personal characteristics. For both surveys, three rounds of paper surveys were sent to home addresses. The first survey sample was obtained through the state medical association, and led to a final response rate of 45 percent (usable n = 441). The second survey sample included all PCPs employed by HCO in 2002, from a list provided by the organization's administration, leading to a final response rate of 62 percent (usable n = 147).

Background: traditional physician careers and organizations

My interview informants from traditional private practices often reflected the careers and career values of the historical US medical tradition. That archetypal career took place in a small, stable practice that was either solo or in partnership with a few other physicians. In that setting, the logic of an individual physician's work and career was organized around the needs of sick patients. In addition to long hours in regularly scheduled appointments with patients, the doctor was on call for patient emergencies as they arose, day or night. As a physician's practice expanded over the years, so would clinical responsibilities and hours. Other myriad responsibilities involved in running a small business would also take substantial time and energy. Over the entire career, the demands on a physician's time were relentless (Starr, 1982; Laster, 1996). The physician in this archetypal career model was typically male, with a wife at home to raise his family – a division of household labor that was essential to permit the physician to have the availability to meet the demands of patients at all times.

Some PCPs I interviewed who were nearing retirement reflected on the profound constraints that the earlier career tradition and organizational context placed on them, even with a traditional breadwinner/homemaker family structure. One had practiced from the 1960s through the 1980s in a suburban solo medical office, and the demands of that setting were daunting. He reflected on the toll this took on his home life:

> And the worst thing about it wasn't so much the time constraint, although that was horrible, but it was that it made you unreliable. There were these long episodes, of which dozens occurred, when I called up and said: "Gee, I thought I was going to be home for dinner but something's come up, I'll be home in time to read a story to the kids," and an hour later you call up again and say: "I'll be home in time for bed," and then you didn't get home at all. Until the kids turn you off, and when you say: "I'll be home" your kids say: "Yeah, sure, dad."

Clearly, the inability to protect time from his patients was a dominant theme in this informant's work career, and, consequently, in every other aspect of his life, including his family and marriage. Another PCP reflected a similar sentiment at a more internal, psychological level:

> [H]ow do you turn it off? You have patients out there in the world, and they have problems and you want them to be OK. After a while, you may not actually be in the clinic, but it's on your mind and you're not free of it – the responsibility.

This informant described an inability to "turn off" the demands of patients, even when she was not working. She went on to discuss the way this developed out of a common professional belief in full personal responsibility for patients, combined with a minimal organizational structure that provided little in the way of support for her to rely on anyone else in looking after those patients. She did, in fact, have other career interests that she wanted to pursue while practicing as a primary care physician, but she was prevented from ever pursuing them by the overriding fear of not providing adequate care for her patients.

The flexible careers of physicians practicing at HCO

In contrast to these solo or small-practice physicians, those at HCO described being engaged in a remarkable range of career activities beyond their core patient care responsibilities – while at the same time still seeing patients for part of their time. What makes this high level of non-traditional career activities all the more remarkable is that they all required those PCPs engaging in them to have protected windows of time in which they could be guaranteed that their patients' needs would not interfere with their other activities – and, at the same time, that those patients' needs would still be adequately and safely met.

The main career activities among PCPs at HCO can be categorized into (1) "true" part-time clinician, (2) clinician and administrator, (3) clinician with alternative role, and (4) exclusive, regular full-time patient care. Below, the typical character of each career path is summarized, along with a few examples drawn from my informant interviews. This is followed by a discussion of the quantitative frequency of these career activities in HCO based on surveys.

True part-time clinician

"Part-time" for physicians can include as many as forty weekly work hours, since the definition of regular full-time is commonly viewed as upward of fifty hours per week (Barnett and Gareis, 2000). I define a

true part-timer as someone who self-identified as working part-time in patient care during a period of time, and was not engaged in other career activities that brought him or her up to full-time. In HCO, part-time clinicians were responsible for a reduced number of patients, and tended to report fewer weekly patient office visit hours. Pay was prorated and on-call schedules were scaled back in proportion to the diminished clinical load, though this was not always true in other bureaucratic medical practice organizations I studied. Part-time status was maintained by some PCPs for a period of months, and by others for much longer, including permanently.

Many physicians described their interest in coming to HCO as being based on the availability of a true part-time practice. These individuals wanted to see patients – the core client service activity for which they had trained – and still have something approximating a regular schedule that included time and energy away from work, particularly for family responsibilities. The ability to define and contain the workload, the level of schedule predictability, and the on-call burden were frequently mentioned by these respondents. For example, Brenda, a female PCP, was attracted to HCO right out of residency because she thought it would help her with the juggling act of simultaneously starting a family and starting her practice while her husband, a surgeon she had met in medical school, worked even longer hours during his (longer) residency and fellowship training. While Brenda liked working in an organization committed to innovation in the organization of medical care delivery, it was not the main reason for her decision to join. In fact, she confessed that when she had joined she was hoping privately not to become too involved in any activities beyond patient care.

Clinician and administrator

Many PCPs had also served as administrators with official managerial capacity in HCO. The most common such position was chief for a regional office and a particular medical specialty. Higher-level positions included medical specialty chiefs across all offices, and various other centralized roles including chief medical officer. These appointments varied in length, from around one year to much longer. Responsibilities in these posts included colleague evaluation, communicating with other departments and/or offices, and resolving conflicts among staff or occasionally between staff and patients (see also Betson, 1986, and Montgomery, 2001). Almost all physician-administrators in

the study maintained a clinical practice at some reduced level. As a result, the overall work hours for these administrators were often comparable to those of regular full-time PCPs. Physician-administrators received additional income for their additional responsibilities.

A large number of informants described involvement in administration, and most reported doing so as a result of a proactive interest in administration. One example is Adrian, a physician who joined HCO after an early career stint in PCP private practice, which he had found to lack stimulation. Adrian had an interest in public health, and at the time he joined he had believed that organizations such as HCO had the potential to revolutionize medicine. He explained that his interests were broader than just delivering patient care, and that he wanted to be part of the leadership that continued to advance the state of health care delivery; he thought that HCO was a unique setting for him to do that while still "being a real doctor" (i.e. seeing patients). From the start of his tenure Adrian had been involved in a string of different administrative roles, from office chief to more senior organizational governance activities in which he was able to help develop some of the standards and routines that contributed to the somewhat more bureaucratic feel of the organization. Adrian's latest activity along these lines was planning an organizationally sponsored experiment in which patients with chronic conditions would meet as a group to discuss the social/psychological issues related to managing their condition.

Clinician with alternative role

There were many other assorted roles that could be found among PCPs. One example is a relatively new position known as the "hospitalist" (Hoff, Whitcomb, and Nelson, 2002). In this role a physician representing the medical group is based in a hospital or hospitals where patients of that medical group are treated. Instead of the patients' regular PCPs coordinating their care through telephone calls and periodic visits to the hospital, the hospitalist takes over that coordinating role and serves as a liaison between the patients, their PCPs, and the hospital physicians carrying out treatment. PCPs also worked in nursing homes or other extended care facilities doing similar types of work, in addition to seeing their regular patients. These positions existed because they were intended to increase the efficiency and/or quality of health care services provided to patients. Often individual PCPs choosing to pursue them saw them as valuable sources of growth and renewal in the course of

their own career trajectories, however. Other PCPs were engaged in roles outside the organization, such as involvement in public health research or patient advocacy. Some physicians had purposefully pursued these alternative roles, and others had ended up in them through more circuitous events, but seemed to have been pleased with their ability to juggle these new roles with their clinical patient care practice.

Full-time patient care

My finding is that true regular full-time patient care, though relatively straightforward in terms of career structure, was associated with two types of career orientations. Some informants professed a pragmatic orientation toward their work in HCO, recognizing the financial security and predictability of life in the larger, more bureaucratic organization when compared with traditional private practice. They had few idealistic conceptions of the differences between one organizational setting or another, but consistently recognized the value of being free from the headaches of private practice. For example, Peter, a young physician who had recently come to HCO, was anxious to begin paying his medical school debt. He did not want to haggle with colleagues in private practice over compensation, staffing, and other office policies. He just wanted to see patients, be paid without worry, and start enjoying some of the rewards of his long training.[5]

Frequency and pattern of flexible career activities in HCO

Perhaps even more surprising than the presence of these different career activities among practicing PCPs is the frequency of their use and ability to switch between them over time. Using survey results from those with at least ten years' experience in the organization, I find that 42 percent of HCO physicians reported undertaking a true part-time position in the past decade, 46 percent an administrative role, and 28 percent an alternative clinical or extra-organizational role (see table 7.1). It was actually rare for HCO physicians to have

[5] "Peter" generally reflected the norm, but some regular full-time patient care informants were more ambivalent about their organizational context. These individuals seemed more aware of the autonomy they had given up, and fit the more traditional professional ideal type. They expressed dismay regarding both the organization (HCO) and the wider heath care system.

remained exclusively in regular full-time patient care (only 7 percent fitted this description). The figures for surveyed physicians from comparable large medical practice organizations were of a similar magnitude. By comparison, the incidence of these career activities among physicians who had practiced in traditional small private practices was as follows: 16 percent reported a true part-time position, 33 percent an administrative position, and 15 percent an alternative role. These figures indicate considerably less involvement in activities beyond the core professional work of client service for those in traditional small private practices.

These non-traditional career paths within HCO appeared to be temporary engagements for some but more enduring for others. Of those who reported having been part-time in the past decade, nearly a half (45 percent) had subsequently returned to regular full-time practice. Among those who had reported an administrative stint, only 30 percent were currently working at least ten hours in administration. In short, some were using the part-time patient care option as a long-term career strategy, while others were making shorter-term use of it.

In some cases, informants had availed themselves of this career flexibility to a remarkable extent. Consider the comments of one informant:

> I worked full-time for the first couple years. Then I had two children . . . At first I was working just part-time and nothing else, but eventually I did a total array of other things they had to offer. I've been a chief of department, I've been on a board committee. In the late '80s I also did some national activities in quality measurement.

Throughout the time she was engaging in these activities, this informant continued to see patients. Other HCO informants discussed similarly dynamic changes in their careers over time. In sum, physicians had been in both part-time and administrative posts with frequency, and many had moved in and out of these positions over time.

Reasons for, and importance of, career flexibility

Non-traditional career paths (i.e. paths other than full-time regular clinical practice) were common among HCO doctors. My survey data suggests that individual physicians were most often choosing various career paths in order to accommodate their individual needs and interests rather than being forced into those options. First, consider the true

Table 7.1 *Frequency of career activities reported by individual physicians over the previous ten years*

	True part-time clinician (part-time patient care without additional administrative or alternative roles)	Clinician and administrator (administrative role within a medical practice organization held while also providing patient care)	Clinician with alternative role (alternative role inside or outside medical practice organization held while also providing patient care)
HCO (physicians working in HCO: number of physicians ~ 500, workplace control score = 1.18, n = 116)	42%	46%	28%
Other large organizations (physicians working in organizations other than HCO with at least 50 physicians: average number of physicians = 162, workplace control score = 1.19, n = 70)	28%	38%	26%
Small organizations (physicians working in practices with fewer than 10 physicians: average number of physicians = 5, workplace control score = 1.42, n = 252)	16%	33%	15%

Notes: Values reflect the percentage of physicians from each organizational category who reported ever engaging in that career activity during the past ten years. Many individuals did more than one of these activities during the time period, so columns sum to over 100 percent. Uniform data was not collected for regular full-time patient care, which is the default career activity for patient care physicians.

Fisher exact tests for difference in frequencies between the HCO sample and the small organizations sample, and between the other large organizations sample and the small organizations sample, are all significant at the 95 percent level, with one exception: the difference between the administrative frequency for other large organizations and small organizations is significant only at the 10 percent level. The administrative frequency figure for small organizations includes responsibilities associated with practice ownership; a second estimate excluding those responsibilities yields an 8 percent involvement in administration among small private practice physicians.

Source: 2002–3 survey of Massachusetts PCPs (see Briscoe, 2003, for more details).

part-time position. The most common reason reported for undertaking this career option was an interest in having more family or personal time (77 percent). One informant encapsulated this view in this comment: "Although it was difficult to relinquish control of the day-to-day details of my practice, I have really appreciated the clinical support here and I love working part-time. I feel that I am truly able to enjoy both my work and my family." Other reasons, less commonly cited, included the hope of practicing better medicine (31 percent) and the excessive workload of the full-time position (29 percent). A small group (11 percent) indicated that the organization required them to take this position.

Interviewees also took administrative positions for a wide range of reasons, the most common of which was an interest in leadership (78 percent). One informant commented, "I have loved the opportunities to grow and expand all within one organization. I've changed my career here from primary care internist to oncologist to building and chiefing an oncology department." This comment reflects a sense of vertical growth, and an appreciation toward the organization for facilitating that growth. Many who had taken administrative posts also reported, however, that the organization needed them to do so (73 percent) – revealing a degree of organizational pressure. More than a half of the interviewees also indicated that they hoped the work would be more interesting (55 percent), and that they wanted to change the organization (54 percent). About a third hoped for greater autonomy in the administrative post (33 percent) or saw it as a step to other positions (29 percent). In sum, the reasons given for pursuing non-traditional career activities varied widely.

How does bureaucracy facilitate handoffs and, hence, career flexibility?

In HCO I observed a more organizationally sophisticated workplace that, from the perspective of PCPs, carried with it more bureaucratic constraint in the form of rules and procedures and authority structures. Key features were the required use of an electronic medical record, the standardization of clinical work processes, and the development of stronger organization-level (as opposed to individual-level) relationships with patients. What is the link between these generally more bureaucratic organizational practices and the career flexibility enjoyed by PCPs? The key to understanding this connection lies with

the importance of the patient handoff. All these "bureaucratic" organizational practices enhance the ability of PCPs to hand off their patients amongst one another. Such handoffs serve organizational ends, to the extent that they increase the flexibility of the organization to allocate physician labor and other resources. In addition, however, and largely by coincidence, those handoffs also open up a range of career options and a wider scope for dynamic career flexibility over time.

To see how this process of bureaucratization functions to enhance the personal career flexibility of PCPs, it is helpful first to see why the patient handoff event is a limiting step in the achievement of flexibility. Without effective handoffs, one PCP has to be available to respond to the demands of patients whenever they arise, including during times when that PCP would otherwise be pursuing other career activities. Hence, in the absence of effective handoffs, attempts at other career activities beyond full-time patient care (or attempts to achieve part-time practice in order to accommodate family needs) tend to be dissatisfying. The following account summarizes a theoretical model of career flexibility and handoffs presented in Briscoe (2007), based on fieldwork at HCO and the other large medical practice organizations described in the methods section above.

A PCP (call her Dr. X) will hand off some of her patient responsibilities to another PCP (call him Dr. Y) during a year-long stint when she is acting as chief of Primary Care. During that year-long period many of Dr. X's patients will present complex problems that require Dr. Y to make decisions about diagnosis and treatment. For those diseases for which the organization has adopted clinical protocols – standardized diagnosis and treatment plans – Dr. Y's decision may be expected to be more similar to those that Dr. X would have made herself. Standardizing guidelines for patient care therefore reduces the scope for disagreement and misunderstandings between Drs. X and Y.

A second set of handoff issues arises when the patient's trust is based on an individualistic relationship with one physician – Dr. X – making that patient reluctant to trust Dr. Y when seen for medical problems during the handoff period. Organizational processes that shift the relationship and locus of trust to the organizational level can therefore also enable handoffs. At HCO, this took place through organizational efforts to communicate a positive and consistent organizational identity that transcends individual physicians.

A third set of handoff issues arises from the sequential dependence of patient care interactions. Many patient interactions depend greatly on knowledge of the patient and his/her medical problems garnered from past interactions. When Dr. X hands off to Dr. Y, that knowledge needs to be codified in some way. The electronic medical record system at HCO provides a vehicle for such knowledge transfer. The system provides a common syntax for communication, and requires a certain degree of record completeness from those who use it. In addition, because Dr. X knows that her records are likely to be used by Dr. Y or someone else at some point, she may elaborate more than if her notes were simply for herself. Again, this can improve handoffs by heading off disputes stemming from associated patient care decisions.

In sum, in those organizational contexts in which I observed these bureaucratic processes to a greater degree, handoff capabilities were accordingly enhanced. From the perspective of PCPs, this, predictably, influenced their autonomy (negatively); more interestingly, however, it also influenced their career flexibility (positively).

Extending the model of bureaucracy, handoffs, and career flexibility to other industries

The handoffs-based model of career flexibility takes as its starting point the reality that client service work impedes career flexibility, since client demands are likely to hamper any attempts at reserving time for career activities *other* than full-time regular client service. When handoffs are enabled through organizational processes such as those outlined above for PCPs, options for combining client service and other career activities are revealed.

If it can be generalized, this career model has the potential to offer valuable insights into understanding the ways that workers respond to the increasingly prevalent bureaucratic organizational forms spreading across other professional service settings. There are several considerations to take into account in transferring the model across settings, though. First, there are boundary conditions associated with the nature of the work that underlie the model. These are (1) the tendency of clients to make unpredictably timed demands on workers, and (2) the one-to-one specificity between clients and workers that limits the scope for handoffs whenever clients' needs arise. In occupations in which the

nature of the work hews closely to these boundary conditions, we should expect a positive role for bureaucracy in enhancing client handoffs and enabling flexibility for professionals. Likely examples include many medical specialties, corporate lawyers, laboratory scientists, financial advisors, investment bankers, university professors, accountants, architects, management consultants, and advertising and design professionals. The exact nature of the work varies across and within these occupations, yet, to the extent that the above conditions are met, temporal flexibility problems should exist and the model of career flexibility based on client handoffs should apply.

The model may also generalize further beyond client-based occupations. Conceptually at least, the logic of specificity limiting handoffs could be extended to two other categories of professional work: project-based work and internal service work. In project settings, which are common in technology organizations, a worker seeking flexibility has to orient toward the project team much like the physician does toward his or her patient. The worker has to be responsive to demands that arise from others on the team at unpredictable times, and he or she cannot hand off those demands to someone else because of his/her unique role in the team. Internal service workers, such as computer network administrators, endure similar constraints, in the sense that they must be responsive to unpredictably timed demands and cannot easily hand off those demands to another person. Here, too, greater bureaucratization may provide increased flexibility.[6]

Alternative models of career flexibility in professional service organizations

A few alternative routes to career flexibility have been suggested in professional services, though each appears to be limited in feasibility and few have been explored systematically. One example is the possibility of limiting or changing the composition of the clients to whom the organization (or individual professional) provides services. In

[6] Another factor influencing the model's relevance to other professions relates to the degree of labor market power that workers possess. Power matters in order to ensure that organizational handoff capabilities are made available for workers' own purposes, rather than being usurped by organizational leaders in the service of other goals.

practice, this strategy would appear to be limited to certain narrow types of client work, in which career flexibility is less of a problem to begin with.

Another alternative is to alter the service expectations of existing clients, particularly around the importance of worker availability for high-quality services. Cynthia Fuchs Epstein, Carroll Seron, Bonnie Oglensky, and Robert Saute (1999, p. 135) suggest that this may be feasible in certain areas of legal practice. Again, however, the extent to which this approach would be tolerated by clients is unclear. It may sometimes also be possible to alter the *timing* of clients' demands, though many professional services are valued precisely because they guarantee the timely address of unforeseen problems as they arise for clients.

Of course, many professional organizations themselves perpetuate an unnecessarily hostile stance toward the notion of career options beyond client service (Perlow and Bailyn, 1997). In many organizations, cultural barriers present themselves to those seeking alternative career activities and career flexibility, and addressing those cultural factors may itself go some way toward opening up career options. Yet again, it is unclear how far a culture shift can address the real underlying dangers presented when a professional blocks off windows of time away from clients and says, "At this point in my career, I am only going to be available for clients during certain times . . ." When clients are buying timely expert services, it would seem that limits on professional worker availability have to be matched with (organizational) systems that can ensure that the clients are guaranteed access to high-quality services during those off times.

Costs and benefits of the career flexibility model

As with any model, there are likely to be costs and benefits associated with a career flexibility model based on client handoffs. Some of these costs and benefits can be identified for the employees, organizations, and clients involved, and also for society at large.

Employees

In terms of advantages for employees, the model offers a way for professional workers to combine a career of client service with the flexibility to pursue many other work and non-work activities. This

possibility appears to match the changing career interests in the workforce that I outlined above. If organizational leaders view the ability to offer this flexibility as a human resource capability that they can use to attract and retain valued professionals, this may further solidify access to career flexibility among professionals in organizations.

The central cost of the model is probably the declining level of individual autonomy that appears to be inextricably linked to greater schedule and career flexibility. This tradeoff complicates the historical portrait of uniform alienation arising from increasing bureaucracy (see Adler and Borys, 1996). An additional potential cost to employees is the loss of labor market power associated with weakening the specific bond between an individual client and an individual worker. This is a benefit to companies, however, as it removes some of the threat that a professional worker may leave the organization and steal away clients. In the extreme, the combination of enhanced worker substitution and diminished worker power may open the door for organizational leaders to reallocate labor strictly in line with organizational needs – and in so doing restrict the career flexibility made possible by those handoff-enabling organizational processes in the first place.

In my research, some informants noted another implication: a sense of emotional loss because they no longer had such long-term connections to clients (in this case, patients and their families). This and other changes in the work itself raise important questions about which types of individuals may be more attracted to, and capable of, working in an organization in which handoffs are routine.

Organizations/employers

A key attraction of the career flexibility model for organizations would seem to be the strategic HR advantage in attracting and retaining young professionals of diverse backgrounds. In my field research, however, I came across only a nascent recognition of this potential in the medical field. Instead, the advantages identified with the types of organizational processes that enabled handoffs were more focused around direct impacts on the efficiency and effectiveness of professional service work.

There may be other positive and negative impacts for organizations. For example, increasing the number of handoffs within an organization leads to new learning triggered by the increased necessity for interaction between otherwise isolated professional workers. My fieldwork

uncovered instances in which PCPs had made discoveries about their colleagues' work practices only as a result of discussing handoff cases. Those discoveries could lead, in turn, to beneficial changes in individual work practices or organizational policies. This process resembles the kind of dynamic professional reflection that Donald Schon (1983) finds to be central in professional learning – but that he speculated would be attenuated under increasingly bureaucratic organizational conditions.

Clients

The impacts on clients are as yet unclear. A primary concern is that the enabling of handoffs will be associated with lower-quality services for clients. The organizations I studied that enabled handoffs showed no public evidence of lesser quality, however, and in fact HCO had received national quality awards. Further, within HCO an unpublished study concluded that part-time physicians compared favorably to full-time colleagues, spending longer with each patient on average, receiving higher patient satisfaction scores, and scoring similarly on measured health outcomes. Nonetheless, there clearly may be situations in which the quality of service delivery is affected by handoffs, and, given the difficulty that clients have in evaluating service quality in professional settings, many are likely to be concerned with the added uncertainty associated with organizations engaging in handoffs (Miller, Kochan, and Harrington, 2003).

Even if handoff systems are developed further in organizations that serve a wide range of clients, high-end clients seeking professional services may always demand timely personalized attention. Professional work conducted in that market segment may continue to be organized along traditional lines, and the careers of those engaged in that segment would therefore probably follow the more traditional professional career model with relatively little flexibility.

Society

There are two themes in the career flexibility model that hold implications for society in general. The first is the potential value in helping to retain talented current and future workers in the professional service occupations. Some evidence suggests that exit rates are increasing across a wide range of professions, and that women in particular are leaving professions even after considerable training investments

(Preston, 2004; Landon *et al.*, 2006; Kay, 1997). To the extent that the career flexibility model provides an avenue for more workers to remain in these occupations, at varying levels of involvement over the course of their careers, this may be seen as socially beneficial – all the more so given the unique and valuable activities conducted by professional service occupations.

The second societal theme is closely related: professional organizations can play a key role in accommodating "family time" for those in the growing professional workforce. The rise of the dual-earner (and dual-professional) family has placed heavy limits on family involvement in this segment of the workforce (Bailyn, Drago, and Kochan, 2000). Through the career flexibility model, professional organizations may support worker involvement in high-quality professional work while also keeping that work from overflowing into all other corners of the worker's life, facilitating a positive work–life balance (Moen, 2003). To the extent that professional service work is becoming the template for organizing and managing other types of workers as well, the presence of a viable career flexibility model in that sector may be viewed as even more vital.

Concluding remarks: implications for career theory

Career theory has begun to address the need for individual flexibility. Throughout much of the recent literature, however, there is a pervasive notion that bureaucratic organizations are inherently part of the problem. For example, the observation that careers have become less attached to particular organizations is often interpreted as an opportunity for individuals to chart their own courses, including their own balance between work and family, and between various career "projects" (Arthur and Rousseau, 1996).

My research tells a different story. For PCPs, bureaucratic organizational processes are themselves the key ingredients to career flexibility, and firmly embedding oneself into an organization that is capable of effective handoffs is the key to achieving flexibility. This turns on its head much of the thinking by career theorists about organizational attachments. For example, instead of part-time work implying less attachment to an employer, here achieving part-time careers requires greater attachment to an employer. Future research needs to explore this surprising link between career flexibility and

bureaucratic organizations, and document the implications for professional workers as well as their clients.

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