Article

"Stress, Satisfaction and Militancy among Canadian Physicians"

Ronald J. Burke

Relations industrielles / Industrial Relations, vol. 50, n° 3, 1995, p. 617-635.

Stress, Satisfaction and Militancy among Canadian Physicians

RONALD J. BURKE

The present study utilized a stressor-strain framework to understand physician militancy in Canada. Data were collected from 2,584 physicians in 1986 using questionnaires. Four militant attitudes or activities were considered: approval of binding arbitration in the event of deadlocks in fee negotiations with governments, approval of withdrawal of services in the event of inadequate income settlements, approval of the reconstitution of medical associations as labour unions, and whether they had participated in an organized job action involving withdrawal of services.

The present exploratory study of militant attitudes and activities among Canadian physicians utilizes well-established stressor-strain models as an organizing framework. There is a considerable body of empirical research which examines experiences of occupational stress among physicians (Krakowski 1982a, 1982b). This research, consistent with occupational stress research in general, focuses on relationships between a variety of stressors and indicators of strain. The latter typically include individual satisfaction, psychological well-being and physical health measures. The present investigation extends this line of work by including measures of physician militancy as dependent variables. This is particularly relevant to the Canadian context because of the way in which health care is provided.

- BURKE, R.J., Faculty of Administrative Studies, York University.

- This research was supported in part by the Faculty of Administrative Studies, York University. I would like to thank the Institute for Social Research, York University for making the data available. My colleagues, Astrid Richardsen and Cobi Wolpin assisted in the preparation of the manuscript. Yitzhak Fried also provided helpful comments.

PHYSICIANS IN THE CANADIAN CONTEXT

The relationship between the medical profession, government and other political actors in Canada has been characterized by regular and increasing conflict since the introduction of universal government health insurance in the 1960s (Stevenson and Williams 1985; Taylor 1978; Touhy 1976). This conflict has focussed primarily on the control of medical affairs. Physicians have defended their professional autonomy in the face of what they viewed as unwarranted government intrusion in medical affairs (Coburn, Torrance, and Kaufert 1983; Heiber and Deber 1987).

It is important to understand the historical development of the federal-provincial health insurance system in Canada to fully appreciate the political issues and conflicts (Stevenson, Williams, and Vayda 1988). The following brief review captures the highlights of the struggle for control of the health care system. Government health insurance was proposed in the early 1930s following the Depression. In 1934, the Canadian Medical Association (CMA) requested that such programs be administered to guarantee the dominance and autonomy of the medical profession within the health care delivery system. This position was taken not simply for self-interest but also because the medical profession believed that their interests and the health of the general public were overlapping. Draft federal legislation for a national health insurance program presented in 1943 generally accommodated the medical profession's key demands. As a result the CMA endorsed the principle of government health insurance.

This legislation, however, foundered as a result of federal-provincial disagreements on financial arrangements following World War II. The CMA backed away from its earlier position in 1949, and proposed instead that governments pay into voluntary private plans for individuals unable to pay for their own health care. Government-sponsored health insurance moved forward during 1952-1962, opposed by the CMA. But physicians complied since they still dominated decision and policy making and had experienced windfall income gains in the early years of Medicare.

In 1962, the social democratic government in Saskatchewan extended its health insurance plan to cover all physician's services. This action resulted in a month-long strike during which physicians in that province withdrew all but emergency services. The end result was a compromise which acknowledged the right of government to introduce and operate a public health insurance program while permitting physicians to "extra-bill" patients at more than the government-insured rates. This compromise moved to the national level in the federal Medical Care Insurance Act of 1966 which established government health insurance programs in all ten Canadian provinces. The CMA objected to this national initiative, but, once

again, cooperated because of the continued autonomy and dominance of the profession and extended fee-for-service payment schedules.

During the late 1960s and early 1970s governments faced increasing pressure to control health care costs. Professional opposition to Medicare increased, culminating in a 1970 strike of Quebec specialists, and increasing use by physicians of extra-billing above government insured fee schedule. These events prompted concern that the principle of access seen to underlie Medicare was being threatened. A federal Royal Commission established in 1979 reaffirmed the principle of access, and led in 1984 to the introduction of the Canada Health Act. This action against extra-billing was seen by the medical profession as an attack on its autonomy. The CMA criticized the legislation; physicians and their professional associations described it as an intrusion on their freedom which rendered physicians to the status of civil servants.

The peak of the conflict came with the Ontario doctors strike of 1986. The Ontario government called for an end to extra-billing which would result in physicians accepting fees ensured under Medicare as full payment for services. The Ontario Medical Association (OMA) initially undertook a two-day strike supported by an estimated 60-75 percent of Ontario doctors. When this had almost no effect, an unlimited strike was called – lasting 25 days – in which only emergency services were provided. This strike was also unsuccessful in preventing the government from extending its control over health insurance. Although the strike position taken by the OMA received very little support from the public at large, it may have increased the solidarity of Canadian physicians. This shows up in continued tension and sniping in the media between the medical associations and government.

OCCUPATIONAL STRESS AND SATISFACTION AMONG PHYSICIANS

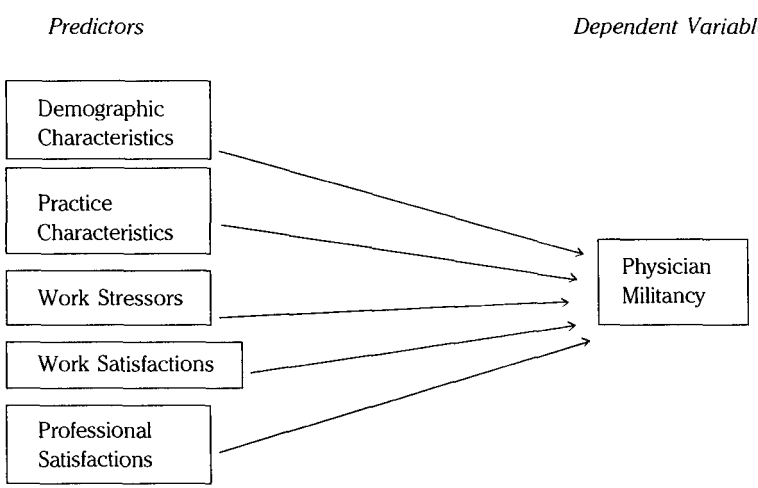
Literature reviews in the area (Butterfield 1988; Lee 1986; Scheiber 1987) reveal a growing amount of published work on sources of stress and strain inherent in medical practice. Work pressures consistently linked to job stress among physicians include heavy work loads, time "on call", fatigue, conflicts between work and personal lives, dealing with problem patients, dealing with life and death situations, and financial pressures, among others (Mawardi 1979; McCue 1982, 1985; Linn et al. 1985). Studies that have investigated job stress and job satisfaction have generally found inverse relationships between several job stressors and job satisfaction. In a study of general practitioners in England, Cooper, Rout and Farragher (1989) found that four job stressors (demands of the job and patients' expectations, interference with family life, constant interruptions at work and home, and practice administration) were predictive of high levels of job dissatisfaction and lack of mental well-being.

In addition to the work pressures inherent in medical practice, disruptive events on the job may be stressful. Physicians are increasingly exposed to actual or threatened malpractice suits, and this is becoming an important job stressor that seems to have some relationship to job satisfaction (Charles, Wilbert, and Franke 1985; Mawardi 1979). It is likely that other disruptive events, such as moving, being audited, or the death of a patient, also contribute to the experience of job stress among physicians.

The present study of militant attitudes and activities among Canadian physicians was consistent with the basic work stress framework. First, a variety of work stressors were examined. In addition, several individual difference characteristics were considered, including demographic and situational factors. The research model (see Figure 1) included five types of antecedent variables: individual demographic variables, practice characteristics, work stressors, work satisfactions and professional satisfactions. The sequence of these antecedent variables, from top to bottom, indicate a predictive ordering hypothesized to explain physician militancy. The particular order of these panels of variables was consistent with theory (Cooper and Marshall 1976, 1978; Edwards 1992) and empirical research (e.g., Jackson, Schwab, and Schuler 1986) in which individual difference characteristics are treated as control variables before considering the effects of stressors on outcome measures.

FIGURE 1

Research Framework



There is both theory and empirical support for the inclusion of these five panels of variables to aid our understanding of militant attitudes and behaviors (Wight-Bakke 1975; Hartley 1992; Summers, Betton and DeCotiis 1986; Kochan 1980). Kochan (1979, 1980) has summarized relationships between individual demographic characteristics and propensity to unionize. Shostak (1980) has identified a variety of work characteristics associated with both experienced stress and union activity. Both stressful work circumstances and dissatisfying job conditions have been found to motivate employees to seek change, to join unions, and to engage in behavior aimed at reducing frustration and anxiety and improve working conditions, standard of living and equality (Farber and Saks 1990; Kirmeyer and Shirom 1986; Gordon, Beauvais, and Ladd 1984; Hammer and Berman 1981; Muchinsky and Maassarani 1980; Odewahn and Petty 1980; Schriesheim 1978; Youngblood, et al 1984; Zalesny 1985).

This research complements the more common examination of industrial relations as a source of stress (Hartley 1992; Bluen and Barling 1988). In fact, the opposite perspective is taken here. That is, various aspects of the work environment that are potentially stressful and dissatisfying are hypothesized to affect militant attitudes and activities of physicians.

METHOD

This study is a secondary analysis of data from a 1986 National Survey of Canadian Physicians that was conducted by the Institute for Social Research at York University. It was designed to determine physicians' evaluation of Medicare, government involvement in the delivery of health care, and the 1984 Canada Health Act. Some measures had to be developed specifically for this investigation since none existed. In addition, the survey gathered information about physicians' satisfaction with practice and the levels of stress associated with practice. The survey included some demographic background of physicians and characteristics of their practice. The data collection phase of the project was completed between November 1986 and May 1987.

Respondents

Data were collected from 2,584 physicians using questionnaires. A random sample of physicians representative of Canadian physicians in each of the ten provinces was included. Twenty-one hundred physicians who participated in a 1982 survey of five provinces were included in the sample, and the remainder were randomly selected within each province from the 1986 Canadian Medical Directory. The sample included both general

practitioners and physicians with specialist certification, and about 10% of the sample were female physicians. Table 1 shows demographic characteristics of the sample

TABLE 1

Demographic Characteristics of the Physicians

	N	%		*N*	%
Sex			Province		
Male	2136	87.6	NFLD-PEI	36	1.5
Female	303	12.4	NS	196	8.0
			NB	39	1.6
Metropolitan Area			Quebec	691	28.3
Yes	1493	61.2	Ontario	819	33.6
No	946	38.8	Manitoba	125	5.1
			Saskatchewan	74	3.0
			Alberta	153	6.3
			BC	306	12.5
Hours Worked Typical Week			Years Practiced in this City		
40 or less	664	28.8	1-5	469	20.0
41-50	781	33.9	6-10	554	23.7
51-60	585	25.3	10-15	432	18.5
61-70	173	7.6	15-20	344	14.7
71 and over	103	4.4	20 or more	541	23.1
In Partnership			Ever Extra-Billed?		
Yes	1248	52.9	Yes	395	17.1
No	1112	47.1	No	1912	82.9
Involvement in Provincial Association			Withdrawal of Service		
Executive	238	10.2	Yes	527	22.7
Active Member	550	23.5	No	1796	77.3
Member	1318	56.4			
Non-Member	231	9.9	Specialist Certification		
			General Practice	1376	53.9
			Specialist	1178	46.1
Year of Graduation					
1950 or before	308	12.3	1985 Income		
1951-1960	579	23.7	$50,000 or less	225	10.0
1961-1970	694	28.5	$50,000-$100,000	1410	52.6
1971-1980	751	30.5	$100,000- $150,000	417	18.5
1981-or later	114	4.7	$150,000 or more	200	8.9

Procedure

An eight-page, self-administered questionnaire was sent to approximately 4,200 physicians across Canada. Each physician could receive up to three mail contacts requesting participation in the study. The first and third mailing consisted of a covering letter, questionnaire, and return envelope. The second mailing consisted of a reminder card. In addition, attempts were made to contact all non-respondents by telephone after the third mailing. The final response rate was close to 70%, which compares favourably with other surveys of physicians.

Measures

Demographic Characteristics

The following four demographic characteristics were included: sex (male coded 1; female coded 2), net income before taxes (respondents indicated this figure in $1,000s), year of graduation, and language (1 = French; 2 = English).

Practice Characteristics

Six practice characteristics were considered. These were: whether in partnership or business association with other physicians (1=yes; 2=no); percentage of professional earnings derived from fee-for-service (physicians wrote in this percentage); hours worked in last typical working week, exclusive of "on call" time (physicians wrote in the number of hours), location of practice (1=metropolitan area, 2 = non-metropolitan area) and whether the respondent was a specialist or generalist (1 = generalist, 2 = specialist).

Work Stress

Physicians indicated how important each of thirteen specific concerns were as sources of stress in their personal experience and practice. A five-point scale ranging from "not important" (1), to "very important" (5) was provided. The specific items were: time "on call", total hours worked, medicare paperwork, office management/administration problems, need to maintain level of knowledge, life and death situations, counselling patients about non-medical problems, profession-government relations, need to maintain an adequate income, uncertainty about diagnosis or treatment, delays in having patients admitted to hospital, coordinating service like referrals, homecare, hospital admissions, tests and treatments, and threat of malpractice litigation.

Work Satisfactions

Physicians indicated how satisfied or dissatisfied they were with twelve aspects of their work as physicians. Responses were made on a five-point scale ranging from "very dissatisfied" (1), through "neutral" (3) to "very satisfied" (5). Work aspects included: relations with their patients, relations with other physicians, relations with non-physician health personnel, their ability to treat illness, access to support staff and equipment, their financial security, their standing in the profession, the public's view of the medical profession, their own working conditions, their ability to "keep up" their professional knowledge, time available for family and personal life, and their ability to maintain their own personal health.

Professional Satisfactions

This area was assessed by four single-item measures. These were: "First, in general, how satisfied or dissatisfied are you in the practice of medicine at the present time?" Responses ranged from "very dissatisfied" (1) through "neutral" (3) to "very satisfied" (5). "What is your overall assessment of the functioning of the medical and hospital care plan in your province?" Responses ranged from "excellent" (1) through "good" (3) to "poor" (5). "During the past ten years, would you say that the general quality of health care in this province has become better, become worse, or remained about the same." Responses ranged from "much worse" (1), "about the same" (3) to "more better" (5). "Do you think that physicians are 'losing ground' economically, that the incomes of other occupational groups are rising at a faster pace?" Five responses were provided ranging from "strongly disagree" (1) through "neutral" (3) to "strongly agree" (5).

Physician Militancy

Four militant attitudes or activities were included, each measured by single item measures. These were: "Do you approve of binding arbitration in the event of deadlocks in fee negotiations with governments?" A five point response scale ranging from "strongly disapprove" (1) through "neutral" (3) to "strongly approve" (5) was provided. "Do you approve or disapprove of withdrawal of non-emergency services by physicians in the event of inadequate income settlements?" The same five-point scale was used. "Do you approve or disapprove of the reconstitution of medical associations as labour unions under provincial labour laws?" Once again, the same five-point scale was used. "In the last three years since the passage of the Canada Health Act have you participated in an organized 'job action' which involved the withdrawal of your services to the general public?" (yes = 1, no = 2).

RESULTS

How Militant are Canadian Physicians?

Before proceeding to an analysis of the research model, it is important to understand the general level of militancy of Canadian physicians. This question is best addressed by examining descriptive information on measures of militant attitudes and activities. The following comments are offered in summary. First, the sample of physicians was approving (x = 3.8, S.D. = .99) of binding arbitration as a dispute resolution mechanism in the event of deadlock between governments and the medical profession over incomes (3 = neutral, 4 = approve). Second, physicians expressed slight disapproval (x = 2.6, S.D. = 1.26) of the proposal to reconstitute medical associations as labour unions under provincial labour laws (3 = neutral, 2 = disapprove). Third, physicians expressed slight disapproval of withdrawal of non-emergency services by physicians (x = 2.5, S.D. = 1.25) if negotiations with government fail to produce settlements which they felt were adequate (3 = neutral, 2 = disapprove). Fourth, 527 physicians had withdrawn their services to the general public (22.7%). As a professional body, Canadian physicians do not seem very willing to endorse militant positions or undertake militant actions in advancing their cause.

Examining the Research Framework

Hierarchical multiple regression analyses were undertaken to examine the relative explanatory power of the five panels of predictors with variables being entered in blocks. The dependent variables were the four measures of militant attitudes and activities. Predictor variables were entered in a specified order. The first block that was entered were the four individual demographic characteristics. These were considered as control variables. The second block that was entered were the six practice characteristics. The third block that was entered were the thirteen work stressors. The fourth block that was entered were the twelve measures of work satisfaction. The fifth (and final) block that was entered were the four measures of professional satisfaction.

Tables 2 through 5 present the results of regression analyses in which the four dependent variables were regressed on the five blocks of predictor variables. They show, for each dependent variable, the R^2 for each block of predictors, the increment in R^2 with each additional block of predictors and specific variables within a block of predictors that had significant βs indicating significant and independent relationship with the dependent variable.

Approval of Binding Arbitration in Fee Disputes

Table 2 shows the results of regression analyses in which physician approval of binding arbitration to settle fee disputes was regressed on the five blocks of predictor variables. No block of predictor variables explained significant amounts of variance in the dependent variable. English-speaking physicians were more approving of the use of binding arbitration than were French-speaking physicians.

TABLE 2

Predictors of Approval of Binding Arbitration

		Approve Binding Arbitration in Fee Disputes[a]	
Predictors	β	R^2	ΔR^2
Demographic Characteristics		.01	.01
Language	.06		
Practice Characteristics		.01	.00
Work Stressors		.02	.01
Work Satisfactions		.02	.01
Professional Satisfactions		.03	.00

[a] N=1407

Approval of Withdrawal of Non-Emergency Services

Table 3 presents the results of regression analyses in which physician approval of the withdrawal of non-emergency services was regressed on the five blocks of predictor variables. Each block of predictor variables contributed significant and unique increments in explained variance on this dependent variable.

Several variables within each panel of predictors had significant and independent relationships with the dependent variable. Thus, French-speaking physicians, physicians reporting higher income, and physicians graduating more recently were more approving of withdrawing non-emergency services. In addition, physicians working fewer hours, excluding on call hours, were more approving of withdrawing services. Physicians reporting greater stress from government profession relationships, total hours worked and life and death situations were more approving of withdrawing services. Physicians who were less satisfied with their relationships

with their patients, less satisfied with time available for family and personal life and more satisfied with their ability to maintain their own health were more approving of withdrawing services. Finally, physicians who believed they were losing economic ground and felt that health care was worsening were more approving of withdrawing services.

TABLE 3

Predictors of Approval of Withdrawal of Services

		Approve Withdrawal of Non-Emergency Services[a]	
Predictors	β	R^2	ΔR^2
Demographic Characteristics		.04	.04***
Language	-.10		
Net Income	.09		
Year of Graduation	.08		
Practice Characteristics		.05	.01*
Hours Worked	-.08		
Work Stressors		.14	.09***
Government Relations	.16		
Total Hours Worked	.10		
Life and Death Situations	.07		
Work Satisfactions		.16	.03***
Relations with Patients	-.10		
Time for Family	-.10		
Maintain Health	.09		
Professional Satisfactions		.18	.02***
Losing Economic Ground	.10		
Health Care Worsening	.07		

*** $p<.001$

* $p<.05$

[a] N=1408

Approval of Medical Associations of Labour Unions

Table 4 shows the results of regression analyses in which physician approval of reconstituting medical associations as labour unions was regressed on the five blocks of predictor variables. Each block of predictor variables contributed significant and unique increments in explained variance on this dependent variable.

Several variables within each panel of predictors had significant and independent relationships with the dependent variable. Thus, French-speaking physicians were more approving of forming labour unions. In addition, physicians who were not in partnerships and who were generalists were more approving of forming labour unions. Physicians reporting greater stress from government-profession relationships and less satisfaction from their standing in the profession and from their relationships with their patients were more approving of labour unions. Finally, physicians reporting greater beliefs that physicians were losing economic ground were more approving of medical associations as labour unions.

TABLE 4

Predictors of Approval of Medical Associations as Labour Unions

		Approve Medical Associations as Labour Unions[a]	
Predictors	β	R^2	ΔR^2
Demographic Characteristics		.07	.07***
Language	-.25		
Practice Characteristics		.08	.01***
Business Partnerships	.06		
Specialist	-.06		
Work Stressors		.13	.04***
Government Relations	.08		
Work Satisfactions		.16	.03***
Standing in Profession	-.08		
Relations with Patients	-.06		
Professional Satisfactions		.16	.01*
Losing Economic Ground	.05		

*** p<.001
* p<.05
[a] N=1403

Withdrawn Services to General Public

Table 5 presents the results of regression analyses in which physician withdrawal of services to the general public was regressed on the five blocks of predictor variables. Four of the five blocks of predictors contributed significant and unique increments in explained variance on this variable (all but professional satisfaction).

Individual variables within each panel of predictors had significant and independent relationships with the dependent variable. Thus, English-speaking physicians and physicians earning more money had withdrawn services. In addition, physicians deriving a higher percentage of their income from fee-for-service and physicians working fewer hours per week exclusive of hours "on call" had withdrawn services. Physicians reporting greater stress from government-profession relationships but less stress from counselling patients about non-medical problems had withdrawn services. Physicians less satisfied with their relationships with their patients and physicians more satisfied with their standing in the profession had withdrawn services. Finally physicians believing that the quality of health care was improving had withdrawn services to the general public.

TABLE 5

Predictors of Withdrawing Service to General Public

		Withdraw Services to General Public[a]	
Predictors	β	R^2	ΔR^2
Demographic Characteristics		.05	.05***
Language	-.15		
Net Income	-.06		
Practice Characteristics		.06	.01**
Income Fee for Services	-.07		
Hours Worked	.06		
Work Stressors		.13	.07***
Government Relations	-.18		
Counselling Patients – Non Medical	.09		
Work Satisfactions		.15	.02***
Relations with Patients	.10		
Standing in Profession	-.07		
Professional Satisfactions		.16	.00
Health Care Worsening	-.06		

*** $p<.001$

* $p<.01$

[a] N=1388

DISCUSSION

Usefulness of the Research Model

Stress researchers have argued persuasively for the use of more comprehensive research frameworks in future studies of work stress (Edwards 1992; Frese and Zapf 1988). The present investigation of militant attitudes and activities among physicians was consistent with this recommendation. It was based on a research model (see Figure 1) containing several panels of variables included in previous work (Cooper and Marshall 1976, 1978). The model served both as a useful organizing framework for a complex process as well as suggesting a meaningful analytic strategy.

The model received considerable support. Almost without exception, each of the five panels of predictor variables were consistently and significantly related to measures of physician militancy. Thus, individual demographic variables, practice characteristics, work stressors, and physician satisfaction with work and professional practice were significant and independent predictors of physician militancy.

For the most part, levels of self-reported work stress, as well as levels of work and professional satisfaction, were found to be associated with militant attitudes and activities. Physicians reporting greater stress and less satisfaction expressed more militant viewpoints.

The present investigation makes a contribution to our understanding of work and professional stress among physicians by including a relatively neglected individual response measure, the endorsement of militant attitudes and actions. Previous research has examined the effects of work stress on attendance behaviors, and some (e.g. Cooper and Marshall 1978) have suggested that work stress may increase counter-productive behavior and acts of sabotage, particularly in unionized organizations characterized by labour-management hostility. In addition it is more common to consider the ways in which labour-management hostility leads to stress than ways in which work stress leads to increased militancy (Bluen and Barling 1988).

Future Research Issues

Several issues appear to be fruitful avenues for future research which examines stress, satisfaction and militancy among physicians. These include:

1. Physicians are an elite, highly educated, well-paid profession that has historically enjoyed a high level of respect. They do not see themselves or their profession as militant. Yet some physicians withhold services (strike) and a majority of physicians have undertaken political action

and protest. Physicians also know that the public at large have little sympathy for their demands. How does this circumstance affect performance, morale and professional attitudes of physicians?

2. Governments are increasingly finding themselves in financial difficulty, resulting in increased competition for fewer resources, the need for greater accountability, restraint and retrenchment. These factors will likely increase the levels of conflict between governments and the medical profession. How will the medical associations respond? How will individual physicians respond?

3. As in any professional group having elected officials, the question of whether the leadership is representative of the membership and can speak for the members must be considered. There is some evidence that activist members of federal and provincial physician associations were in fact more militant than physicians serving on profession committees (Stevenson, Williams, and Vayda 1988).

4. The sample in this study comprised health care service providers who received the majority of their income from government sources yet did not work for government. As such, they are somewhat different from other health care providers (e.g., nurses) who receive salaries from employing organizations. In addition, physicians place a high value on autonomy and physician control of medical affairs. This increases levels of tension and conflict which may be unique to professionals who work under this type of contractual basis. In what way are other professions similarly affected?

5. It would also be informative to consider the effects of participating in militant activities (e.g., withdrawal of services) on levels of experienced stress and satisfaction (Bluen and Barling 1988; Macbride, Lancee, and Freeman 1981).

6. Some of the predictors within one block of variables were found to be more strongly correlated with predictors within a second block of variables than they were with measures of physician militancy. Future research should examine relations among blocks of predictors. It may be that a particular block of predictors (e.g., work stressors) mediates the relation between predictors in another block and militant attitudes and behaviors.

7. The relationship between language as a predictive variable and militancy, while significant, was not obvious. Language was obviously influenced by province of practice, recent conflicts in particular provinces (e.g., Quebec), and labour relations activity in a province as a whole. These factors must be addressed in future work.

REFERENCES

BLUEN, S. D., and J. BARLING. 1988. "Psychological Stressors Associated with Industrial Relations." *Causes, Coping and Consequences of Stress at Work.* C. L. Cooper and R. Payne, eds. New York: John Wiley, 175-205.

BUTTERFIELD, P. S. 1988. "The Stress of Residency: A Review of the Literature." *Archives of Internal Medicine,* Vol. 148, 1428-1433.

CHARLES, S. C., J. R. WILBERT, and K. J. FRANKE. 1985. "Sued and Nonsued Physicians Self-Reported Reactions to Malpractice Litigation." *American Journal of Psychiatry,* Vol. 142, 437-440.

COBURN, D. G., M. TORRANCE, and J. M. KAUFERT. 1983. "Medical Dominance in Canada in Historical Perspective: The Rise and Fall of Canadian Medicine." *International Journal of Health,* Vol. 13, 407-432.

COOPER, C. L., and J. MARSHALL. 1976. "Occupational Sources of Stress: A Review of the Literature Relating to Coronary Heart Disease and Mental Health." *Journal of Occupational Psychology,* Vol. 49, 11-28.

COOPER, C. L., and J. MARSHALL. 1978. "Sources of Managerial and White Collar Stress." *Stress at Work.* C. L. Cooper and R. Payne, eds. New York: John Wiley, 81-105.

COOPER, C. L., U. ROUT, and B. FARRAGHER. 1989. "Mental Health, Job Satisfaction, and Job Stress among General Practitioners." *British Medical Journal,* Vol. 298, 366-370.

EDWARDS, J. R. 1992. "A Cybernetic Theory of Stress, Coping and Well-Being in Organizations." *Academy of Management Review,* Vol. 17, 238-274.

FARBER, H. S., and D. H. SAKS. 1990. "Why Workers Want Unions: The Role of Relative Wages and Job Characteristics." *Journal of Political Economy,* Vol. 88, 349-369.

FRESE, M., and D. ZAPF. 1988. "Methodological Issues in the Study of Work Stress: Objective vs Subjective Measurement of Work Stress and the Question of Longitudinal Studies." *Causes, Coping and Consequences of Stress at Work.* C. L. Cooper and R. Payne, eds. New York: John Wiley, 375-412.

GORDON, M. E., L. L. BEAUVAIS, and R. T. LADD. 1984. "The Job Satisfaction and Union Commitment of Unionized Engineers." *Industrial and Labor Relations Review,* Vol. 37, 359-370.

HAMMER, T. H., and M. BERMAN. 1981. "The Role of Non-Economic Factors in Faculty Union Voting." *Journal of Applied Psychology,* Vol. 66, 415-421.

HARTLEY, J. F. 1992. "The Psychology of Industrial Relations." *International Review of Industrial and Organizational Psychology.* C. L. Cooper and I. T. Robertson, eds. New York: John Wiley, 201-243.

HEIBER, S., and R. DEBER. 1987. "Banning Extra-Billing in Canada: Just what the Doctor didn't Order." *Canadian Public Policy,* Vol. 13, 62-74.

JACKSON, S. E., R. L. SCHWAB, and R. S. SCHULER. 1986. "Toward an Understanding of the Burnout Phenomenon." *Journal of Applied Psychology,* Vol. 71, 630-640.

KIRMEYER, S. L., and A. SHIROM. 1986. "Perceived Job Autonomy in the Manufacturing Sector: Effects of Unions, Gender and Substantive Complexity." *Academy of Management Journal*, Vol. 29, 823–840.

KOCHAN, T. A. 1979. "How American Workers View Labor Unions." *Monthly Labor Review*, Vol. 102, 23–31.

KOCHAN, T. A. 1980. *Collective Bargaining and Industrial Relations.* Homewood, Ill.: Irwin-Dorsey.

KRAKOWSKI, A. J. 1982a. "Stress and the Practice of Medicine: The Myth and Reality." *Journal of Psychosomatic Research*, Vol. 26, 91–98.

KRAKOWSKI, A. J. 1982b. "Stress and the Practice of Medicine: II. Stressors, Stresses, and Strains." *Psychotherapy and Psychosomatics*, Vol. 38, 11–23.

LEE, C. 1986. "Professionals in Medical Settings: The Research Evidence in the 1980s." *Journal of Organizational Behavior Management*, Vol. 8, 195–213.

LINN, L. S., J. YAGER, D. COPE, and B. LEAKE. 1985. "Health Status, Job Satisfaction, and Life Satisfaction among Academic and Clinical Faculty." *Journal of the American Medical Association*, Vol. 254, 2775–2782.

MACBRIDE, A., W. LANCEE, and S. FREEMAN. 1981. "The Psychosocial Impact of a Labor Dispute." *Journal of Occupational Psychology*, Vol. 54, 125–134.

MAWARDI, B. H. 1979. "Satisfactions, Dissatisfactions, and Causes of Stress in Medical Practice." *Journal of the American Medical Association*, Vol. 241, 1483–1486.

MCCUE, J. D. 1982. "The Effects of Stress on Physicians and their Medical Practice." *New England Journal of Medicine*, Vol. 306, 458–463.

MCCUE, J. G. 1985. "The Distress of Internship: Causes and Prevention." *New England Journal of Medicine*, Vol. 312, 449–452.

MUCHINSKY, P. M., and M. A. MAASSARANI. 1980. "Work Environment Effects on Public Sector Grievances." *Personal Psychology*, Vol. 33, 403–414.

ODEWAHN, C. A., and M. M. PETTY. 1980. "A Comparison of Level of Job Satisfaction, Role Stress and Personal Competence between Union Members and Non-Members." *Academy of Management Journal*, Vol. 23, 150–155.

RHOADS, J. M. 1977. "Overwork." *Journal of the American Medical Association*, Vol. 237, 2615–2618.

SCHEIBER, S. C. 1987. "Stress in Physicians." *Stress in the Health Professions.* R. Payne and J. Firth-Cozens, eds. New York: Wiley, 23–44.

SCHRIESHEIM, C. A. 1978. "Job Satisfaction, Attitudes towards Unions, and Voting in a Union Representation Election." *Journal of Applied Psychology*, Vol. 63, 548–552.

SHOSTAK, A. B. 1980. *Blue Collar Stress.* Reading, Mass.: Addison-Wesley.

STEVENSON, H. M., and A. P. WILLIAMS. 1985. "Physicians and Medicare: Professional Ideology and Canadian Health Care Policy." *Canadian Public Policy*, Vol. 11, 504–521.

STEVENSON, H. M., A. P. WILLIAMS, and E. VAYDA. 1988. "Medical Politics and Canadian Medicare: Professional Response to the Canada Health Act." *The Milbank Quarterly*, Vol. 66, 65–104.

SUMMERS, T. P., J. H. BETTON, and T. A. DECOTIIS. 1986. "Voting for or against Unions: A Decision Model." *Academy of Management Journal*, Vol. 11, 643–655.

TAYLOR, M. G. 1978. *Health Insurance and Canadian Public Policy: The Seven Decisions that Created the Canadian Health Insurance System.* Montréal: McGill-Queen's University Press.

TAYLOR, M. G., H. M. STEVENSON, and A. P. WILLIAMS. 1984. *Medical Perspectives on Canadian Medicare: Attitudes of Canadian Physicians to Policies and Problems of the Medical Care Insurance Program.* North York, Ontario: Institute for Behavioral Research, York University.

TOUHY, C. J. 1976. "Medical Politics after Medicare: The Ontario Case." *Canadian Public Policy*, Vol. 2, 192–210.

WIGHT-BAKKE, E. 1975. "To Join or Not to Join." *Industrial Relations and the Wider Society.* B. Barrett, E. Rhodes, and J. Beishon, eds. London: Collier-MacMillan.

YOUNGBLOOD, S. A., A. S. DENISI, J. L. MOLLESTON, and W. H. MOBLEY. 1984. "The Impact of Work Environment, Instrumentality Beliefs, Perceived Labor Union Image and Subjective Expected Norms on Union Voting Intentions." *Academy of Management Journal*, Vol. 27, 576–590.

ZALESNY, M. D. 1985. "Comparison of Economic and Non-Economic Factors in Predicting Faculty Vote Preference in a Union Representation Election." *Journal of Applied Psychology*, Vol. 20, 243–256.

RÉSUMÉ

Stress, satisfaction et militantisme chez les médecins canadiens

Il résulte de l'introduction d'un système national de soins de santé au Canada un conflit régulier et croissant entre la profession médicale, les différents niveaux de gouvernement et d'autres acteurs politiques. Le cœur de ce conflit portait d'abord sur le contrôle des affaires médicales. Les médecins ont défendu leur autonomie face à ce qu'ils percevaient comme une intrusion gouvernementale non justifiée dans les affaires médicales.

La présente étude utilise un cadre que nous appellerons « agents stressants-tensions » pour mieux comprendre le militantisme des médecins au Canada. Le modèle de recherche comprend cinq types de variables antécédentes : les caractéristiques démographiques individuelles (v.g., âge et année d'obtention du diplôme), les caractéristiques de la pratique médicale (v.g., lieu de pratique, heures travaillées par semaine, spécialiste ou généraliste), les facteurs de stress au travail (v.g., formules à remplir, délai d'entrée des patients à l'hôpital), la satisfaction au travail (v.g., relations

avec les patients, conditions de travail, temps disponible pour la vie personnelle et familiale) et la satisfaction professionnelle (v.g., si les médecins sont en perte de vitesse économiquement, évaluation globale du système de santé dans leur province).

Nous avons considéré quatre attitudes ou activités de militantisme : l'approbation de l'arbitrage obligatoire en cas de blocage lors de la négociation des tarifs avec le gouvernement, l'approbation d'arrêt de service à l'occasion d'ententes sur les revenus inadéquates, l'approbation du retour des associations médicales au statut de syndicat et la participation à une action concertée impliquant le retrait des services.

La collecte de données s'est fait par questionnaires en 1986 auprès de 2 584 médecins. Nous avons bâti un échantillon représentatif de médecins dans chacune des dix provinces. Près de 10 % des répondants étaient féminins. Suite à un rappel, le taux de réponse a atteint près de 70 %.

Lorsque nous avons examiné l'information descriptive, les médecins canadiens, comme groupe professionnel, n'endossaient pas des positions militantes ni n'étaient prêts à recourir à l'action militante pour faire avancer leur cause. Les médecins désapprouvaient de reconstituer leurs associations médicales en syndicat ainsi que le retrait de leurs services. Moins de 20 % des répondants ont surfacturé et près de 20 % ont retiré leurs services au public en général. La plupart étaient inactifs à l'intérieur de leurs associations et ils approuvaient l'arbitrage obligatoire en cas de différends avec le gouvernement sur leurs revenus.

Des analyses de régression multiple hiérarchique ont été effectuées pour établir le pouvoir explicatif des cinq ensembles de prédicteurs. Les ensembles ont été entrés dans l'ordre indiqué dans le modèle de recherche. Nous avons trouvé un support empirique au modèle. Chaque ensemble de prédicteurs avait une relation unique et significative avec la plupart des mesures de militantisme chez les médecins. Les médecins se disant plus stressés et moins satisfaits exprimaient des points de vue plus militants.