Self-Evaluations and Perceived Evaluations of Occupational Prestige: A Study of Podiatrists

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(ABSTRACT)

Occupational prestige has a long history of sociological investigation in terms of the overall rankings assigned to a wide variety of occupations. However, few studies have examined intraoccupational differences in prestige or how individuals rate the prestige of their own profession. Utilizing a national sample of podiatrists, an integrated model is proposed to determine what factors are involved in the rating of one's profession. Multiple regression models were estimated to determine the most important predictors of podiatrists' self-evaluations and prestige interpretations of their profession. Among 12 demographic, job-related, and attitudinal measures, it was found that the perceived evaluations of others explains the most variance in podiatrists' self-evaluations of their profession. Due to the nature of the integrated theoretical model proposed, separate multiple regression models were estimated for novice and established podiatrists. Contrary to the expectation, there was no difference in the predictors of novice and established podiatrists' ratings of their profession. Implications of these findings are considered along with suggestions for further research in this area of occupational sociology.

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Table of Contents

List of Illustrations

List of Tables

CHAPTER 1: INTRODUCTION

Occupational prestige is a multidimensional concept which affects many integral parts of everyday living. The prestige of one's occupation has ramifications concerning one's quality of life, job satisfaction, and self-esteem. Occupational prestige has a long history of sociological investigation in terms of the overall ranking or hierarchy of a wide variety of occupations in the United States and other modern industrialized countries. However, little research has examined the comparative prestige afforded occupations within the same profession or how individuals rate the prestige of their own professions. For instance, what factors account for the variation in individuals' ratings of the prestige of their own profession or their perceptions of the rankings given to their profession by significant others? This study will attempt to account for variations in these occupational prestige interpretations of individuals within one medical field, that of podiatry.

In the process of self-examination, information is gathered as to how others perceive individuals' behavior, self-worth and status. Reviewing studies of self-development and self-evaluation, a core issue involves individuals' perceptions of how others see them. Individuals compare their own self-images with the reflected or perceived evaluations from others. This process of reflected appraisals and the looking-glass self seems to be relevant to assessing the determinants of prestige rankings given to one's own profession. Specifically, the prestige rankings of one's own occupation should be largely determined by the perceptions of one's significant others and by various work-

related factors. Some evidence (Podell, 1971) suggests that within the field of medicine, podiatrists rank relatively low in terms of their prestige, yet this assessment may not be consistent with how they view themselves, or with their perceptions of what others think.

Most social psychological theories of self-evaluation (e.g. Secord and Backman, 1964) posit that actors strive to maintain some congruency between their self-concept and feedback from others. When there is an apparent inconsistency between the two, these theories would predict that observers will either selectively inflate the image of others and/or devalue the negative evaluations of their occupation. This process of exaggerating one's self-image is especially likely to occur among individuals who occupy lower positions in an occupational hierarchy. When individuals lack important structural features of their profession (i.e.,length of time in an acknowledged specialty, type of clientele), they may exaggerate their attitude (i.e.,opinions of others, belief in service to public, autonomy). Within a profession, as the structural components are fulfilled, the attitude is downplayed and secondary; where the structural elements are lacking, the self-validating attitude will be strong.

The purpose of the study is to examine the work and structural determinants of podiatrists' prestige rankings of their occupation. By examining the correlates of podiatrists' self-evaluations of their professional group, this study will investigate how ratings of one's profession are influenced by the perceived evaluations of others and various job-related and demographic characteristics. It is important to examine podiatrists' self-perceptions and their views of peer perceptions, since a paradoxical image can hinder social interaction. Given that such a discrepancy may contribute to poor working relations among different medical professionals, the results of this study have implications for working relationships among professionals. For example, does the gap between self-evaluations and perceived evaluations of others get in the way of effective functioning as health care providers? Drawing upon the seminal works of Rosenberg (1981,1986), Cooley (1956) and Hall (1968), this analysis uses an integrated model to examine the fit between the perceived or subjective reality of podiatrists and the perceived reality podiatrists garner from Medical doctors and Doctors of Osteopath.

CHAPTER 2: REVIEW OF THE LITERATURE

What are the ingredients which constitute what sociologists have come to call occupational prestige? What are the determining criteria whereby certain occupations are granted higher prestige than others? Are there universal characteristics which explain these evaluations? In terms of broad categories, it seems apparent that "rankings of occupations are remarkably consistent," (Haug and Widdison,1975:3) across industrial societies (Hodge, Treiman, and Rossi,1966) and across time (Hodge, Siegel, and Rossi,1964). What factors account for the ratings given by individuals to their occupation? Each of these issues will be addressed in this chapter.

I. Occupational Prestige

Numerous studies of occupational prestige have been undertaken over the past fifty years. The research conducted by the National Opinion Research Center is among the most famous. The first of these studies was directed by Cecil C. North and Paul K. Hatt in 1947. The opinions about various occupations were gathered from a representative sample of 2,920 U.S. citizens. Eighteen percent of the sample (NORC, 1953:418) cited the following criteria as the main determining factors by which their respective occupational ratings were achieved: income, service to humanity, educa-

tion, and social prestige. In 1963, this study was replicated, utilizing a sample of 657 adults (Hodge et al. 1966). This study provided very similar results, thereby supporting the previous research.

The standard procedure used in earlier studies of occupational prestige was to present each respondent a set of occupations to evaluate in terms of their general standing. The choices range from "1" (excellent standing) to "5" (poor standing). After rating each occupation, numerical weights are then assigned to adjust the values to a composite score, ranging from 100 for excellent to 20 for poor. In the resultant ranking, professional occupations scored the highest ranking, which includes a score of 93 for a physician, 89 for a chemist, and 90 for a college professor (Hodge et al. 1966:324-325). The lowest scores were commonly associated with the unskilled or manual labor jobs, including occupations such as garbage collector and janitor. Between these two groupings were found semi-skilled or clerical occupations such as office or sales positions. A sampling of the NORC scores for 1963 may be found in Appendix A.

Inkeles and Rossi (1956) hypothesized that the prestige ordering of occupations may reflect the cultural values of a society and may differ greatly from one society to another. Essentially, their project entailed an application of this cultural hypothesis. To date, many authors suggest a complementary agreement between the hierarchy of occupational prestige in the United States and those of some foreign countries. For instance, Inkeles and Rossi (1956) found that occupational rankings were highly correlated across six industrialized societies (i.e. U.S., Great Britain, New Zealand, Japan, U.S.S.R, and Germany). The relative similarity of occupational ratings across cultures has also been replicated by Hodge et al. (1966). Furthermore, average occupational prestige ratings have also been found to be remarkably consistent across various racial, class, and gender groupings (see Kahl, 1982; Treiman, 1977), as well as over time periods within countries (Hodge et al. 1966; Coleman and Rainwater,1978).

Treiman (1977) proposes a structural model of occupational prestige determination, in contrast to a cultural theory of prestige determination. According to this structural theory, occupational systems are virtually the same in all complex, modern societies. The division of labor affords

characteristic "differences among occupations in the extent of power exercised" (Treiman, 1977:103). These power differences revert to prestige differentiations, therefore "intersocietal similarities reflect intersocietal similarities in occupational power and privilege" (Treiman, 1977:103). This theory may account for the relative consistency of prestige ratings across social groups.

While there is a rich research tradition in the area of occupational prestige, there are several methodological problems which need to be considered. First, several studies are based on unsystematic samples, such as utilizing students or peasants as the entire sample. Other studies have utilized well-designed area probability samples of entire nations. Factors such as these must be realized and considered prior to performing any type of comparative analysis. Second, the number of occupations rated varies from as few as 13 to as many as 90. Third, the techniques of rating vary from minor alterations of the NORC procedure of having respondents judge occupations using the range of excellent to poor, according to their own personal attitude toward certain occupations, to the "task of ranking occupations according to the extent they are looked up to" (Hodge et al. 1966:313). The numerical measures of prestige derived from these studies are no less diversified: average ratings, weighted scores, mean and median rankings, and even the ordering of statistics from aggregate scores derived by one of the above-mentioned procedures. Nonetheless, across these different methods there is widespread agreement on the relative prestige afforded particular occupations.

II. The Meaning of Prestige

What is the basis of this phenomenon we label prestige? What are the attributes that confer prestige? Shils (1968:106) defines these attributes as "deference-entitlements," which include: "occupational role and accomplishment, wealth, income,...(and) educational attainment." A second basis for occupational prestige, according to Shils, is described quite nicely in his summary:

> Of course, occupational roles and their
> incumbents are also deferred to on account

> of certain highly correlated deference-entitling properties such as the income which the practice of the occupation provides, the educational level of its practitioners, the ethnic qualities of its incumbents, etc...nonetheless, occupational role is an independent to deference (1968:107).

According to Theodorson and Theodorson (1969:312), prestige is best defined as a "general type of social status that carries with it social recognition, respect, admiration, and some degree of deference. Different groups may grant prestige for the achievement or possession of different values." In a series of studies, Garbin and Bates define occupational prestige "as a social value which is positively evaluated by societal members. It is manifested in the form of sentiments of admiration or deference which some people have with respect to certain work positions" (Garbin and Bates,1961:131).

Many sociologists seem to define prestige in terms of esteem. In 1944, Fairchild defined prestige in terms of esteem. Kahl, in his American Class Structure (1957), connected the concepts of prestige and esteem stating, "you can have a combination of low esteem and high prestige or vice versa, while informants usually combine esteem and high prestige into a single judgement of over-all merit" (Kahl, 1957:21). Treiman (1977) compared prestige synonymously with honor, regard, respect, standing, and esteem. Goode (1978) defined prestige as "esteem, respect, or approval that is granted by an individual or a collectivity for performances or qualities they consider above the average" (p.7). Goode (1978) also viewed prestige as a mechanism of social control. His analysis highlights how "granting or withdrawing prestige or esteem controls the actions of both individuals and groups" (1978:15). Finally, Kahl (1957) discussed the prestige of a position. This author acknowledged that the prestige of a position tends to flow over within the general expectation one has for a person or for his/her occupational performances. Essentially, this means that there will be a tendency to give a higher rating or evaluation to the performances of persons in higher prestige positions than those of more lowly positions.

III. Correlates of Prestige

There have been several major studies which assess the correlates of occupational prestige ratings. Previous research has identified various occupational and work-related factors that account for the relative positioning of occupations in a prestige hierarchy. These correlates are summarized below.

Garbin and Bates (1966), in an investigation of occupational correlates, queried 490 individuals concerning their evaluations of 30 occupations. They found the leading correlates of occupational prestige were: "regarded as desirable to associate with" ($r = .95$), "intelligence required" ($r = .94$), scarcity of personnel who can do the job" ($r = .93$), "interesting and challenging work" ($r = .91$), "training required" ($r = .91$) and "education required" ($r = .90$). In their second investigation, they incorporated the methodological refinement of utilizing "diverse groups of people" (1966:296). The sample consisted of 490 individuals, including students, bankers, secretaries, professors, morticians, and manual workers. A questionnaire similar to the type employed in their previous research was administered. The subjects indicated their personal ratings for 30 occupations. A mean prestige score was then derived from the responses.

The researchers wanted to discover what proportion of the total variation in the dependent variable, prestige, could be explained by the independent variable, traits of the occupation. Based on an R^2 of .99, Garbin and Bates (1966:301) conclude that occupational prestige should be understood as a "generalized subjective attitude of deference given an occupation, which is built up of several different variables which adds to the whole." A second conclusion they note, "(is the) tendency for occupations which are allocated a very high or high average score or ranking in such traits as 'regarded as desirable to associate with,' intelligence required,'...'education required,' 'income,' 'having influence over others,' and 'honorable and morally good work,' to rate or rank very high in the prestige hierarchy" (1966:301).

Lewis and Lopreato (1963) investigated the relationship between the "functional importance" of occupations and prestige. A self-administered questionnaire, based upon a rating of 24 occupations, was incorporated in the research design. A five point scale ranging from 1 = excellent standing to 5 = poor standing, was given when rating the 24 occupations, which included; (1) professional; (2) educational; (3) commercial; (4) skilled; (5) gambling; (6) unskilled (Lewis and Lopreato, 1963:56-57). Prestige scores for each occupational category were calculated by finding the mean prestige rating for each occupation in the category. The most striking finding was the similar ratings for the two samples chosen (one from Amherst, the other from Las Vegas). Educational and professional occupations ranged from excellent to good (Lewis and Lopreato, 1963:57). This research suggested that functional importance does not explain variations in the prestige of occupations (1963:59).

A more recent study in the prestige of occupations compared the prestige accorded males and females in the same profession. Powell and Jacobs (1984), authors of the "Prestige Gap," sought to investigate the belief that prestige obtained by an occupation is conferred equally upon all incumbents in that occupation. They found contradictory results. Males were granted greater prestige in the traditionally male occupations (e.g. architecture, mining). In traditionally female settings such as elementary school teaching, nursing, and secretarial positions, women attained higher prestige.

In his examination of the profession of dentistry, Kreisberg (1962) argued for further research on how individuals attribute prestige to occupations and their perception of other characteristics of these occupations. The researcher reviewed a NORC survey on attitudes and practices in the field of dental care. A national sample of 1,862 adults was interviewed concerning a wide range of topics related to dentists and dental care. He investigated the possible reasons for differences in the prestige attributed the dentists by examining the relationship between the relative prestige accorded dentists and certain perceptions of them. Kreisberg (1962:238) found there was not a "high relationship between the amount of prestige individuals believe an occupation has and their perceptions of other characteristics of the same occupation or of its incumbents."

The education and income of occupational incumbents have also been found to correlate with the public prestige of their work. Alba Edwards (1930) developed an occupational scale for the U.S. Census by utilizing education as a measure of workers' social status and as a measure of their economic status. Years later, Duncan used these same factors to develop a prediction equation for a prestige rating. In 45 census occupations, education and income accounted for 82% of the variance in the public's ratings as determined by the NORC survey (Reiss, 1961). Adler and Kraus (1985) found education to be the predominant variable in predicting occupational prestige in Israel, greatly contrasting Duncan's regression equation in the U.S. where the regression weights of both education and income were equal.

Many studies cite skills and training as important variables in determining one's occupational prestige. Adler and Kraus (1985) reported the skill and knowledge needed for an occupation is the best single predictor of the prestige accorded the occupation. Simpson and Simpson (1960) had 21 graduate students in social science evaluate 90 occupations in terms of the degree of responsibility involved, the training, education, and skills required, and the degree of personal autonomy allowed in performing the occupations' duties. They reported very strong correlations between prestige and training-education-skill ($r = .95$), prestige and responsibility ($r = .93$), and prestige and autonomy ($r = .81$).

IV. Intraoccupational Prestige Differences

Previous research reveals that there is substantial variation between and within occupational groups in prestige rankings. Given that differences between occupational groups in the level of prestige are generally attributed to differences in education, income, the degree of responsibility, autonomy, skill and knowledge, it seems obvious that intraoccupational differences should be attributed to the same factors. Most research has examined interoccupational differences, with little research investigating prestige differences within occupation groupings. Yet, an examination of the

legal and medical professions reveals that prestige distinctions among occupations are also made in accordance to the various job-related factors.

Under the Duncan scale, Supreme Court judges are afforded high levels of prestige in the legal profession, followed by lawyers, probation officers, police officers, and prison guards. These differences in prestige ratings within the legal profession follow differences in responsibility, autonomy, income, and educational attainment associated with each of the positions.

In examining the medical profession, the hierarchy of specialties generally takes the following form: neurosurgeons, cardiologists, pediatricians, gynecologists, and podiatrists. Various specialties would fill in the hierarchy, but this gives a sense of ranking and prestige accorded medical specialties. Once again, the discrepancies between the various specialties seem to follow differences in responsibility, autonomy, income, and educational attainment.

Placing podiatrists at the bottom presumes that of all the specialties they have the lowest prestige and therefore lower self-esteem. Skipper and Hughes (1984), in a survey of podiatrists in the state of Virginia, found that nearly two-thirds had status problems. The researchers report, "64 percent believed that the general public did not treat them the same as MDs in terms of respect and prestige" (Skipper and Hughes, 1984:621). When podiatrists compared themselves to physicians, "the feeling of status differential was even stronger...24 percent felt that physicians looked upon them as 'marginal practitioners' (and) 19 percent of the sample stated that they found physicians hostile and impersonal toward them in everyday interaction." Podell (1971) discusses the issue of the place and image of podiatrists in the American health care system. Originally, podiatrists were known as little more than "corn cutters" who went from door to door, tools in hand (Podell, 1971:587). Podell feels that the ghosts of corn cutters haunt the image of podiatry even today.[1] The overall feeling of physicians toward podiatrists is exemplified by the following quote from Podell's work: "Podiatrists are not trained to and do not recognize the systemic implications of what they see on

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[1] For two excellent reviews of the history of podiatry, see Podell (1971) and Skipper and Hughes (1983).

the foot...Only a physician can do this...Let's face it, there is no such thing as half a doctor" (1971:588).

V. Summary

There are several important points which came to bear during an analysis of the relevant literature. First, prestige is usually defined in terms of respect and esteem. Second, there exists a great deal of consensus in rankings of occupational prestige across social groups, time and cultures. Third, differences in ratings of occupational prestige are largely attributable to differences in income, education, skill, knowledge, training, and autonomy associated with various occupational groupings. Fourth, few studies have investigated intraoccupational differences in prestige. Given that individuals' evaluations of their work are strongly related to overall job satisfaction and quality of life, an assessment of podiatrists' ratings of the prestige of their own occupation may be especially important in cultivating more harmonious relationships among clients and other medical professionals.

CHAPTER 3: THEORETICAL MODELS AND HYPOTHESIS FORMATION

The previous chapter mapped out the various dimensions of occupational prestige as it has been examined in sociological research. The present chapter examines the components of two theoretical perspectives individually, and then combines them into an integrated theoretical model to be examined in this study. Before discussing these theoretical perspectives, a few introductory comments are needed.

First, consistent with predictions from various theories of self-evaluation, it will be argued that podiatrists' assessments of their profession will be strongly influenced by the perceived evaluations of significant others (i.e. MD/DOs). Second, from theories of professional socialization, it will be argued that various demographic and job-related factors will influence podiatrists' self-evaluations of their profession, both directly and indirectly by affecting the contact with and perceived evaluations of other medical professionals. The structure of this model is outlined in Figure 1.

I. Social Psychological Theories of Self-Evaluation

The present section describes two complementary theories of self-evaluation which will be used to explain podiatrists' occupational prestige. The concepts of self-concept, reflected appraisals, self-evaluation, and validation are introduced in order to facilitate an understanding of the mechanisms by which podiatrists evaluate the prestige of their own occupation, a specialty which is somewhat devalued within the medical occupational hierarchy.

Social psychologists have long been interested in the complementary areas of self-conception and self-validation. Self-conception and self-validation are important processes because both involve how individuals evaluate themselves and try to maintain favorable evaluations (Lindesmith and Strauss, 1968).

Many theories of self-development and self-evaluation stress individuals' perceptions of how others see them. Attention is centered on the process by which individuals' compare their ideas about themselves with the existing social norms, that is, with the expectations they believe other persons have concerning what they should be like. These theories focus on the effects that perceived evaluations of significant others have on individuals' self-images.

The importance of self-evaluation and validation is firmly rooted in the work of C.H. Cooley. Cooley compares others' perceptions of us to that of a "reflection" in a mirror (looking-glass). Describing the "looking-glass self" Cooley states,

> as we see our face, figure, and dress in the glass,
> and are interested in them because they are ours,
> and pleased or otherwise with them according as
> they do or do not answer to what we should like
> them to be; so in the imagination we perceive
> in another's mind some thought of our appearance,
> manners, aims, deeds, character, ... and are variously
> affected by it ... the imagined judgement
> is quite essential (1956:152).

Cooley has devoted much attention to the self-concept. There are three principal components to Cooley's idea of the self-concept. First, the imagined appearance of an individual to the other person. Second, the imagined judgement of that appearance to the other person. Third, a type of self-feeling which may be positive or negative (Cooley, 1956). Obviously, we do not actually see into another's mind to discover their feelings toward us. Nonetheless, individuals' self-images are strongly influenced by the reflected perceptions of other persons (1956:152). In fact, many studies suggest a strong relationship exists between an individual's perceptions of how others evaluate her/him and the individual's self-concept (Manis, 1955; Miyamoto and Dornbusch, 1956; Rosenberg, 1981).

The image of a looking-glass self is also evident in Rosenberg's work on "reflected appraisals." According to Rosenberg (1986), individuals' self-concepts are substantially influenced by their perceptions of others' attitudes toward them. However, it is not others' attitudes toward us, but what we think their attitudes are toward us that is essential to our self-concept construction.

Similar to Cooley, Rosenberg (1981) identifies three components of the self. The self-concept (SC) is how the individual views himself/ herself. How people actually view individuals is the social or accorded self (SS). The reflected or perceived self (RS) is defined as how the *"individual believes others see him/her"* (Rosenberg, 1981:597).[2]

Rosenberg (1981:597) reports that data consistently support the principle of reflected appraisals, since the perceived self is a stronger predictor of self-concept than the social self. Other research has also shown a strong and consistent relationship between the reflected self (RS) and the self-concept (SC). For instance, Miyamoto and Dornbusch (1956) found convincing evidence that self-conceptions consist not only of what individuals' believe others think of them, but also what others actually think of them. However, these researchers conclude that a person's perception of others' images is far more important in determining one's self-image than the actual image of the

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[2] According to Rosenberg (1986), the perceived self is a crucial dimension in the formation of the self-concept.

person held by others. Furthermore, in an investigation of the empirical evidence for the "looking-glass self" in approximately 50 studies, Shrauger and Schoeneman (1979) found a substantial relationship between people's self-evaluations and the *imagined evaluations* of others, but little relationship between the real evaluations held by others and people's self-concept. These results are significant because they suggest that podiatrists' evaluations of their profession are more determined by the *imagined evaluations* of others than by the *actual evaluations* that others make.

The present research extends self-evaluation theories to the study of practitioners' evaluations of their profession. Following the logic that individuals' self-evaluations are strongly influenced by the perceived evaluations of others, podiatrists' evaluations of their profession also should be influenced by what they think significant others[3] think of them in their occupational role.[4] Furthermore, the present study examines two components of Rosenberg's structure of the self. Specifically, the podiatry data afford the opportunity to examine the relationship between the self-image of an occupational group and the perceived evaluation of significant others. While data on the social self is not available, the exclusion of this component is not especially problematic since the reflected/perceived self is a stronger predictor of self-image than is the social self.

II. Model of Professional Socialization

The social psychological theory of self-evaluation reviewed above provides a foundation for examining the relationship between one's self-image of their occupational group and reflected appraisals. The theory suggests that evaluations of one's occupation will mirror the reflected appraisals of others. Yet, this theory itself is limited in its ability to address how job-related factors will influence self-ratings of one's occupation. Therefore, another model which will be addressed is Hall's

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[3] The "significant others" in this study are Medical doctors and Doctors of Osteopath. It must be emphasized that MD/DOs are the most significant others to podiatrists within the medical field.

[4] How we evaluate ourselves concerning our occupation also contributes to our overall self-concept (Rosenberg, 1986).

professional model. Before discussing this model, however, a few comments about professional socialization are in order.

Work provides a major source of an individual's identity. An individual's occupational role is one key that unlocks who he/she is. The type of work one engages in is a determinant of their social status and occupational prestige. Whether preparing for a career, through formal education, or actually working at a job, individuals are constantly undergoing occupational/professional socialization (Ritzer and Walczak, 1986).

Professional socialization involves the whole process by which people take on the necessary skills and ability for the profession (Ritzer and Walczak, 1986). Throughout one's occupational lifetime, professional socialization occurs both formally and informally. In the case of podiatrists, they are formally socialized in Podiatric Schools of Medicine where they learn the skills and knowledge essential to the practice of podiatry. Podiatrists' acquire their professional norms and values through informal contact with colleagues, patients, and other members of the health care team (Ritzer and Walczak, 1986). Similar to Medical Doctors, novice podiatrists learn to "play the game." The newcomer to podiatry must learn how to deal with senior podiatrists, patients, administrators, Medical Doctors, and other health care personnel, while struggling to build his/her own sense of professional identity. The longer the podiatrist is in the profession, the more acquainted he/she becomes with the rules of the game.

The model of socialization into a profession used in this study is an extension of Hall's "professional model." According to Hall (1968:92), the professional model is composed of a series of attributes which "are important in distinguishing professions from other occupations." The professional model is composed of two types of attributes: characteristics which involve the structure of the profession, and attitudinal components.

According to Hall (1968), during the process of professionalization, the attitudinal and structural characteristics may not fluctuate together. Those less professionalized groups may have strong at-

titudes (e.g., belief in service to public) to compensate for being less "established." On the other hand, the more "established" professional groups may place less importance on the professional attitudes. These attitudinal characteristics include a belief in service to public, sense of calling to the field, and feelings of autonomy (Hall, 1968).

The thrust of Hall's argument is that those less professionalized groups may have strong attitudes to compensate for lacking the structural components. In contrast, those professionalized groups who have obtained the structural components may rely less on professional attitudes as a source of status. The present research is a logical extension of Hall's argument about professions, to the attitudes of persons within a profession. This study also extends Hall's insights about interoccupational differences to intraoccupational differences in occupational attitudes. Another difference is that this research is also testing different attitudes (i.e., self-evaluations in terms of economic rewards, authority, prestige, functional importance, and psychological reward) than those tested in professional groupings by Hall. Nonetheless, from Hall's work on interoccupational differences, it follows that persons who are new to a profession will lack some of the structural job-related characteristics and therefore have strong self-validating attitudes. As the professional practitioner gains experience and develops a clientele, the importance of the attitudinal component should diminish.

A reflected appraisals perspective, however, would suggest several alternative expectations concerning the importance of the perceived evaluations of significant others and other attitudes in the evaluation of one's profession. First, the perceived evaluations of significant others may be equally important to both novice and established podiatrists. Rosenberg (1986) documents how individuals' self-evaluations are strongly influenced by the perceived evaluations of significant others. Yet, an extension of Rosenberg's argument would suggest that perceived evaluations from significant others will continue to be important throughout an individual's life cycle. If true, the perceived evaluations of MD/DOs should be equally important to both groups of podiatrists. Secondly, the reflected appraisals perspective would predict that established podiatrists would have more positive reflected appraisals than novice podiatrists, because established podiatrists have the structural components or "perks" of their profession, therefore, they have higher evaluations. On the other

hand, novice podiatrists who lack the structural characteristics, may perceive low evaluations of their profession from significant others and may have lower self-evaluations of their profession.

Although Medicine is considered an "established" profession (Wilensky, 1964), there exist considerable variations within this field as to how "established" certain specialties are. Podiatry is still in the process of asserting its professionalization and this may account for the low external evaluations of podiatrists (see Podell, 1971). It is expected that novice podiatrists, in particular, will rely heavily on the "attitudinal" component of the professional model since they lack the structural components of the profession. Specifically, novice podiatrists who have not built up their practices, lack a certain type of clientele, do not hold hospital appointments, and are deficient in other professional or structural characteristics will, in order to compensate, exaggerate their attitudes and the views of their profession held by significant others. Such podiatrists are likely to perceive a more positive image of their own profession. On the other hand, those podiatrists who are already established and have the structural components of their profession satisfied are likely to be less compelled to exaggerate their attitudes and the images held by significant others. Thus, if one assumes that the perceived feedback from others is part of the extension of Hall's "attitude component", it seems possible to link this professional model with the reflected appraisals model discussed earlier to form an integrated theoretical model.

III. Integrated Theoretical Model

This section centers on a discussion of the union of the theoretical models outlined above.[5] The integration of the Reflected Appraisals Model and the extension of the Professional Model enables one to assess whether or not job-related and demographic characteristics influence self-evaluations of occupational prestige both directly and indirectly through perceived evaluations of others. By combining these models, it is assumed that the impact of the demographic and job-related charac-

[5] See Figure 1 for a graphic representation of the model.

teristics are, in part, mediated through the perceived evaluations of others. Such a model allows us to examine how the contact or interaction podiatrists have with MD/DOs (e.g. through hospital appointments and referrals) influences the evaluations podiatrists believe MD/DOs have of them and their own self-evaluations of their profession.

To establish the linkages between the two models, the underlying theoretical reasoning is now reviewed. Self-evaluation theories argue that what we think significant others think about us (perceived self-image) is important to our own overall self-image. Interlocking this with the professional model carries us a step further. As we become socialized and more established in a profession, what we think others think of us may diminish in its importance to our self-evaluation of our profession. In the extension of Hall's model, this attitudinal component is replaced by the structural benefits from being in the profession. Specifically, this professional socialization theory argues that a change occurs over time in what factors are important to our self-evaluation of our profession. Novice podiatrists who lack the structural components will exaggerate their attitudes to boost their self-evaluations of their profession. Accordingly, for more established podiatrists, the importance of the perceived evaluations of significant others weakens as structural aspects are fulfilled. If these relationships hold true, one might expect greater agreement between novice podiatrists' self and perceived evaluations than those of more established podiatrists. Established podiatrists will place greater emphasis on their achieved job characteristics. To conclude, it is quite possible to integrate these theoretical perspectives in this research.

V. Summary of Research Questions

The stage is now set to employ this integrated theoretical model to address several questions pertaining to podiatrists' occupational prestige. How does their presumed external image of "no respect" trickle down and affect podiatrists' perceptions of themselves? They are a group of people viewed as somewhat less than adequate in the external world by Medical doctors and Doctors of Osteopath - - under these conditions how are their evaluations of their profession influenced? Are

podiatrists' self-evaluations of their profession consistent with the reflected appraisals of others? What is the degree of discrepancy between podiatrists' self-evaluations and their ideas of how those higher up in the hierarchy of medicine rate them? Is there greater convergence between self and perceived others' evaluations among novice podiatrists than among more established ones? What other factors (e.g. job-related, demographic) explain podiatrists' ratings of the prestige of their profession? And, do the importance of these factors change once controls are introduced for the perceived evaluations of others?

Hypothesis Formation

The present section centers on a discussion of the hypotheses which have been generated from the literature review and the theoretical models presented in this thesis. The hypotheses will be stated informally. The specific hypotheses are:

H^1: Overall, there should be a strong correspondence between podiatrists' self-evaluations of their professional group and the perceived evaluations of their profession from MD/DOs. This outcome is derived from the research tradition of the looking-glass self and reflected appraisals.

H^2: Podiatrists with more education, higher incomes, and who perform more skillful procedures (i.e. surgery) and have greater autonomy (i.e. solo practice) should have higher self-evaluations of their profession than their counterparts. If general rankings of the prestige of occupations are largely determined by job-related skills, it follows that the podiatrists who possess these characteristics would be especially likely to have higher subjective evaluations of their profession. These relationships are expected to hold true even after controlling for the perceived evaluations from MD/DOs.

H^3: The impact of the perceived evaluations from significant others and job characteristics on self-ratings of one's profession will vary by occupational group. The perceived evaluations of significant others should be more important for novice podiatrists, and job characteristics should be more strongly related to ratings of one's profession among established podiatrists. This is expected from Hall's model of professional socialization which implies that as podiatrists become more established in the field of podiatry they develop the structural components and no longer rely so heavily on the attitudinal components. This hypothesis also provides a direct confrontation and test of the two theoretical models which form the integrated model. Reflected appraisals would predict the opposite of the augmentation of Hall's model. Under a reflected appraisals approach, established podiatrists would have higher evaluations because they possess the structural characteristics of the profession.[6] Novice podiatrists will lack the structural characteristics of the profession and therefore, have lower perceived evaluations from significant others, which would contribute to lower self-evaluations of their profession.

[6] Alternatively, given the importance of reflected appraisals over the life cycle, this theory would also predict that perceived evaluations would be important for each group of podiatrists.

CHAPTER 4: RESEARCH METHODS

The present chapter addresses the methodological issues considered in the investigation of podiatrists' occupational prestige ratings. The three major components covered include a description of the sample, measures of the variables, and a summary of the data analytic strategies utilized in this study.

I. Sample Description

The data for this study come from the 1984 National Survey of Podiatrists conducted by James K. Skipper Jr. and J. Marvin Pippert. The researchers' goal was to update a profile of the profession of Podiatry and its practice.

The survey instrument for the 1984 study consisted of a self-administered mail questionnaire, which was jointly constructed by the American Podiatric Medical Association (APMA) and the researchers in July of 1983. A copy of the survey instrument is included in Appendix B. The questionnaire was extrapolated from the 1974 National Survey of Podiatrists, along with a questionnaire given to a state sample of podiatrists. Skipper and Pippert administered a pretest of the

survey instrument in August, 1983. The final draft contains revisions and wording changes as a result of the pretest.

The survey of podiatrists was carried out from December, 1983 to August, 1984. The sampling frame was compiled from the American Podiatric Medical Association's membership roster. The APMA mailed the questionnaires out from their head office in Washington, D.C. At the time of the first mailing, 9,871 surveys were mailed to podiatrists in 49 states, the District of Columbia, and Puerto Rico. In February, 1984, a "reminder note" was sent out to all the podiatrists in the study, asking those who had not already done so to return a completed questionnaire. The Postmaster returned 1.3 percent of the questionnaires as undeliverable. The response rate of 50.3 percent was calculated based on 4,876 questionnaires returned, out of the 9,746 surveys which were actually received by the podiatrists. Regarding the representation of the sample, Skipper and Pippert state, "this sample of podiatrists is not overrepresented in some states and underrepresented in others ... there is a relatively uniform rate of returns across states and the sample would appear to be representative" (Skipper and Pippert, 1985:5).

Several additional comments concerning the sample are in order. First, the large sample size of 4,876 is substantial for each of the research questions under investigation. Second, the coders were periodically examined during the data entry stage to ensure uniformity and a minimal amount of coding error. Finally, the present study relies on secondary data which has advantages and limitations. Nonetheless, the sample of podiatrists is well-suited for examining the predictors of self-ratings, reflected ratings and the convergence between these two evaluations.

II. Measures of Variables

A. Dependent Variable

The major dependent variable, self-evaluation of one's professional group, was measured by

creating an index. Five dimensions were combined to form this index. The measure of podiatrists' self-evaluations of their professional group (podiatrists' evaluations of their own profession) is based on their answers to the question "how (do) you feel podiatrists rank on each of the five characteristics from very low to very high." The five dimensions include:[7]

Economic Rewards: Any monetary reward derived from the occupation.
Authority: Control over the behavior of others as part of the job.
Prestige: Reputation, or social ranking attached to the job.
Functional Importance: How necessary or indispensable an occupation is.
Psychological Reward: The degree of satisfaction an individual derives from his job.

Each response was recoded so that the higher the number the more positive the evaluation (Very High = 5, High = 4,Medium = 3,Low = 2,Very Low = 1). All five items were combined in an index (SELFRANK) to measure podiatrists' evaluations of their profession.

The reliability of the composite index was computed using Cronbach's alpha. According to Bohrnstedt and Knoke (1982:360), Cronbach's alpha is a measure of the internal consistency or reliability of a set of items. Alpha "ranges from zero [no internal consistency] to unity [perfect internal consistency]." This analysis allowed the Investigator to determine the overall reliability of the scale and whether the five items formed a reliable composite, or were tapping different evaluative dimensions. The inter-item reliability of the Selfrank scale as measured by Cronbach's alpha was .68.[8]

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[7] It is important to note that the Prestige dimension is measuring the podiatrists' own self-perception of their social ranking. The other four dimensions (Economic Rewards, Authority, Functional Importance, and Psychological Reward) are measuring podiatrists' social comparisons, that is, they are rating their profession on each of these characteristics relative to other professions.

[8] The five dimensions were combined because previous research has found these occupational characteristics to be important in predicting occupational prestige. To assess the predictive power of the four dimensions in explaining prestige, separate regression analyses were performed. Economic Rewards, Authority, Functional Importance, and Psychological Reward explained 35 percent of the variation in Prestige ratings. Coupled with the reliability analysis reported above, these results provide additional support for combining all measures into a single scale.

B. Independent Variables

Several independent variables were introduced into the analysis. They included the perceived evaluations from other professionals, number of years in practice, age, gender, education, income, interaction or contact with MD/DOs, hospital staff status, treatment toward podiatrists by MD/DOs, surgery privileges, and type of practice. The following discussion demonstrates how each of the independent variables was measured according to the survey instrument.

The perceived evaluations of other medical professionals were gauged by the question, "how do you feel that MD/DOs in your community rate podiatrists on each of the above five occupational characteristics?" The same five dimensions were presented: Economic Rewards, Authority, Prestige,[9] Functional Importance, and Psychological Reward. Again, responses ranged from 5 "very high" to 1 "very low" and analysis was performed on the composite measure.[10] The reliability of the perceived evaluation of others scale (PORANK) was .81.

The number of years in practice was measured by asking the podiatrists their number of "Years active since graduation from a college of Podiatric Medicine." This was deemed an important measure to distinguish those new to the profession (novice podiatrists) from those more established. Years in practice was recoded: 0 = 0-5 years (novice); 1 = 6 or more years (established).[11] Age was measured by asking for the respondents' specific age at last birthday and was recoded into young (25-35), middle (36-59), and older (60-86) age categories. The gender of the podiatrists was recoded as 0 = Female and 1 = Male.

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[9] The Prestige dimension for this independent variable (PORANK) is now measuring the perceived self-image, or how podiatrists believe MD/DOs evaluate them on their social ranking.

[10] Separate analyses were performed on each dimension. The same trends were found as when the items were combined into the scales. Therefore, the creation of the scales did not detract from the explanatory power of the models. Further elaboration on the single-item analysis is presented in the Results section.

[11] Because of the necessity to distinguish those podiatrists who were fairly new in the profession from those who were quite established, these groupings were selected. From a professional socialization perspective, it seems reasonable to consider "novices" to be persons who have engaged in the profession for less than 5 years and "established" to be in practice for a longer period.

A scale to measure podiatrists' educational status was composed of the following three items: (1) "Did you complete a residency approved by the Council on Podiatry Education?" Categories range from 1 (No) to 4 (Yes-3 or more years), (2) "Have you ever been awarded any other degree in addition to the DPM?" The responses range from 1 (No) to 6 (Doctorate), and, (3) "About how many hours of continuing education have you accumulated during the past two years?" Possible responses ranged from 1 (None) to 6 (31-40 hours). This scale proved to be unreliable with a Cronbach's alpha of only .26 and consequently, it was dropped from the analysis. Instead, two separate measures were employed to measure education. Whether or not the podiatrists had completed a residency was measured by the survey item, "Did you complete a residency approved by the Council on Podiatry Education?" Residency was recoded into a dummy variable (no = 0, yes = 1). The second measure of educational status used was whether the podiatrists were Board Certified, Board Eligible or neither. The specific question used was, "Are you Board Eligible or Board Certified?" Board status was recoded in the following manner: 1 = neither, 2 = Board Eligible, 3 = Board Certified. Podiatrists who are Board Certified have passed state/national examinations. Podiatrists who are only Board Eligible have completed their training, but have not taken state/national examinations.

Income was measured by the question, "Approximately what was your net income from your podiatric practice only last year?" Income categories ranged from 1 (less than $30,000) to 9 ($170,000 and above). To determine the degree of social interaction between podiatrists and MD/DOs (REFERRAL), respondents were asked "On average, what percentage of your patients come from MD/DO referrals?" Here, responses ranged from 1 (None) to 11 (Over 60 percent).

Several measures of job-related factors were also available in the survey. Respondents were asked whether they were on staff at a hospital (this variable was recoded into a yes/no dummy variable). Whether podiatrists have surgery privileges or not was tapped by the following item, "If you have hospital privileges, do you have delineated surgical privileges?" Response categories ranged from 1 (No) to 4 (Yes-fore foot and mid foot and rear foot). This measure was also recoded into a yes/no dummy variable. How podiatrists felt MD/DOs treated them was measured by the

survey item, "In your professional contacts with MD/DOs how do they usually treat you?" Responses were recoded: 1 = As an auxiliary health practitioner, 2 = As somewhat less than an equal, 3 = As an equal health practitioner. Finally, the type of practice the podiatrist is engaged in was considered one measure of their autonomy in the work setting. The specific questionnaire item was, "Which category best describes your current principal form of podiatric employment?" The categories ranged from 1 (Self-employed-solo practice) to 12 (College of Podiatric Medicine). Practice was recoded: 0 = Solo, 1 = Other.

III. Relevant Statistical Techniques

The pattern of analysis which is followed in this research is threefold. First, descriptive statistics are presented for the total sample and for two groups (i.e., novice and established). Second, tests of statistical significance are performed in order to rule out the possibility that the bivariate relationships could have occurred by chance. Third, multiple regression is used to examine the determinants of podiatrists' self-evaluations of their profession. This latter analysis addresses how much variation in self-evaluations is attributable to the reflected/perceived evaluations of others, demographic characteristics, and job-related factors, and what factors significantly influence these ratings among podiatrists.

CHAPTER 5: RESULTS

In this chapter, the results are organized and presented in the following manner. First, descriptive statistics are introduced for the total, novice, and established podiatrists samples. Second, results of the estimated regression models for the total sample and subsamples are shown to give a general description of the major predictors of self-evaluations for each group. And finally, formal tests of the hypotheses are presented.

I. Discussion of Descriptive Statistics

The summary statistics for the total, novice, and established samples are reported in Table 1. Summarizing the characteristics of the total sample of podiatrists, we find that they are young (mean age of 43), and male (96.6 percent). The average net income for podiatrists fell within the upper end of the category corresponding to $30,000 to $50,000 per year. Podiatrists also have higher self-evaluations of their profession ($\overline{x}$= 18.9) than their perceived evaluations of others about their profession ($\overline{x}$= 15.0).

A comparison of the descriptive statistics for each group reveals that novice podiatrists are more likely than established podiatrists to be younger in age, female, to have completed a residency, be on staff at a hospital, and to perform surgery. Established podiatrists are more likely to be in solo practice than novice podiatrists; however, solo practice is quite common for both. Comparing the mean incomes for both groups, we find a significant gap between the two, with established podiatrists having higher incomes. This was expected since novice podiatrists have not been in the profession long enough to have built up their practices and thus could not generate as much income. Finally, both novice and established podiatrists have higher self-evaluations of their profession than how they think significant others (MD/DOs) evaluate their profession.

Podiatrists' attitudes concerning how they feel MD/DOs treat them in their professional contacts offer interesting insights. Virtually one-half of all podiatrists feel that MD/DOs treat them as "equal health practitioners." However, this means that slightly less than one-half of the podiatrists feel MD/DOs treat them as "less than equals or as auxiliary health practitioners." Approximately 29 percent feel they are treated "as somewhat less than an equal," and 17.9 percent believe they are treated as "auxiliary health practitioners."[12] This trend was consistent for both the novice and established podiatrists.

Examining how podiatrists rated themselves on the five occupational domains (see Table 2), we find the following trends. The mean scores[13] for novice podiatrists are: Economic Rewards (3.93), Authority (3.51), Prestige (3.43), Functional Importance (3.85), and Psychological Reward (3.97). In contrast, when novice podiatrists were asked their perceptions of how MD/DOs in the community rate them on the same occupational characteristics, we find the means are Economic Rewards (3.64), Authority (2.81), Prestige (2.59), Functional Importance (2.73), and Psychological Reward (2.97). The means for the self-evaluations of the established podiatrists follow a similar trend (Economic Rewards [3.90], Authority [3.49], Prestige [3.55], Functional Importance [3.93],

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[12] This finding is consistent with the results of examining the means presented in this section. Podiatrists consistently perceive MD/DOs as rating podiatrists lower than the podiatrists rate themselves.

[13] As reported earlier, the scale ranges from 5 "Very High" to 1 "Very Low."

and Psychological Reward [4.12]). The means for the perceived other ratings for established podiatrists are Economic Rewards (3.54), Authority (2.88), Prestige (2.80), Functional Importance (2.85), and Psychological Rewards (3.07).

Several interesting trends should be noted. First, established podiatrists have higher self-evaluations than novice podiatrists in three intrinsic occupational domains (i.e., prestige, functional importance, and psychological reward). A second trend is both groups of podiatrists consistently have higher self-evaluation ratings than perceived other ratings. These findings further support the argument that podiatrists believe their specialty has a devalued status in the field of medicine. Podiatrists rank themselves in the upper medium to high categories, whereas podiatrists perceive MD/DOs as ranking them considerably lower than they rank themselves. Furthermore, while established podiatrists' ratings are generally higher in each domain, there are no major differences between novice and established podiatrists self-ratings of their profession and the perceived evaluations of others for their profession in each domain.

The bivariate correlations among all variables for the total sample are shown in Table 3. The bivariate correlations for novice and established podiatrists are presented in Tables 4 and 5, respectively. For the total sample (see Table 3), the strongest correlates of podiatrists' self-evaluations of their profession (SELFRANK) are the perceived evaluations of others ($r = .429$), treatment by MD/DOs ($r = .233$), and Income ($r = .158$). Similar relationships are observed within each group of podiatrists. The intercorrelations among the independent variables are also consistent with expectations. For example, the ability to perform surgery is moderately correlated with whether or not podiatrists completed a residency ($r = .344$). Income is positively correlated with the age of the podiatrist ($r = .140$). Treatment by MD/DOs is also positively correlated with the amount of referrals from MD/DOs ($r = .205$).

II A. Modeling Self-Evaluations of One's Profession

The net impact of the demographic, job-related, and perceived evaluations of others variables on podiatrists' self-evaluations of their profession for the entire sample are displayed in Table 6. As shown in this table, Model 1 contains the demographic and job-related variables. Model 2 incorporates these same predictors and introduces a measure of the perceived evaluations of significant others into the analysis. This latter regression model is estimated in order to assess whether and to what extent perceived evaluations of others mediate the impact of demographic and job-related factors on podiatrists' self-evaluations of their profession.

As shown in Model 1 of Table 6, podiatrists' assessments of how they are treated by MD/DOs exerts the strongest direct impact on self-evaluations for the total sample of podiatrists. Podiatrists who have higher incomes also have significantly higher evaluations of their profession. The job characteristics of surgery status, referrals from MD/DOs, and completion of residencies are also significant predictors of podiatrists' self-evaluations of their profession. Together, the demographic and job-related variables explain 8 percent of the variation in self-ratings of their profession ($R^2 = .078$).

When podiatrists' assessments of the evaluations from MD/DOs are included, the ability to predict self-evaluations increases considerably. In fact, the perceived evaluations of others is the strongest predictor of self-evaluations, with an additional 13 percent of the variation accounted for by this factor alone. Controlling for the perceived evaluations of others also alters the impact of the independent variables of referral and residency. Each of these variables become insignificant in their ability to explain podiatrists' self-evaluations of their profession once controls for perceived others' evaluations are introduced. Overall, 21 percent of the variation in podiatrists' self-evaluations of their profession is explained by factors relating to podiatrists' demographic profile, job-related characteristics, and perceived evaluations of others for the total sample ($R^2 = .211$).

II B. Group-Specific Models of Self-Evaluations

After performing multiple regression analyses for the total sample, separate multiple regression models were estimated for the novice and established podiatrists. The regression analyses for the sample of novice and established podiatrists are presented in Tables 7 and 8. As was true in the total sample, Models 1 and 2 in these tables successively include the demographic attributes and job-related factors, and then the perceived evaluations of significant others as predictors of self-evaluations.

As shown in Model 1 of Table 7, favorable treatment by MD/DOs is the most potent predictor of self-evaluations of their profession among novice podiatrists. Residency training and greater incomes are also positive predictors of novice podiatrists' self-evaluations of their profession. As a group, the demographic and job-related variables explain 8 percent of the variation ($R^2 = .075$).

Examining Model 2, we find that the inclusion of the perceived evaluations of others with the demographic and job-related predictors increases the explanatory power over Model 1 by an additional 12 percent. As was true of the total sample, the perceived evaluations of others is the strongest predictor of self-evaluations. Novice podiatrists who have higher incomes, complete a residency, and who think significant others treat them more favorably continue to report significantly higher self-evaluations even after perceived others' evaluations are controlled. Overall, 20 percent of the variation in novice podiatrists' self-evaluations of their profession is explained by demographic and job-related characteristics, and the perceived evaluations of significant others ($R^2 = .198$).

The effects of the demographic attributes, job-related factors, and perceived evaluations of others on the evaluations of one's profession held by established podiatrists are displayed in Table 8. The format and structure of Table 8 is identical to that of Tables 6 and 7.

As shown in Model 1 of Table 8, how established podiatrists feel they are treated by MD/DOs is the strongest predictor of the ratings of their profession. Established podiatrists who have higher incomes and do not perform surgery, ceteris paribus, also hold higher evaluations of their profession. As a group, the demographic and job-related variables explain 8 percent of the variation in established podiatrists' self-evaluations of their profession ($R^2 = .079$).

Model 2 (Table 8) incorporates the perceived evaluations of others into the analysis for established podiatrists. The perceived evaluations of significant others, again, is found to be the strongest predictor of the podiatrists' self-evaluations of their profession. The net effects of income and perceived treatment by significant other professionals are reduced somewhat in strength in this model, and surgery is no longer a significant predictor of the established podiatrists' evaluations. When the perceived evaluations of significant others are entered into the analysis, an additional 13 percent of the variation in the dependent variable is explained over and above that accounted for by the other predictors. Taken together, 21 percent of the variation in established podiatrists' self-evaluations of their profession is explained by factors relating to podiatrists' demographic characteristics, job-related experience, and perceived evaluations of others.

III. Test of Hypotheses

Hypothesis 1

Overall, there should be a strong correspondence between podiatrists' self-evaluations of their professional group and the perceived evaluations of their profession from MD/DOs.

Consistent with social psychological theories of self-evaluations, the perceived evaluations of others are strongly related to the self-evaluations of both the novice and established podiatrists. In fact, perceived evaluations of others are the strongest predictors of self-evaluations for both groups

of podiatrists (Table 7:Beta = .377; Table 8:Beta = .390). This finding supports Hypothesis 1 in which it was expected that there would be a strong correspondence between podiatrists' self-evaluations of their profession and the perceived evaluations of others (i.e. MD/DOs). Regardless of the group, the perceived evaluations of others is the strongest predictor of self-evaluations and significantly alters the impact of the demographic and job-related variables on self-evaluations.

At an aggregate level, the specific direction or nature of the relationship between self and perceived evaluations among podiatrists is as follows. For the total sample of podiatrists, 87.1 percent of them had higher self-ratings of their profession than the perceived evaluations of others. Approximately eight percent of these podiatrists gave equal ratings for both their evaluations of their profession and the perceived other evaluations from MD/DOs. Only five percent of the total group of podiatrists had higher perceived other evaluations than self-evaluations.

These same trends hold constant when examining separately the ratings for novice and established podiatrists. Eighty-eight percent of the novice podiatrists evaluated their profession higher than the evaluations of perceived others. There was congruency between self and perceived evaluations of novice podiatrists in 6.7 percent of the cases, whereas 4.8 percent of the respondents felt that MD/DOs would rate them higher than they rated themselves. For the established podiatrists, 81.4 percent had higher self-evaluations, 13.5 percent had matched ratings, and 5.1 percent had perceived ratings greater than self-evaluations. T-tests were performed in order to determine whether or not there were significant differences across the two groups. The results of this test revealed no significant difference between novice and established podiatrists' evaluations in the level of discrepancy between self and perceived other ratings. Regardless of group, self-ratings of one's profession were higher than perceived evaluations.

The computed differences between the self-evaluations and perceived evaluations for the five occupational domains (i.e. Economic rewards, Authority, Functional Importance, Prestige, and Psychological reward) also were examined separately. The self-evaluations were higher than the

perceived evaluations for four of the five domains. Economic rewards was the only domain in which podiatrists had rated themselves equally to those of the perceived evaluations of MD/DOs.

Hypothesis 2

Podiatrists with more education (i.e., residency), higher incomes, and who perform more skillful procedures (i.e. surgery) and have greater autonomy (i.e. solo practice) should have higher self-evaluations of their profession than their counterparts.

If general rankings of the prestige of occupations are largely determined by job-related skills, it follows that podiatrists who possess these characteristics would be especially likely to have higher subjective evaluations of their profession. These relationships are expected to hold true even after controlling for the perceived evaluations from MD/DOs. As shown in Tables 3 through 8, this hypothesis is supported. For instance, the strongest correlates for self-evaluations of their profession for both the novice and established podiatrists are the perceived evaluations of others ($r = .422$; $r = .429$), income ($r = .083$; $r = .168$), treatment by MD/DOs ($r = .247$; $r = .230$), referrals ($r = .078$; $r = .092$), and residency ($r = .091$; $r = .047$). As expected, podiatrists with greater incomes, residency training, and who receive more referrals from MD/DOs, have higher self-evaluations of their profession. After controlling for the perceived evaluations of others, these relationships continue to hold true (see tables 6,7,8).

Hypothesis 3

The impact of the perceived evaluations from significant others and job characteristics on self-ratings of one's profession will vary by occupational group. The perceived evaluations of significant others should be more important for novice podiatrists, and job characteristics should be more strongly related to ratings of one's profession among established podiatrists.

Hypothesis 3 is derived from the extension of Hall's model of professional socialization which implies that as podiatrists become more established in the field of podiatry they develop the structural components and no longer rely so heavily on the attitudinal components. However, this hypothesis also provides a direct confrontation and test of the two theoretical models which form the integrated model. Reflected appraisals would predict the opposite of the augmentation of Hall's model. Under this model, established podiatrists would be expected to have either equal or more positive reflected appraisals and self-ratings than novices.

The prediction about the attitude component from the extension of Hall's model was tested by examining the standardized regression coefficients for the models of novice and established podiatrists' self ratings (see tables 7 and 8). Contrary to expectations from this model, the perceived evaluations of significant others are equally important for both novice (Beta = .377) and established podiatrists (Beta = .390).[14]

The expectation that job-related characteristics would be more important among established podiatrists also was not supported. The most important predictors of self-evaluations for the established podiatrists are the perceived evaluations of others, income, and favorable treatment from MD/DOs. For novice podiatrists, the perceived evaluations of others, favorable treatment from

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[14] In addition, it is important to note that no significant difference was found between novice and established podiatrists on self-evaluations once controls for demographic, job-related, and perceived evaluations of others are introduced (see table 5). This finding also supports the claim that novice podiatrists did not "inflate" their attitude once controls for job characteristics are included.

MD/DOs, greater education (i.e. completion of residencies), and higher incomes are the most important predictors of self-evaluations.

In contrast to expectations based on a professional model, these findings suggest that attitudes and job-related characteristics are equally important to the self-evaluations of both types of podiatrists. Thus, the social psychological theory of reflected appraisals as applied to self-evaluations of one's profession received support, whereas the professional socialization model used in this study was not supported.[15]

[15] Separate regression models were also estimated for each of the five occupational domains (i.e., economic rewards, authority, prestige, functional importance, and psychological reward). The perceived evaluations of significant others are the strongest predictors for each domain. Regardless of the particular domain, perceived evaluations of others also mediate the effects of the demographic and job-related variables on self-ratings.

CHAPTER 6: DISCUSSION AND CONCLUSIONS

The present study indicates the significance of the perceived evaluations of others as a major predictor in the self-assessment of one's profession. As expected, perceived evaluations of others consistently were associated with self-evaluations, regardless of which group of podiatrists was analyzed. Consequently, the results of the data analysis lend support to Hypothesis 1. The perceived evaluations of others concerning one's profession are strongly related to the self-evaluations that podiatrists have concerning their profession. This finding concurs with the social psychological component of the integrated model explored in this research. Therefore, extending self-evaluation theories to the study of self-assessments of one's profession has future research potential.

As expected (see Hypothesis 2), podiatrists who enjoy higher incomes, complete a residency, and gain more referrals from MD/DOs, have higher self-evaluations of their profession than those podiatrists who lack these job-related characteristics. This supports the argument that general rankings of prestige are influenced by job-related skills. Further, although the data show that the perceived evaluations of others are strongly related to the self-evaluations of podiatrists, the hypothesis (Hypothesis 3) that novice podiatrists would view their own profession as more prestigious

and view others' images of their work more positively than established podiatrists was not supported.

According to Hall (1968:103), "less professionalized groups may have strong attitudes to compensate for being less established." The present research extends this idea to the study of how individuals within the same profession vary in their degrees of professionalism. It was postulated that those persons who are new to a profession would lack job-related characteristics and therefore, in order to compensate, would exaggerate their attitudes. One indicator of an exaggerated attitude would be how individuals evaluate their own profession or perceive how others view this profession. On the other hand, more established professionals would possess structural benefits from being in a profession, and would not need to "boost" their attitudes. Through time a shift may occur in relation to self-evaluations. As persons become more immersed in their profession, they will gain the job-related characteristics and may no longer need the strong self-validating attitudes.

However, in the present research this trend was not found. Established podiatrists had higher self-evaluations and perceived evaluations of their profession than novice podiatrists. Several alternative explanations are offered as to why novice podiatrists did not have higher evaluations than established podiatrists for the composite ratings.

One possible explanation for the lack of major difference in self-ratings and perceived other ratings for both groups of podiatrists may be that novice podiatrists are leaving the Podiatric Schools of Medicine already highly socialized as to what to expect when they enter the field. With the advent of residency training for podiatrists, perhaps they are increasingly socialized, formally and informally, into the profession. The novice podiatrists may realize that it does take time to build up their practices and to reap the rewards and benefits of the profession. Contrary to the professional model expectation, the novice podiatrists may not need to exaggerate their attitudes and bolster their self-evaluations. They may take on a "wait and see attitude" in respect to what their professional futures may encompass. This reasoning may help explain the present findings.

A second explanation for the current findings involves the time period chosen to differentiate between novice and established podiatrists. Specifically, the choice of a five year endpoint for the classification of a "novice" may have involved too long of a period of socialization which masks differences between "novice" and "established" podiatrists. To investigate this possibility, a separate analysis was performed on podiatrists engaged in the practice for each of the first five years. To determine if a "shift" in attitudes had occurred before the fifth year in practice, t-tests for the differences in means were performed. The mean ratings on self and perceived evaluations were virtually identical for podiatrists who had been in practice in yearly intervals from one to five years. These results reinforce the choice of a five year period for defining "novice" podiatrists and also suggest that such a classification does not distort the socialization experiences of new podiatrists.

A third possible explanation for the results is the reflected appraisals model. Under this model, persons who lack the structural features of a profession may perceive significant others' evaluations of them as quite low, which in turn lowers their self-evaluations of their profession. If this was true, reflected appraisals model would predict that established podiatrists would have more positive reflected appraisals than novice podiatrists because they possessed the structural characteristics of the profession. This argument is in direct contrast to the adaptation of the professional model. However, between differences in the self-ratings of novice and established podiatrists disappeared after controlling for job characteristics. Thus, reflected appraisals were equally important to both novice and established podiatrists.

A final explanation for the findings has to do with the specification of Hall's Professional Model as utilized in this research. The attitudinal component of the extension of Hall's model was operationalized as relating to the self-evaluations of one's profession and the perceived evaluations of others in terms of economic rewards, authority, prestige, functional importance and psychological reward.[16] Self-evaluations were computed by summing the ratings given on these five occupational dimensions. It was predicted that the novice podiatrists would have the highest scores on this

[16] As previously stated, this research is testing different attitudes than those tested by Hall.

measure, in other words, have the strongest attitudes. The present research did not find support for this expectation, and subsequently, the presumed shift from "attitudinal" to "structural" components of one's profession was not supported.[17]

However, it is important to note that we can not conclusively state that the adaptation of Hall's model to the study of one's profession lacks utility. Further research is necessary to test this approach on other members of the health care team who, like podiatrists, are externally located in devalued statuses. For example, testing the adaptation of Hall's model on a sample of gynecologists, pediatricians, or other group may yield contradictory results compared to the present findings, and therefore, give credence to the utility of the extension of Hall's model as used in this research. Similar tests could also be performed within more established medical areas (i.e., heart surgeons). Such a comparison would allow us to ascertain whether there is something unique about the professional socialization of podiatrists that is different from that of other medical professionals. Additional research may also determine whether Hall's model is applicable to both intraoccupational and interoccupational differences.

Of significant relevance to the present study are the findings regarding the integrated model employed in this research. Evidence for the usefulness of extending social psychological theories of self-evaluation to the assessment of one's profession was supported. What we think a significant other thinks of us in our professional role influences our self-evaluations. One of the major findings in this study was the strong relationship between self-evaluations of a profession and the perceived evaluations of a profession for both novice and established podiatrists.

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[17] A related explanation for the nonsignificant findings of the extension of the professional model, involves measurement. Perceptual variables are more likely to correlate highly with other perceptual, rather than structural variables. This factor could additionally account for why perceived evaluations of significant others are more strongly related to self-evaluations of one's profession than job-related measures among both types of podiatrists. For a related discussion of the relationship between perceptual and structural measures see for instance, Price and Mueller (1986) and Anderson (1971).

Implications and Suggestions for Future Research

The current findings emphasize the potential benefits of using social psychological theories of self-evaluation to the study of locating the determinants for rating one's profession. For instance, the similar effects of the perceived evaluations of others on self-evaluations of one's profession held by novice and established podiatrists suggest that the reflected appraisals of others are important determinants of self-evaluations throughout one's professional socialization. Likewise, the greater interaction and contact established professionals have with other medical professionals may enhance the imagined evaluations of others and, accordingly, enhance their self-evaluations of their profession.[18] Following the idea that evaluations of one's profession are one factor in the make-up of our self-concepts (Rosenberg, 1986), a greater understanding of this relationship between our self-evaluations and the perceived evaluations of others about our profession may contribute to better working conditions, feelings of job satisfaction, and better quality of life. Therefore, an examination of the attitudinal and structural components of one's profession may have important implications for one's overall self-concept.

This research also has important implications for the self-evaluations of podiatrists, their success in meeting patients' needs, and obtaining good working relationships with MD/DOs. In the attainment of the third goal, podiatrists need to increase their interaction with MD/DOs as one solution to reducing the discrepancy between the evaluations podiatrists hold of their profession and those held by significant others. Acknowledging the fact that we do not have measures of how MD/DOs really view podiatrists,[19] the gap between self-evaluations and perceived evaluations seems to be detrimental to effective social interaction. To reiterate, the image of "no respect" may hamper

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[18] Separate multiple regression analyses were performed to determine the most important predictors of the perceived evaluations of significant others. The two most significant predictors were the contact variables, perceived treatment and referrals from MD/DOs. If we can assume that the contact between podiatrists and MD/DOs influences how MD/DOs feel about podiatrists, this in turn will influence podiatrists' perceived evaluations from MD/DOs and will contribute to their self-evaluations.

[19] As previously reviewed, social psychological theories of self-evaluation posit that what we think others think of us is more important to us than what they actually think of us.

podiatrists' dealings with other medical professionals. Greater interaction can be achieved through improvements in required education (i.e., residencies), more hospital staff appointments, and overall contact in general. Through increased contact may come better treatment from MD/DOs and mutual understanding, resulting in podiatrists' perceiving more positive attitudes from these significant others which, in turn, may bolster their own self-images. Additionally, this improvement in the relationships between MD/DOs and podiatrists can only lead to improved health care functioning and better patient care. In sum, encouraging more harmonious relationships between MD/DOs and podiatrists should improve the evaluations MD/DOs make of podiatrists, the reflected appraisals of others, and the podiatrists' own self-evaluations.

Finally, this study should stimulate further research in the area of occupational sociology. Specifically, studies incorporating the social psychological theories of self-evaluation are needed to assess the major predictors of evaluations of one's profession. More stringent measures of job-related characteristics, self-evaluations, and perceived evaluations of others are also needed. Although the independent variables explained a respectable proportion of the variation, the majority of variation in self-evaluations of one's profession was not explained by the demographic, job-related, and perceived other measures used in this study. By being cognizant of the issues raised in this study, we will be better able in future research to examine the structural and interpersonal determinants of self-evaluations of one's profession and understand whether the importance of these factors changes over time during one's professional socialization.

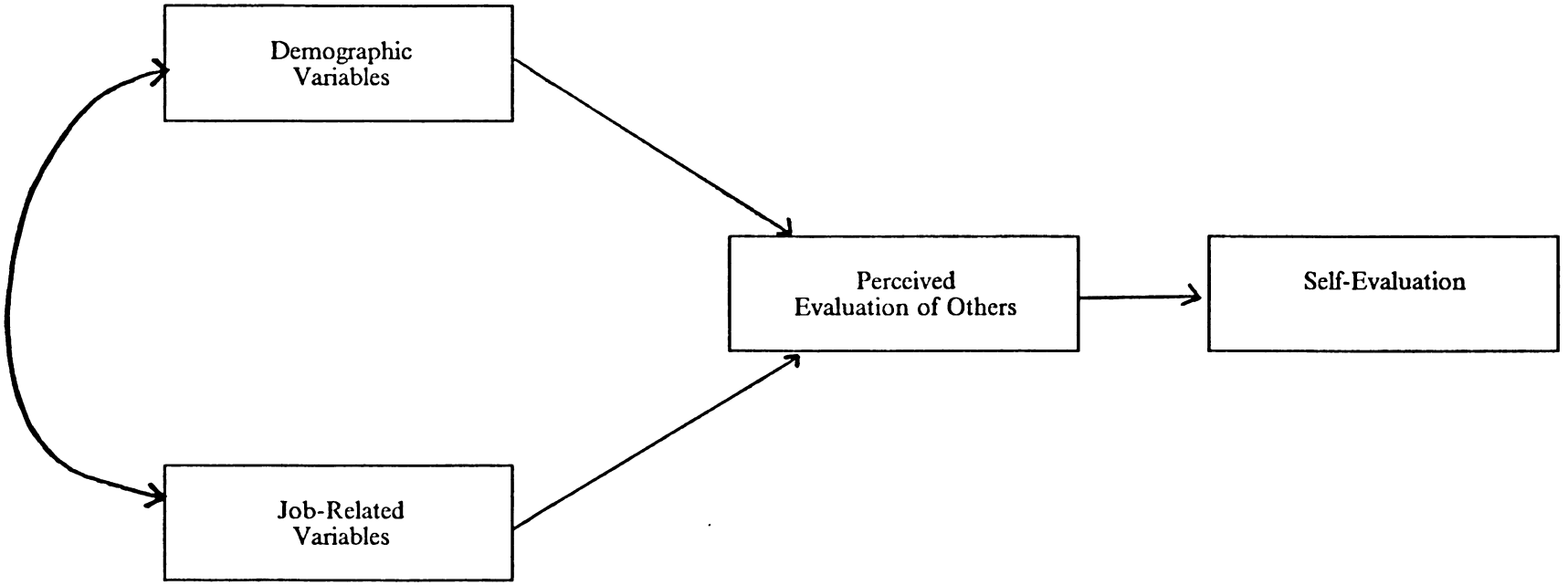

Figure 1. Integrated Model

Table 1

Variables, Coding, and Summary Measures

Variable (Name)	Codes	Mean or Percent (Standard Deviations) Total (n = 3306)	Novice (n = 1006)	Established (n = 2300)
Independent Variables				
a. Demographic Characteristics				
Age (AGE)	1 25-35 years	40.6%	90.7%	18.6%
	2 36-59 years	47.0%	9.2%	63.7%
	3 60-86 years	12.4%	.1%	17.7%
		$\bar{x}$ = 43.1	$\bar{x}$ = 31.3	$\bar{x}$ = 48.0
Gender (MALE)	0 Female	3.4%	6.9%	2.0%**
	1 Male	96.6%	93.1%	98.0%
Net Income (INCOME)	1 < $30,000	$\bar{x}$ = 2.9	$\bar{x}$ = 1.9	$\bar{x}$ = 3.3**
	2 $30,000-$50,000	(1.9)	(1.4)	(1.9)
	3 $50,000-$70,000			
	4 $70,000-90,000			
	5 $90,000-$110,000			
	6 $110,000-$130,000			
	7 $130,000-$150,000			
	8 $150,000-$170,000			
	9 $170,000 and above			
Education (RESIDENCY)	0 No	54.7%	30.5%	65.2%**
	1 Yes	45.3%	69.5%	34.8%
Board Status (BOARD)	1 neither	62.2%	65.9%	60.7%
	2 Board Eligible	16.9%	27.3%	12.3%
	3 Board Certified	17.0%	5.0%	22.3%
b. Job Characteristics				
Number of Years in Practice (YEAR)	0 0-5 years	30.8%	--	--
	1 6 or more	69.2%	--	--
Type of Practice (PRACTICE)	0 Solo	69.9%	67.5%	71.6%**
	1 Other	30.1%	32.5%	28.4%
Treatment by MD/DOs (TREAT)	1 Auxiliary health practitioner	17.9%	14.9%	19.2%
	2 As somewhat less than an equal	29.4%	32.7%	28.0%
	3 As an equal health practitioner	52.7%	52.4%	52.8%

Table 1 Continued

Variables, Coding, and Summary Measures

Variable (Name)	Codes	Mean or Percent (Standard Deviations) Total (n = 3306)	Novice (n = 1006)	Established (n = 2300)
Referrals from MD/DOs (REFERRAL)	0 None 2 1-5% 3 6-10% 4 11-15% 5 16-20% 6 21-25% 7 26-30% 8 31-40% 9 41-50% 10 51-60% 11 over 60%	$\bar{x}$ = 3.6 (2.3)	$\bar{x}$ = 3.7 (2.4)	$\bar{x}$ = 3.5 (2.2)
Hospital Staff (HOSPITAL)	0 No 1 Yes	25.0% 75.0%	17.2% 82.8%	28.4%** 71.6%
Surgery Privileges (SURGERY)	0 No 1 Yes	37.5% 62.5%	25.9% 74.1%	42.6%** 57.4%
c. Attitude Component				
Perceived Other Evaluations				
(PORANK)	5-item scale (0-25)	$\bar{x}$ = 15.0 (3.1)	$\bar{x}$ = 14.7 (3.0)	$\bar{x}$ = 15.1** (3.1)
SELFRANK-PORANK (DIFFERENCE)				
S > PO[1]		87.1%	88.5%	81.4%
S = PO[1]		7.9%	6.7%	13.5%
PO > S[1]		5.0%	4.8%	5.1%
Dependent Variable				
Self-evaluations of Professional Grouping (SELFRANK)	5-item scale (0-25)	$\bar{x}$ = 18.9 (2.5)	$\bar{x}$ = 18.7 (2.4)	$\bar{x}$ = 19.0** (2.6)

NOTES:

[1]S = Self-evalautions; PO = Perceived Other Evaluations

*Significant differences in means or proportions between Novice and Established podiatrists at $p < .05$, ** $p < .01$.

Table 2

Means for Novice and Established Podiatrists' Self-Evaluations and Perceived Other Evaluations for the Five Occupational Domains

	NOVICE		ESTABLISHED	
	Self	Other	Self	Other
Economic Rewards	3.93	3.64	3.90	3.54
Authority	3.51	2.81	3.49	2.88
Prestige	3.43	2.59	3.55	2.80
Functional Importance	3.85	2.73	3.93	2.85
Psychological Reward	3.97	2.97	4.12	3.07

Table 3

Bivariate Correlations for Podiatry Study (Total Sample)

	Selfrank	Year	Age	Male	Income	Residency	Board	Practice	Treat	Referral	Hospital	Surgery
Selfrank												
Year	.053											
Age	.017	.621										
Male	-.013	.124	.070									
Income	.158	.305	.140	.106								
Residency	.040	-.321	-.410	.038	-.023							
Board	.071	.144	-.015	.052	.296	.213						
Practice	.014	.-029	-.058	-.014	.041	.055	.080					
Treat	.233	-.018	-.031	.006	.081	.086	.111	.045				
Referral	.085	-.039	-.086	-.010	.059	.149	.190	.112	.205			
Hospital	.034	-.118	-.247	.040	.094	.287	.252	.074	.126	.215		
Surgery	.011	-.159	-.307	.025	.065	.344	.271	.094	.135	.196	.733	
Porank	.429	.062	.069	-.047	.082	.022	.052	.017	.314	.149	.048	.032

N = 3306

Table 4

Bivariate Correlations for Novice Podiatrists

	Selfrank	Age	Male	Income	Residency	Board	Practice	Treat	Referral	Hospital	Surgery
Selfrank											
Age	-.022										
Male	-.013	.013									
Income	.083	.066	.090								
Residency	.091	-.052	-.035	.007							
Board	.039	-.018	.004	.123	.295						
Practice	-.018	-.035	-.030	.036	.004	.066					
Treat	.247	.016	.024	.099	.099	.107	.014				
Referral	.078	.033	-.002	.005	.106	.187	.152	.145			
Hospital	.022	-.002	.043	.096	.264	.165	.054	.076	.133		
Surgery	.007	-.015	.038	.084	.311	.184	.040	.086	.134	.750	
Porank	.422	-.006	-.042	.061	.096	.058	.005	.336	.156	.063	.075
N = 1006											

Table 5

Bivariate Correlations for Established Podiatrists

	Selfrank	Age	Male	Income	Residency	Board	Practice	Treat	Referral	Hospital	Surgery
Selfrank											
Age	-.021										
Male	-.027	-.019									
Income	.168	-.089	.073								
Residency	.047	-.344	.031	.107							
Board	.069	-.149	.058	.297	.275						
Practice	.030	-.056	.005	.059	.068	.093					
Treat	.230	-.035	-.003	.091	.077	.118	.056				
Referral	.092	-.109	-.007	.099	.161	.206	.091	.230			
Hospital	.046	-.266	.071	.148	.265	.302	.079	.142	.244		
Surgery	.024	-.323	.056	.130	.314	.333	.112	.151	.218	.723	
Porank	.429	.051	-.069	.070	.023	.040	.025	.307	.150	.053	.030
N = 2300											

Table 6

Regression Models of Podiatrists' (Total Sample) Self-Ratings of Their Profession[1]

Predictors[2] [3]	Model 1	Model 2
Novice	-.031	-.021
Age	-.005	-.036
Male	-.031	-.008
Income	.135*	.118*
Residency	.040*	.029
Board	-.001	.005
Practice	-.004	-.003
Treat	.216*	.103*
Referral	.035*	-.001
Hospital	.023	.013
Surgery	-.059*	-.051*
Porank		.387*
R^2	.078	.210
N = 3306		
*p < .05		

NOTES:

[1]The numbers in the table are the standardized partial regression coefficients for the variables in each model.

[2]Male, Residency, Hospital and Surgery are dummy variables.

[3]See text for descriptions of all variables.

Table 7

Regression Models of Novice Podiatrists' Self-Ratings of Their Profession[1]

Predictors[2] [3]	Model 1	Model 2
Age	-.029	-.024
Male	-.021	-.022
Income	.070*	.056*
Residency	.079*	.060*
Board	-.017	-.011
Practice	-.031	-.024
Treat	.232*	.113*
Referral	.050	.009
Hospital	.023	.024
Surgery	-.062	-.071
Porank		.377*
R^2	.075	.198
N = 1006		
*p < .05		

NOTES:

[1]The numbers in the table are the standardized partial regression coefficients for the variables in each model.

[2]Male, Residency, Hospital and Surgery are dummy variables.

[3]See text for descriptions of all variables.

Table 8

Regression Models of Established Podiatrists' Self-Ratings of Their Profession[1]

Predictors[2] [3]	Model 1	Model 2
Age	-.001	-.031
Male	-.036	-.009
Income	.149*	.130*
Residency	.021	.015
Board	.001	.006
Practice	.008	.007
Treat	.212*	.101*
Referral	.029	-.004
Hospital	.024	.011
Surgery	-.059*	-.044
Porank		.390*
R^2	.079	.214
N = 2300		
*p < .05		

NOTES:

[1]The numbers in the table are the standardized partial regression coefficients for the variables in each model.

[2]Male, Residency, Hospital and Surgery are dummy variables.

[3]See text for descriptions of all variables.

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Appendix A.

National opinion on prestige of occupations

Occupations	NORC score,1963
U. S. Supreme Court Justice	94
Physician	93
Nuclear physicist	92
Scientist	92
Cabinet member in the federal government	90
College professor	90
Chemist	89
Lawyer	89
Dentist	88
Member of board large corporation	87
Civil engineer	86
Banker	85
Accountant (large business)	81
Public School teacher	81
Small factory owner	80
Building contractor	80
Policeman	72
Bookeeper	70
Carpenter	68
Mail carrier	66
Truck driver	59
Clerk in a store	56
Farmhand	48
Janitor	48
Garbage collector	39

Source: Hodge et al. 1966:324-325

Appendix B.

1983 SURVEY OF PODIATRISTS AND PODIATRIC PRACTICE

Confidentiality

The information supplied on this questionnaire will be for the sole use of the American Podiatry Association. Only aggregate statistical data will be reported. Individual names and addresses and other characteristics will not be reported. Thank you for your cooperation.

Instructions

When completing items on the questionnaire use the week of November 14–19, 1983, as the base for all responses. For example, when asked, "How many patients do you see each week"? Please list the number of patients seen during this week in November.

Whenever possible, circle the number corresponding to your response.

---

1. Age at last birthday.

_____

2. Sex.

1. Male
2. Female

3. Race-Ethnic. (Circle one number only)

1. White (Non-Hispanic)
2. White (Hispanic)
3. Black
4. Oriental
5. American Indian
6. Other (Please specify) _____

4. Years active in podiatry since graduation from a college of podiatric medicine.

_____

5. In what state or states are you licensed to practice podiatry?

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

In what state do the majority (50% or more) of your patients reside?

_____

How many office sites do you have in your practice? (Circle one number only)

1. Zero
2. One
3. Two
4. Three
5. Four
6. Five
7. More than 5 (Please specify number) _____

Did you complete a residency approved by the Council on Podiatry Education? (Circle one number only)

1. No
2. Yes—1 year
3. Yes—2 years
4. Yes—3 or more years

Are you Board Eligible or Board Certified? (Circle one number only)

1. Neither
2. Board Eligible: American Board of Podiatric Surgery
3. Board Certified: American Board of Podiatric Surgery
4. Board Eligible: American Board of Podiatric Orthopedics
5. Board Certified: American Board of Podiatric Orthopedics

Which category best describes your father's occupation while you were growing up? (Circle one number only)

1. Podiatrist
2. MD
3. Other professional
4. Business executive
5. Service occupation
6. Small business
7. White collar
8. Skilled labor
9. Unskilled labor
10. Agriculture

Have you ever applied to a medical, dental or school of veterinary medicine? (Circle one number only)

1. No
2. Yes—Medical School
3. Yes—Dental School
4. Yes—School of Veterinary Medicine

What age did you make the decision to become a podiatrist? (Circle one number only)

Before age 15
15–16
17–18
19–20
21–22
23–25
Over the age of 25 (Please specify) _____

ease rate the following items in terms of importance to your decision to become a podiatrist. (1 = Very portant, 2 = Important, 3 = Neutral, 4 = Not Important, 5 = Very Unimportant)

	Very Important	Important	Neutral	Not Important	Very Unimportant
come	1	2	3	4	5
estige	1	2	3	4	5
rvice to others	1	2	3	4	5
utonomy	1	2	3	4	5
ealth related	1	2	3	4	5
mily tradition	1	2	3	4	5
(a parent or close relative was a podiatrist)					
ther (Please specify)					
_____	1	2	3	4	5
_____	1	2	3	4	5

At which *location* did you receive your podiatry degree? (Circle one number only)

1. San Francisco, California
2. Chicago, Illinois
3. Cleveland, Ohio
4. New York, New York
5. Philadelphia, Pennsylvania
6. Other (Please specify) _____

Have you been awarded any other degrees in addition to the DPM? If yes, please check the highest appropriate degree. (Circle one number only)

1. No
2. Yes—Associate (AA)
3. Yes—Bachelors (BS or BA)
4. Yes—Master of Public Health
5. Yes—Master of Arts or Sciences
6. Yes—Doctorate
7. Yes—Other Professional Degree (Please specify) _____

Approximately what was your gross income from your *podiatric practice only* last year? (Circle one number only)

1. Less than $30,000
2. $30,000—$50,000
3. $50,000—$70,000
4. $70,000—$90,000
5. $90,000—$110,000
6. $110,000—$130,000
7. $130,000—$150,000
8. $150,000—$170,000
9. $170,000—$190,000
10. $190,000 and above

11. Approximately what was your net income from your *podiatric practice only* last year? (Circle one number only)

1. Less than $30,000
2. $30,000—$50,000
3. $50,000—$70,000
4. $70,000—$90,000
5. $90,000—$110,000
6. $110,000—$130,000
7. $130,000—$150,000
8. $150,000—$170,000
9. $170,000 and above.

12. Which category below *BEST* describes your current principal form of podiatric employment? (Circle one number only)

1. Self-employed—solo practice
2. Self-employed—partnership practice
3. Self-employed—group practice
4. Self-employed—Preferred Provider Organization (PPO)
5. Employee of Federal Government
6. Employee of Health Maintenance Organization (HMO)
7. Employee of State or Local Government
8. Employee of non-governmental organization or institution
9. Employee of non-prepaid group health plan
10. Employee of other podiatrist
11. Retired
12. College of Podiatric Medicine
13. Other (Please specify) _____

13. About how many hours of continuing education have you accumulated during the past two years? (Circle one number only)

1. None
2. 1—5 hours
3. 6—10 hours
4. 11—20 hours
5. 21—30 hours
6. 31—40 hours
7. 41—50 hours
8. 51—75 hours
9. 76—100 hours
10. Over 100 hours

14. How do you plan to vote in the next state election? (Circle one number only)

1. Democrat
2. Republican
3. Other party (Please Specify) _____

Listed below is an explanation of five occupational characteristics.

a. *Economic Rewards*—Any monetary reward derived from the occupation.
b. *Authority*—Control over the behavior of others as part of the job.
c. *Prestige*—Reputation, or social ranking attached to the job.
d. *Functional Importance*—How necessary or indispensable an occupation is.
e. *Psychological Reward*--The degree of satisiaction an individual derives from his job.

11. Please indicate how *you* feel podiatrists rank on each of the five characteristics from very low to very high.

	Very High	High	Medium	Low	Very Low	Not Certain
Economic Rewards	1	2	3	4	5	6
Authority	1	2	3	4	5	6
Prestige	1	2	3	4	5	6
Functional Importance	1	2	3	4	5	6
Psychological Reward	1	2	3	4	5	6

12. How do you feel that *MD/DOs* in your community rate *podiatrists* on each of the above five occupational characteristics?

	Very High	High	Medium	Low	Very Low	Not Certain
Economic Rewards	1	2	3	4	5	6
Authority	1	2	3	4	5	6
Prestige	1	2	3	4	5	6
Functional Importance	1	2	3	4	5	6
Psychological Reward	1	2	3	4	5	6

1. What percentage of your time per week do you spend in each of the following podiatric activities?

_____% percentage in patient care
_____% percentage in teaching podiatric related courses—clinical
_____% percentage in teaching podiatric related courses—didactic
_____% percentage in podiatric research
_____% percentage in program or institutional administration
_____% percentage of other podiatric activities (e.g., training received after podiatric degree, etc.)

********** STOP **********

you are *not* currently providing patient care, *STOP*—the remainder of the questionnaire does not apply. ase return this questionnaire in the prepaid return envelope provided. Thank you for your participation.

On average, how many hours per week do you spend in podiatric practice?

_____

What percentage of your professional time during the week of November 14—19, 1983 was spent in the following activities?

_____% percentage in general practice
_____% percentage in surgery
_____% percentage in foot orthopedics or biomechanics
_____% percentage in sports medicine
_____% percentage in other clinical practice activity (Please specify) _____

How many different patients did you see during the week of November 14–19, 1983, regardless of setting? Count each "different patient" only once, regardless of the number of times seen or the setting.

_____ number of different patients

What percentage of all the different patients seen by you during the week of November 14–19, 1983 were in the age categories specified?

_____% percentage 16 years or less
_____% percentage 17 to 44 years
_____% percentage 45 to 64 years
_____% percentage 65 years or more
100 % = all different patients seen

On average, what percentage of your patients are female? (Circle one number only)

1. 0–25%
2. 26–35%
3. 36–40%
4. 41–45%
5. 46–50%
6. 51–55%
7. 56–60%
8. 61–65%
9. 66–70%
10. 71% and over.

On average, what percentage of your patients are Black, or Spanish speaking?

Black	*Spanish Speaking*
1. None	1. None
2. 1–2%	2. 1–2%
3. 3–5%	3. 3–5%
4. 6–10%	4. 6–10%
5. 11–20%	5. 11–20%
6. 21–30%	6. 21–30%
7. 31–40%	7. 31–40%
8. 41–50%	8. 41–50%
9. 51–75%	9. 51–75%
10. 76–100%	10. 76–100%

What is the approximate population size of the community where the majority of your patients reside?

1. Less than 2,500
2. 2,500–9,999
3. 10,000–49,999
4. 50,000–99,999
5. 100,000–499,999
6. 500,000 and over

Of the patients seen by you during the week of November 14–19, 1983, how many patient visits do these represent? The number of "patient visits" is the total number of times you saw patients during the week of November 14–19, 1983. Include each separate patient visit, even if the same patient was seen more than once.

_____ number of patient visits

12. What percentage of your patient visits during the week of November 14–19, 1983 were spent in each of the settings specified?

_____% percentage in private office
_____% percentage in hospital, inpatient
_____% percentage in hospital, outpatient
_____% percentage in clinic (non-hospital clinic)
_____% percentage in surgi-center
_____% percentage in nursing home
_____% percentage in resident facility or school for the handicapped
_____% percentage in patient's home
_____% percentage in other setting(s)

13. Of the patients seen by you during the week of November 14–19, 1983, what percentage had the following diagnoses?

Corns and callosities	_____%
Onychomycosis	_____%
Other diseases of the nail	_____%
Ulcerations	_____%
Warts	_____%
Bursitis/synovitis	_____%
Symptomatic flatfoot	_____%
Hallux valgus/varus	_____%
Hammertoes	_____%
Sprains and strains	_____%
Fractures	_____%
Tumors	_____%
Vascular disorders	_____%
Others (Please specify)	_____%
_____	_____%
_____	_____%
_____	_____%

14. On average, what percentage of your patients come from MD/DO referrals? (Circle one number only)

1. None
2. 1–5%
3. 6–10%
4. 11–15%
5. 16–20%
6. 21–25%
7. 26–30%
8. 31–40%
9. 41–50%
10. 51–60%
11. Over 60%

15. On average, what percentage of your patients do you refer to MD/DOs for the evaluation and treatment of systemic diseases? (Circle one number only)

1. None
2. 1–5%
3. 6–10%
4. 11–20%
5. 21–30%
6. Over 30%

36. On average, how often during a week do you discuss the issues of patient care with MD/DOs? (Circle one number only)

1. Never
2. 1 time
3. 2—3 times
4. 4—6 times
5. 7—10 times
6. More than ten times

37. In your professional contacts with MDs/DOs how do they usually treat you?

1. As an equal health professional
2. As somewhat less than an equal
3. As an auxillary health practitioner
4. Other (Please specify) _____

38. On average, what percentage of your reimbursement comes from Medicare payments? (Circle one number only)

1. None
2. 1—10%
3. 11—25%
4. 26—50%
5. 51—75%
6. 76—100%

39. On average, what percentage of your reimbursement comes from Medicaid payments?

1. None
2. 1—10%
3. 11—25%
4. 26—50%
5. 51—75%
6. 76—100%

40. What percentage of your reimbursement comes from third party payers other than government? (Circle one number only)

1. None
2. 1—10%
3. 11—25%
4. 26—50%
5. 51—75%
6. 76—100%

Are you on staff at a hospital? (Circle one number only)

1. No
2. Yes—Medical Staff
3. Yes—Other Professional Staff

********** STOP **********

ou are *not* on the staff at a hospital, *STOP*—remainder of questionnaire does not apply. Please return this stionnaire in the prepaid return envelope provided. Thank you for your participation.

42. If you have hospital privileges do you have delineated surgical privileges? (Circle one number only)

1. No
2. Yes—Fore foot
3. Yes—Fore foot and mid foot
4. Yes—Fore foot and mid foot and rear foot

43. Indicate with an "X" in the space provided below the hospital privileges which you have been granted.

	Incision	Excision	Introduction	Repair	Destruction	Manipulation
Integument and Soft Tissue	1	2	3	4	5	6
Musculoskeletal	7	8	9	10	11	12
ripheral Vascular	13	14	15	16	17	18
heral Nervous	19	20	21	22	23	24

uthorized by the hospital to amputate a part of the foot?

uch for your cooperation. If there is anything else you would like to tell us about yourself, patients and the profession of podiatry, please use the space provided below or attach a naire. Please return this questionnaire in the prepaid return envelope provided.

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