Maria Cancian and Deborah Reed examine how changes in family structure have affected progress in reducing poverty. They find that the increasing percentage of single-mother families and related declines in two-parent households have been the most important impediments to progress, although the increase in female labor force participation has moderated their effects to some extent. Richard Freeman finds evidence that the poverty rate has become less sensitive to changes in economic growth and the unemployment rate. He forecasts that improvements to growth in the future will have less impact than in the past because the poor are now disproportionately composed of the disabled, retirees, and unskilled immigrants, groups largely unaffected by labor market opportunities; he also predicts that any rise in unemployment will increase poverty because it will reduce employment among those with minimal access to government transfers. John Karl Scholz and Kara Levine examine trends in spending on means-tested and social insurance programs and find that total cash transfers have slowly risen over time, as expenditure declines for single mother programs like AFDC-TANF have been outweighed by increases in the Earned Income Tax Credit, but that major growth has occurred in Medicaid, Supplementary Security Income, and Food Stamp spending, which has led to large increases in overall spending. While this upward trend in expenditures would ordinarily be expected to reduce poverty, it has been overmatched by rising inequality and the increasing atomization of households.

Other important topics covered in the volume are trends in U.S. poverty compared to those in other countries (Smeeding, Lee Rainwater, and Burtless); whether poverty is permanent or transitory, and how it affects children (Mary Corcoran); changes in recent welfare reform policies (Ladonna Pavetti); trends in health policies for the non-elderly poor (John Mullahy and Barbara Wolfe); and human capital programs (Lynn Karoly). Three rarely examined subjects that receive attention are housing discrimination and poverty (John Yinger), membership theories of poverty (Steven Durlauf), and community revitalization (Ronald Ferguson).

The last three chapters contain brief final thoughts by three authors. Glenn Loury argues that finer distinctions are needed to capture different concepts of poverty, not all of which are easily quantifiable, and that racial differences need special attention. David Harris discusses whether the high-tech revolution could affect discrimination. Finally, Jane Waldfogel discusses various possible poverty-related factors that are not treated in the other chapters.

Robert A. Moffitt

Professor of Economics
Johns Hopkins University

Company Doctor: Risk, Responsibility, and Corporate Professionalism. By Elaine Draper. New York: Russell Sage Foundation, 2003. 328 pp. ISBN 0-87145-249-8, $39.95 (cloth).

Doctors have long been regarded as the ideal type of the autonomous professional. As Eliot Freidson observed in *Profession of Medicine* (New York: Harper & Row, 1970), doctors, unlike other workers, have traditionally possessed a great deal of autonomy because they have been relatively free, within the privacy of their consulting rooms, to give patients sound medical advice, unfettered by the constraints of organizational requirements. Since the 1960s, however, medical practice has been transformed from the ideal of physician as solo practitioner to the doctor as employee in some form of group practice or organizational setting. Within this context, many social scientists argue that doctors, like practitioners in other occupations before them, are increasingly becoming deprofessionalized and captives of their employing organizations. Elaine Draper's *The Company Doctor: Risk, Responsibility, and Corporate Professionalism* is a welcome addition to this important debate about the role of medicine in a corporate America increasingly preoccupied with the bottom line.

Company doctors have been regarded as standing on the lowest rungs of the medical profession, because it is not always apparent whether they are their patients' allies or their employers' agents of social control. To their credit, corporate physicians have worked hard to improve their professional image. The American Occupational and Environmental Medical Association's code of ethics, for instance, requires corporate physicians to "accord the highest priority to the health and safety of the individual." Spurred by federal funding for health and safety in the 1970s, medical schools greatly expanded physician training in occupational and environmental medicine, and since the 1980s the occupation has increasingly attracted a new breed of physician committed to, and trained in, public health and disease preven-

tion. Nevertheless, as corporate physicians have become more professional, the conditions under which they labor have shifted dramatically, pushing them from the privacy of their consulting rooms into the corporate mainstream, where they are expected to act as "team players" by controlling the costs associated with employees' health. This shift in emphasis has been driven by changes in the legal environment. Laws such as the Occupational Safety and Health Act, the American Disabilities Act, and the Drug-Free Workplace Act, while seeking to hold corporations accountable for their behavior, have turned the practice of corporate medicine increasingly toward managing corporate risks and liabilities.

Despite the important role of corporate medicine in American businesses, there have been few studies of what company doctors actually do. Draper, drawing on in-depth interviews, historical documents, and archival materials, examines the work-a-day world of corporate physicians. Rather than apply abstract ethical standards to doctors' behavior, she puts their actions in social and economic context, which allows the reader to grasp fully that the problems of company physicians are due not to "bad values" but to their position within the corporation.

Although company doctors are expected to be team players, they are seldom fully accepted as equals by managers, who tend to view them as too sympathetic to employees and unsophisticated about managing budgets and to see their services as an operating expense contributing little or nothing to the immediate bottom line. In order to reduce the costs associated with corporate medical programs and spread around their liability for employee health, many companies have turned to outsourcing, which puts pressure on the remaining doctors and programs to contain costs and protect their employers' interests. Within this context, well-intentioned corporate physicians have a hard time selling management on prevention activities, especially those that might unearth serious workplace hazards, necessitate changes in production processes, create bad publicity, and prompt employee, consumer, and shareholder lawsuits. Instead of focusing on workplace risks, company doctors increasingly emphasize detecting and preventing individual health risks.

Drug testing, for example, has become big business and is a prototype for how corporate physicians collect and use employees' medical information. Although the federal law does not require drug testing of employees in all industries, employers generally approach the legislation as though it does. Employers fear that if they do not drug-test and their competitors do, they will gain a reputation as being soft on drugs and become a magnet for drug users and addicts. At the same time, questions about the efficacy of drug testing and its relationship to privacy and industrial jurisprudence abound. Despite the many questions about drug testing, company doctors, following the leadership of the American Occupational and Environmental Medical Association, have embraced it as a mechanism for increasing their budgets and giving them more clout within the company. Corporate doctors perform a variety of drug screens—pre-employment, random, for-cause, and compliance. In each instance, the medical program collects and stores the information, which is used by management in making critical decisions about an individual's employability. Corporate doctors are well aware that this new policing role conflicts with their clinical function as advocates for employees, and many wish aloud to be rid of it. Still, the majority have adapted to it, justifying it as a cost of doing business in modern America, distancing themselves from their police role, and arguing that they are simply making workers fit for duty and not making employment decisions.

Today, being a corporate physician requires collecting a wide range of health information that may be used against employees in a variety of legal and quasi-legal situations with their employers, including workers' compensation cases, arbitration hearings, and insurance claims. In addition to drug testing and routine medical examinations, corporate doctors collect a wide array of genetic and psychological information. Despite claims of confidentiality and regulations designed to protect employee privacy, this information routinely finds its way into employer-employee disputes, which typically are resolved in the employer's favor. As with drug testing, corporate physicians have simply rationalized their role in these proceedings as ensuring a healthy work force.

Company Doctor, which was probably on its way to press as the recent rash of corporate scandals hit the press (particularly the role of Arthur Andersen in helping Enron cook its books), highlights the dual loyalty bind that all professional workers—lawyers, accountants, engineers—find themselves in when they become corporate employees. When confronted with corporate circumstances that their autonomous professions would describe as unethical, how do they respond? Professional codes of

ethics and training programs too often present these as simple normative choices. This book reminds us that in today's corporate bottom-line world, professionals are under relentless structural pressures to adjust their beliefs, values, and norms in line with their employers' economic interests, and Draper compellingly describes and illustrates the ease with which they are able to rationalize those adjustments. In that sense, Draper's argument goes beyond a simplistic picture of compliant professionals who are inadequately socialized by their professions. Instead, she underscores that professionalization and corporatization are evolving together and reinforcing one another. The professions orient professionals to work in large bureaucracies, where they may hold beliefs at odds with the corporation's interests but are still required to act as team players because the social and legal context determines how they do their job.

Company Doctor is a distressing cautionary tale that should be read by anyone—professional or otherwise—employed by a large complex organization. On one hand, it alerts us to the ways in which the fundamental tenets of modern medicine, and by implication of other professions, can, in a corporate environment, mutate to serve employers' overriding interest in controlling workers and maximizing profits. On the other hand, the book also indirectly offers hope: if the social and legal context of professional work is responsible for the breakdown of professional ethical codes, then reform may be possible by changing that context.

William J. Sonnenstuhl
Professor of Industrial and Labor Relations
Department of Organizational Behavior
Department of Extension
ILR School, Cornell University

The Labor Market Experience of Workers with Disabilities: The ADA and Beyond. By Julie L. Hotchkiss. Kalamazoo, Mich.: W.E. Upjohn Institute for Employment Research, 2003. 229 pp. ISBN 0-88099-252-2, $40 (cloth); 0-88099-251-4, $20 (paper).

This book uses relatively straightforward and appropriate estimation methods to measure the effect of the Americans with Disabilities Act (ADA) on the labor market experience of disabled people. The main part of the book takes each component of labor market experience and measures changes in the experience of disabled people, relative to non-disabled people, before and after the passage of the ADA. The components of experience include employment, wages, hours, and occupational and industrial distribution. Where appropriate, the author controls for important potential selection effects. The empirical results are revealing and credible, and the book overall—despite some policy analysis that is disconnected from the empirical analysis and not well defended—is quite useful for understanding trends in labor market experience of disabled people over the 1990s.

The first chapter after the Introduction examines changes in employment patterns among disabled people and considers the effect of the ADA on those changes. Other researchers, such as Thomas DeLeire in *Journal of Human Resources* (Vol. 36, No. 1, Winter 2001) and Daron Acemoglu and Joshua Angrist in *Journal of Political Economy* (Vol. 109, No. 5, Oct. 2001), have shown that the effect of the ADA was to reduce employment rates among disabled people. Hotchkiss provides important results relevant to understanding the earlier researchers' findings. First, she shows that the observed pattern is really a labor force participation effect rather than an employment effect. In particular, the labor force participation rate of disabled people fell after the passage of the ADA, and, once one controls for changes in labor force participation, the employment effect disappears. Second, she shows that the reduction in the labor force participation rate is due to a movement of people from self-described non-disabled out of the labor force to self-described disabled out of the labor force. This is consistent with other work (for example, Brent Kreider in *Journal of Human Resources,* Vol. 34, No. 4, Fall 1999) that suggests the self-classification of disability may be endogenous. While Hotchkiss's results do not imply that the ADA was harmful to disabled people, neither do they imply that it significantly benefited them.

The second chapter looks at the effects of the ADA on wages of disabled people after controlling for employment. Hotchkiss finds a small reduction in disabled people's wages, especially among those with musculoskeletal problems. She provides some evidence that the reduction occurred for all disabled people and not just those at firms covered by the ADA. She concludes that, since the reduction affects all disabled people, it does not reflect the cost of accommodation.

The reasoning here is weak. Consider the