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Monique A. Anawis

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THE ETHICS OF PHYSICIAN UNIONIZATION: WHAT WILL HAPPEN IF YOUR DOCTOR BECOMES A TEAMSTER?

*Monique A. Anawis**

INTRODUCTION

At first consideration, the tenants of collective bargaining via unionization appear to be directly opposed to the ethics of physicians as healers in our society. Physicians as professionals have ethical obligations to first "do no harm," and further, to attend to the interests of their patients before any personal interests. Unions, by definition, are created to safeguard the interests of employees and seek improved working conditions and benefits for their members. These potentially conflicting goals raise several questions: Will unionization of physicians work to the detriment of patients? Will the professional identity of physicians need to fundamentally change with unionization? Are physician unions ultimately doomed to failure because medical ethics are incompatible with unions *or* will a new modified form of unionization emerge?

This article will review the traditional concepts of collective bargaining in the United States including the National Labor Relations Act (NLRA) and anti-trust legislation in the medical setting. Evolving legislation and case law will be discussed in the context of the ethical considerations of patient care.

* Monique A. Anawis is a surgeon and professor of Ophthalmology and an attorney concentrating in Health Law and Medical Malpractice. She holds M.D. and B.A. degrees from Brown University, and a J.D. degree with a Certificate in Health Law from DePaul University College of Law. The author wishes to express gratitude to Mark K. Borsody, M.D., Ph.D for his review of this article.

WHY WOULD PHYSICIANS WANT TO UNIONIZE?

Picture spending your most productive and vital years, ages eighteen through your thirties, studying all hours of the day and night and all too frequently finding yourself caring for strangers who may be less than grateful by nature, circumstance, or illegal substances. As a physician-in-training, one spends many years in self-sacrifice while learning skills for the greater goal of serving society. Next, picture that at the end of this long tunnel of delayed personal gratification, the future is filled with 100,000 or more dollars of debt to be repaid over the ensuing decades in which you may hope to start a family and provide for them. While this financial scenario is familiar to most individuals who pursue graduate education in law, business or the sciences, physicians are very different. The autonomy and ability of physicians to practice their skills are now severely impeded if not frankly curtailed by financially constrained hospitals, profit-seeking managed care and increasingly invasive government policing. Of all physicians in the United States, 43.6% are employees of hospitals, universities, government or managed care organizations.¹ Up to 90% of all physicians who complete their medical training today will be employees instead of working for themselves.² This historical evolution of medicine coupled with the financial and personal pressures of being a physician has urged many physicians to raise their lone, seemingly impotent voices in a powerful coalition: a union.

Unions exist to protect employees from oppressive employers and substandard working conditions. The voice of a single employee does not have the impact to make change that hundreds or thousands of employees joined in a coalition with a representative voice and the power to strike have. A union's purpose is to safeguard employees' rights. By contrast, businesses aim to make money. The result is that employees and bosses have opposing goals that may become more polarized through unionization. Physicians desire similar benefits for themselves and improved quality of care for their patients. Unions are a mechanism to equalize the bargaining power between physicians who

¹ Elizabeth Thompson Beckley, *Strength In Numbers: Employed Physicians Enlist Unions for Bargaining Clout*, MODERN PHYSICIAN, Feb. 26, 2001, available at <http://www.modernphysician.com/archive/article.php3?refid=1191&phrase=strength+in+numbers> (last visited Jan 12, 2003).

² *Id.*

are constrained by reimbursement economics and insurance companies that impose these restrictions.

WHY IS IT DIFFICULT TO UNIONIZE DOCTORS?

Doctors are in a fiduciary relationship with patients. As a result, unionization appears to create a conflict of interest for the physician between serving the patient's best interest or his own personal needs. These conflicts are illustrated below in the concepts of autonomy, non-maleficence, beneficence, confidentiality, honesty and distributive justice.

Autonomy

Some people say that where you have two physicians you get at least three opinions. A more benign observation would be that physicians are taught to consider several possible diagnoses and treatments and then narrow these options via physical examination and laboratory testing to reach a final diagnosis. This analytical thought process expresses their *autonomy* as professionals but is at odds with managed care efforts to save money by performing as few tests and procedures as possible. With the increasing prevalence of managed care, physicians have fought the limitations that these systems place on patient care. In accordance with their Hippocratic Oath, physicians strive to deliver the best care and this is often the most expensive care.

By contrast, managed care seeks to deliver health care while making a profit. As such, managed care more closely follows a utilitarian approach. Physicians do not function in a vacuum of their own autonomy, but rather, within a patient-physician relationship. This relationship is much less likely to fit a utilitarian model than a Kantian model. "According to Kant, *things* possess a 'market value' (their worth consists precisely in the uses to which they can be put); but *persons* alone possess dignity, or intrinsic worth, which cannot be reduced to a market value."³ In a Kantian model, the patient and physician share a moral reciprocity and may struggle with each other to uphold individual goals and dignity, meaning, their autonomy.

Unions may be a vehicle for physicians to reclaim the autonomy that they have lost to managed care organizations and government

³ BARRY R. FURROW ET AL., *BIOETHICS: HEALTH CARE LAW AND ETHICS*, 16 (West Publ'g Co. 3rd ed. 1997) (emphasis added).

regulations. As a means to an end of greater good for physicians, the union appears more utilitarian. The very goal of individual physician autonomy is likely to be subsumed, however, by the majority rules of union policy. Before autonomy can be achieved through unionization, physicians must first relinquish some individuality by virtue of being union members. Physicians need to have colleague physicians as their union spokespersons; otherwise, their ideals may be contorted as an unintended means to an end. Thus, physician autonomy is lost to the union coalition in the process of seeking autonomy.

Non-maleficence (Do No Harm)

The Hippocratic oath articulates an ethical cornerstone of physicians: first, do no harm. It states: "I will follow that system of regimen which, according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous."⁴ In seeking union representation, how will doctors avoid harming patients? Any physician union would need to create safeguards for patient care. One such safeguard is the policy of most physician unions including the American Medical Association (AMA) sponsored union, Physicians for Responsible Negotiation, of prohibiting strikes.⁵ The no-strike policy is not mandated by statute but is voluntarily adopted by physician unions for ethical reasons.

Traditional labor unions have successfully used strikes to accomplish their goals. When other bargaining tools are exhausted, striking may be the only way short of employee concessions to resolve disputes. Airline pilots are an example of how contract disputes that culminate in strikes can bring a business to its knees. If physician unions are not permitted to strike then will their union be powerless? No. It does mean, however, that doctors do not have a key bargaining tool and will have to find other means including arbitration and mediation to resolve differences.

In addition, federal or state legislation may be used to protect both physicians and patients in the union setting. Texas, for example, was the first state to pass legislation giving doctors anti-trust immunity for specific joint negotiation activities with health care plans.⁶

⁴ *Id.* at 27, quoting the Oath of Hippocrates.

⁵ Beckley, *supra* note 1, at 5.

⁶ 1 Tex. Ins. Code § 29.06(a) (2002).

Beneficence

The beneficent goals of medicine are intimately linked with those of non-maleficence. As further stated in the Hippocratic Oath: "Into whatever houses I enter, I will go into them for the benefit of the sick, and will abstain from every voluntary act of mischief and corruption."⁷

Physician unions will have their greatest potential impact on third parties: patients. Physician unions are unique because the real beneficiaries (or possible victims) may be patients, not member-doctors. While aiming to protect doctors, these unions must also serve a higher goal of improving patient care benefits. Physician unions have the potential to negotiate appropriate lengths of hospital stay for patients and to expand services covered by insurance. While these may be pipe dreams, a potential for such beneficial changes exists.

Confidentiality

Maintaining patient confidentiality is key to the patient-doctor relationship: "Whatever, in connection with my professional practice, or not in connection with it, I see or hear, in the life of men, which ought not to be spoken of abroad, I will not divulge, as reckoning that all such should be kept secret."⁸

Managed care and electronic transmission of patient billing and privileged information threaten patient confidentiality. Unions may further erode patient confidentiality if patients' medical records are revealed during the course of negotiation for increased patient benefits. Additionally, patients' willingness to confide in their doctors may be undermined by their perception of unions. Although an absurd caricature, the doctor as "God" may be easier to trust than the doctor as a "Teamster."⁹

Honesty

Physicians' honesty and integrity demand full disclosure of all pertinent information to patients. This allows patients to be informed in their decision making. In order to safeguard individual patients and protect the public, physicians may need to disclose the existence of infectious diseases or health hazards in the environment or workplace through

⁷ FURROW, *supra* note 3, at 27.

⁸ *Id.*

⁹ Teamster is defined as a "driver of a team," or driver of a "motor truck for transporting goods." J.B. Sykes, *THE OXFORD DICTIONARY* 935 (6th ed. 1978). This term has been used to refer to truckers who are union members.

scientific publication or the media. In this circumstance, the physician protects the privacy of his patients by not revealing their identities while still informing potential patients or employers of health risks. Unions could act as a shield to protect physicians who in good faith have disclosed critical patient information and suffered dire consequences.

Dr. David Kern was the founder and director of the Occupational and Environmental Health Service and an employee of Memorial Hospital of Rhode Island.¹⁰ He was also a tenured faculty member of the Brown University School of Medicine.¹¹ In the course of teaching medical students, in December 1994, he visited the Microfibres, Inc. (Microfibers) factory where he was asked to evaluate a patient for a specific lung condition.¹² During this visit, Dr. Kern and his industrial hygienist signed a routine confidentiality agreement designed to protect the company's trade secrets.¹³ Dr. Kern determined that the patient did not have the condition in question.¹⁴ More than one year later, he returned to the factory and discovered that one worker, in a cluster of eight patients, was suffering from a potentially fatal lung condition directly due to inhalation of nylon fibers.¹⁵ Later, he discovered that a pathologically similar cluster had occurred in 1990-1991 at Microfibres' Canadian factory.¹⁶ Dr. Kern named the potentially fatal lung disease "flock worker's lung."¹⁷ He had no idea that an international controversy would ensue over the next few years when he attempted to properly warn his patients, their employers and the scientific community of this serious condition. The company's quest to protect profits instead of worker's health and to block the publication of Dr. Kern's discovery, coupled with company ties to the university, culminated in Dr. Kern losing his job and the Occupational and Environmental Health Service being shut down.

In October 1997, Dr. Kern filed a complaint with the federal Occupational Safety and Health Administration (OSHA) alleging a

¹⁰ David G. Kern, M.D., M.O.H., *The Unexpected Result of an Investigation of an Outbreak of Occupational Lung Disease*, 4 J. OF OCCUPATIONAL AND ENVTL. HEALTH 19 (Jan-Mar 1998).

¹¹ *Id.*

¹² *Id.* at 20.

¹³ *Id.*

¹⁴ *Id.*

¹⁵ Kern, *supra* note 10, at 20.

¹⁶ *Id.* at 21.

¹⁷ *Id.*

violation of his Section 11C rights under the OSHA Act.¹⁸ Section 11C prohibits discrimination against employees who assert their OSHA rights.¹⁹ Dr. Kern's wife, Robin Kern, who previously practiced labor law, was the first attorney to articulate a legal theory defending 11C rights for an employed physician. The Regional Director of OSHA found merit in Dr. Kern's allegations against the company, the hospital and the university, and referred his case to the U.S. Department of Labor (DOL) in Boston that litigated such claims. In response to Dr. Kern's letter appealing the dismissal of his complaint, he received a letter in January of 1999 that OSHA in Washington, D.C. and the U.S. DOL were requesting all files from their field office for a review of his case. Dr. Kern has received no further communication from these two agencies.

Dr. Kern is currently in private medical practice in Maine and has been hailed by colleagues worldwide with awards for his courage in placing his patient's care and disclosure of his scientific research for the public welfare ahead of his career. In addition to OSHA, unions could act to protect physicians like Dr. Kern as well as unwitting victims of occupational hazards.

Distributive Justice

The principle of distributive justice means that benefits and burdens should be distributed equitably between individuals or groups of people. Resources should be apportioned fairly. People should act in a way that third parties are equally benefited and burdened in order to balance potential hardships such as limited resources.

In the current medical climate, physicians are being forced to take more responsibilities each year without commensurate benefits. As the costs of medical testing, procedures and business overhead continue to increase, managed care organizations are steadily decreasing reimbursements or refusing to pay at all for services rendered by physicians and hospitals. Despite managed care organizations' denial of reimbursements, physicians remain morally, legally and ethically responsible to their patients. While physicians have always had the looming specter of malpractice, physicians now must be liable as gatekeepers for managed care organizations. With each advancing year, managed care organizations further limit physicians in terms of:

¹⁸ *Id.* at 29.

¹⁹ *Id.*

(1) the number and type of tests and procedures utilized and (2) the hospital and specialist services requested.

Courts, however, are increasingly unwilling to let managed care escape the liability of bad patient outcomes created by refusing or limiting health care services. In *Petrovich v. Share Health Plan of Illinois, Inc. (Petrovich)*, the Illinois Supreme Court found that the defendant managed care plan and its independent contractor physicians were negligent in failing to timely diagnose the patient's oral cancer.²⁰ In August of 1989, the plaintiff first sought the professional services of Dr. Marie Kowalski, the primary care provider she had chosen from Share's provider list.²¹ The plaintiff's employer had selected and enrolled her in Share.²² Dr. Kowalski was employed by Illinois Masonic Medical Center at a satellite facility that contracted with Share to provide medical services.²³ In September of 1990, the plaintiff saw Dr. Kowalski for persistent pain in the right sides of her mouth, tongue, throat and face.²⁴ Dr. Kowalski referred the plaintiff to Dr. Slavick and Dr. Friedman who both contracted with Share.²⁵ Despite Dr. Friedman's recommendation of either a magnetic resonance image (MRI) or computerized tomography (CT), Dr. Kowalski told the plaintiff that Share would not allow any new tests.²⁶ Dr. Kowalski then provided Dr. Friedman with an old MRI report.²⁷ The plaintiff sought no redress from Share because she was not aware of Share's grievance procedures.²⁸

On October 31, 1990, a new MRI was done per Dr. Kowalski's order but failed to show the anatomical area of concern.²⁹ The plaintiff testified that on November 19, 1990, Dr. Kowalski told her that this MRI showed no abnormalities.³⁰ Due to the plaintiff's complaints of

²⁰ See *Petrovich v. Share Health Plan of Ill., Inc.*, 719 N.E. 756 (Ill. 1999) (defendant managed care plan found negligent in failure to timely diagnose patient's oral cancer); *Sloan v. Metropolitan Health Council of Indianapolis Inc.*, 516 N.E.2d 1104 (Ind. App. 1987) (HMO could be found vicariously liable for the negligent acts of its employed doctors); *Dunn v. Praiss*, 606 A.2d 862 (N.J. Super. Ct. App. Div. 1992) (employed physician was "controlled" by the managed care organization, and thus, vicariously liable for his negligent acts).

²¹ *Id.* at 761.

²² *Id.*

²³ *Id.*

²⁴ *Petrovich*, 719 N.E. at 761.

²⁵ *Id.*

²⁶ *Id.*

²⁷ *Id.*

²⁸ *Id.*

²⁹ *Petrovich*, 719 N.E. at 761.

³⁰ *Id.* at 763.

persistent pain, Dr. Kowalski referred her back to Dr. Friedman in April or May of 1991.³¹ Biopsies performed by Dr. Friedman in June of 1991 revealed squamous cell cancer necessitating surgical removal of the base of the plaintiff's tongue and portions of her palate, pharynx and jaw bone as well as radiation treatment and rehabilitation.³²

The court in *Petrovich* used the two-step analysis of apparent authority that emerged from *Gilbert v. Sycamore Municipal Hospital (Gilbert)* in 1993.³³ *Gilbert* was the first Illinois case to apply the doctrine of apparent authority to medical malpractice and held that "a hospital can be held vicariously liable for the negligent acts of a physician providing care at that hospital, regardless of whether the physician is an independent contractor, *unless the patients knows, or should have known*, that the physician is an independent contractor."³⁴ The first step of the *Gilbert* test requires the plaintiff to demonstrate that there was a "holding out," meaning that "the HMO, or its agent, acted in a manner that would lead a reasonable person to conclude that the physician who was alleged to be negligent was an agent or employee of the HMO."³⁵ The second step requires the plaintiff to show that he acted in "justifiable reliance" on the hospital or HMO agent-physician's conduct "consistent with ordinary care and prudence."³⁶ The *Petrovich* court extended the analysis of hospitals in *Gilbert* and its predecessor cases to contracts between physicians and HMOs. The plaintiff's estate in *Petrovich* settled for \$1,232,000 in October of 2001.

Unions may be a means by which physicians could balance the scales of distributive justice so that physicians, hospitals, managed care organizations and other health care entities are *jointly* responsible to patients and regulatory bodies. Of course, unions have no influence over case law. Unions could help avoid litigation by promoting conditions that are more equitable for patients and doctors.

³¹ *Id.*

³² *Id.*

³³ *Gilbert v. Sycamore Municipal Hospital*, 156 Ill. 2d. 511, 524 (1993). Apparent authority implies that conduct of the principal and/or the agent would lead a third party to reasonably believe that an agency relationship exists. Agency is a fiduciary relationship created by express or implied contract or by law in which one party (the agent) may act on behalf of another party (the principal) and bind that principal party by words and actions. See THE OXFORD DICTIONARY 23, 52.

³⁴ *Id.*

³⁵ *Id.* at 525.

³⁶ *Id.*

CAN ANY PHYSICIAN JOIN A UNION?

The National Labor Relations Act specifies the persons and rules that govern collective bargaining in the United States.³⁷ The National Labor Relations Board (NLRB) is the federal agency charged with administering and enforcing the NLRA. The key to the Act is Section 7 which endows employees with the "right to self-organization, to form, join or assist labor organizations, to bargain collectively through representatives of their own choosing, and to engage in other concerted activities for the purpose of collective bargaining or other mutual aid and protection..."³⁸ Collective bargaining refers to a group of employees called "bargaining units" who share a "community of interest," meaning similar skills and abilities, coming together to voice a concerted opinion.³⁹ Employees also have the right *not* to join the union as stated by "the right to refrain from any or all such activities."⁴⁰ Under Section 8 of the NLRA, employees are given protection from both the employer and the union.

Section 2(3) of the NLRA specifically excludes supervisors and independent contractors from collective bargaining.⁴¹ The reason that supervisors are excluded from NLRA protection is that they are part of management, and therefore, are aligned with the employer from whom employees are seeking protection. Independent contractors work for themselves, and thus, have no employer. Only physicians employed by hospitals or health care systems who are not statutorily defined as "supervisors" are eligible to join a union. These exclusions are particularly troublesome in the health care setting where it is not always clear who is characterized as a "supervisor" as opposed to an "employee." As a result, the main dispute in many labor law cases is whether the employees in question are supervisors.

The NLRA was drafted in the 1930s and amended in the 1950s, when only two to 3% of the workforce were "professionals." The NLRA's intent was to balance the inequality between employers and employees. This became a governmental concern because of the

³⁷ The National Labor Relations Act, 29 U.S.C. §§ 151-69. The NLRA governs the federal and private sector. State laws regulate teachers in local school districts and municipalities.

³⁸ *Id.*

³⁹ *Id.*

⁴⁰ *Id.*

⁴¹ *Id.*

resulting burdens and effects on the flow of commerce and the economy that could be created by problems with the production of goods or services. Laws that permit organization and collective bargaining safeguard commerce by protecting employees making goods and providing services. This is accomplished by: (1) removing certain recognized sources of industrial strife and unrest and (2) encouraging more amicable resolutions of disputes pertaining to wages, hours and working conditions. The NLRA aims to eliminate employee-caused obstacles to free flowing commerce by: (1) encouraging the practice and procedure of collective bargaining and (2) protecting the employees' rights to full freedom of association and self-organization via unions that designate representatives. The purpose of unions, therefore, is to help negotiate the terms and conditions of employment, mutual aid and protection of its members.

The NLRA was conceived in the context of factory work and could not have anticipated a world of Internet workers and high-tech medicine. Those first to organize in academia were the Yeshiva University faculty members who unsuccessfully argued that they were not supervisors, and therefore, could not be excluded from unionization.⁴² The NLRB successfully reasoned that faculty authority was "exercised in the faculty's own interest rather than in the interest of the university " who was their employer.⁴³

Controversies surrounding the health care industry and unionization were partly resolved by regulations and case law. In 1989, the NLRB final regulations held that the appropriate bargaining units in acute care hospitals were limited to: (1) all physicians, (2) all registered nurses, (3) all professionals except for registered nurses and physicians, (4) all technical employees, (5) all skilled maintenance employees, (6) all business office clerical employees, (7) all guards and (8) all non-professional employees except for technical employees, skilled maintenance employees, business office clerical employees and guards.⁴⁴ *American Hospital Association v. NLRB* held that the Board's limitation to eight (and only eight) specified bargaining units was not facially invalid.⁴⁵

⁴² *Yeshiva University v. NLRB*, 444 U.S. 672, 685. The NLRA governs the federal and private sectors. State laws regulate teachers at local school districts and municipalities.

⁴³ *Id.*

⁴⁴ 29 C.F.R. § 103.30 (2002).

⁴⁵ *Am. Hosp. Ass'n v. NLRB*, 111 S.Ct. 1539 (1991).

The majority of American physicians, approximately 325,000, are independent contractors. As such, Section 2(3) of the NLRA specifically excludes these physicians from the rights and protections provided to employees via unionization. In 1999, this was tested by physicians from Cape May and Atlanta Counties in New Jersey whom the Philadelphia regional NLRB found to be independent contractors, and therefore, not eligible to form a collective bargaining unit.⁴⁶ The physicians argued that they were *de facto* employees because they were essentially dominated by the health care plan. This argument did not work because most independent contractor physicians were providers for several managed care plans; therefore, no single plan could be expected to dominate them.

CAN HOSPITAL HOUSE STAFF JOIN A UNION?

After completing medical school, physicians begin a course of training called a residency that lasts at least three years and upwards of eight years. The first year of residency is called "internship." After residency, physicians may continue specialized training in fellowships. Interns, residents and fellows are collectively referred to as "house staff" because their duties usually require overnight stays "in-house," meaning in the hospital.⁴⁷ The teaching of house staff is called graduate medical education. Attending physicians, by contrast, have completed all of their training, are licensed to practice medicine and often teach the house staff.

In 1974, Congress extended the NLRB's jurisdiction to nonprofit health care facilities. In 1976, the *Cedars-Sinai* case held that house staff members were "students" not employees, and thus, not eligible to join a union because they did not fit into one of the eight recognized bargaining units defined by the NLRA.⁴⁸ The majority reasoned that the primary purpose of house staff was to engage in graduate medical education.⁴⁹ "They [house staff] participate in these [graduate medical education] programs not for the purpose of earning a living; instead they are there to pursue the graduate medical education that is a

⁴⁶ AmeriHealth Inc./AmeriHealth HMO, Case 4-RC 19260 (Reg'l. Dir. Dec. May 24, 1999).

⁴⁷ Some fellowships are completed under the guise of a private practice; therefore, these individuals would not be considered house staff.

⁴⁸ *Cedars-Sinai Hosp. Med. Ctr.*, 223 NLRB 251 (Mar. 23, 1976).

⁴⁹ *Id.* at 253.

requirement for the practice of medicine."⁵⁰ The NLRB found that graduate medical education programs did not exist to meet hospital's staffing requirement, but rather, provided an arena "allow[ing] the student to develop, in a hospital setting, the clinical judgment and proficiency in clinical skills necessary to the practice of medicine in the area of his choice."⁵¹ The NLRB considered house staff remuneration to be a "stipend," not a salary, because it was a flat fee not determined by the nature or number of services rendered or the numbers of hours worked.⁵² The NLRB quoted the *Essentials of an Approved Internship* and the *Essentials of an Approved Residency* manuals that were prepared by the Council on Medical Education and approved by the American Medical Association and used as guidelines for graduate medical education programs.⁵³ These manuals characterized remuneration as a "scholarship for graduate study."⁵⁴ Furthermore, house staff members were not eligible for *Cedars-Sinai* retirement, a fringe benefit given to "employees."⁵⁵

The dissent in *Cedars-Sinai* found these arguments unpersuasive.⁵⁶ NLRB Member Fanning used the *Essentials* to support his position citing the mandate approved by the AMA House of Delegates in January of 1975 and distributed to all approved teaching hospitals.⁵⁷ The *Guidelines for Housestaff Contracts or Agreements* state that hospital graduate medical education programs must "provide fair and equitable *conditions of employment* for all those performing the duties of interns, residents and fellows..."⁵⁸ Other guidelines from the *Essentials* manuals described appropriate salaries, hours of work, off-duty activities, vacations, leave, insurance benefits, professional liability insurance and disciplinary procedures. Member Fanning stated: "I do not see how my colleagues can ignore such compelling evidence that the *ultimate authority governing house staff relationships*

⁵⁰ *Id.*

⁵¹ *Id.*

⁵² *Id.* at 252.

⁵³ *Cedars-Sinai Hosp. Med. Ctr.*, 223 NLRB at 252.

⁵⁴ *Id.*

⁵⁵ *Id.*

⁵⁶ *Id.* at 254.

⁵⁷ *Id.* at 256.

⁵⁸ *Cedars-Sinai Hosp. Med. Ctr.*, 223 NLRB at 257. See, *Hearings Before the Subcommittee on Labor of the Committee on Labor and Public Welfare*, S. 794, S. 2292, 93rd Cong. (1st Sess. 1975) [hereinafter *Hearings*].

and programs [the Council on Graduate Medical Education] so clearly considers these individuals [house staff] to be employees."⁵⁹

The *Cedars-Sinai* dissent also found support in the legislative history and language of the NLRA. Section 2(12) created a special definition of a "professional employee," thus, permitting such individuals to unionize.⁶⁰ Section 2(12)(a) directly addresses house staff as "any employee engaged in work . . . requiring knowledge of an advanced type in a *field of science* or learning customarily acquired by a prolonged course of specialized intellectual instruction and study in an institution of higher learning or a *hospital*. . . ."⁶¹ The House Conference Report accompanying the Taft-Hartley amendment to the NLRA specifically includes house staff in the group of "such persons as legal, engineering, scientific medical personnel *together with their junior professional assistants*."⁶²

Finally, the dissent looked to the *respondeat superior* doctrine. In the common law master-servant relationship, masters may be held vicariously liable for the actions of servants who function as their agents. Likewise, hospitals and institutions can be held vicariously liable for the actions of their house staff.⁶³

In November of 1999, the NLRB specifically overruled *Cedars-Sinai* and decisions following it in *Boston Medical Center* stating that "while they [house staff] may be students learning their chosen medical craft, [they were] also 'employees' within the meaning of Section 2(3) of the Act [NLRA]."⁶⁴ Boston City Hospital (BCH) is a public sector hospital and part of the Boston Medical Center. BCH had a house staff collective bargaining unit organized in 1969 which had negotiated approximately ten collective bargaining agreements with BCH by 1970.⁶⁵ In 1996, the Boston City Council required that the merger between BCH and University Hospital recognize the petitioner (House Officers' Association/Committee of Interns and Residents) as the collective bargaining representative of the 280 BCH house staff members.⁶⁶ This petition resulted from the October 1997 decision by

⁵⁹ *Cedars-Sinai Hosp. Med. Ctr.*, 223 NLRB at 257.

⁶⁰ *Id.*

⁶¹ *Id.* (emphasis added).

⁶² *Id.* at 258 (emphasis added).

⁶³ *Id.* at 255.

⁶⁴ *Boston Med. Cntr. Corp. and House Officers' Ass'n/Comm. of Interns and Residents*, 330 NLRB 152 (1999).

⁶⁵ *Id.* at 152-53.

⁶⁶ *Id.*

the NLRB Regional Director dismissing the petition seeking certification for a unit of house staff.⁶⁷

The NLRB in *Boston Medical Center* listed several reasons why house staff members, although seeking educational credentials, were employees under Section 2(3) of the NLRA. First, house staff members work for a statutorily-defined "employer" as specified by Section 2(2) of the NLRA.⁶⁸ Second, house staff members receive compensation for their services in the form of a stipend from which federal and state income tax and social security is withheld.⁶⁹ Their fringe benefits include workers' compensation, paid vacations and sick leave, parental and bereavement leave, coverage for health, dental, life and malpractice insurance.⁷⁰ Third, the house staff provide patient care for the hospital as "junior professional associates" analogous to traditional apprentices.⁷¹ Fourth, house staff members are *unlike* typical students because they do *not*: (1) pay tuition or student fees, (2) take conventional examinations for grades that decide advancement or remediation, (3) register in a typical manner or (4) seek a diploma.⁷² In reviewing prior graduate student cases, the NLRB found that "...there [had] been no question that students [were] statutory employees."⁷³

In answer to fears of house staff employees infringing on the constitutional autonomy of employers and undermining the educational process, the majority in *Boston Medical Center* cited two state supreme court cases. In *Regents of the University of Michigan*, the court found that due to the "unique nature" of the University of Michigan, the breadth of collective bargaining "may be limited" if the issue was "clearly within the educational sphere."⁷⁴ Likewise, in *The Regents of the University of California*, the court found that the "doomsday cries" by the university that house staff would undermine education were "premature."⁷⁵ The dissent in *The Regents of the University of California* by Justice Brames and other alarmists overlooked the ethical

⁶⁷ *Id.* at 152.

⁶⁸ *Id.* at 162.

⁶⁹ *Boston Med. Cntr. Corp.*, 330 NLRB at 162.

⁷⁰ *Id.*

⁷¹ *Id.*

⁷² *Id.*

⁷³ *Id.*

⁷⁴ *Regents of the Univ. of Mich. v. Eemployment Relations Comm'n*, 204 N.W.2d 218, 224 (Mich. 1973).

⁷⁵ *The Regents of the University of California v. Pub. Employment Relations Bd.*, 715 P.2d 590, 604 (Cal. 1986).

obligations of physicians and their obvious priority to learn instead of undermine the education they seek at tremendous personal and financial sacrifice.

Boston Medical Center stands for the proposition that house staff can be *both* students and employees. Reversal of *Cedars-Sinai* is probably the result of the new Democratic NLRB that appeared to favor a broader interpretation of the NLRA. Clearly, this holding can be extended to graduate students in nearly all disciplines and petitions to the NLRB are now proceeding.

RECENT CASE LAW AND THE FUTURE OF PHYSICIAN UNIONS

The future of physician unionization has been dealt a lethal legal blow with two recent Supreme Court cases defining "supervising" nurses. In May 2001, *NLRB v. Kentucky River* was decided by the U.S. Supreme Court with the majority opinion appearing to broaden, and perhaps cloud, the definition of supervisors.⁷⁶ The Court held that "independent judgment" was "indisputably ambiguous and it was settled law that the NLRB's interpretation of ambiguous language in the NLRA was entitled to deference."⁷⁷ Furthermore, "professional employees by definition engage in work 'involving the consistent exercise of discretion and judgment.'"⁷⁸ If such judgment "makes one a supervisor under §152(11), then Congress's intent to include professionals in the NLRA will be frustrated because 'many professional employees (such as lawyers, *doctors*, and nurses) customarily give judgment-based direction to the less-skilled employees with whom they work.'"⁷⁹ The Court found ambiguity in the NLRA statutory language: "there may be some tension between with Act's exclusion of [supervisory and] managerial employees and its inclusion of professionals but we find no authority for 'suggesting that that tension can be resolved' by distorting the statutory language in the manner proposed by the Board."⁸⁰ "Perhaps the Board could offer a limiting interpretation of the supervisory function of responsible direction by distinguishing employees who direct the manner of others' performance of discrete

⁷⁶ *Nat'l Labor Relations Bd. v. Kentucky River Cmty. Care, Inc.*, 532 U.S. 706 (2001).

⁷⁷ *Kentucky River*, 532 U.S. at 725.

⁷⁸ *Id.*

⁷⁹ *Id.* at 720 (emphasis added).

⁸⁰ *Id.*

tasks from employees who direct other employees as §152(11) requires."⁸¹ These Court conclusions appear to place attending physicians in the role of "supervisors," thus, excluding employed and independent contracting attending physicians from union eligibility. It remains to be determined by the circuit courts whether or not house staff can maintain the collective bargaining status that they have benefited from for the past few decades.

What Is the Status of House Staff Unionization in Chicago?

In November 2000, the NLRB Region 13 decided against *Advocate Health and Hospital Corporation (Advocate)* in a petition initiated by the Physicians for Responsible Negotiation (PRN) on behalf of Lutheran General Hospital house staff who wanted an election to vote whether to be represented by PRN for purposes of collective bargaining.⁸² The Petitioner, PRN, is a labor organization created on November 21, 1999 by signing a constitution and creating by-laws. Formation of PRN was facilitated by a loan from the AMA. "The stated purpose of the PRN is to be a labor organization that will promote the art and science of medicine, the betterment of public health and the integrity of the doctor patient relationship through collective bargaining."⁸³ Practicing physicians of medicine and osteopathy and house staff in accredited programs are eligible to join PRN.⁸⁴ A national nine-member board with three locally employed officers operates PRN.⁸⁵

The NLRB reached several conclusions in the *Advocate* case. First, PRN is a labor organization under the NLRA and is not disqualified from representing Advocate employees in collective bargaining.⁸⁶ Second, the NLRB upheld *Boston Medical Center* in finding that house staff members were employees under the NLRA.⁸⁷ Third, chief residents (those most senior in training) are not "supervisors" under the NLRA, and therefore, are not excluded from collective bargaining.⁸⁸ Fourth, Advocate is not a "joint employer" of

⁸¹ *Id.*

⁸² *Advocate Health and Hosp. Corp. D/B/A Lutheran General Hosp. (Advocate) and Physicians for Responsible Negotiation, (PRN)*, (Petitioner), Case 13-RC-20426 (2000).

⁸³ *Id.* at 3.

⁸⁴ *Id.*

⁸⁵ *Id.*

⁸⁶ *Id.* at 10.

⁸⁷ *Physicians for Responsible Negotiation*, Case 13-RC-20426 at 10.

⁸⁸ *Id.* at 11.

the rotating residents defined as house staff of other Chicago area hospitals who spend one or more months training at Lutheran General; therefore, rotating residents are properly excluded from the petitioned for unit.⁸⁹ Finally, attending physicians were employed by Advocate while house staff were employed by Lutheran General Hospital; therefore, attending physicians and house staff could not be placed in the same collective bargaining unit because they had different employers.⁹⁰

Advocate appealed to the full NLRB panel in Washington, D.C. which dismissed their argument that house staff were mere students ineligible for collective bargaining but agreed to further review the questions of: (1) whether certain chief residents were "supervisors" and (2) whether rotating house staff should be included in the unit. After the United States Supreme Court issued the decision in *Kentucky River*, the NLRB remanded the *Advocate* case for further review on these two issues. In November 2001, the NLRB reaffirmed its previous holding that the appropriate unit for collective bargaining includes house staff and chief residents but excludes rotating house staff. Advocate's request for a full NLRB panel hearing is pending.

Why Might House Staff and Attending Physicians Not Fit Into the Same Bargaining Unit?

In the *Advocate* case, attending physicians and house staff do not have a common employer as required for inclusion in the same collective bargaining unit.⁹¹ Advocate attending physicians do not have a "community of interest" with the house staff meaning that attending physicians' goals and priorities appear to be different from those of house staff.⁹² For example, house staff may desire better on-call sleeping quarters, free cafeteria meals or additional didactic lectures. These issues are not germane to the attending physicians because they do not take part in the house staff training program. Some house staff demands (such as additional lectures) may in fact impose upon the attending physicians who would be asked to provide additional teaching services. Furthermore, Advocate attending physicians are

⁸⁹ *Id.* at 12.

⁹⁰ *Id.* at 15.

⁹¹ *Physicians for Responsible Negotiation*, Case 13-RC-20426 at 15.

⁹² *Id.*

contractually in a "different hierarchy" given their higher salary, different method of payment and their roles as teachers of house staff.⁹³

The NLRB indicated that contracts between the employed house staff and attending physicians were essentially different. It may be a fundamental obstacle to union formation if attending physicians and house staff do not fit into the same bargaining unit. The NLRB currently allows eight, and only eight, recognized collective bargaining units. "All physicians" are placed in one group. Does this mean that petitions need to be made to the NLRB to expand the number of units? What other options exist for employed attending physicians to express statutorily given rights to unionize?

What Is the Status of Employed Attending Physician Unionization In The United States?

In July of 2000, PRN filed a formal petition requesting a union election for occupational health physicians employed by Occupational Health Centers of New Jersey and Concentra Managed Care, Inc. (Concentra).⁹⁴ Concentra operates the nation's largest network of occupational health centers with 350 physicians in more than 200 centers in thirty-two states.⁹⁵ In August of 2000, the Regional NLRB determined that Concentra physicians were not supervisors and ordered elections.⁹⁶ In September 2000, the full panel of the NLRB in Washington, D.C. granted review. In June of 2001, the full NLRB remanded to the Regional NLRB in Newark, New Jersey to consider the facts again under the *Kentucky River* standard to: (1) determine whether Concentra physicians "assign and responsibly direct" other employees and (2) define the degree of "independent judgment" used to exercise this authority.⁹⁷ In January of 2002, the Regional NLRB determined that Concentra physicians were not supervisors.⁹⁸ In October of 2002, the full NLRB granted Concentra's request to review this regional decision.⁹⁹ Both parties must file briefs to the full NLRB by the end of November 2002.¹⁰⁰

⁹³ *Id.*

⁹⁴ See www.4prn.concentra/index.html.

⁹⁵ *Id.*

⁹⁶ *Id.*

⁹⁷ *Id.*

⁹⁸ *Id.*

⁹⁹ See www.4prn.concentra/index.html.

¹⁰⁰ *Id.*

What Does the Future Hold for Independent Contractor Physicians?

The majority of doctors in the United States are independent contractors, and therefore, not eligible to join unions. Section 2(3) of the NLRA specifically excludes independent contractors from joining unions. The NLRA was created to protect employees from unscrupulous employers. Independent contractors, by definition, do not have employers because they work for themselves. In the medical setting, emergency room medicine physicians, pathologists, anesthesiologists and radiologists are specialists that often form groups to independently contract with hospitals or managed care organizations. From whom or what would independent contractor physicians need protection?

In the current medical climate, physicians want to reclaim their autonomy and be protected from intrusive policies of managed care and government regulations which often limit how, where, for how long and in what manner they may care for patients. If unions are not an option for independent contractor physicians then they must appeal to legislatures to change laws. Given the propensity for ever-increasing government regulation and the millions of dollars annually re-cooped by *qui tam* (or "whistle blower") investigations, this is not a realistic option.¹⁰¹ The Department of Justice (DOJ) reports that *qui tam* actions filed by private citizens are the fastest growing source of health care fraud cases.¹⁰² In 1998, the DOJ reported that *qui tam* suits increased 1527% between 1987 and 1997, with recoveries of \$355,000 in 1987 sky-rocketing to \$625 million by 1997.¹⁰³ Nearly half of all money recovered in health care fraud cases is the result of *qui tam* suits.

Independent contractor physicians can form large groups in order to obtain more desirable contracts with managed care organizations. While there is strength in numbers, considerable obstacles exist. The quest for individual autonomy means that doctors traditionally have a very difficult time getting together and agreeing on anything. Larger

¹⁰¹ "Qui tam" is taken from the Latin expression "*qui tam pro domino rege quam pro se ipso in hac parte sequitur*" meaning "he who brings the action for the king as well as for himself." *Erickson v. American Institute of Bio. Sciences*, 716 F.Supp. 908, 909 at n.1 (E.D. Va. 1989). See WILLIAM BLACKSTONE, COMMENTARIES ON THE LAW OF ENGLAND, BOOK III, 160 (1768).

¹⁰² 5 BNA Health L. Rep. 1502 (Oct. 4, 1996).

¹⁰³ On file with author, Professor James Dechene, DePaul Health Care Reimbursement and Delivery Systems Course, classnotes, Fall 2000. See also U.S. Dept. of Justice, Publications and Documents, at <http://www.usdoj.gov/dag/pubdoc.html>.

numbers of doctors needed to effectuate change may create schisms within the coalition, particularly if different medical specialties are put together. Finally, physicians may be accused of violating anti-trust laws through monopoly formation.

How Do Anti-trust Laws Affect Collective Bargaining?

The Sherman Act Section 1 prohibits all contracts, combinations and conspiracies in unreasonable restraint of trade.¹⁰⁴ Price fixing amongst competitors is a *per se* violation of the Sherman Act.¹⁰⁵ The U.S. Supreme Court in *Arizona v. Maricopa Medical Society* first held that independent contractor physicians were prohibited from fixing prices and from collectively negotiating with managed care plans under the Sherman Act.¹⁰⁶ As a result, physicians in the United States are prohibited from collectively negotiating unless there is substantial financial or clinical integration amongst them.¹⁰⁷ Anti-trust laws will be discussed for: (1) exclusive versus non-exclusive network structures, (2) financially integrated networks, (3) clinically integrated networks and (4) messenger model structures.

Exclusive Versus Non-Exclusive Networks

Protection from anti-trust violations exists for certain physician joint venture structures if specific criteria are met. These joint venture structures can exist in exclusive or non-exclusive networks of physicians. An *exclusive* network is only open to a select panel of physicians who additionally must meet criteria and credentialing established by the network.¹⁰⁸ An *exclusive* network is protected from anti-trust challenges when it: (1) includes less than 20% of doctors in any specialty with active hospital privileges in a relevant geographic market and (2) all member-physicians share substantial financial risk.¹⁰⁹ One physician may be included in the network on a non-exclusive basis if his specialty has less than five physicians.¹¹⁰ A *non-exclusive* network is open to all hospital-affiliated physicians who wish to join and who are approved by the credentialing committee. A *non-*

¹⁰⁴ The Sherman Anti-trust Act, 15 U.S.C. §§ 1-7 (2002).

¹⁰⁵ *Id.*

¹⁰⁶ *Arizona v. Maricopa Medical Society*, 457 U.S. 332 (1982).

¹⁰⁷ See U.S. Dept. of Justice and Fed. Trade Comm'n *Statements of Anti-trust Enforcement Policy in Health Care*, 3 Trade Reg. Rep. (CCH) ¶13 at 151.

¹⁰⁸ *Id.*

¹⁰⁹ *Id.*

¹¹⁰ *Id.*

exclusive network is not challenged by anti-trust regulation when it (1) consists of less than 30% of physicians in any specialty with active hospital privileges in the relevant geographic market and (2) all member-physicians share substantial financial risk in the network.¹¹¹ One physician in a non-exclusive network can be included if his specialty has less than four doctors.¹¹² Outside these proscribed safety zones, networks will be evaluated under the rule of reason looking for adequate integration of physician services producing significant efficiency.

Financially Integrated Networks

Physicians can avoid *per se* anti-trust violations if their networks are either *financially* or *clinically* integrated. *Financial* integration of networks means that all participating doctors share in the financial risk of the network, and therefore, can avoid *per se* illegal price fixing allegations. The four main forms of payment in financially integrated networks are: (1) capitation, (2) percent of premium contracts, (3) discounted fee-for-service and (4) global case rates.¹¹³

Capitation means that each physician receives a predetermined fixed payment per patient over a specified period of time that is intended to cover all services needed for those patients. Each patient office visit, therapeutic intervention, or referral to another physician essentially deducts money from the pool of cash already received by the doctor. Even the conscientious physician can lose money if his patients are so sick that he exhausts the monies allotted to him. Capitation is arguably a conflict of interest. The fewer patients seen, tests ordered and operations performed, the more money the doctor makes. The utilitarian premise of managed care is cloaked in the more important corporate goal of making a profit. The profit motives of managed care organizations create temptations to physicians including increased income and year-end bonuses received from profitable networks. This often means that patients receive *less* care, not more efficient care.

Percentage-of-premium contracts link each physician's compensation to the financial performance of all physicians in the network. If *as a group* physicians act in a manner to create more profit,

¹¹¹ *Id.*

¹¹² *See, supra* note 107.

¹¹³ *Id.* at 153.

then each physician makes more money. This logically creates resentment toward those physicians performing more services and having sicker patients because these physicians result in the *group* losing money. In a Darwinian fashion, there is motivation to exclude from the network less "fit" physicians who cost the network profits. While capitation encourages each physician to look out for himself, percentage of premium contracts may result in some physicians "ganging up" on other network physicians who want to or have to do more for their patients.

Discounted fee-for-service is a third means of payment for physicians in financially integrated networks. This model usually involves a withheld pool of reimbursement that can be distributed to participating physicians *if* the network makes money by year's end. If the network does not meet its financial goals then the physician only gets the initial discounted fee-for-service with no payments from the withheld pool which then reverts to the payer. Having already received a predetermined fee, the physician's only incentive may be to pursue a year-end bonus from the pool. This payment method appears, therefore, to create fewer conflicts of interest for physicians. There is also less incentive to withhold care because the physician is paid (though at a discounted rate) for each patient seen. Utilitarians may argue that fee-for-service in *any* form encourages physicians to see patients more frequently and render unnecessary services. Utilitarians would likely find that the lack of year-end bonus is not a strong enough disincentive for physicians to regulate their dispensation of services.

A fourth type of network uses global fee payments. A single global fee is paid per patient for an entire course of treatment no matter how long the patient stays in the hospital or how many tests or operations are needed. Patients, however, differ greatly in their responses to treatments. Simplistic global patient fees assume, for example, that diagnosis X always requires A, B, and C tests and 5 days in the hospital. These estimates of patient care needs and lengths of hospital stay are often very inaccurate and can grossly underestimate true costs. In its best inception, this model encourages physicians of different specialties to work together with greater communication, thus, avoiding duplicating tests and treatments. Physicians may need to relinquish some individual autonomy for the better integrated care of the patient. The obvious pitfall is that all physicians treating the patient will lose financially if their patient requires more services than are covered by the global fees. As a result, there is an incentive for

physicians to discharge patients sooner and perhaps perform fewer tests. Patients may be discharged "quicker and sicker."

These and other evolving networks allow independent contractor physicians to join forces and negotiate for more desirable contracts with managed care. Networks may enhance physician autonomy by using contracts as tools for better fees and increasing covered patient services and lengths of hospital stay.

The reality, however, is that managed care organizations currently dictate prices despite the large numbers of physicians in networks. This has reached the point that managed care organizations frequently deny all payments for procedures and tests they deem "not medically necessary" (a term poorly defined). Additionally, hospital-based networks may negotiate packages with several managed care organizations and contractually bind participating physicians to some undesirable plans. The "options" for physicians faced by undesirable managed care contracts are to not join the network *or* to withdraw in ensuing years when contract terms become unsatisfactory. Physicians must be very careful in contracting because they may bind themselves for longer terms than anticipated. Of greater concern is that non-participating physicians in geographic regions heavily controlled by managed care are unable to make a living because they have no access to patients!

Clinically Integrated Networks

Even without financial integration, networks may avoid anti-trust violations via *clinical* integration. No black letter guidelines exist to define clinical integration. DOJ Policy Statements, however, indicate that networks are clinically integrated if they satisfy two elements.¹¹⁴ Networks must have active and continuing programs to: (1) assess and modify practice patterns of participating doctors and (2) promote a high level of cooperation and interdependence amongst physicians to provide quality care and control costs.¹¹⁵

Physicians in clinically integrated networks may have greater contracting leverage with managed care organizations but at the expense of professional autonomy. Networks may eliminate physicians who they feel are inefficient by virtue of longer than average hospitalization or higher than average use of diagnostic testing or

¹¹⁴ *Id.*

¹¹⁵ *Id.*

surgical intervention. Networks do not consider that some physicians have sicker patients needing longer hospital stays and more tests. Utilization Review personnel look to tables showing how long a "typical" patient with the same diagnosis is likely to stay in the hospital.¹¹⁶ Patients do not necessarily "read the tables" of expected lengths of hospital stays or treatment outcomes. Physicians are bound by their ethical code to provide the most comprehensive care even if they (and the hospital) are not paid. Efficient care is the goal of these networks. This, however, may not be the *best* care.

Messenger Models

In contrast to financially and clinically integrated models, non-integrated "messenger models" minimize but do not escape the risk of anti-trust price-fixing liability. The messenger model uses an agent or third party "messenger" to convey information from physicians to payers regarding contract issues and payment terms. Messenger models do not allow collective bargaining with payers.

Even modified forms of the messenger model have violated anti-trust laws. The DOJ filed suit against a union of orthopedic surgeons for organizing a boycott and price-fixing conspiracy against Blue Cross of Delaware.¹¹⁷ The DOJ prevailed in its claim that the union and member-physicians misused the messenger model to create an illegal cartel.¹¹⁸

Similarly, in Florida, a consent decree was entered against a Florida physicians' union and its consulting firm who acted as the network's messenger in illegal price-fixing and boycotting.¹¹⁹ The joint venture lacked sufficient financial and clinical integration.¹²⁰ The DOJ alleged that network surgeons performed 87% of the general and vascular surgeries at five Tampa hospitals.¹²¹ The DOJ alleged that the messenger did not merely transmit information between the physicians

¹¹⁶ Utilization Review is the process hospitals and health care facilities employ to check the appropriate lengths of hospital stays and patient treatment. This process is typically performed by nursing, medical or other personnel who review patients' medical charts after hospitalization.

¹¹⁷ *United States v. Fed'n of Physicians and Dentists, Inc.*, No. 98-475 (Del. 1998).

¹¹⁸ *Id.*

¹¹⁹ *United States v. Fed'n of Certified Surgeons and Specialists, Inc. and Pershing Yoakley & Assoc.*, No. 99-167-CIV-T-17F (M. D. Fla. 1999).

¹²⁰ *Id.*

¹²¹ *Id.*

and the health plans.¹²² Instead, the network's consultant tried to negotiate higher fees and informed payers that network surgeons would terminate their contracts unless the payers contracted with all surgeons participating in the network.¹²³ Under the consent decree, the network was prohibited from involvement in any collective contracting efforts.¹²⁴ The network's consultant was enjoined from acting as a messenger for the network or any other competing physician group comprised of more than 20% of its members.¹²⁵

These models and any others do not operate in a vacuum. Hospitals also need to make money to stay in business. Hospital and managed care utilization review officers are constantly assessing the "need" for patient admissions and putting pressure on physicians to discharge their patients.

CONCLUSION

Currently, only hospital-based house staff physicians and employed attending physicians who are not "supervisors" can join a union. These attending physicians may need to petition the NLRB for formation of an additional category for acute care hospital employees if they do not share a community of interest with a house staff union. Alternatively, attending physicians may petition the legislature for expanded NLRB jurisdiction to cover all health care-providing institutions.

The majority of American physicians are independent contractors and cannot unionize. These physicians want to level the playing field stacked against them by managed care organizations, hospitals and ever-increasing government regulation. Independent physicians need to form coalitions similar to unions, yet with patient care as the ethical ideal as exemplified by a policy of no strikes or boycotts. The traditional union model permitting strikes is not an option in medicine, neither legally nor morally. Upholding patient ethics and quality care means that doctors must create a new union form with the voices of physicians and patients both being heard. This could be accomplished with union board membership including patient representation to draft and periodically review union practices. Union by-laws must incorporate safety measures to assure quality patient care which

¹²² *Id.*

¹²³ *Id.*

¹²⁴ Pershing Yoakley & Assoc., No. 99-167-CIV-T-17F (M. D. Fla. 1999).

¹²⁵ *Id.*

remains a higher priority than physician income. At the same time, physicians should not be expected to provide free health care simply because managed care organizations want to make a profit. In order to avoid anti-trust violations, such unions need lawyers experienced in labor law and health care law who understand patient needs. The MD/JD of the future is likely to be the best person to effectuate these changes. Additionally, the new physician union could be a forum to promote women and minorities in medicine who remain underrepresented and underpaid as physicians.

Physicians-in-training continue to have case law in favor of their unionization even after *Kentucky River* and, hopefully, will retain union status. After decades of concern for patient safety and house staff welfare, fifteen countries in the European Union voted in 1999 to decrease the length of the work week for house staff to 48 hours by 2012.¹²⁶ Despite some similar efforts in New York, many house staff members commonly work up to 72 or more hours without relief. The longest consecutive hours worked are typically in the surgical training programs where top physical and mental performance of physicians is critical to proper patient care. Without house staff unions, these physicians must appeal to their chairperson or the Residency Review Committee which grants accreditation and considers grievances in graduate medical programs.

Unions are not a panacea for what ails America's financially-challenged health care system which is overrun with managed care organizations seeking profit over quality patient care. Unions are one mechanism to balance the overwhelming power of managed care organizations compared to increasingly regulated and constrained physicians. Bills in Congress initially as the Campbell Bill and reintroduced in a revised form this year as the Barr-Conyers Bill proposed simulated test groups of physicians, not in a union model, who would contract with managed care organizations but be exempt from the NLRA. The goal was to study this new prototype but the bill fell victim to elections which frequently oust politicians supporting these measures. As a result, the Barr-Conyers Bill was never heard in the House of Representatives. The lack of progress toward physician unionization should not make physicians abandon their efforts.

¹²⁶ Paul R. McGinn, *Europe Will Limit Resident Work Hours*, AMERICAN MEDICAL NEWS No. 35, at 40 (Sept. 20, 1999).

The vast majority of physicians' complaints and efforts to unionize stem directly from problems generated by managed care organizations which have imposed themselves between the patient and physician and sought to ration care and services in the quest for profit. Creating universal health care coverage for all people in the United States would eliminate this unnecessary "middleman" in the guise of managed care organizations and could provide additional money for patient care and research.