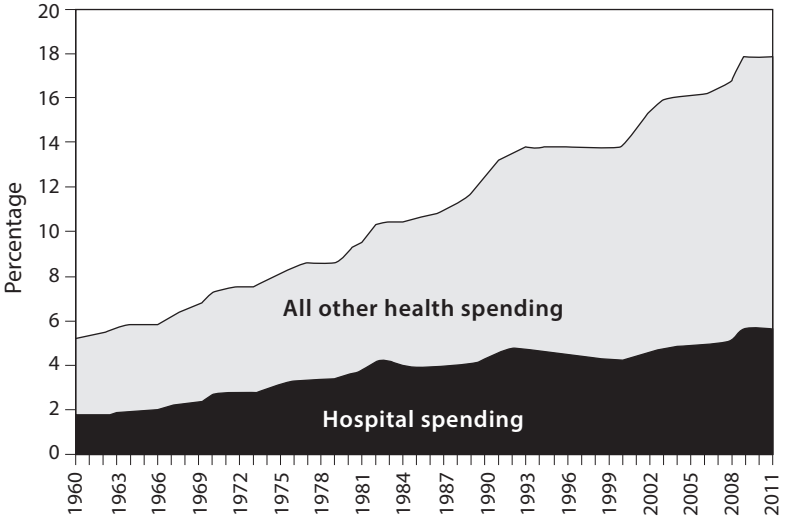
Introduction

The hospital has a paradoxical place in U.S. society.[1] It is central to the nation's economy, yet many of us are uncomfortable with what is implied by a market for hospital care. The hospital remains a last resort for the poor and desperately sick. It is a place where most of us were born and most of us will die. And it is a place to which we often turn in our moments of greatest physical uncertainty and emotional vulnerability. We have intimate connections to hospitals and strong feelings about them. Perhaps as a result of our ambivalence about the market for hospital care, the vast amount of money that changes hands as a result of this care rarely changes hands *within* the hospital itself.[2] As the hospital historian Rosemary Stevens observes, hospital organizations continue to "carry the burden of unresolved, perhaps unresolvable contradictions."[3] Such contradictions, between the mission of hospital care and the market for it, are the focus of this book.

The United States is unique among modern industrial nations in the extent to which it has relied on the market to determine the organization and allocation of hospital (and all health care) services. By "market" I mean, most basically, the principle of exchange for profit or gain. The market has played an important role in the organization of the American hospital since at least the first decades of the twentieth century. Still, over the past forty years, public health concerns, professional autonomy, and charitable impulses have given way even more dramatically to a focus on profit making and the bottom line.[4]

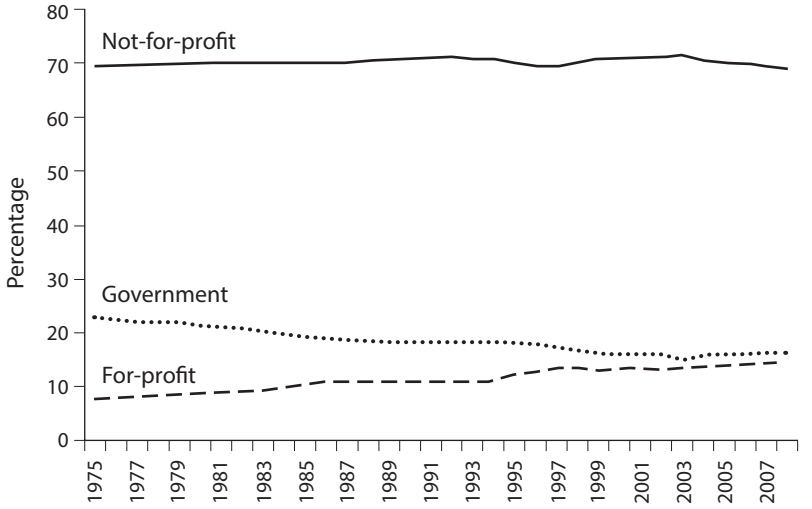
Since all hospitals today must compete for the dollars that accompany patient utilization, all are under pressure to engage in similar practices, such as reducing the amount of free care they provide, investing heavily in capital improvements,



I.1. ▸ Health expenditures as percentage of GDP, 1960–2011.
Centers for Medicare & Medicaid Services, 2012.

increasing their provision of profitable services, negotiating more aggressively with insurance providers and physicians' groups, and using staff more efficiently.[5] The local ties that made some voluntary hospitals "community" organizations have also frayed: most hospitals are now connected with large state or national hospital systems, derive very little money from local foundations or charitable giving compared with government or private insurance reimbursement, and spend much more money on capital investments than on supporting any kind of community program.[6]

Health spending has continued a seemingly inexorable increase as a proportion of gross domestic product, reaching nearly 18 percent in 2010. This rise can be seen both as a cause and a consequence of the ascendance of market actors and market logics across the health care industry.[7] And while hospitals are only one facet of the burgeoning health care sector, they remain a central player. Throughout the period from 1960 to 2011, hospital spending has made up a consistent proportion of health spending (approximately one-third). Hospital spending was responsible for 5.6 percent of gross domestic product in 2010 (see figure I.1). The medical advances that have occurred over this period—from dramatic reductions in infant mortality to the successful fight against cardiovascular disease—remind us that growth in health spending is not inherently problematic if these increases lead to improvements in health.[8] Nevertheless, cross-national comparisons suggest that while Americans spend much more on health care than other industrial nations, we do not get much for this additional spending.[9]



I.2. ▸ Percentage of short-term hospital beds by type of control, 1975–2008.
American Hospital Association, Hospital Statistics.

Market actors wield tremendous power within the hospital industry, but they are not the entire story. Despite market pressures, between 1975 and 2008 the percentage of hospital beds under the control of not-for-profit organizations remained virtually unchanged at around 70 percent (see figure I.2).[10] In a broader health care environment dominated by for-profit insurers, Big Pharma, medical-device manufacturers, for-profit physicians' groups, and other such entrepreneurs, the hospital might seem a last redoubt of the not-for-profit ethic. And despite similar market pressures confronting all hospital organizations, there continues to be a surprising amount of variation in contemporary hospital practice—both across different geographic areas and across different hospitals within the same communities.[11]

Moreover, the development of the hospital market has been mitigated historically by a variety of institutional rules and norms that buffer hospital care from the market's worst excesses.[12] The recently passed Patient Protection and Affordable Care Act, or "Obamacare," intervenes in the market along these lines, changing the broader rules of the game by—for example—increasing access to health insurance for the currently uninsured and incentivizing evidence-based medical practice and quality outcomes. (For more about this legislation, see "Conclusion" in this book.)

So while market forces and market actors have become increasingly important to contemporary hospital practice, the commodification of hospital care in

the United States remains uneven and incomplete.[13] At the same time that hospitals compete in a competitive marketplace, many hospitals—and the people within them—work to sustain social values that sit in uneasy tension with this market.

Welcome to Las Lomas

In order to understand these contradictions, we must look not only at the broad sets of rules and regulations through which the market for hospital care is structured but also at the meanings, practices, and people that make up the hospital itself. This book is a detailed study of three hospitals within the same medium-sized city of Las Lomas. Each hospital was founded in a different era of American medicine to serve a different kind of patient and solve a different sort of problem. Today, these historical legacies frame each hospital's ongoing struggle with a different contradiction in the commodification of hospital care, as each works—imperfectly—to reconcile the social values on which it was founded with the imperatives of the competitive marketplace. (For a detailed discussion of methods, see "A Note on Methods" in this book.)

Located within a few miles of one another, PubliCare, HolyCare, and GroupCare serve as the only major hospital facilities in the larger 500,000-person county. Each is a part of a different not-for-profit health system (PubliCare previously had been the county's public hospital but was privatized in 1996). Each considers the other two as its primary competitors for the county's pool of insured patients. The three hospitals offer many of the same services, and they face many of the same market pressures. Despite these similarities, however, they are in many ways worlds apart.

Katherine Taylor, a nurse manager at GroupCare, had strong opinions about all three. We spoke together while sitting on flimsy plastic chairs on a small patio just outside GroupCare's basement cafeteria. Taylor remembered getting into the nursing profession because of a desire to care for people in difficult times. She had a particular "affinity for children," she said, and assumed she would become a pediatric nurse. But this same emotional connection she felt with kids ultimately made pediatrics overwhelming: "Because I love them so much . . . [it] was really hard for me, to deal with my emotions around it." And so—like many other nurses I would come to meet in the city—Taylor had found ways to manage her emotional vulnerability at work. She realized that she either would have to "shut down" or would have to find another area of hospital practice. Taylor found the intensive care unit: "I have a very fast-working brain, so it was just the constant stimulation: information, machines, critical patients. It kept me on the edge of my seat for the whole twelve hours I was working. So that was really enticing for me."

She would escape her vulnerability in the pediatrics ward via the frenetic hum of critical care.

Taylor had been working in Las Lomas for the last fifteen years as a critical care nurse and nurse manager. During this time she had been employed at each of the three hospitals. PubliCare, she thought, was remarkable for the "mutual respect" among the doctors and the nursing staff there: "It was a rare moment at PubliCare that we would have a physician be rude, obnoxious, disrespectful—any of that." But this egalitarianism, she thought, sometimes digressed into a kind of sloppiness: "The nurses would sit at the nurses' station and laugh at the physicians, talk about things that I was, like, 'Oh! Ugh! What?!' " People dressed "a little flowerier and funkier" than she was used to. And while the care was "pretty good," she did not think it was "exceptional." No one seemed particularly concerned with national hospital standards: "Compliance . . . wasn't really part of what they talked about at PubliCare." Taylor worked her way into a more managerial role at PubliCare and helped oversee an inspection during which the hospital almost lost its accreditation. But she liked the place and loved the people: "The people are delightful. Physicians were delightful. . . . It had this great personality, but it really needed to rise up to the level of, you know, clean, competent." The manager before she arrived was "a real hippie."

At HolyCare, in contrast, "everything was impeccable—I mean, uniforms were impeccable, your presentation was impeccable, your conversation was impeccable." She appreciated the professionalism of the place and took pride in the fact that "we were giving exceptional care." But the care came at a cost among the staff: "There was a lot of negativity, a lot of disciplinary stuff, people going through your charts, and, like, if your 'i' wasn't dotted, you'd get a conversation." The staff at HolyCare often wound up feeling like "Big Brother is watching," she told me. Strict standards of professionalism came with a lot of "hostility," both among the nursing staff and in their relationships with the physicians: "the standard egotistical, degrading, demoralizing" stuff, she laughed.

Most recently she had come to GroupCare, though she had been somewhat reluctant to make the move given her "preconceived notions" about the place. At this point in my interview with Taylor her voice dropped to a conspiratorial whisper. Before arriving at GroupCare she had heard that it was "kind of the meat market of health care," a reputation she said was partially deserved. Granted, GroupCare did much more in terms of preventative care than either of the other hospitals: "You know, you have a child with asthma, they've got a program, they've got all kinds of resource for you. So that's fantastic." But the inpatient hospital experience was different. GroupCare had "substandard people working for them," Taylor thought. Physicians would refuse to call nurses back. Staff would fight in the middle of the floor. And while Taylor approved of the organization's

massive investment in electronic medical records and other integrative technology, she sometimes worried about what happened to patients as a result: practitioners "were so focused on the computer that patients' lights were going off, their alarms were going off," and no one was noticing. The computerized system was "fantastic for pulling out data," she thought, and allowed the organization to streamline its operations, but it did not always serve the individual patient. Things had "come a long way" since her arrival, she assured me, and the care was getting better. But the process of change at GroupCare had felt "like war."

Morals and Markets in Medical Care

Taylor described dramatically different hospital organizations. That differences exist is not particularly surprising. It is something of a commonplace that there continues to be enormous variation in contemporary U.S. hospital practices—both across different geographic areas and across different hospitals within the same communities.[14] But while this variation has been well documented, it remains poorly understood. From where do these differences spring? What are the underlying repertoires of practice and meaning that help to sustain them? In Las Lomas, I will show, these different cultures of practice emerge out of each hospital's attempts to grapple with a different contradiction inherent in the commodification of hospital care.

A contradiction implies a problem, which begs the question: Why might it be problematic for us to buy and sell hospital care? While no one, so far as I know, has spelled out these different problems as they pertain to the hospital, sociologists, philosophers, and other thoughtful people *have* suggested three separate reasons why the commodification of certain goods and services might cause problems.[15]

THE PROBLEM OF SOCIAL RIGHTS

First, scholars have made the normative argument that turning some things into commodities depends on the denial of social protections or social rights. As a result, commodification is unjust, or coercive.[16] In different forms, this idea is prevalent throughout economic and moral philosophy.[17] In *Why Some Things Should Not Be for Sale: The Moral Limits of Markets*, for example, the economic philosopher Debra Satz argues that there are "universal features of an adequate and minimally decent human life,"[18] and that the commodification of certain things—from child labor to the vote—makes this life impossible. For her, any conception of social rights must necessarily place boundaries on what can be for sale. The philosopher Michael Sandel makes a similar point in a book with a similar title (and identical subtitle), *What Money Can't Buy: The Moral Limits of Markets*. Paying for access to congressional hearings (through a company that hires people to wait

in line), for example, creates an unjust inequality in political influence;[19] paying poor women to sterilize themselves may have long-term economic benefits but it denies these women the right to their own bodies.

The political philosopher Michael Walzer relates this same idea more specifically to medical care: "Doctors and hospitals have become such massively important features of contemporary life that to be cut off from the help they provide is not only dangerous but degrading."[20] He continues, "Needed goods are not commodities."[21] In order for hospital care to be turned into a commodity, according to this argument, it must be denied to those people unwilling or unable to pay for it. Yet this denial constitutes an erosion of basic social protections and the denial of basic social rights.

THE PROBLEM OF DEBASEMENT

A second, separate argument against the commodification of certain things is that it may undermine or debase the very value of these things.[22] Whereas the problem of social rights implies that some things *should* not be bought and sold, the problem of debasement implies that some things *cannot* be bought and sold and still retain their integrity. Were we to try to buy friendship, the argument goes, this purchase would erode the very meaning of "friendship."

Perhaps most famously, this line of argument has been pursued in relationship to altruism and the blood supply.[23] Richard Titmuss found that a system of blood allocation based on *donations* was associated with blood of a higher quality than a system in which donations were coupled with financial incentives. The commodification of blood, he argued, eroded the social values and social institutions through which it was otherwise given and received. To the extent that blood was treated as a commodity it became degraded. Even Kieran Healy's compelling critique of Titmuss's findings maintains that market incentives can "crowd out" other sources of motivation.[24] This idea makes sense intuitively and finds support across a broad range of other studies.[25] When we do something we understand as being an expression of generosity or citizenship or honor or love, an offer of cash compensation for it can undermine the value we thought we were expressing. Even if we did not object to buying access to congressional hearings on the basis of inequality, Sandel points out, we might object to it on the grounds that it erodes some value essential to democratic governance.

Just as hospital care might be understood as a social right, it might also be understood as this kind of social and moral good. Hospital care is often a deeply emotional experience for patients and their loved ones, and it depends—at least to an extent—on professionals' and other workers' vocational commitments. Private hospitals are still often classified as "voluntary hospitals," a phrase derived from their origins in philanthropy or religious charity. Well before the hospital

was able to provide much in the way of medical cures, those within it were able to offer spiritual guidance and emotional support. And even today, many of us look for emotional connection and support from those with whom we interact in the hospital. The surgeon may need to regard us as a piece of meat when we are under the scalpel, but we want to be seen as a *person* before and after an operation. To the extent that hospital care is commodified, the hospital might be unable to foster noneconomic values central to care itself.

THE PROBLEM OF UNCERTAINTY

Third, distinct from the denial of social rights or the problem of debasement is the danger of malcoordination and anarchy caused by uncertainty in the value of some things.[26] If the other two problems concern the potential *effects* of a market for certain things (on people's rights or on the integrity of the things themselves), this problem concerns the difficulty of *establishing* a market in the first place. If the other two problems concern the relationship between the market and other social values, this third problem concerns the market on its own terms.

It is well established that doctors often do not know the medical value of the services that they provide.[27] Indeed, for most of medical history, doctors have been remarkably *incompetent* in a technical sense.[28] Despite huge investments in recent years in medical research, information technology, and evidence-based medicine, there is still (and will always be) much uncertainty in the diagnosis and treatment of particular conditions.[29] More profoundly, the value of health—and by association, hospital care—is remarkably difficult for people to assess in a rational and calculating way, meaning that weighing costs and benefits in relationship to it is fraught. This is not to say that people do not put a price on these things implicitly or explicitly.[30] But it is challenging for people to weigh preferences in relationship to them.

Finally, even when practitioners know the value of a particular intervention, patients often do not. Commodity exchange presumes a market of buyers and sellers with equal amounts of information. But patients are almost by definition dependent on the authority of doctors to tell them what they need[31]—what economists call *supplier-driven demand*. Patients' uncertainty makes them unable to discern between different choices. Combined, these sources of uncertainty mean that a market for hospital care can never approach the conditions that economists assume to exist when they discuss "markets" in the abstract.

The Contradictory Commodification of Hospital Care

For philosophers like Debra Satz and Michael Sandel, the dangers posed by commodification mean—quite simply—that some things should not or cannot be

bought and sold. This is pretty much where their arguments end. Economic sociologists such as Viviana Zelizer and Kieran Healy have gone further by working to understand why and where people draw the distinctions between moral and immoral economic activity, and how people use "different payment systems and exchange tokens to express and define different social relations."[32]

Within this "moralized markets" school, the normative claims of previous theorists—whether critics or defenders of markets—are themselves subject to analysis. The important insight is that moral-market understandings and practices, or "relational packages,"[33] serve to maintain social ties and distinguish different sorts of relationships from one another. Where Sandel emphasizes how industries such as life insurance threaten to degrade the value of human life,[34] for example, Zelizer documents instead how life insurance came, over time, to be understood as a way of *sanctifying* death.[35] Where Satz discusses the ways in which sex work undermines women's right to equal standing,[36] Zelizer shows how the distinction between gifts and payments helps us sustain the distinction between girlfriends and prostitutes.[37] Where Titmuss argues that market incentives debase the altruism necessary for a healthy blood supply, Healy demonstrates how different economic motivations have different effects within different environments and how all organizations are constrained by the types of economic motivation on which they rely.[38]

This moralized markets school has done much to illuminate the creative capacity and agency that people have in their economic activities. People work hard to live connected lives, to reconcile their economic activities with their values. And yet, at the same time, this perspective has been less attentive to the broader institutions—sets of rules, practices, and understandings[39]—that, on the one hand, constrain individuals' moral-market understandings and practices and, on the other, constitute the material and symbolic environments within which moral-market understandings and practices exist.

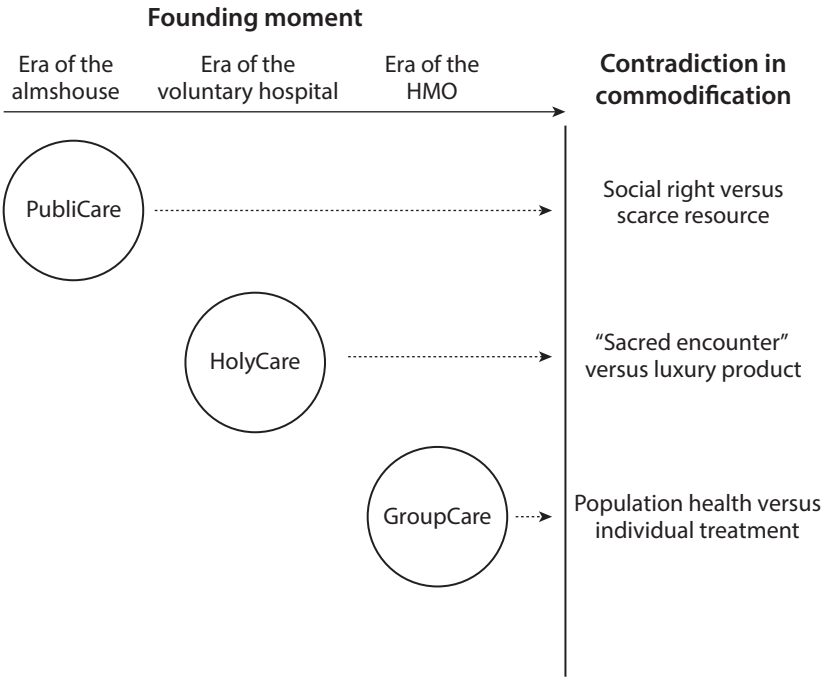
First, while actors may have a degree of agency and creativity in their moral understandings of market activity, they exist within already-moralized worlds. The moral frameworks they elaborate and maintain do not arise out of thin air but rather were shaped historically, institutionalized in the organizations in which they participate and the social positions they inhabit. History, in this sense, should not be understood as a static starting point from which all future events can be read off in path-dependent fashion. Rather, history is embedded in the structures of formal organizations, shaping (but not determining) the way that the organizations and actors make sense of and act in the present.[40] Different moral positions can thus usefully be traced to different institutional trajectories and histories, though they live on in the understandings and practices of the actors who inhabit the organizations today.

Second, actors' efforts to understand and structure their economic activities so as to preserve important social distinctions take place within an evolving

institutional environment in which market logics are increasingly powerful. At the level of individual actors, Zelizer is certainly right that an ideal-typical market—anonymous, self-interested, utility-maximizing buyers and sellers making one-time transactions based on full information—is a fiction. Yet, at a more macro institutional level, this market ideal remains a *powerful* fiction with real social consequences. Margaret Somers and Fred Block, for example, demonstrate just how powerful this idea continues to be in their study of welfare reform in the 1990s.[41] Indeed, the notion of markets as "self-regulating natural entities" that "must be set free" continues to guide much of social policy in the United States.[42] We live in a time when this understanding of markets seems particularly powerful, a time, as Marion Fourcade and Kieran Healy put it, of "undeniable growth in the commercialization of certain goods and services, notably in the areas of domestic labor, care work services, and human goods."[43]

Zelizer admits that she has focused more intensively on "interpersonal interaction" than on the relationship between micro- and macroprocesses.[44] The question, then, is how individuals' moral-market understandings and practices relate to the broader organizational and institutional contexts within which they exist. As Fourcade reminds us, "if people produce meanings through the use of goods and money, they (to paraphrase Karl Marx) do so out of circumstances not of their own choosing."[45] It follows that while people may be *trying* to lead connected lives, they may not always be able to achieve them. And so we should not only be looking for "good matches" between economic activity and social values, as Zelizer does, but also for *bad matches*.[46] We should be looking for situations in which people try and fail to connect their values with their economic activities, for situations in which people use thin moral scripts to justify their economic activities, and for situations in which market actors seem to generate a self-referential conception of morality—a morality of efficiency.[47] We should be looking not only for connected lives but for *contradictory* lives, as individuals and organizations work imperfectly to reconcile their values with broader forces out of their control.[48]

As I argue in what follows, hospitals founded in different periods in the history of U.S. medicine arose from different institutional foundations, embedding an emerging market for health care in different sets of social relations and different understandings of care. Different hospitals implicitly addressed different problems with the market for care, like those outlined above. (1) Early hospitals in the United States were indistinguishable from almshouses, and guaranteed the poor a basic (if limited) right to care. As the primary source of state relief in many communities, they simultaneously were intended to dissuade a burgeoning working class from reliance on poor relief. (2) By the beginning of the twentieth century, the private hospital had emerged as an organization catering to a new clientele of paying patients. In order to distinguish itself from the public hospital,



I.3. ▸ Hospital founding moments and contemporary contradictions.

and in order to convince a wealthier clientele to leave their homes for medical care, this new kind of hospital emphasized the dignity of the patient and the individualized treatment he or she would receive within it. Thus, at the same time the private voluntary hospital made possible a market for hospital services, it did so by emphasizing how much it was like an upscale home—and downplaying its own commercialism. (3) Finally, in the last decades of the twentieth century, medical costs began to spiral, and new constituencies—from middle-class patients to the employers who insured them—began to call into question the autonomy and authority of the medical profession. In this environment, a new form of health organization gained prominence that promised to rationalize the provision of medical care, reducing medical uncertainty and reining in medical spending through risk management across established populations.

Today, actors in hospitals confront different contradictions between these previously institutionalized values and intensifying market pressures (see figure I.3). (1) At PubliCare, a hospital founded to provide care as a right for the poor, actors confront the contradiction between health care as a right and health care as a scarce commodity. (2) At HolyCare, a hospital founded to highlight the emotional and vocational dimensions of care, actors today wrestle with the relationship between these vocational commitments and the *marketing* of "caring"—

I.4. ▸ Contradictions in contemporary hospital practice.

	PubliCare	HolyCare	GroupCare
Founding orientation	Social right . . .	Sacred encounter . . .	Population health . . .
Market contradiction	Versus scarce resource	Versus luxury product	Versus individualized treatment
Morals and markets within organization	Insurgency (bottom-up)	Frame (top-down)	Incorporation

a patina of spirituality and authenticity encouraged by administrators and presented to the public, which threatens to reduce these vocational dimensions of care to little more than rhetoric. (3) At GroupCare, a health care organization founded to rationalize care across a population of patients, actors wrestle with the tension between the flourishing of each individual patient and the well-being of the population as a whole.

These contradictions have implications both for the way that each hospital relates to its patients and for the social relations within the hospital—among actors who relate to moral-market orientations from different standpoints and with different motivations.[49] In other words, the contradictions can be seen in each hospital's efforts to make its mission consistent with its participation in the market for care, and also within each hospital as different constituencies relate differently to the moral project elaborated by the organization as a whole (see figure I.4).

PROTECTING RIGHTS: REBUFFING THE MARKET AT PUBLICARE

At PubliCare Hospital, many practitioners were committed to the idea of providing care as a social right to the poor, a legacy of the hospital's history as a public institution. These practitioners worked against the interests of the upper administration of the hospital, who had been trying since the facility's privatization to make the organization financially viable. The providers of care thus waged a kind of insurgency against the financial interests of the hospital administration. Among these practitioners, the market was viewed as a threat to the hospital's mission and was kept—as much as possible—at the periphery of medical practice. Physicians at PubliCare were not incentivized to practice in any particular way, and conversations among practitioners used the language of duties and reciprocal obligations.

Yet care at PubliCare was also distinctive for its disorganization and inefficiency. Doctors, nurses, and ancillary staff worked side by side with relatively little role differentiation among them when compared with the other hospitals.

Many practitioners discussed being resourceful in the face of a lack of resources, but practitioners' resourcefulness as individuals was accompanied by a significant amount of organizational inefficiency.

PubliCare rested on a backward-looking traditionalism and was plagued by perverse incentives and unintended consequences. By providing care as a right, PubliCare to some extent prevented the commodification of hospital services. Yet as its practitioners provided care as a right, they subjected the poor to other sorts of moral evaluations and indignities. And the hospital operated with such high levels of inefficiency—due both to patients' boundless needs and to the organization's inability to reconcile the right to care with the market for care—that it was always on the brink of collapse. While practitioners had been able to sustain a degree of care for the poor and uninsured at PubliCare Hospital, the long-term viability of their strategy was questionable at best. The hospital had been losing money ever since it was privatized in 1996, and it seemed likely to close in the near future. Nevertheless, the hospital's historical commitment to the provision of care as a right gave practitioners some degree of leverage over hospital administration through the channels of local government and public opinion.

OVERCOMING DEBASEMENT: MORALIZING THE MARKET AT HOLYCARE

At HolyCare Hospital, administrators, hospital leaders, and a few select categories of nursing staff expressed most clearly the hospital's mission of preserving the moral and spiritual dimensions of care, but they worked to do this *through* the market rather than in opposition to it. HolyCare was the most explicitly mission driven of the three hospitals in Las Lomas, given its close connection to the Catholic Church and its conscious investment in its Department of Mission Integration and Spiritual Care. Yet this spiritual mission served as a framework that made possible some of the most clearly entrepreneurial behavior among the three hospitals—both by the organization itself (in relationship to the medical environment) and by its medical staff (in relationship to their patients and the hospital). Since its inception, the hospital's focus on the emotional and spiritual dimensions of care was designed for a wealthy clientele—a constituency seeking a personal touch along with medical care.

At HolyCare, the hospital's attention to the spiritual dimensions of the patient experience allowed care to be sold as a sort of luxury good. Like many private facilities of both religious and secular origins, the organization emphasized the social and emotional significance of care at the same time it sold this care to a wealthy clientele. The extensive chaplaincy program, like the oak chairs in the facility's cafeteria, helped to give patients the feeling of personal attention and comfort that made the organization resemble a fancy hotel.

Paradoxically, this patina of spirituality allowed the doctors at HolyCare to behave as entrepreneurs: their professional roles merged almost seamlessly with their roles as economic actors. Unlike the doctors at either PubliCare or GroupCare, most of the doctors at HolyCare did their own billing, meaning they were paid based entirely on the number of paying patients they saw. According to doctors at the other hospitals, the doctors at HolyCare tended to maximize the treatment they gave in order to make money. Within the hospital, doctors at HolyCare were conscious of competing for those patients who paid the most. Outside the hospital, doctors based at HolyCare also seemed more likely to convert their professional expertise into financial gain. For the doctors themselves, however, this market orientation to medicine felt consistent with (and in some respects made possible) their commitment to the delivery of high-quality care.

Whereas staff roles were relatively undifferentiated at PubliCare Hospital, at HolyCare there was a clear demarcation between the medical staff and the nursing and ancillary staffs. Administrators highlighted the sisters' historical ideal of sacrifice in order to secure an obedient and subservient workforce. Ancillary staff members were encouraged to be "good stewards," subordinating their own interests for the interests of the hospital, and wages at HolyCare tended to be lower than at either of the other two hospitals. When workers made claims for organizational power, they were most successful when they made these claims on a moral, rather than economic, terrain.

Despite accusations among other doctors in the county that those at HolyCare overtreated their patients in order to increase revenue, many practitioners at all three hospitals said that they would rather be treated at HolyCare than anywhere else. Not only was it the nicest-looking hospital of the three (several interviewees compared it to a hotel), but it also had the reputation (unsubstantiated by any third-party monitoring agency) for being the facility where patients received the highest-quality care. HolyCare historically had been quite financially successful because it framed the market in moral terms.

REDUCING UNCERTAINTY: TAMING THE MARKET AT GROUPCARE

GroupCare, an integrated health management organization, sought to overcome the uncertainty inherent in medicine through an extensive bureaucracy and technical infrastructure. Whereas the mission at PubliCare was insurgent, espoused by practitioners against the market; and the mission at HolyCare was ideological, espoused by administrators to moralize the market; the mission at GroupCare was *integrated* across the facility's administration, its physician staff, and its nursing and ancillary workers. Through bureaucratization, standardization, and the

creative use of technology, several different constituencies worked together to tame the market.

In the name of scientific medicine, GroupCare generated protocols based on the latest medical evidence, and it conducted small experiments with changes in procedure that—if successful—were diffused across the entire organization. Given its focus on an efficient use of medical resources, more resources were invested in ensuring that patients managed chronic health conditions and avoided the hospital than were invested in acute care. Within the hospital, there was an emphasis on avoiding costly medical mistakes and on eliminating redundant tests and interventions.

Because GroupCare depended for its survival on patient-members, however, it had to balance its own conception of efficiency with the desires of patients themselves. Patients, in turn, were expected to play an active role in their health. Membership satisfaction scores and surveys were used to incentivize doctors and change procedures, and members were encouraged to take part in hospital-sponsored educational seminars and fitness classes.

Doctors at GroupCare seemed to understand themselves to some extent as line workers, sacrificing professional identity and entrepreneurship for the security and stability of a nine-to-five job. With that said, the organization worked to discipline doctors in such a way that their professional identities could be reconciled with bureaucratic subordination. Relations between doctors and staff were rule-bound: doctors and staff shared some degree of power, as they did at PubliCare. Yet where this egalitarianism was informal and relational at PubliCare, at GroupCare it was formal and bureaucratic. Workers were fully incorporated into the organization's decision-making structure through a strong union and innovative labor-management partnership.

GroupCare, as a planned economy, certainly offered the most promising long-term possibility for containing the commodification of hospital care. Yet it did so in part by excluding the uninsured, who received less care at GroupCare than at either of the other two hospitals, and in part by reducing health to a set of discrete, quantifiable variables and reducing health care to a series of technical interventions. The system's bureaucracy also left room for the emergence of a class of bureaucrats who used it for purposes other than the perfection of scientific medicine. And since there are (and will always be) limits to the reach of evidence with regard to medical practice, the system was only able to prescribe behavior within relatively narrow parameters.

Most problematic, however, was that the organization did not explicitly grapple with the extent to which it inevitably *rationed* care in the process of rationalizing care—thus concealing difficult organizational decisions about the economic value of life and the relationship between the individual and the broader

constituency of GroupCare members. In both the organization's practices and in the ways that practitioners discussed their work, the health of each individual member was conflated with the health of the membership as a whole.

An Outline of What Follows

The core of this book consists of detailed case studies of PubliCare, HolyCare, and GroupCare. Most broadly, as I have argued, each case should be understood as a historically rooted response to an ongoing contradiction in the commodification of hospital care. In order to highlight this history, I begin each case with a brief historical account of the hospital's founding moment. I do not claim that these histories are responsible for shaping the attitudes and practices of the people within them. It seems equally likely that practitioners with different ideas about the market for hospital care decide to work at different hospitals. In other words, I use the cases not to explain *why* hospital care varies so much as to explore the dimensions of its variation—to understand the different constellations of ideas and practices by which actors in each hospital work, imperfectly, to reconcile their social values with their economic activities.[50]

Furthermore, while all hospitals must navigate the problems with the commodification of hospital care, the three responses highlighted here are not evenly distributed across the contemporary landscape of U.S. hospital care. While the model offered by PubliCare is obsolescent, GroupCare seems to offer a plausible pathway for health care's future. HolyCare, with its emphasis on individualized treatment and its premium on professional autonomy, continues in most parts of the country to be the dominant model through which hospital care is delivered.

After situating each case historically, I examine three dimensions of care, corresponding to three separate chapters per case. First, I explore the contradictions embedded in each hospital's conception of care. At PubliCare, care is understood as a social right, and practitioners consistently treat the most marginalized patients in the city for a variety of medical and social problems. Yet practitioners consistently confront both the boundless needs of their patients and the limited resources they have to respond to these needs, thus placing them in a perpetual state of crisis and disorganization. At HolyCare, care is understood as a "sacred encounter." But while this hospital does attend more explicitly to the emotional experience of hospitalization, many who work there have come to see this attention as a disingenuous marketing ploy—particularly as the Sisters of St. Francis who traditionally owned the hospital have handed over authority to lay leaders. At GroupCare, care is understood as maximizing the health of its prepaid membership in the aggregate. Yet many practitioners within the organization conflate

the good of the membership as a whole with the good of each individual member, leaving unaddressed the inevitable tension between the two.

Second, I explore how each organization structures the work of its physician staff. In days past, the hospital was considered the doctor's workshop, offering him (and it was almost always a "him") the tools and personnel to do his work, but guaranteeing him professional independence as well. And while the hospital is no longer so subservient to the medical profession, the work that doctors do within the hospital remains central to its functioning. But what is this work, exactly? What do doctors do, how do doctors understand what they do, and how do these tasks vary across different organizational contexts? I argue that we can productively understand professional work as akin to what Viviana Zelizer calls a "relational package."[51] In their everyday work, doctors interact with their patients, with their medical colleagues, and with hospital staff and administrators. They also work according to a particular system of financial incentives and under certain rules governing the way they go about making and documenting medical decisions. Finally, they work with certain understandings of what it means to be a doctor—with a set of ideas about the nature of the medical profession, the nature of medical knowledge, their ethical obligations, and their status privileges.

Different hospital organizations foster different kinds of relational packages. At PubliCare, doctors try to uphold an ideal of the profession as an altruistic and cooperative community apart from the market. At HolyCare, in contrast, doctors' professional identities seem to serve as a cloak of legitimacy for their own entrepreneurship, just as the hospital's spiritual emphasis helps to mask its market participation. At GroupCare, doctors' work seems to have been disciplined in such a way so that their professional interests become consistent with subordination to the bureaucracy as a whole.

Third, I explore how the delivery of care is organized among the different constituencies that work within it. Hospitals are large, highly differentiated bureaucracies that depend upon a great degree of coordination and continuity across different departments and different occupational groups, and at different times of day. They are also places in which power is allocated unequally across different roles. The question here is how the different sort of market problem each hospital faces relates to the way in which work is organized and power distributed within it.

At PubliCare, the division of labor was less precise than it was at the other hospitals. Practitioners discussed with pride their resourcefulness despite a lack of resources. Yet practitioners' resourcefulness as individuals was accompanied by a significant amount of organizational inefficiency. Where staff roles were relatively undifferentiated at PubliCare, at HolyCare there was a clear demarcation between the medical staff and the nursing and ancillary staff; staff members were

encouraged to be "good stewards," putting the hospital before themselves. Finally, at GroupCare, relations between doctors and staff were bureaucratic and rule-bound: doctors and staff shared some degree of power, as they did at PubliCare. Yet, where this egalitarianism was informal and relational at PubliCare, at GroupCare it was formal and bureaucratic.

Within each hospital, people work imperfectly to manage the relationship between social values and the market for hospital care, but they do so very differently in different organizational contexts—working, respectively, to rebuff, moralize, or tame a market that each regards as potentially undermining its core social commitment. This book tells a story about the contradictions inherent in a market for hospital care; the methods different hospitals use to try to manage these contradictions; the different historical trajectories driving differences in contemporary hospital practice; and the perils and possibilities inherent in different models of care. It is a story of the different souls of modern American medicine.