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**IS YOUR PHYSICIAN BECOMING A TEAMSTER:  
THE RISING TREND OF PHYSICIANS  
JOINING LABOR UNIONS IN  
THE LATE 1990s**

*Jeremy Lutsky\**

**INTRODUCTION**

Changes in the health care industry brought about by the developments in the American economy in the late 1980s and early 1990s, as well as the subsequent growth of managed care, have permanently altered the practice of medicine in America. Health care is now big business with physicians caught between corporate payers attempting to maximize profits, and consumers and government agencies demanding cuts in health care spending. Today, the health care industry is controlled not by the physicians, but by large insurance companies, health maintenance organizations (HMOs), physician practice management companies and for-profit corporations. Physicians are finding themselves as cogs in the corporate health care machinery, working more hours for less money with increasingly less control over crucial decisions affecting the care of their patients. To regain the prestige, independence, control and financial security physicians once enjoyed and possibly took for granted, physicians are turning to labor unions. As Joseph L. Murphy, M.D. stated in a recent article:

The merciless erosion of medical decision making capability and professional influence has resulted in a sense of untold frustration

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and hopelessness [among physicians]. This dawning of physician discontent has provided the intellectual fodder for the revival and popularity of unionism as a proactive strategy to right the wrongs of this era and return the economic and power leverage to physicians."<sup>1</sup>

The purpose of this Article is threefold. First, an analysis will be made of the current health care climate in order to understand why physicians are doing what may be deemed unthinkable and turning to collective bargaining and labor unions to voice their concerns. Next, a comprehensive analysis of the law of unionization will be made to determine which physician groups can and cannot organize. Finally, an examination will be made of the current status of the physician unionization movement in an attempt to predict the course it will take in the future.

This Article begins with a brief overview of both the American and Canadian health care payment systems in order to provide an understanding of the development of the current health care climate and potential for success of the physician unionization movement. The next section of the Article will undertake a general analysis of the labor exemption to the antitrust laws and the law of union formation. Next, consideration will be given to whether physicians are allowed to unionize and collectively bargain under current labor laws. Within this discussion, physicians will be divided into three groups: employee-physicians; post-graduate medical students including residents, interns and fellows; and independent physicians. Having determined which physicians groups can unionize, the focus of the discussion will shift toward the reasons why American physicians are turning to labor unions. The discussion will attempt to identify why physicians should not be singled out from other high-paying professions allowed to collectively bargain and unionize. Also, an effort will be made to explain why physicians are turning to unions rather than existing professional associations such as the American Medical Association (AMA). Finally this Article concludes with an update of the current status of physician unions in the United States and an attempt to predict the future growth of physician unions.

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<sup>1</sup>Joseph L. Murphy, *Physician Unions: Bane or Balm?*, CHICAGO MEDICINE, Aug. 21, 1997, at 1, 2.

## THE STRUCTURE OF THE AMERICAN PAYMENT SYSTEM

### The American Payment System

The United States generally relies on a free market approach to health care.<sup>2</sup> In contrast to the Canadian single-payer system discussed below, United States consumers have three primary sources of payment for physician services: private insurance; the federal Medicaid/Medicare programs; and consumers' own funds.<sup>3</sup> Traditionally, the American physician has been free to set a reasonable fee, and if the insurance company did not pay for the entire bill, the patient would become responsible for the remainder.<sup>4</sup> For much of this century, American physicians were fairly and adequately compensated for their services, and they enjoyed a strong bargaining position with respect to third-party payers.<sup>5</sup> However, recent attempts to reform the American health care system have tipped the bargaining scales toward insurance companies and have severely limited physicians' ability to ensure fair compensation for their services.

Under the various reimbursement in operation physicians are placed at the mercy of private insurers and the government to negotiate fair reimbursement rates for individual medical procedures. Insurance companies, with the bargaining power of their total membership, can essentially force physicians to accept the insurance companies' fee schedules or risk losing patients.<sup>6</sup> As a result of the inequality of bargaining power, physician groups are starting to merge into larger units in order to create leverage in their negotiations with large insurance companies. However, individual physicians and small groups are still at a severe disadvantage in negotiating reimbursement rates with private insurers. Further, managed care entities such as preferred-provider-organizations (PPOs), point-of-service plans (POS) and health maintenance organizations (HMOs) are forcing physicians to accept less than their total fee, in exchange for membership in an insurer's provider

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<sup>2</sup>Daniel Srsic, *Collective Bargaining in the United States and Canada*, 15 COMP. LAB. L.J. 89, 99 (1993).

<sup>3</sup>*Id.*

<sup>4</sup>*Id.*

<sup>5</sup>Grace Budrys, *WHEN DOCTORS JOIN UNIONS* 15 (1997).

<sup>6</sup>Srsic, *supra* note 2, at 99.

network. Insurers push consumers (patients) toward network providers by offering total, rather than partial, reimbursement. Therefore, providers not included in an insurer's provider network risk losing a portion of their existing or potential practice unless they agree to join the network according to that insurer's terms.

Physicians fare no better in their reimbursement struggles with the government. In fact, physicians are often better compensated by private insurance than by government insurance.<sup>7</sup> Medicare, the federal health insurance program for persons over age sixty-five or disabled, does maintain reasonably favorable rates for physicians. Medicare Part A rates cover all in-patient hospital charges, and reimbursement is calculated according to fee schedules for diagnostic-related-groups (DRGs). Such DRGs may be favorable to physicians depending on each individual patient's medical needs and how effective each physician is at managing patient care. Further, Medicare does not require physicians to accept the Medicare fee as full payment, thus, allowing in-patient hospital facilities to bill patients for the unreimbursed portion of their bills.

Unlike the Medicare program, the rules governing reimbursement under Medicaid, the federal program designed to provide health coverage to the poor, are less generous to physicians. Physicians are paid for treating Medicaid patients based on a fixed fee schedule and are strictly prohibited from charging the difference between a physician's typical fee and the amount reimbursed by Medicaid. Therefore, physicians are unable to recover the full value of their services when treating Medicaid patients, and thus are forced to either pass these costs on to other patients or sacrifice part of their fee.

Physicians are in a similarly compromised position under a managed care reimbursement system. Independent physicians, whether they are paid at capitated rates (a fixed sum per patient, per a given time period), or are reimbursed for individual services, are still at the mercy of large HMOs and insurance companies who are able to compel physicians to accept unfavorable rates. Once again, in exchange for being included in a payer's network, physicians accept less than the full value of their services. Further, under managed care, physicians are being stripped of their medical autonomy since they often are required to gain approval prior to providing certain services. In addition, under managed care, many

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<sup>7</sup>*Id.*

physicians now are salaried employees; without the ability to collectively bargain, physicians at the mercy of providing only those services covered under their employer's health plans. The conditions described above have created an atmosphere conducive for unions to assist providers in regaining control over the health care industry from corporate payers.

### The "Single Payer" Payment System in Canada

The payment structure of the health care systems in the United States and Canada have led to widely different unionization patterns in the two countries, with Canadian physicians turning to unions much earlier than their American counterparts. With the recent surge in physician unionization in the United States, it is important for Americans to learn from the successes and failures of the Canadians.

Pursuant to the Canada Health Act of 1984, which consolidated the Hospital Insurance Act of 1957 and the Medical Care Insurance Act of 1966, health care in Canada is paid for by the government under a "single payer system."<sup>8</sup> The federal government distributes funding directly to health service programs administered by each of the ten provinces and two territories.<sup>9</sup> The costs of the National Health Insurance are recovered from multiple sources including income and gasoline taxes at both the federal and provincial levels.<sup>10</sup> All "medically necessary" inpatient services are covered and "although the universality provision initially mandated that 95% of the population be covered, the requirement now approach[es] universal coverage."<sup>11</sup>

Under the single payer system in Canada, physicians automatically belong to a professional association within their appropriate province or territory.<sup>12</sup> These associations bargain on behalf of all member physicians and negotiate two vital issues: (1) the total dollar allocation to medical services for the year, and (2) the fee schedule that determines the amount a physician will be paid for each specific procedure.<sup>13</sup> Further, once the government determines a yearly sum for medical care, the medical

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<sup>8</sup>Malcolm G. Taylor, *INSURING NATIONAL HEALTH CARE: THE CANADIAN EXPERIENCE* 14 (1990).

<sup>9</sup>*Id.*

<sup>10</sup>Jerry Geisel, *Canadian-Style System Works Well - In Canada*, *BUSINESS INSURANCE*, May 11, 1992, at 16.

<sup>11</sup>Srsic, *supra* note 2, at 93 (citing Taylor, *supra* note 8, at 16-17).

<sup>12</sup>*Id.* at 94.

<sup>13</sup>*Id.*

associations divide the gross allocations between the different practice areas.<sup>14</sup> This is in marked contrast to the American system where multiple smaller unions exist and unionization is optional. Under the United States legal framework, employee groups, such as physicians, working for a specific employer, like an HMO, have a choice of potential unions and must vote to certify a specific union as their collective bargaining representative.

The implementation of the National Health Insurance plan in Canada was initially opposed by many physicians. Criticism of the plan revolved around the fear that many Canadian physicians would emigrate to the United States to receive greater earnings, along with the traditional fear that physicians would strike on a massive scale leaving large populations without health care.<sup>15</sup> However, the move abroad of Canadian physicians has been matched with an equal rise in enrollment in Canadian medical schools.<sup>16</sup> The fear of the crippling effects of physician strikes has been handled by government regulation. Guidelines regulating strikes by Canadian physicians have been established by the College of Physicians and Surgeons providing for continued emergency care throughout the course of the labor dispute.<sup>17</sup> Therefore, while necessary and emergency medical services are to be provided, the most devastating effect of a strike for Canadians is the long waiting lists for non-emergency procedures such as elective surgery.<sup>18</sup> With the government regulation mentioned above, Canadian strikes are "inconvenient without threatening public health."<sup>19</sup>

The 1986 province-wide physician strike in Ontario is representative of the few physician strikes that have occurred in Canada. Strikes are conducted on a province-wide scale following the decision by a physicians' association's governing body to strike.<sup>20</sup> For example, the Ontario Medical Association (OMA) has a 250-member governing body that has been granted the authority to vote on issues such as whether its nearly 20,000 members of the professional association strike.<sup>21</sup> In 1986, the OMA governing body voted to strike in response to legislation

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<sup>14</sup>Taylor, *supra* note 8, at 26.

<sup>15</sup>*Id.*

<sup>16</sup>Srsic, *supra* note 2, at 95.

<sup>17</sup>*Id.*

<sup>18</sup>*Id.*

<sup>19</sup>*Id.*

<sup>20</sup>*Id.*

<sup>21</sup>*Id.*

limiting a physician's bills for services to the provincial fee schedule.<sup>22</sup> Physicians perceived the legislation as a serious threat to their earning potential, as well as their autonomy to set fees that are appropriate considering skill levels and other factors.<sup>23</sup> Therefore, the OMA voted in favor of a province-wide strike, and estimated that 11,000 of the 17,000 member physicians participated in a protest by closing their offices and canceling elective surgeries.<sup>24</sup> One month after it began, the OMA called off the strike in exchange for a fair deal on fee increases with the government.<sup>25</sup>

Canadian physician strikes such as the OMA strike, have often stemmed from attempts to place limits on earning potential. In 1992, physicians in British Columbia went on strike to protest the province's attempt to limit the amount of money an individual physician could earn.<sup>26</sup> The strike was settled by a compromise agreement to limit billing on a province-wide, rather than personal, level.<sup>27</sup>

Although the Canadian medical associations, under the single-payer system, bargain on a much larger scale than physician unions in the United States, their successful history in fighting for physician rights serves as a valuable resource for American physician unions to learn from and follow. The recent Ontario and British Columbia strikes are illustrative of how a large physicians' union can successfully stand up to government and corporate payers and defend physician rights to fair salary increases and autonomous decision-making.

Americans can learn from and emulate Canadian patient care guidelines with regard to strikes. As discussed above, one of the strongest arguments against physician unionization stems from the fear that a strike will leave some segment of the population without healthcare. By agreeing to maintain emergency care during strikes, physician unions in the United States could assuage public fears and gain vital public support for the right to collectively bargain.

The future of the Canadian single-payer system is unclear. The Canadian guarantee of universal fee-for-service health care without any

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<sup>22</sup>*Id.* at 96.

<sup>23</sup>*Id.*

<sup>24</sup>*Id.*

<sup>25</sup>*Id.*

<sup>26</sup>Douglas Todd, *For Whose Health Are We Caring?*, VAN. SUN., Aug. 15, 1992, at D13.

<sup>27</sup>*Id.*



controls on over-utilization, such as balance billing and user fees, has led to large increases in national health care spending. Ideas for reform include the American concepts of compensating physicians on a salary, rather than on a fee-for-service basis, introducing the managed care concepts of capitation and assumption of risk by physicians or insurance companies, and allowing balance billing and user fees such as co-payments and deductibles.<sup>28</sup> If these ideas take hold, Canadian physicians would be forced to bargain with individual employers and insurance companies, making physician unions in Canada similar to American physician unions, as discussed below.

### THE LAW OF UNION FORMATION IN THE UNITED STATES

As the American Medical Association House of Delegates (AMA) discussed in its June 1997 report (AMA Report) on the status of physician unions, "there is a conflict between the goals of the antitrust laws and the labor laws [in the United States]."<sup>29</sup> "[A]ntitrust laws bar combinations and other collective actions among sellers and buyers of goods and services to raise prices or otherwise set the terms of dealing."<sup>30</sup> The purpose of the antitrust laws is to prevent individual competitors from collaborating to set high prices to the detriment of consumers. The proponents of these laws argue competition benefits consumers because competitors are forced to create other favorable conditions, such as lower prices, in order to take business away from others in the market. In contrast, "the purpose of the labor laws is to keep human labor from being treated as a commodity, and to permit collective agreements and action among laborers to raise wages and improve working conditions. Strikes, boycotts, and other collective activity to raise wages are permitted and even favored by the labor laws."<sup>31</sup>

Antitrust laws, such as the Sherman and Clayton Acts are broad enough to cover human labor; however, an exemption has been created through statutory and legal interpretations to exempt collective activities

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<sup>28</sup>Srsic, *supra* note 2, at 97.

<sup>29</sup>AMA House of Delegates Report 41 of the Board of Trustees (A-97), *Physicians and Unions*, at 4.

<sup>30</sup>*Id.*

<sup>31</sup>*Id.*

among laborers from violating federal and state laws. The labor exemption, first set forth in Sec. 20 of the Clayton Act in 1914<sup>32</sup> is the result of four sets of statutes and judicial case law.<sup>33</sup> The exception states that “the labor of a human being is not a commodity or an article of commerce,” and “nothing contained in the antitrust laws shall be construed to forbid the existence and operation of labor.”<sup>34</sup> As the AMA Report states, “the Clayton Act is not specific about what constitutes labor organizations and their activities, so four other acts are referred to in order to interpret the scope of the exemption.” The other relevant statutes include the following:

- 1) the Norris-Laguardia Act;
- 2) the National Labor Relations Act (the Wagner Act);
- 3) the Labor Management Relations Act (the Taft-Hartley Act); and
- 4) the Labor Management Reporting and Disclosure Act (the Landrum-Griffin Act).<sup>35</sup>

The National Labor Relations Act (NLRA) is by far the most significant of these acts and is discussed below. In addition, federal courts have attempted to clarify the scope of the exemption when the four statutes do not provide enough guidance.<sup>36</sup> The rules of law developed in these cases are referred to as the “non-statutory” labor exemptions.<sup>37</sup>

The NLRA of 1935 created the National Labor Relations Board and is the “basis for the comprehensive federal code that regulates labor unions.”<sup>38</sup> The NLRA addresses “[t]he inequality of bargaining power between employees who do not possess full freedom of association or actual liberty of contract, and employers who are organized in the

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<sup>32</sup>15 U.S.C. § 17(20) (1914).

<sup>33</sup>The Norris-Laguardia Act, 29 U.S.C. § 101-115 (1932); The National Labor Relations Act (NLRA), 29 U.S.C. § 151 *et seq.* (1935); The Labor Management Relations Act (The Taft-Hartley Act), 29 U.S.C. § 141 *et seq.* (1947); The Labor Management and Disclosure Act (The Landrum-Griffin Act), 29 U.S.C. § 401 *et seq.* (1959).

<sup>34</sup>*Id.*

<sup>35</sup>The Norris-Laguardia Act, 29 U.S.C. § 101-115 (1932); The National Labor Relations Act (NLRA), 29 U.S.C. § 151 *et seq.* (1935); The Labor Management Relations Act (The Taft-Hartley Act), 29 U.S.C. § 141 *et seq.* (1947); The Labor Management and Disclosure Act (The Landrum-Griffin Act), 29 U.S.C. § 401 *et seq.* (1959).

<sup>36</sup>AMA Report, *supra* note 29, at 5.

<sup>37</sup>*Id.*

<sup>38</sup>*Id.*

corporate or other forms of ownership association.”<sup>39</sup> The Act, therefore, “creates a legally enforceable right for employees to organize, requires employers to bargain with employees through employee elected representatives, and gives employees the right to engage in concerted activities for collective bargaining purposes or other mutual aid or protection.”<sup>40</sup>

The NLRA attempts to define terms such as “employer,” “employee,” and “supervisor,” as discussed below, and explicitly provides for those individuals meeting the definition of “employees” to collectively bargain with their employers.<sup>41</sup>

### DOES THE LABOR EXEMPTION APPLY TO PHYSICIANS?

Traditionally physicians were prohibited from collectively bargaining on issues regarding their fees and working conditions because they were deemed independent contractors as opposed to “employees.”<sup>42</sup> Employees, unlike independent contractors, are covered by the labor union exception to the antitrust laws and are allowed to unionize and collectively bargain.<sup>43</sup> Since the passage of the NLRA, several arguments have been posed seeking to bar physicians from coverage under this labor exception because: 1) most physician-employees are independent contractors; and 2) physicians who meet certain indicia of “employees,” such as collecting a salary and working solely for one employer, still function more as supervisors than employees. For most of this century, the majority of physicians have passively accepted this position. However, with the vast changes in the health care industry over the last ten years, physicians are reevaluating their status as employees and their rights to collectively bargain. With the growth of managed care and the elimination of the corporate practice of medicine doctrine, as discussed below, physicians are becoming increasingly more like traditional employees by:

- 1) working as employees for one employer;

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<sup>39</sup>NLRA, 29 U.S.C. § 151(1).

<sup>40</sup>AMA Report, *supra* note 29, at 5.

<sup>41</sup>NLRA, 29 U.S.C. § 152(3).

<sup>42</sup>NLRA, 29 U.S.C. § 152(1) (1974).

<sup>43</sup>*Id.*

- 2) collecting a salary and bonuses tied to performance; and
- 3) having terms of employment dictated to them and not bargained or negotiated for.

Further, even physicians working as “independent contractors” are realizing they are rapidly losing their independence in their ability to set rates and make medical decisions, and therefore, believe they too should be able to join together and assert their rights.

The right to collectively bargain under the antitrust laws labor exemption turns greatly on whether a group of workers qualify as “employees” under the NLRA.<sup>44</sup> Employees of a single employer are deemed not to be competitors and are allowed to collaborate and collectively negotiate terms such as hours and wages. The right to band together and collectively bargain is extremely important for single employees who otherwise are at a tremendous disadvantage in negotiating terms with a powerful employer. While employers may deem a single or small number of employees expendable, a large group of employees, taken as a whole, are highly valuable to the employer and may force an employer to agree to more favorable terms than if each employee bargained on an individual basis.

Instead of providing an exact definition of what constitutes an “employee,” the NLRA provides broad guidelines and leaves the determination of whether specific individuals qualify as “employees” open to interpretation.<sup>45</sup> The NLRA states in pertinent part:

The term employee shall include any employee, and shall not be limited to the employees of a particular employer ... and shall include any individual whose work has ceased as a consequence, or in connection with, any current labor dispute or because of any unfair labor practice ... but shall not include any individual having the status of an independent contractor, or any individual employed as a supervisor.<sup>46</sup>

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<sup>44</sup>NLRA, 29 U.S.C. § 152(1) (1974).

<sup>45</sup>Richard B. Gallagher, *Hospital House Staff Physicians as “Employees” Under § 2(3) of the National Labor Relations Act (29 U.S.C. § 152(3))*, 57 A.L.R. Fed. 603 stating: “In construing the term ‘employee’ under the National Labor Relations Act, it generally has been held that the term is not a word of art having a broad and definite and fixed meaning, but rather that the term is to be given a broad, comprehensive meaning and read in the light of the policy of the legislation as well as the end to be attained.”

<sup>46</sup>NLRA, 29 U.S.C. § 152(3) (1974).

The subject of whether physicians can legally organize and collectively bargain under the antitrust laws' labor exemption should be divided into three categories:

- 1) employee-physicians;
- 2) post-graduate medical students working as residents, interns, and clinical fellows; and
- 3) self-employed physicians ("independent contractors").

Employee-physicians who can prove they meet the traditional criteria for "employees" under the NLRA are protected by the labor exemption and may join unions. However, physicians have had difficulty proving they meet this criteria. As discussed below, physicians are having trouble proving they are employees rather than supervisors, who are not protected under the Act. In addition, residents, interns, and fellows (collectively referred to as "house staff" or "house officers") also claim they should be allowed to organize and collectively bargain; but they have been denied these options on the basis that they are considered students, not employees.

In contrast to employee-physicians, self-employed physicians or independent contractors are generally not allowed to collaborate and collectively bargain. The joining together of independent competitors to set prices is a per se violation of the Sherman Act.<sup>47</sup> Further, the NLRA was explicitly interpreted in 1947 by the "Taft-Hartley Act," as discussed below, to only cover employees and not independent contractors.<sup>48</sup> However, independent contractors, subject to controls of payers over rate setting and medical decision making, are becoming increasingly successful in their argument that their relationship with such payers is similar to an employee-employer relationship. Further, support is also growing for the rights of independent contractor physicians to bargain over non-economic issues, such as professional autonomy, peer review, and grievance procedures, which is not a violation of federal or state antitrust laws.

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<sup>47</sup>Sherman Act, 15 U.S.C. § 1 (1890).

<sup>48</sup>Landrum-Griffin Act, 29 U.S.C. § 401 (1959).

### “Employee” Physicians

As stated above, physicians who are employees of health plans or hospitals fall within the labor exemption and may engage in collective bargaining with their employers. With the recent changes in health care, specifically the growth of managed care, an increasing percentage of physicians meet the definition of “employees” and are turning to unions to assert their rights. According to 1996 data published in the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION, over 40 percent of physicians are now employed by health care organizations.<sup>49</sup> Of that 40 percent, an AMA spokesman stated that “medical schools account for 23 percent of employed physicians, hospitals have 21 percent, and state and local governments and health maintenance organizations each account for about 10 percent of employed physicians.”<sup>50</sup> These percentages may change significantly as states reform their corporate practice of medicine doctrines and allow medical students to join unions as discussed below.

State rulings abolishing the corporate practice of medicine, such as the decision by the Illinois Supreme Court in *Berlin v. Sarah Bush Lincoln Health Center*, are paving the way for corporate entities, such as hospitals, to directly employ physicians.<sup>51</sup> The corporate practice of medicine doctrine prohibits corporations from directly providing medical services by employing physicians.<sup>52</sup> Public policy arguments in favor of this outdated doctrine “espouse the dangers of lay control over professional judgement, the division of the physician’s loyalty between his patient and his profit making employer, and the commercialization of the profession.”<sup>53</sup> The concerns of supporters of this doctrine are serious and legitimate; however, the corporate practice of medicine doctrine does not effectively address these concerns. Instead of taking the corporate presence out of health care, this doctrine simply creates the opportunity for lawyers to creatively structure affiliation agreements between “independent” physician groups and hospitals to circumvent the law and maintain the hospital’s control over their physicians. Further, with the large number of physicians directly working for other corporate entities

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<sup>49</sup>*Physician Unions: Managed Care, Growing Employee Status Spur Physician Interest in Unionization*, Health Law Rptr. (BNA), July 10, 1997, at D3.

<sup>50</sup>*Id.*

<sup>51</sup>*Berlin v. Sarah Bush Lincoln Health Ctr.*, 688 N.E.2d 106 (Ill. 1997).

<sup>52</sup>*Id.*

<sup>53</sup>*Id.* at 110.

such as HMOs, the corporate practice of medicine is outdated in today's managed care environment. As the *Berlin* Court stated: "[T]he emergence of corporate health maintenance organizations [who directly employ physicians] ha[s] greatly altered the concern over the commercialization of health care."<sup>54</sup> In addition, as the Illinois Supreme Court pointed out: "It would be incongruous to conclude that the legislature intended the hospital to accomplish what it is licensed to do without utilizing physicians as independent contractors or employees .... To conclude that a hospital must do so without employing physicians is not only illogical but ignores reality."<sup>55</sup>

The abolition of the corporate practice of medicine in Illinois and other states is a significant victory for union advocates in their argument that physicians working for hospitals are either actual or constructive employees and should be allowed to collectively bargain. Another recent landmark decision holding physicians are employees and should be allowed to unionize involves the Thomas-Davis Medical Centers in Tucson, Arizona. The argument against unionization made by management at Thomas-Davis was that the physicians were actually supervisors rather than employees, and thus are excluded from collective bargaining under the NLRA. However, as discussed below, the National Labor Relations Board (NLRB) recently held that although the physicians did act in a supervisory nature at times, they were primarily employees and should be allowed to join a union and collectively bargain.<sup>56</sup>

The facts of the Thomas-Davis conflict are as follows. In 1981, 133 Thomas-Davis physicians owned and operated their own HMO, Intergroup Healthcare, and by the mid-1980s, Intergroup had become Arizona's largest HMO, insuring 379,000 members.<sup>57</sup> In November 1994, the physicians sold Intergroup Health Care and Thomas-Davis to Foundation Health Corporation in San Francisco, California.<sup>58</sup> Each of the physician-owners received Foundation stock worth \$3.2 million; however, the physicians soon realized they had sold more than just their practice

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<sup>54</sup>*Id.* at 114.

<sup>55</sup>*Id.* (citing *St. Francis Medical Ctr. v. Weis*, 869 P.2d 606, 618 (Kan. 1994)).

<sup>56</sup>*Medical Center Physicians Fight to Form Union*, PHYSICIAN PRACTICE OPTIONS, Aug. 1997, at 1, 6.

<sup>57</sup>*Id.*

<sup>58</sup>*Id.*

revenues to the large managed care organization.<sup>59</sup> Soon after Foundation bought the Thomas-Davis clinic, it sold Thomas-Davis to Federation of Physicians and Dentists/National Union of Hospital and Health Care Employees (FPA), claiming the clinic was losing money.<sup>60</sup> In preparation for the sale, Foundation began a number of cost-saving measures including “firing twenty-six physicians, including many specialists; increasing the number of patients physicians needed to see; and eliminating records clerks so that physicians had to type their own notes.”<sup>61</sup> In a matter of months, the previously autonomous physician-owners of Intergroup Health Care and Thomas-Davis Medical Clinic became physician-employees of Thomas-Davis under the complete control and discretion of Foundation, and later FPA Medical Management.

Dr. Don W. Hill, an oncologist who resigned from Thomas-Davis’ Tucson clinic in June 1997, sums up the frustrations of the 129 physician-employees practicing in the Tucson area who resigned as the result of changes instituted by FPA management. Dr. Hill laments: “We sold out because we didn’t know how to take care of ourselves. And now we’re suffering the consequences. We’d give the damn money [from the sale to Foundation] back if we could figure out how to do it right.”<sup>62</sup> Keith Dveirin, a pediatrician employed at the clinic, explained the reason why Dr. Hill, himself, and many other physicians employed by FPA were so unhappy: “[D]isputes with FPA include obstacles to specialist referrals, unrealistically high patient loads, and nursing and support staff cuts. Management also installed a new mandatory compensation plan resulting in physician salary cuts of 20 percent to 50 percent.”<sup>63</sup> Dr. Hill serves as a prime example of the adverse affects that the recent changes in health care have had on physicians and why they need advocates, such as unions, to help them regain control of their practices and their lives. He recently stated “I sat there and reflected over the past year. I had been on call every other day and every other weekend. My blood pressure was up, I

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<sup>59</sup>*Id.*

<sup>60</sup>*Id.*

<sup>61</sup>*Id.*

<sup>62</sup>Jane Erikson, *Turmoil in Tucson: Bad Blood Flows Between Ariz. Physicians’s Union, Management*, AM. MED. NEWS, Sept. 8, 1997, at 54.

<sup>63</sup>*Physician Unions: Managed Care, Growing Employee Status*, *supra* note 49, at D3.



had no viable hobbies, no life outside work. I was to the limit. I couldn't go on."<sup>64</sup>

As a result of the changes instituted by Federation and FHP, on December 5, 1996, ninety-three out of 125 physicians at Thomas-Davis voted to unionize by joining the FPD, an American Federation of State, County and Municipal Employees affiliate.<sup>65</sup> The election took place after the regional director of the NLRB determined that physicians were not supervisors or managers, and were therefore allowed to vote to certify a union representative.<sup>66</sup> On January 7, 1997, FPA denied management's request for a new hearing, and on February 3, the NLRB certified FPD as the bargaining agent for some 150 physicians at the HMO's six locations in the Tucson area.<sup>67</sup> Between February 28 and July 24, Thomas-Davis refused to bargain with the union representative; however, on July 24, the NLRB reaffirmed its denial of Thomas-Davis' appeals and ordered the Medical Centers to "cease and desist from refusing to bargain with the Federation of Physicians and Dentist/AHPE, NUHHCE, AFSCME, AFL-CIO as the exclusive bargaining representative of the employees in the bargaining unit."<sup>68</sup>

Advocates of physician unionization view the Thomas-Davis decision as a strong statement by the NLRB that physicians are not supervisors and should be allowed to organize if they meet other traditional indicia of employees.<sup>69</sup> Further, they hope this decision will clear the way for other physician groups to certify a bargaining representative and regain control from the corporation over the practice of medicine.<sup>70</sup> Union officials such as Jack Seddon, executive director of FPD, state that "the major issue in the organizing drive was the physicians' right to practice medicine and not be overruled on decisions affecting patient care." Officials "expect a victory [at Thomas-Davis] to encourage widespread organizing by physicians at HMOs and medical

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<sup>64</sup>Erikson, *supra* note 62, at 54.

<sup>65</sup>*Representation: Physicians at Tucson Medical Clinic Vote to Join ACFSME Union Affiliate*, Health Law Rptr. (BNA), Jan. 30, 1997, at D19.

<sup>66</sup>*Physician Unions: NLRB Orders HMO to Bargain with Physicians Union; Company Appeals*, Health Law Rptr. (BNA), Aug. 7, 1997, at D23.

<sup>67</sup>*Id.*

<sup>68</sup>*Thomas-Davis Medical Centers, P.C.*, 324 NLRB 15 (1997).

<sup>69</sup>*Physician Unions: NLRB Orders HMO to Bargain*, *supra* note 66, at D23.

<sup>70</sup>*Id.*

groups.”<sup>71</sup> As Dr. Robert Osborne triumphantly stated, “this is a tremendous victory for all of medicine,” and will “dramatically begin the process of allowing physicians to return to their traditional roles as patient advocates.”<sup>72</sup>

The position taken by FPA Medical Management, that the physicians at Thomas-Davis function more as supervisors than employees and hence should not be allowed to collectively bargain under the NLRA, is the traditional argument against allowing employee-physicians to unionize. The NLRA defines “supervisor” as:

any individual having the authority, in the interest of the employer, to hire, transfer, suspend, lay off, recall, promote, discharge, assign, reward, or discipline other employees, or responsibility to direct them, or to adjust their grievances, or effectively to recommend such action, if in connection with the foregoing the exercise of such authority is not of a merely routine or clerical nature, but requires the use of independent judgement.<sup>73</sup>

The NLRA specifically states “individuals employed as a supervisor” are not exempt under antitrust laws because such individuals do not fall under the definition of “employees.”<sup>74</sup>

In its struggle with physicians at Thomas-Davis, FPA attempted to use the same argument that has proven successful in thwarting employee-physician attempts to unionize in the past<sup>75</sup> “physicians are supervisors and directly manage care, and are not entitled to be part of a collective bargaining unit.” For instance, in 1985, the Union of American Physicians and Dentists (UAPD) lost its bid to represent a group of physicians employed by the Family Health Plan in Southern California when the court determined that physicians were “management employees ... who formulate and effectuate management policies” and “represent management interest by taking or recommending actions that effectively

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<sup>71</sup>Mary Chris Jaklevic, *Physicians Find Power in Unions: A Small But Growing Number of Docs Are Using Organized Labor to Gain Economic Advantage*, MODERN HEALTHCARE, Oct. 6, 1997, at 99.

<sup>72</sup>Representation: *Physicians at Tucson Medical Clinic Vote to Join AFSCME*, *supra* note 65, at D19.

<sup>73</sup>NLRA, 29 U.S.C. § 152(11) (1974).

<sup>74</sup>NLRA, 29 U.S.C. § 152(3) (1974).

<sup>75</sup>*Physician Unions: Managed Care*, *supra* note 49, at D3.

control or implement employer policy.”<sup>76</sup> In *Family Health Plan*, the NLRB found participation by employee-physicians on committees such as peer review constitutes managerial authority which disqualifies them from labor exemption protection.<sup>77</sup> However, as the recent *Thomas-Davis* decision indicates, the NLRB no longer considers employee-physicians with a limited degree of supervisory authority to be supervisors.<sup>78</sup>

The NLRB appears to have reached the logical conclusion espoused by the minority opinion in *NLRB v. Health Care and Retirement Corp. of America* that, although some of the work performed by professional employees is inherently supervisory, the nature of their work taken as a whole is markedly different from the work of traditional “supervisors” who act as surrogates for management.<sup>79</sup> The question before the court in *Health Care and Retirement Corp.* was whether nurses in supervisory positions had the right to bargain collectively.<sup>80</sup> Although the NLRB held that the nurses were not supervisors and should be reinstated, the Supreme Court upheld the Court of Appeals decision which reversed the NLRB decision.<sup>81</sup> The 1994 decision was a defeat for advocates of the position that both nurses and physicians are employees entitled to collectively bargain under the labor exemption. However, a spark of hope emerged from the unionists defeat: the decision included a strong dissent which argued the majority did not give sufficient attention to the fact that the very nature of professionals’ work responsibilities meant they must on occasion direct and supervise the work of others.<sup>82</sup> The dissent maintained that acting in a “supervisory capacity” by directing other employees did not make physicians “supervisors” in a traditional sense.<sup>83</sup> The physicians in question did not meet the NLRA definition of “supervisors” as they did not “have the authority, in the interest of the employer, to hire, transfer, suspend, lay off, recall, promote, discharge, assign, reward or discipline other employees.”<sup>84</sup>

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<sup>76</sup>Budrys, *supra* note 5, at 119.

<sup>77</sup>NLRB v. FHP, 274 N.L.R.B. 1141 (1985); Srsic, *supra* note 2, at 108.

<sup>78</sup>*Thomas-Davis Medical Centers*, 324 NLRB at 4.

<sup>79</sup>NLRB v. Health Care and Retirement Corp. of Am., 987 F.2d 1256 (6th Cir. 1993).

<sup>80</sup>*Id.*

<sup>81</sup>*Id.*

<sup>82</sup>*Id.* at 1261.

<sup>83</sup>*Id.*

<sup>84</sup>NLRA, 29 U.S.C. § 151 (2)(11); *Health Care Retirement Corp.*, 114 S. Ct. at 1771.

### Interns, Residents and Fellows

A debate is currently raging as to whether the unique group of physician-employees comprised of post-graduate medical students qualifies as “employees” entitled to protection under the labor exemption, or as “students” who are not allowed to collectively bargain. These individuals are recent medical school graduates participating in “apprentice-like programs” at hospitals or medical centers in order to learn a specialty.<sup>85</sup> These physicians are officers who work extremely long hours for low pay and, as such, are “prime candidates” for organization.<sup>86</sup> As union advocates argue: “House officers may work eighty to one hundred hours a week for pay that averages out to the minimum hourly wage. With hospitals downsizing, merging and closing, the house officers say their need for protection under United States labor law is greater now than ever.”<sup>87</sup> Dr. Jodi Wenger, chief pediatric resident at Boston Medical Center sums up the plight of house staff when she states: “We tend to be a disenfranchised group. We’re hungry, we’re exhausted. It’s hard to have a voice when you’re so overworked.”<sup>88</sup>

As underpaid and overworked employees, many house officers possess the motivation to organize and collectively assert their rights; however, the NLRB currently does not recognize their right to join unions. As the NLRB stated in its landmark decision, *NLRB v. Cedars Sinai Medical Center and Cedars-Sinai House Staff Association*, “interns, residents and clinical fellows, although they possess certain employee characteristics, are primarily students ... [W]e conclude that interns, residents, and clinical fellows ... are not ‘employees’ within the meaning of Section 2(3) of the [National Labor Relations] Act.”<sup>89</sup> The NLRB majority dismissed the petition of house officers at Cedars-Sinai Hospital in Los Angeles to unionize on the basis that “the purpose of internship and residency programs [is] to put into practice the principles ... that the medical school graduate learned in medical school.”<sup>90</sup> Since, the NLRB considered the house officers to be primarily students rather than

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<sup>85</sup>Srsic, *supra* note 2, at 104.

<sup>86</sup>*Id.*

<sup>87</sup>Dolores Kong, *Hospital Residents Seek Right to Unionize; Boston Medical Center Case Watched Closely*, BOSTON GLOBE, Aug. 24, 1997 at A1.

<sup>88</sup>*Id.*

<sup>89</sup>*Cedars Sinai Medical Center and Cedars Sinai House Staff Association*, 223 NLRB 251 (1976).

<sup>90</sup>*Id.*

professional employees, it refused to recognize their right to collectively bargain.<sup>91</sup>

The *Cedars-Sinai* opinion did include, however, a strong dissenting opinion which may serve as a future majority opinion if the issue of the right of house officers to organize comes before the NLRB again. The dissent in *Cedars-Sinai* argued that even if house officers are determined to be primarily “students,” under the NLRA this determination does not preclude them from also being considered “employees” who are allowed to collectively bargain.<sup>92</sup> The dissent pointed to that Section 2(3) of the NLRA which “include[s] any employee ... unless the Act explicitly states otherwise,” and continues by drawing attention to the Act’s explicit exclusion of certain employees such as agricultural laborers.<sup>93</sup> Interns, residents and clinical fellows clearly demonstrate certain elements of being “employees” as they usually work for a single employer such as a hospital or academic medical center, spend the majority of their time on clinical patient services (often without supervision) for the benefit of the employer, and collect a salary by means of a stipend. Since “students” who are also employees are not specifically excluded under Section 2(3) and “the relationship between student and employee is not mutually exclusive,” house officers should be allowed to organize under the NLRA.<sup>94</sup>

The dissent in *Cedars-Sinai* further points out that the definition of “professional employees” in Section 2(12) of the NLRA also supports the conclusion that house officers should be considered employees and be allowed to organize.<sup>95</sup> Section 2(12) defines “professional employees” as:

(a) any employee engaged in work ... (iv) 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 ...

or

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<sup>91</sup>*Id.*

<sup>92</sup>*Id.* at 253.

<sup>93</sup>*Id.*

<sup>94</sup>*Id.*; NLRA, 29 U.S.C. § 151(2)(3) (1974).

<sup>95</sup>NLRA, 29 U.S.C. § 152(12) (1974).

(b) any employee who (i) *has completed the courses of specialized intellectual study described in clause (iv) of paragraph (a), and (ii) is performing related work under the supervision of a professional person to qualify himself to become a professional employee as defined in paragraph (a).* [Emphasis supplied].<sup>95</sup>

Interns, residents and fellows meet the exact definition of “professional employees” as they have completed “courses of specialized intellectual instruction,” and are “performing related work under the supervision of a professional person.”<sup>97</sup> Since house officers qualify as “professional employees,” which are by definition “employees,” and further are not specifically exempted from the definition of “employees” in Section 2(3) of the NLRA, they should be allowed to unionize.<sup>98</sup>

Although the NLRB ruled house officers in private hospitals are students, certain state laws, relying on the logic from the dissent in *Cedars-Sinai*, have allowed such physicians to unionize at public hospitals.<sup>99</sup> Advocates of the rights of house officers to organize state:

Professional employees are explicitly covered by the NLRA, and in the trade of medicine, the house staff may be as much apprentices as they are students. This type of reasoning, in addition to the fact that house staff of state owned hospitals in both California and New York are considered employees under the state labor laws applicable to them, indicate that a sympathetic NLRB may be the only thing needed to overturn the *Cedars-Sinai* decision.<sup>100</sup>

For instance, in New York, the largest house officers union, the Committee of Interns and Residents (CIR), has been allowed to grow to more than 9,000 members and has participated in collective bargaining and conducted strikes.<sup>101</sup> In addition, the California Supreme Court took an independent course from the NLRB by upholding a decision of the

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<sup>96</sup>*Id.*; *Cedars-Sinai*, 223 NLRB at 256.

<sup>97</sup>NLRA, 29 U.S.C. § 152(12) (1974).

<sup>98</sup>NLRA, 29 U.S.C. § 152(3) (1974).

<sup>99</sup>Dolores Kong, *Hospital Residents Seek Right to Unionize: Boston Medical Center Case Watched Closely*, BOSTON GLOBE, Aug. 24, 1997, at A1.

<sup>100</sup>Srsic, *supra* note 2, at 106.

<sup>101</sup>Kong, *supra* note 99, at A1; Srsic, *supra* note 2, at 106.

California Public Employment Relations Board finding house officers to be employees under the Higher Education Employer Employee Relations Act.<sup>102</sup> The Court “relied on the fact that house staff spend a substantial quantity of time in clinical activities and direct patient care” and “discounted the importance of the supervision and educational benefits received by the house staff as being subordinate to the services they render.”<sup>103</sup> Further, some private hospitals, such as the Boston Medical Center discussed below, have voluntarily recognized the rights of house officers to collectively bargain.

The recent struggle by residents and interns at the Boston Medical Center to unionize “has the potential to change graduate medical education” if it falls upon the ears of a “sympathetic NLRB” in the near future.<sup>104</sup> The conflict over the right of interns and residents to organize stemmed from the July 1, 1996 merger of the public Boston City Hospital with the private Boston University-affiliated hospital. Previous to the merger, the House Officers Association represented about 260 physicians-in-training at the former Boston City Hospital; however, since the new hospital (Boston Medical Center) was now private, it was not compelled to recognize house officers unions under the *NLRB v. Cedars-Sinai* decision.<sup>105</sup> After months of “adamant opposition to a union for interns and residents at the new Boston Medical Center,” after 78 percent of the 162 residents and interns at the former Boston University Medical Center Hospital indicated by signing cards that they favored representation, the institution’s management finally voluntarily recognized the House Officers Association in September 1996.<sup>106</sup> The union now represents 420 residents, interns, and fellows at the Boston Medical Center.<sup>107</sup>

Although the House Officers Association won formal recognition from the Boston Medical Center, the Association joined with the largest

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<sup>102</sup>*Regents of the Univ. of Calif. v. Pub. Employment Rel. Bd.*, 715 P.2d 590 (Cal. 1986).

<sup>103</sup>*Srsic*, *supra* note 2, at 107 (citing *Univ. of Calif. v. Pub. Employment Rel. Bd.*, 41 Cal. 3d at 590).

<sup>104</sup>*Collective Bargaining: NLRB Rejects Resident's Claim*, HEALTH LINE, Oct. 20, 1997.

<sup>105</sup>Richard A. Knox, *Boston Medical Center Recognizes Union for Interns and Residents*, BOSTON GLOBE, Sept. 19, 1996; *Cedars Sinai Medical Center and Cedars Sinai House Staff Association*, 223 NLRB 251 (1976) (As mentioned earlier, housestaff at *private* hospitals are not entitled to collective bargaining rights; however, some states such as Massachusetts have allowed housestaff at *public* hospitals to organize.)

<sup>106</sup>Knox, *supra* note 105.

<sup>107</sup>*Id.*

house officers union, the aforementioned Committee of Interns and Residents, in filing a petition with the regional office of the NLRB "to make their future more secure" by attempting to overturn *Cedars-Sinai*.<sup>103</sup> On October 17, 1997, the regional office of the NLRB dismissed the petition, but left the door open for an appeal with the NLRB.<sup>109</sup> According to Sandy Shea, the area director for the Association, members of the union "knew from the beginning that this case had to go to D.C. for a decision," and view the regional decision as a stepping-stone rather than a setback.<sup>110</sup> Therefore, the decision by NLRB regional director, Rosemary Pye, did not damage the position of supporters of unions for house officers. Pye simply upheld past NLRB precedent and stated: "Whether or not the Board's prior decisions in this area should be reversed is a matter that can be resolved only by the Board itself."<sup>111</sup> Pye's statements leave much room for optimism that the full NLRB may finally overturn *Cedars-Sinai* and recognize the right of residents, interns, and fellows to unionize in the near future.

This case has tremendous significance not just for the Association, but for "the 110,000 interns, residents, and fellows who provide care at the approximately 400 teaching hospitals across the country."<sup>112</sup> As Dolores Kong of the Boston Globe states:

From the perspective of many current and former residents, being able to bargain collectively - for things such as wage increases, safe and clean rooms to sleep in while on call for 36 hours or so, or adequate ancillary patient services, such as language interpretation - would improve not only officers' lives, but patient care, too.<sup>113</sup>

The issues in the Boston Medical Center case are of such importance to the future of the medical industry that influential medical associations such as the American Medical Association (AMA) and the Association of American Medical Colleges (AAMC) have considered "weighing in" on

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<sup>103</sup>Kong, *supra* note 99, at A1.

<sup>109</sup>Dolores Kong, *Resident Doctors Lose One Round; Plan Appeal of Labor Decision*, BOSTON GLOBE, Oct. 18, 1997, at B1.

<sup>110</sup>*Id.*

<sup>111</sup>*Id.*

<sup>112</sup>Kong, *supra* note 99, at A1.

<sup>113</sup>*Id.*



opposing sides.<sup>114</sup> In July 1997, the AMA notified the regional director of the NLRB of its intention to file an amicus brief in support of the house officers; however, the AAMC mounted a campaign to pressure the AMA to change its plan.<sup>115</sup> The AAMC filed its own amicus brief against the Association's petition, while the AMA decided to take the less radical stance of "work[ing] within organized medicine to push for a hospital medical staff structure to address house officers' concerns."<sup>116</sup> While the results of the Association's appeal are still pending, the Association at the Boston Medical Center has already made significant strides toward improving the working conditions for residents, interns, and fellows not just in Boston, but throughout the United States.

### "Independent" Physicians

In contrast to employee-physicians, independent physicians (independent contractors) are not exempt from prosecution under the antitrust laws for organizing and collectively bargaining. As the recent AMA House of Delegates Report stated: "Before physicians can engage in collective bargaining under the labor exemption, the bargaining process must be part of a labor dispute. For there to be a labor dispute, the collective bargaining must concern the terms and conditions of employment."<sup>117</sup> Therefore, the AMA Board of Trustees report suggests that only when physicians are deemed to be employees in an "employment relationship" and involved in a genuine "labor dispute" will they be able to collectively bargain with employers.<sup>118</sup> As the AMA states, traditionally there has been "no labor dispute for purposes of the labor exemption if the physicians are independent contractors, entrepreneurs, or independent businesses."<sup>119</sup> However, the definition of what constitutes an "employment relationship" necessary to trigger a "labor dispute" is rapidly expanding with the changing nature of relationships between payers and providers brought about by the growth of managed care.

The determination of whether a worker is an employee or independent contractor is determined by the common law "right of control

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<sup>114</sup>*Id.*

<sup>115</sup>*Id.*

<sup>116</sup>*Id.*

<sup>117</sup>AMA Report, *supra* note 29, at 6.

<sup>118</sup>*Id.*

<sup>119</sup>AMA Report, *supra* note 29, at 7.

test.”<sup>120</sup> The NLRB in *Gary Enterprises* defined the “right to control test” as follows:

If the person for whom the services are performed retains the right to control the manner and means by which the results are to be accomplished, the person who performs the services is the employee. If only the results are controlled, the person who performs the services is an independent contractor.<sup>121</sup>

The most important factor in this test is the extent of control which the employer may exercise over the worker.<sup>122</sup> As the court in *North American Van Lines v. NLRB* stated: “The [right to control] test requires an evaluation of all the circumstances, but the extent of the actual supervision exercised by a putative employer over the ‘means and manner’ of the workers’ performance is the most important element to be considered in determining whether or not one is dealing with independent contractors or employees.”<sup>123</sup>

In addition to the extent of control the employer has over the worker’s performance, there are many other facts which courts must consider in determining whether a worker is an employee or independent contractor. As the NLRB discussed in *Gary Enterprises*, the factors “considered significant at common law” in connection with the “right to control test” include:

- 1) whether individuals perform functions that are an essential part of the Company’s normal operation or operate an independent business;
- 2) whether they have a permanent working arrangement with the Company which will ordinarily continue as long as performance is satisfactory;
- 3) whether they do business in the Company’s name with assistance and guidance from the Company’s personnel ...

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<sup>120</sup>*North American Van Lines v. NLRB*, 869 F.2d 596 (1989); *Gary Enterprises*, 300 NLRB 1111 (1990); *Glen Falls Newspapers*, 303 NLRB 614 (1991).

<sup>121</sup>*Gary Enterprises*, 300 NLRB at 1118.

<sup>122</sup>*North American Van Lines*, 869 F.2d at 599, *Gary Enterprises*, 300 N.L.R.B. at 1119.

<sup>123</sup>*North American Van Lines*, 869 F.2d at 599.

- 4) whether the agreement which contains the terms and conditions under which they operate is promulgated and changed unilaterally by the Company;
- 5) whether they account to the company for the funds they collect under a regular reporting procedure prescribed by the Company;
- 6) whether particular skills are required for the operations subject to the contract;
- 7) whether they have a proprietary interest in the work in which they are engaged; and
- 8) whether they have the opportunity to make decisions which involve risks taken by the independent [physician] which may result in profit or loss.<sup>124</sup>

The facts of each case “must be individually considered, so physicians do not pass or fail as a group.”<sup>125</sup>

While the number of employee-physicians is increasing, most physicians still do not meet the traditional indicia of salaried employees bound to one employer. Support is growing, however, for the argument that “physicians who are not employees of a hospital or health plan, but who are subject to a high degree of control by the hospital or health plan, should qualify for the labor exemption because they are not truly independent.”<sup>126</sup> As a recent article on the growth of physician unions in the United States and Canada describes:

Many American physicians are sacrificing autonomy in order to survive financially. A physician has traditionally exercised complete control over his or her decision making and style of practice. However, as HMOs and other forms of managed care grow, the traditional autonomy that physicians have enjoyed ... is being threatened. If professional autonomy is being sacrificed, physicians are less and less in control of the means and manner in which their work is performed.<sup>127</sup>

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<sup>124</sup>*Gary Enterprises*, 300 NLRB at 1119.

<sup>125</sup>Srsic, *supra* note 2, at 102 (citing *Capitol Parcel Delivery Co.*, 256 NLRB 302, 303 (1981)).

<sup>126</sup>AMA Report, *supra* note 29, at 7.

<sup>127</sup>Srsic, *supra* note 2, at 102 (citing John K. Iglehart, *Health Policy Report-The American Health Care System-Managed Care*, 327 NEW ENG. J. MED. 742, 743 (1992)).

Advocates of the right of independent contractor-physicians to unionize believe the existence of a formal employment relationship should not be the yardstick by which the right to collectively bargain is determined. Physicians in the current managed care environment are forced to agree to terms such as low reimbursement rates, withholding of a portion of their income for performance and cost savings incentives, and the need to get pre-approval for certain medical procedures. The ability of powerful health plans to dictate these terms to physicians makes these physicians no more "independent" than other traditional employees. As Jack Seddon, executive director of the Federation of Physicians and Dentists (FPD) states: "[M]anaged care (companies), by dictating the terms in these agreements, have created an employer-employee relationship, and they must recognize that the physicians have a collective right to sit down and discuss terms."<sup>128</sup>

Legal precedent and common sense both support independent contract-physicians' rights to collectively bargain with health plans and insurance companies. A strong argument for an expansive definition of what constitutes an "employee" comes from the 1944 Supreme Court decision of *NLRB v. Hearst*.<sup>129</sup> In *Hearst*, the Supreme Court held the protection of the NLRA was "not confined exclusively to 'employees' within the traditional legal distinctions separating them from 'independent contractors' ... ."<sup>130</sup> The Court continued by stating "that inequalities in bargaining power in controversies over wages, hours, and working conditions may as well characterize the status of independent contractors as employees, and that the NLRA may protect persons, who, under traditional concepts and common law definitions, are technically independent contractors."<sup>131</sup> Not long after the *Hearst* case, Congress amended the NLRA with the Labor Management Relations Act (also known as the Taft-Hartly Act) which swung the pendulum back toward a more narrow and traditional definition of "employee" for purposes of the labor exemption.<sup>132</sup> *Hearst*, however, still serves as strong precedent for the proposition that, when certain situations create inequalities of bargaining power, protection under the labor exemption for the right to

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<sup>128</sup>Jaklevic, *supra* note 71, at 99.

<sup>129</sup>AMA Report *supra* note 29, at 7.

<sup>130</sup>*Id.* (Citing *NLRB v. Hearst*, 322 U.S. 111 (1944)).

<sup>131</sup>*Id.*

<sup>132</sup>Taft-Hartley Act, 29 U.S.C. § 141 (1947).

collectively bargain should be expanded to include independent contractors and other "non-traditional" employees.

In a number of instances, courts and the NLRB have found other types of workers, generally considered independent contractors, qualified as employees worthy of protection under the NLRA.<sup>133</sup> For example, in *Roadway Package System*, the NLRB found the company's truck drivers to be employees as the result of employer control over the driver's daily routine and the driver's lack of entrepreneurial freedom.<sup>134</sup> In the similar case of *Blackberry Creek Trucking*, the NLRB "relied upon employer disciplinary rules and a prohibition against drivers swapping hauls to find that truck owner-operators were employees and not independent contractors."<sup>135</sup> The loss of entrepreneurial freedom and autonomy preferred provider organizations (PPOs) with regard to decision making by physicians in HMOs is analogous to the problems faced by the truckers described above. Therefore, independent contractor-physicians may be able to successfully argue that they, too, should be considered employees for purposes of the labor exemption to the antitrust laws.

Another factor in favor of the right of independent-contractor physicians to collectively bargain is the recognition that similar non-employees in other professions have enjoyed the protections of the labor exemption for many years while physicians have been singled out for denial of the right to unionize. The AMA House of Delegates Report specifies that "there are some occupations ... where members who do not have an employment relationship with an employer have been allowed to engage in collective bargaining."<sup>136</sup> As Sanford Marcus, founder of the Union of American Physicians and Dentists (UAPD) stated:

We can cite *ad infinitum* such examples as professional baseball and football players, journey-men, barbers, musicians, motion picture actors and directors, owner-operators of Teamster trucks, and a host of others; none of whom are any more "salaried"

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<sup>133</sup>Srsic, *supra* note 2, at 102.

<sup>134</sup>*Roadway Package System*, 288 NLRB 196 (1988); Srsic, *supra* note 2, at 102.

<sup>135</sup>*Blackberry Creek Trucking*, 291 NLRB 474, 480 (1988); Srsic, *supra* note 2, at 102.

<sup>136</sup>AMA Report, *supra* note 29, at 9 (examples include owner-driver truckers (Local 24, International Brotherhood of Teamsters v. Oliver, 358 U.S. 283 (1959); musicians (American Federation of Musicians v. Carroll, 391 U.S. 99 (1968); and screen directors (Home Box Office v. Director's Guild of America, 531 F. Supp. 578 (S.D.N.Y. 1982), *aff'd* 708 F.2d 95 (2nd. Cir. 1983).

workers than we are, but have been granted the legal right to form unions of their own, to engage in true collective bargaining on economic issues and, most important, to enjoy the applicable exclusions from anti-trust laws that are uniquely guaranteed to bona-fide trade unions but are withheld from professional associations.<sup>137</sup>

Independent contractor physicians are attempting to prove that the degree of control health plans and insurance companies can exercise over physicians is arguably similar to the level of control other employees, who are protected under the labor exemption of the antitrust laws, are subject to. However, significant resistance to the struggle of independent contractors to organize and collectively bargain still exists. As Harris Meyer states, many still believe “insurers currently don’t exercise enough control over the physicians that they contract with to make physicians employees and let them unionize under the National Labor Relations Act.”<sup>138</sup> Powerful groups such as the AMA have noted that while employee-physicians do have the right to organize, independent contractor-physicians do not.<sup>139</sup> According to the AMA: “most independent physicians maintain their own offices and equipment, employ their own staff, and are paid for services rendered - all characteristics that define them as independent contractors.”<sup>140</sup>

The determination that independent contractor-physicians are not employees, and thus are not allowed to unionize and collectively bargain, is currently being challenged by a group of New Jersey physicians who contract with the same HMO.<sup>141</sup> This group of about 200 family physicians and specialists contend that AmeriHealth HMO, a subsidiary of Philadelphia-based Independence Blue Cross, is their employer; because it supervises them, sets their hours, and limits the care they can give to patients.<sup>142</sup> They argue that “every aspect of their practice is controlled by the HMO” and that their relationship with the HMO

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<sup>137</sup>Budrys, *supra* note 5, at 117.

<sup>138</sup>Harris Meyer, *Look for Union Label; Private-Practice Physicians Considering Unionizing*, HOSPITAL & HEALTH NETWORKS, Dec. 5, 1996, at 69.

<sup>139</sup>AMA Report, *supra* note 29, at 8.

<sup>140</sup>Jaklevic, *supra* note 71, at 99.

<sup>141</sup>Sarah A. Klein, *N.J. Doctors Ask to Form Union, Say They're 'HMO Employees,' AM. MED. NEWS*, Nov. 24, 1997, 1, 9.

<sup>142</sup>*Id.*

“mimics that of an employer and employee.” Therefore, they believe they should be given the rights of other employees to collectively bargain.

AmeriHealth and its legal team, however, have made counter arguments. They contend that the independent physicians are “business entrepreneurs who operate their own private medical practices and sell their services to several different organizations.”<sup>143</sup> AmeriHealth stands behind the traditional narrow definition of “employees” who “serve only one master” which does not include independent physicians who “sell their services to whomever they want.”<sup>144</sup> In arguing that independent contractor-physicians are not covered by the labor exemption, the health plans have legal precedent on their side, as discussed above. As Steven R. Wall, an attorney for Philadelphia-based Morgan, Lewis and Bockius specifies, “for [the physicians] to succeed they will have to upset not only Congress’ intent [with the NLRA of 1935] but also fifty years of decisions that have to come down.”<sup>145</sup>

By petitioning the NLRB in October 1997 for employee status, these physicians are the first to test the argument that “the increasing concentration of a smaller number of health plans is making [those] plans the *de facto* employers of physicians who contract with them.”<sup>146</sup> The NLRB is set to rule on the physicians’ petition to appoint United Food and Commercial Workers Local 56 as the group’s representative in December 1997. This is a landmark case as it is the first time physicians, “linked only by the fact that they each contract with several large health plans in their area,” are asking for the right to organize and collectively bargain with health plans over fees and other contract terms.<sup>147</sup> If their petition is successful, the New Jersey physicians would set a legal precedent for “thousands of independent practitioners around the country who have been seeking union representation for increasingly uneven negotiations with HMOs over reimbursement and contract terms.”<sup>148</sup>

As indicated above, independent physician groups are gaining support for their right to enjoy the full collective bargaining rights of employees under the labor exemption. However, while the debate over

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<sup>143</sup>*Id.*

<sup>144</sup>*Id.*

<sup>145</sup>*Id.*

<sup>146</sup>Klein, *supra* note 141, at 1.

<sup>147</sup>*Id.* at 9.

<sup>148</sup>*Id.*

the rights of independent contractor-physicians to unionize continues, many of these physicians are finding ways to collectively assert themselves against powerful insurance companies and health plans. As Victor Van Borg, special counsel for the Service Employees International Union (SEIU) which recently affiliated with the Committee of Interns and Residents, stated: “[T]here is no legal decision that says that it is illegal for unions to bargain on behalf of [self-employed] physicians. The only violation of antitrust law would be if physicians are fixing prices.”<sup>149</sup> He recently informed a group of physicians of a number of non-economic issues open for negotiation with insurance companies and HMOs not involving money including: assurances from the HMOs and other insurance companies that they will not “deny physicians privileges without due process; deny a flow of patients [by not allowing a physician to join a plan]; second-guess physicians about care of patient; [and] require physicians to deny methods of treatment or not to tell patients about other methods of treatment.”<sup>150</sup>

In some cases, independent contractor-physicians have collectively bargained with payers on price terms by circumventing antitrust laws through the use of the antitrust “messenger model.” New guidelines from the Federal Trade Commission (FTC) and the Department of Justice (DOJ) allow groups of independent physicians and hospitals to form networks to negotiate with insurers through a third-party “messenger.”<sup>151</sup> These “messengers” are not allowed to share information between individual physicians *and* collectively bargain. However, applying the theory of strength in numbers, participating physicians benefit from this arrangement because payers are often more willing to offer higher reimbursement rates to a messenger representing a large group of physicians than to the individual physicians themselves.

Experts warn “such partnerships must have significant financial or clinical integration to pass muster.”<sup>152</sup> As Mark Whitener, deputy director of the FTC’s Bureau of Competition stated: “We’ll listen to any sensible argument that a group is really offering something good for consumers ... [b]ut if physicians are just trying to keep prices up and control the market,

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<sup>149</sup> *Collective Bargaining: AMA Delegates Direct Association to Find Ways for Doctors to Bargain*, 5 HCP 27 D36 (July 7, 1997).

<sup>150</sup> *Id.*

<sup>151</sup> Meyer, *supra* note 138, at 69.

<sup>152</sup> *Id.*



that's illegal."<sup>153</sup> However, warnings from the FTC and DOJ have not stopped some independent physicians from successfully collectively bargaining with payers without substantial financial or clinical integration.

Jack Seddon's union, the FPA, has signed up "more than 2,000 private-practice doctors, mostly in Florida or New Haven, Conn. The group collectively negotiated contracts between insurers and physicians who weren't integrated in any way."<sup>154</sup>

Seddon's physicians groups provide advantages to payers and consumers without any integration. The union, acting as a "messenger," surveys members about which fees they will accept and what other conditions they want, such as binding arbitration when a health plan drops a doctor from its panels. It then reviews contracts proposed by plans, suggesting changes to make the terms more acceptable to its membership.<sup>155</sup>

Federal guidelines prohibit third-party "messengers" from influencing or coordinating physician responses to contract offers, and require physicians to determine on their own that physicians must make their own decisions whether to sign the contract.<sup>156</sup> Further, there cannot be an actual or even implied threat of a group boycott.<sup>157</sup> As a result, Seddon stresses that the union "never tells its members not to sign a contract or threatens payers that the members won't sign if the payer does not play ball."<sup>158</sup> However, in late 1994, it was stated that the union is able to exert some degree of bargaining power which would force "an uncooperative insurer to lose all the union physicians."<sup>159</sup>

It must be noted that all physician-hospital networks have been allowed to collectively bargain by the FTC and DOJ without substantial integration. The DOJ won consent orders in 1996 against physician hospital organizations (PHOs) in St. Joseph, Missouri, Danbury, Connecticut, and Baton Rouge, Louisiana, "forbidding them from setting prices and other business terms for their members."<sup>160</sup> The DOJ claimed the PHOs lacked real financial or clinical integration and served mainly

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<sup>153</sup>*Id.*

<sup>154</sup>*Id.*

<sup>155</sup>*Id.*

<sup>156</sup>*Meyer, supra* note 138, at 69.

<sup>157</sup>*Id.*

<sup>158</sup>*Id.*

<sup>159</sup>*Id.*

<sup>160</sup>*Id.*

to gain an unfair advantage by blocking managed care plans from entering the market.<sup>161</sup>

### WHY ARE “PHYSICIANS” JOINING LABOR UNIONS?

Having discussed the current status of labor and antitrust law with respect to the rights of physicians to join unions and bargain collectively, this analysis shifts its focus to why physicians in the 1990s would want to participate in union activities. Dr. Joseph Murphy eloquently sums up the frustrations of the modern physician when he states:

Over the past decade, we physicians have suffered a significant loss in our ability to make decisions on behalf of our patients, as well as a concomitant plunge in practice revenue. We have endured denial, and deselection from managed care health plan panels. Our input, prestige and power within the health-care system continue to dwindle relentlessly... . To a greater and greater extent, payers determine the reimbursement level, the site and type of care, and who the provider participants will be.

Dr. Murphy's statement is representative of the feeling of growing numbers of physicians practicing medicine in the United States in the late 1990s. Medical students beginning their careers today are entering into a wholly different industry than their fathers and grandfathers who worked in the era of private practice medicine. The focus of health care today is not simply on promoting the health of the patient at all costs, and doctors no longer have the autonomy and financial security they once enjoyed.

A recent story on NBC Nightly News attributed the strain placed on physicians by increasingly powerful and oppressive insurance companies as one cause for surging union membership.<sup>162</sup> The story discussed how “only a small number of physicians are union members now, but some believe that will change as insurance companies keep offering physicians take-it-or-leave-it contracts that ratchet down fees and make doctors feel like laborers.”<sup>163</sup> Jack Seddon of the Federation of Physicians and

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<sup>161</sup>*Meyer, supra* note 138, at 69.

<sup>162</sup>NBC News Transcripts: *Movement Across Country for Doctors to Unionize in Effort to Preserve Employment and Patient's Rights*, May 24, 1997

<sup>163</sup>*Id.*

Dentists further described the inferior bargaining position of today's physicians: "the insurance companies have changed the ground rules. They set the hours, they dictate the reimbursement rates; so, in fact, they hire, they fire."<sup>164</sup> By keeping fees low, refusing to cover tests and procedures, and placing pressure on physicians to control costs, insurance companies are both negatively affecting the lifestyles of physicians and the quality of patient care. As Dr. Paul Koss, a union member, lamented "The screws are being tightened so far that it's becoming impossible to really give what I need to give my patients."<sup>165</sup>

The health industry is evolving rapidly: mergers, acquisitions and joint ventures by, and between, provider and payer groups becoming commonplace. Medicine is becoming big business, and as the following examples will demonstrate, the interests of physicians are being lost in the shuffle. Physicians are now turning to unions to reassert their rights, gain economic leverage, and ensure their interests are taken into account.

The proposed sale in the fall of 1997, nine health centers by Blue Cross/Blue Shield of Massachusetts (BCBS of MA) to Birmingham, Alabama-based MedPartners is representative of many of the large scale corporate health care deals taking place today. As Mary Chris Jaklevic decided, "trust was scarce between the Blues and employed physicians."<sup>166</sup> The physicians wanted to ensure MedPartners would give them adequate control over referrals to specialists and hospitals, but BCBS of MA officials refused to give them a voice in the negotiations.<sup>167</sup> Robert Lounsbury, a physician at one of the health centers, stated: "They wanted to pretend we were no more important than the tables and chairs in the health centers, that we could be bought and sold."<sup>168</sup> However, instead of sitting back and allowing their interests to be pushed aside, physicians at six of the outpatient centers took action to increase their clout. They formed a union, with Lounsbury as the president, and in a unanimous vote physicians at Medical West Associates in Springfield, Massachusetts certified the union with the NLRB.<sup>169</sup> The existence of a certified union

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<sup>164</sup>*Id.*

<sup>165</sup>*Id.*

<sup>166</sup>Mary Chris Jaklevic, *Physicians Find Power in Unions: A Small But Growing Number of Docs Are Using Organized Labor to Gain Economic Advantage*, MODERN HEALTHCARE, Oct. 6, 1997 at 99.

<sup>167</sup>*Id.*

<sup>168</sup>*Id.*

<sup>169</sup>*Id.*

obligated BCBS of MA to bargain with the physicians over the effects of the sale.<sup>170</sup> Further, it gave bidders an incentive to meet with their prospective employee-physicians, and allowed the physicians the ability to evaluate finalists and negotiate specific terms with the proposed buyer.<sup>171</sup>

Another example of a place where physicians are seeking the collective bargaining strength of a union is in the Twin Cities region of Minneapolis-St. Paul, Minnesota. According to Douglas Thorsen, founder of the new Minnesota Physician-Patient Alliance, about 500 of the approximately 3,500 physicians in the area have signaled interest in joining the union.<sup>172</sup> The strong interest in unionization stems from the three major payers in the region, Allina, HealthPartners and Blue Cross and Blue Shield of Minnesota “cranking on physicians in the summer of 1997.”<sup>173</sup> According to Thorsen, Blue Cross sent out a fee schedule effective July 1, 1997 “that hit independent practitioners hard.” Healthpartners told specialists in July to increase productivity and to expect a 10 percent salary decrease while the Allina Medical Group told physicians to increase productivity, in some cases up to more than 20 percent, without a salary adjustment.<sup>174</sup> As Hennepin Medical Society Chief Executive Officer, Jack Davis stated: “It looks like there isn’t a balance in power, between buyers and suppliers. I think physicians are probably feeling powerless in a negotiating sense.”<sup>175</sup> Physicians in the Twin Cities are being taken advantage of by the major insurance companies in the region, and are considering unionization as a means to fight back and assert their rights.<sup>176</sup>

The emergence of physician practice management companies, such as MedPartners and FPA, as major corporate players in the health care industry has also led physicians to contemplate joining unions. A debate is ongoing as to whether “FPA and similar management companies save money by bringing new efficiencies to managed care,” or whether they

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<sup>170</sup>*Id.*

<sup>171</sup>*Id.*

<sup>172</sup>John Manning, *Alliance Aims to Form Physician Union*, MINNEAPOLIS-ST. PAUL CITY BUS., Aug. 29, 1997, at 2.

<sup>173</sup>*Id.*

<sup>174</sup>*Id.*

<sup>175</sup>*Id.*

<sup>176</sup>*Id.*

“simply increase pressures on doctors to hurry or deny care.”<sup>177</sup> Increasingly, physicians are answering “yes” to the second question.<sup>178</sup>

FPA’s network of physicians includes 500 salaried physicians, classified as employees, and about 6,500 other independent contractor physicians who contract to provide medical services to FPA patients for fixed monthly fees.<sup>179</sup> The advantage for these independent contractor physician is that FPA represents them in their dealings with HMOs and insurance companies. As Dr. Jeffrey Gordon states: “FPA takes over the hassle factor. They negotiate with insurance companies, routinize and systemize your patient referrals.”<sup>180</sup> However, in exchange for these increased efficiencies, physicians sacrifice much of their autonomy and independence. FPA operates under a system of global capitation rates in which it contracts to provide all medical care for patients in exchange for fixed payments from their HMO. By assuming all financial risk that medical costs may exceed payments, FPA maintains a strong incentive to keep costs down without regard for the needs of its physicians and patients. FPA attempts to maximize profits by pressuring physicians to cut down on services and take on more patients. As Dr. Keith Dveirin, a pediatrician leading a union-organizing effort for FPA physician in Tucson, Arizona points out, to maintain their current incomes under FPA’s system, physicians must see many more patients than before. Dr. Dveirin complains: “It’s a system that puts pressure on you not to see people or not to provide care.”<sup>181</sup>

### PHYSICIANS SHOULD BE ABLE TO JOIN UNIONS LIKE OTHER PROFESSIONALS

Momentum is clearly gaining in the labor movement for physician unionization in the United States; however, one of the largest obstacles union advocates still face is the belief the medical profession is markedly different from other high-paid professions, and thus, should not be allowed to organize and collectively bargain. A public perception exists

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<sup>177</sup>Craig D. Rose, *Locally Based FPA, Which Monitors Care for More than a Million People, is Focus of Growing Debate*, SAN DIEGO UNION-TRIBUNE, Aug. 17, 1997 at I-1.

<sup>178</sup>*Id.*

<sup>179</sup>*Id.*

<sup>180</sup>*Id.*

<sup>181</sup>*Id.*

that physicians are highly-paid professionals who do not have the right to complain about their incomes. Public opinion polls show most Americans and Canadians believe physicians practice a "greed profession."<sup>182</sup> As Daniel W. Srsic predicted in his 1993 article on physician unionization, "this public consensus [has] allow[ed] [and may continue to allow] the governments of the United States and Canada to cut costs in areas of perceived over-spending such as physicians' income," without generating a significant backlash.<sup>183</sup> From a logical standpoint, it is unclear why physicians have been singled out. As discussed earlier, other highly-paid professionals, such as athletes and movie stars have established unions to protect their interests. However, because of its role as the guardian of the health of society, the medical profession stands alone in the widespread perception that it should not be able to rise up and protect its interests.

Opposition to the unionization of physicians comes from within and outside the profession. "Physicians have generally seen themselves as too professional, their services too essential to society and their attitude too independent" to collectively bargain.<sup>184</sup> Further, some physicians shared the fears of Dr. Michael Halberstam that although "unionization would give us some temporary bargaining power, we'd pay for it in loss of prestige, influence and, quickly enough, in loss of income. Medicine is not just the way to earn a living ... it's a profession."<sup>185</sup>

Physicians such as Dr. Halberstam were especially strident against the use of the traditional bargaining tool for unions, namely strikes. As he stated: "The main force of unionization is the threat to withhold services - the strike ... and a strike is the antithesis of everything the practice of medicine is about."<sup>186</sup> However, the response by Dr. Stanley Peterson, president of the American Federation of Physicians and Dentists (AFPD) at the time of Dr. Halberstam's strong condemnation of physician unions (1973) still holds true today: "Physicians [have] no intention of adopting Big Labor's pressure tactics. The physician's unions affiliated with the AFPD were not advocating striking, picketing, or creating procedures that

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<sup>182</sup>Todd, *supra* note 26, at D13.

<sup>183</sup>Srsic, *supra* note 2, at 90.

<sup>184</sup>Manning, *supra* note 174, at 2.

<sup>185</sup>Budrys, *supra* note 5, at 15.

<sup>186</sup>*Id.* at 16.

would restrict members' rights. We'll deserve to be regarded as goons only if we behave like goons, and that will never happen."<sup>187</sup>

In the twenty-five years since the creation of the first major physicians' union, the UAPD, there have been notably few strikes, each with very short durations. In fact, according to a recent study by *Modern Healthcare*, there have only been four strikes by physicians in the past sixteen years.<sup>188</sup> "Two strikes [were] by residents ... [and] only two strikes [were] by nonresident physicians: a 1986 walkout by doctors at Group Health Associations, an HMO in Washington, D. C.; and a 1992 strike by physicians at publicly owned Woodhull Medical and Mental Health Center in Brooklyn, N.Y."<sup>189</sup> The majority of physicians believe their primary goal is to promote the health of their patients and would do nothing to place their patients' health in jeopardy. Physicians should not be penalized for undertaking the noble profession of protecting the health of society by not being allowed to stand up and collectively assert rights that other arguably "less noble" professions are granted.

Finally, the words of Dr. Kenneth Burton, founder of the American Physicians Union of Texas, are prophetic on why physicians should be allowed to unionize. Dr. Burton directly rebuts Dr. Halberstam's claim that physicians should not join unions because of their special role in society. Burton asserts the health of their patients is directly tied to the psychological and emotional health of physicians.

The fact that physicians alone are guardians of the public's health is repeatedly cited as a reason for our not taking strong collective action against those who would weaken and eventually destroy our prerogatives ... . [O]ur interests ... coincide with the interests of our patients. It follows that if our working conditions deteriorate and the quality of our lives suffers, the patient care we provide will become less satisfactory.<sup>190</sup>

He further points out that other employees charged with safeguarding our lives, such as firemen and policemen are unionized while physicians are not.<sup>191</sup>

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<sup>187</sup>*Id.*

<sup>188</sup>Jaklevic, *supra* note 71, at 100.

<sup>189</sup>*Id.*

<sup>190</sup>Budrys, *supra* note 5, at 14.

<sup>191</sup>*Id.*

## UNIONS v. PROFESSIONAL ASSOCIATIONS

The reason physicians are turning to unions, rather than medical associations such as the AMA, is exemplified by a story told by a physician member of the UAPD. In describing his different experiences with the AMA and the union, he states:

When a hospital chain assumed the direction of one of the hospitals which we (radiology group) service, it was rumored that we would no longer be allowed to continue under the agreement that we had negotiated with the advent of Medicare ... . I can remember writing to both the AMA and the ACR (American College of Radiology) ... . Neither organization tried to analyze my particular situation but gave generalized advice along with the old standard of "consult your own attorney." [T]he union ... immediately sent a representative ... and met with our physician members, gathered the complaints of the physicians, and together we chartered a plan of action.<sup>192</sup>

Unions tend to be proactive, taking chances in new areas of employee rights and advocating strongly on behalf of individual members: in contrast, professional associations are more reactive. Professional associations often wait until major issues affect a majority of their membership, then attempt to address those issues on a general, rather than individualized, basis. As Dr. Sanford Marcus said: "The AMA, unfortunately, has always been a responding type of organization, waiting for the course of history and course of sociology to bypass it, and then responding with sort of studied moderation to things that already happened."<sup>193</sup>

The AMA has applied its "wait and see" policy to all phases of the health care industry affected by the growth of managed care, not just the need for unions. Former General Counsel, Kirk Johnson, admitted in 1993, "[t]he AMA has not historically been a strong proponent of HMOs or other types of managed care ... but that attitude has changed markedly in recent years."<sup>194</sup> As Grace Budrys noted, "[t]he AMA seems to have

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<sup>192</sup>Budrys, *supra* note 5, at 89.

<sup>193</sup>*Id.* at 89.

<sup>194</sup>*Id.* at 92.



accepted the fact that physicians are no longer in a position to practice without entering into contracts with various third-party payers and health care delivery organizations.”<sup>195</sup> According to Budrys, the AMA appears to be jumping on the managed care bandwagon and is beginning to support the right of physicians to negotiate with large insurers to “level the playing field.”<sup>196</sup> However, it is doubtful what impact the AMA will have on the struggle for physician unionization, as it is well behind the unions in its knowledge base and is limited by its status as a professional organization.

According to the AMA House of Delegates Report: “Nothing in the antitrust laws prevents a medical association from acting as a labor organization and engaging in collective bargaining on behalf of employed physicians who qualify for the labor exemption.”<sup>197</sup> However, as a non-profit association representing the entire medical community, the AMA is limited in its ability to act as a labor organization in many ways. First, acting as a labor organization may compromise the tax exempt status of a medical society.<sup>198</sup> To maintain its status as a 501(c)(6) organization, the AMA must “engage in activities that benefit all physicians, as opposed to a subset of organizations.”<sup>199</sup> In addition, conflicts of interest could arise, such as a situation in which “some members of the Board of Trustees of the association are owners of the HMOs or other health plans that the association wants to engage in collective bargaining.”<sup>200</sup> Finally, the AMA does not have the resources to actively represent individual physicians in their struggles with specific employers, insurance companies, hospitals, and health plans.

The AMA now recognizes “physicians want more aggressive representation from their medical societies,” and “this representation goes beyond the traditional advocacy roles of medical societies before legislatures, regulatory agencies, and courts, and extends into representation of physicians who have grievances with health plans.”<sup>201</sup> Keeping with this spirit of aggressive advocacy for collective bargaining

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<sup>195</sup>*Id.*

<sup>196</sup>*Id.* at 93.

<sup>197</sup>AMA Report, *supra* note 29, at 10.

<sup>198</sup>*Id.*

<sup>199</sup>*Id.*

<sup>200</sup>*Id.*

<sup>201</sup>*Id.*

rights of physicians, in June 1997, the AMA passed its Resolution 239 which states: "Resolved, That the American Medical Association seek means to remove restrictions, including drafting of appropriate legislation, for physicians to form collective bargaining units in order to negotiate reasonable payments for medical services and to compete in the current managed care environment."<sup>202</sup> Although the AMA does not believe self-employed physicians have the right to collectively bargain under the labor exemption, it is committed to "representing physicians aggressively ... within the limits of federal and state law."<sup>203</sup>

Within this framework, the AMA is now taking proactive steps to aid physicians in their quest to tip the balance of power in the health care industry back in their direction. The AMA has developed, within its Groups on Health Policy Advocacy, a new Division of Representation.<sup>204</sup> This new Division will work with state and county medical societies to help respond "to [a] physician's desire to be represented more aggressively both legislatively and with managed-care plans."<sup>205</sup> Further, in the aforementioned June 1997 House of Delegates Report, the AMA outlines four strategies "that medical societies can pursue to more effectively represent independent physicians and better address those issues that have sparked interest in unions." The four strategies are as follows:

- 1) Medical societies must reinforce their traditional function of advocating on behalf of physicians and patients to legislatures and the courts and must communicate these efforts to members effectively;
- 2) Under the new FTC/DOJ Guidelines, state medical societies can freely discuss with health plans non-economic issues, such as hassle factors, administrative problems, undue delay in precertification, and delays in paying claims;
- 3) Medical societies can form their own management services organizations to assist physicians, or, depending on the market can go one step further and form a health plan in which members can participate; and

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<sup>202</sup>*Id.* at 1.

<sup>203</sup>*Id.*

<sup>204</sup>*Id.*

<sup>205</sup>Jaklevic, *supra* note 71, at 99.

- 4) Medical societies must continue to provide information about managed care and the changing health care delivery system to their members.<sup>206</sup>

### WHAT A UNION CAN DO FOR IT'S MEMBERS

Unions have the potential to serve as a resource for physicians coping with the changing environment of the end of the millenium. In some sense, unions are similar to medical associations: both organizations serve as an invaluable repository of information on the health care industry. However, as Dr. Sanford Marcus discussed, since unions such as the UAPD have been representing physician groups since the 1970s, they possess a much greater knowledge about the collective bargaining rights of physicians than newcomers to physician unionization, such as the AMA.<sup>207</sup> Dr. Marcus stated, in 1979: "The union [UAPD] had developed the single largest repository of information about HMOs, workers' compensation, physicians' negotiating rights, physician-hospital contract negotiation, coping with government inspections, due process rights of physicians, the institutional practice of medicine, collecting from recalcitrant insurance carriers, and medical legislative matters."<sup>208</sup> Further, while medical associations can provide information and lobby for physician groups, unions can go one step further and actually represent individual physicians in their struggles with employers, insurers, hospitals, and health plans.

The kind of assistance and expertise a physician can use depends greatly on whether she is salaried or in private practice.<sup>209</sup> In representing its salaried members who qualify as employees and who are allowed to collectively bargain under the labor exemption, a union can use traditional union organizing and bargaining tactics to achieve improvements in wages and benefits. A union can represent employee-physicians by negotiating contracts with the organization employing them.<sup>210</sup> As Grace Budrys states in her recent book, *WHEN DOCTORS JOIN UNIONS*: "[T]he union identifies the physicians' collective concerns and works to resolve

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<sup>206</sup>AMA Report, *supra* note 29, at 1.

<sup>207</sup>Budrys, *supra* note 5, at 93.

<sup>208</sup>*Id.* at 128.

<sup>209</sup>*Id.*

<sup>210</sup>*Id.*

differences with the management representatives who sit on the other side of the table.<sup>211</sup> More specifically, unions can negotiate over typical issues such as salary benefits, as well as special topics physicians want discussed, including medical staff privileges, peer review, the handling of malpractice suits, and grievance procedures.<sup>212</sup> Finally, with regard to grievance procedures, staff representatives help represent physicians in disputes from payment issues to wrongful termination and ensure that the employer is in compliance with its own bylaws.<sup>213</sup>

For non-employee physicians, a union's role is different since there is not one specific organization with which the union negotiates, or one set of issues the union might address.<sup>214</sup> Budrys describes the complexities faced by unions representing independent contractor-physicians in today's health care market:

Doctors negotiate with managed care companies (usually more than one), hospitals and the organizations they spin off, and joint venture organizations. The new entities might include hospices, home care agencies, and durable equipment companies. Doctors find that they may have to negotiate new contracts every time one of these entities is reorganized. Depending on the circumstances, they may negotiate as individuals, part owners of a group practice, or members of a hospital staff.<sup>215</sup>

Further, many of the complaints from physicians stem from conflicts with payers over particular treatment decisions. These negotiations may involve any of the entities mentioned above, in addition to peer review organizations, Medicare carriers, Medicaid agencies and private insurance companies.<sup>216</sup>

The role of unions representing non-employee physicians is similar to that of an attorney or consultant without the high cost.<sup>217</sup> The expert services the union provides are not easily classified -- it functions as a personal advocate, or as a management consulting firm, even a

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<sup>211</sup>*Id.*

<sup>212</sup>*Budrys, supra* note 5, at 131.

<sup>213</sup>*Id.*

<sup>214</sup>*Id.*

<sup>215</sup>*Id.* at 129.

<sup>216</sup>*Id.*

<sup>217</sup>*Budry's supra* note 5, at 140.

sophisticated self-help organization.”<sup>218</sup> Since independent contractor-physicians are not allowed to collectively bargain up front for contract terms such as compensation and benefits, union representatives often utilize techniques similar to the grievance process in bring individual complaints of physicians to management. As with employee-physicians, unions utilize the rules the organization itself has developed to cover its relationships with physicians, as well the individual contracts members of the union have signed.<sup>219</sup>

Much of the assistance a union can offer physicians in private practice is help collecting reimbursement for work performed in good faith. As Dr. Sanford Marcus stated, “[B]eing denied fees to which they are entitled is one of the basic reasons for doctors’ growing frustration.”<sup>220</sup> By providing the types of “aggravation” the practice management department of the UAPD deals with “[o]ne doctor’s Medi-Cal claim for delivering a baby was denied because, according to the state’s records, the mother was erroneously classified - as a male. The computerized system simply kept refusing the claim. It took the union three years to get the doctor’s claim paid.”<sup>221</sup> Physicians are also turning to union representatives to assist them in receiving reimbursement denied by a third-party payer. Dr. Weinman, past president of the UAPD, describes the bind that physicians are in when, for example:

A patient shows up in the emergency room, you’re called, you go see the patient, you submit your bill and it is denied. It is denied because of the contract the patient signed with *that* company and that you signed with *that* company. You agreed to peer review and the peer review was done, and they decided that it really wasn’t an emergency. Meanwhile, you were there from midnight to 2 a.m. It wasn’t really an emergency so you eat it.<sup>222</sup>

In addition to help with grievance procedures and securing reimbursement, unions for non-employee physicians can also provide valuable advice on entering into contracts with hospitals and pre-paid organizations without actually collectively bargaining. The benefit of

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<sup>218</sup>*Id.* at 141.

<sup>219</sup>*Id.* at 129.

<sup>220</sup>*Id.* at 135.

<sup>221</sup>*Id.*

<sup>222</sup>*Budrys, supra* note 5, at 134.

having a large membership physicians' union is that union representatives can use the information they learned in helping one physician or group practice and pass it on to other physicians facing similar issues. Therefore, the larger the union and the more experience it has in handling problems generated by today's managed care environment, the greater the resource it can be to its physician members.

### THE STATE OF PHYSICIAN UNIONS TODAY

The AMA currently estimates that between 14,000 and 20,000 of the country's greater than 700,000 physicians are enrolled in unions today; including 6,000 to 9,000 residents employed by hospitals.<sup>223</sup> Presently, the UAPD is the largest physician union, representing about 5,000 members.<sup>224</sup> Of those 5,000 members, about 55 percent are employee-physicians and 45 percent are self-employed in independent practice.<sup>225</sup> Dues are \$700 a year for employee-physicians and \$420 for self-employed physician; the disparity in dues is attributed to the inability of the union to engage in collective bargaining on behalf of self-employed physicians.<sup>226</sup> However, self-employed physicians are required to pay a one-time membership fee to become part of the an IPA managed by the union . The union claims to represent three million lives.<sup>227</sup>

Since the AMA Report, the UAPD has strengthened its position as the largest labor organization for physicians by affiliating with the American Federation of State County and Municipal Employees (AFSCME), a government employees union with about 1.3 million members, including 3,000 physicians.<sup>228</sup> The affiliation of the UAPD's existing 5,000 member-physicians with the AFSCME "creates an alliance of 8,000 private and public-sector doctors."<sup>229</sup> According to the unions, "the deal will position them to expand membership, strengthen lobbying and counter the negative forces of for-profit healthcare such as deselection

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<sup>223</sup>AMA Report, *supra* note 29, at 2.

<sup>224</sup>*Id.*

<sup>225</sup>*Id.*

<sup>226</sup>*Id.*

<sup>227</sup>*Id.*

<sup>228</sup>Mary Chris Jaklevic, *Calif. Union to Link with AFSCME*, MODERN HEALTHCARE, Sep.1 1997, at 32.

<sup>229</sup>*Id.*

of physicians by HMOs.”<sup>230</sup> As UAPD Executive Director, Gary Robinson believes “the affiliation [now] provides the UAPD with an infrastructure to recruit members outside its home state,” and “a top-notch research staff and strong political pull,” since AFSCME President, Gerald McEntee, heads President Clinton’s healthcare quality commission.<sup>231</sup>

The combined forces of the AFSCME and UAPD have recently launched a campaign to pressure government employers to offer workers unionized health plans in their benefit packages.<sup>232</sup> As UAPD President, Dr. Robert Weinmann, stated, “the goal is to provide union doctors for union members.”<sup>233</sup> AFSCME will support the UAPD by asking employers to write health-benefit contracts with the union’s own independent physician’s association (IPA) which was formed “to help doctors win better fees from health plans.”<sup>234</sup> In promoting the use of union physicians for other non-physician union members, AFSCME is following the lead of the AFL-CIO which recently announced that it would promote Kaiser Permanente as the best health plan for its members in return for the HMO’s pledge to allow the union to organize its members.<sup>235</sup> Union officials, such as Gerald McEntee, hope that providing union physicians with a large and powerful patient base of union members will “give [both] patients and their doctors more leverage when dealing with cost-cutting managed care health insurers.”<sup>236</sup>

In addition to the UAPD, other large existing physician unions include the FPD and the Doctors Council of New York (DCNY). The FPD has about 2,500 members, is affiliated with the National Union of Hospital and Health Care Providers and the AFL-CIO, and is the union physicians at the Thomas-Davis Medical Center certified as their bargaining representative.<sup>237</sup> The DCNY represents 3,300 attending physicians, dentists, podiatrists, and veterinarians employed by New York City agencies, hospitals, and clinics.<sup>238</sup> In addition to its size, the DCNY

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<sup>230</sup>*Id.*

<sup>231</sup>*Id.*

<sup>232</sup>Samuel Golreich, *AFSCME, Doctors Unite to Push Unionized Health Care*, WASHINGTON TIMES, Aug. 28, 1997, at B12.

<sup>233</sup>*Id.*

<sup>234</sup>*Id.*

<sup>235</sup>*Id.*

<sup>236</sup>*Id.*

<sup>237</sup>AMA Report, *supra* note 29, at 2.

<sup>238</sup>*Id.*

is noteworthy for having led a successful strike to prevent layoffs of hospital personnel and to restore certain services that was ended by a settlement at New York's Woodhull Medical Center.<sup>239</sup> According to the AMA Report, at one point the DCNY represented 10,000 physicians in six states, but halted activities outside New York due to warnings of possible antitrust violations by the FTC.<sup>240</sup> However, under the current favorable climate for physician unionization, the DCNY is once again aggressively recruiting members.<sup>241</sup>

## CONCLUSION

Physician unions already play a significant role in the American healthcare system, and their membership, power, and influence is rapidly growing. Currently, only actual employees of hospitals or health plans are allowed to join labor unions and collectively bargain with their employers. However, as discussed earlier, the definition of "employee" under the labor exemption appears to be expanding.

Although the NLRB still considers residents, interns, and fellows to be students who are not allowed to collectively bargain, this rule may soon change. Recent developments such as the petition by students at the Boston Medical Center to the NLRB to certify a labor union as their bargaining representative, currently on appeal, may allow house officers to collectively bargain in the near future. Similar changes are taking place with regard to the struggle by independent physicians to collectively bargain with health plans and insurers. A group of independent physicians in New Jersey are the first such group of "non-employee" physicians to attempt to have the NLRB officially recognize their right to collectively bargain with large health plans. A decision in their favor would open the door for independent physicians across the country to unionize and would permanently alter the balance of power in the health care industry.

Physicians are frustrated by the impact recent changes in health care have had on their professional autonomy and economic livelihood and are turning to unions to help them fight back. Changes in the practice of medicine in the 1980s and 1990s have forced physicians to band together

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<sup>239</sup>*Id.*

<sup>240</sup>*Id.*

<sup>241</sup>*Id.*



and look beyond traditional medical societies for help in negotiating with powerful corporate payers. As a result, physician unions are quickly expanding and will become an increasingly powerful tool for physicians to use to recapture their status, independence, and financial success in the future.