University of Florida Journal of Law & Public Policy

Volume 13 | Issue 2 Article 2

2001

Collective Bargaining in the Elite Professions—Doctors' Application of the Labor Law Model to Negotiations with Health Care Providers

Tracey I. Levy

COLLECTIVE BARGAINING IN THE ELITE PROFESSIONS — DOCTORS' APPLICATION OF THE LABOR LAW MODEL TO NEGOTIATIONS WITH HEALTH PLAN PROVIDERS

*Tracey I. Levy**

I. INTRODUCTION 269

II. APPLICATION OF THE NLRA TO DOCTORS 272

III. UNIONIZATION EFFORTS AMONG PHYSICIANS 275

IV. ANTITRUST EXEMPTION FOR SELF-EMPLOYED DOCTORS 280

V. HOUSESTAFF AS EMPLOYEES AND THE BIRTH OF UNIONIZATION 288

VI. COLLECTIVE BARGAINING AS A MEANS OF ADDRESSING PATIENT CARE 293

VII. CONCLUSION 297

I. INTRODUCTION

While union membership generally has declined since the 1950s, over the past several years medical professionals have turned to unions and the union collective bargaining model in record numbers. Reports from union leaders and American Medical Association (AMA) executives reflect a 250% increase since 1997 in the number of physicians seeking union membership,[1] and the physician unionization movement is expected to increase significantly in the coming years in response to the trend toward

---

* B.A., Union College; J.D., Albany Law School of Union University; LL.M., Yale University; Labor and Employment Law Associate, Proskauer Rose LL.P.

1. Tanya Albert, *More Doctors Following Trend to Unionize*, AM. MED. NEWS, Nov. 27, 2000. An estimated 12,000 to 14,000 doctors belonged to unions in 1997, while recent reports place that figure at between 45,000 and 47,000 doctors and increasing steadily. *Id.;* Elizabeth Thompson Beckley, *Strength in Numbers: Employed Physicians Enlist Unions for Bargaining Clout*, MOD. PHYSICIAN, Feb. 2001 ("the general consensus is that union membership among doctors has increased steadily in the past five years"). A July 9, 1999 Service Employee's International Union (SEIU) press release claimed that over 4,000 doctors joined the union in the prior year, *available at* http://www.seiu.org/media/press_releases/ (last visited Mar. 1, 2002) (on file with author).

meeting rule is the law in Florida. That, of course, is exactly what will happen if the Florida Supreme Court and Legislature do not address this issue head on. As this Article shows, the legal reasoning and process by which the per se board meeting rule has been foisted upon the citizens of Florida is ludicrous. Neither the Florida Supreme Court nor the Legislature can allow such a situation to stand. Florida's credibility is at stake.[252]

252. Getting it right takes heavy lifting by both the Legislature and the judiciary. *See* State *ex rel.* Newspapers, Inc. v. Showers, 398 N.W.2d 154, 165-66 (Wis. 1987) (construing legislation that attempted to strike a balance between open government and the need for unfettered one-on-one consultation among board members); *see also* McComas v. Bd. of Educ. of Fayette County, 475 S.E.2d 280, 286-93 (W. Va. 1996).

COLLECTIVE BARGAINING IN THE ELITE PROFESSIONS — DOCTORS' APPLICATION OF THE LABOR LAW MODEL TO NEGOTIATIONS WITH HEALTH PLAN PROVIDERS

Tracey I. Levy[*]

I. INTRODUCTION 269

II. APPLICATION OF THE NLRA TO DOCTORS 272

III. UNIONIZATION EFFORTS AMONG PHYSICIANS 275

IV. ANTITRUST EXEMPTION FOR SELF-EMPLOYED DOCTORS 280

V. HOUSESTAFF AS EMPLOYEES AND THE BIRTH OF UNIONIZATION 288

VI. COLLECTIVE BARGAINING AS A MEANS OF ADDRESSING PATIENT CARE 293

VII. CONCLUSION 297

I. INTRODUCTION

While union membership generally has declined since the 1950s, over the past several years medical professionals have turned to unions and the union collective bargaining model in record numbers. Reports from union leaders and American Medical Association (AMA) executives reflect a 250% increase since 1997 in the number of physicians seeking union membership,[1] and the physician unionization movement is expected to increase significantly in the coming years in response to the trend toward

---

* B.A., Union College; J.D., Albany Law School of Union University; LL.M., Yale University; Labor and Employment Law Associate, Proskauer Rose LL.P.

1. Tanya Albert, *More Doctors Following Trend to Unionize*, AM. MED. NEWS, Nov. 27, 2000. An estimated 12,000 to 14,000 doctors belonged to unions in 1997, while recent reports place that figure at between 45,000 and 47,000 doctors and increasing steadily. *Id.;* Elizabeth Thompson Beckley, *Strength in Numbers: Employed Physicians Enlist Unions for Bargaining Clout*, MOD. PHYSICIAN, Feb. 2001 ("the general consensus is that union membership among doctors has increased steadily in the past five years"). A July 9, 1999 Service Employee's International Union (SEIU) press release claimed that over 4,000 doctors joined the union in the prior year, *available at* http://www.seiu.org/media/press_releases/ (last visited Mar. 1, 2002) (on file with author).

managed care. Currently, approximately 45,000 doctors are union members. It is estimated that forty-three percent of physicians are currently employed, primarily by a group practice, private hospital, medical school, or the government, representing a ten percent increase since 1983.[2] Younger physicians, who are more likely to be employees than independent practitioners,[3] have expressed particular interest in unionization.

Doctors are turning to the union model to give themselves leverage in the new managed care environment. Previously, physicians in private practice enjoyed complete autonomy over the provision of patient care.[4] Insurance companies deferred to the judgments of physicians and paid for whatever services the physicians deemed necessary on a fee-for-service basis.[5] In the 1970s and 1980s, skyrocketing health care costs and health insurance premiums prompted an employer and health care consumer demand for an alternative system that would ensure greater cost accountability.[6] Consequently, the managed care system, under which physicians' medical decisions, practices, and procedures are reviewed and shaped by health care managers in the interest of cost efficiency, has largely replaced the insurance indemnification system.[7] Doctors are "mad as hell" about this dramatic alteration in their relationship with their patients and insurers so they are turning to unions, in part, because of a perception that nothing else works.[8]

Under the National Labor Relations Act (NLRA), most doctors do not have a legally protected right to unionize because the NLRA only applies to employees and does not include independent contractors like doctors

---

2. Craig Havighurst, *A Union Answer*, AM. MED. NEWS, Jan. 11, 1999; Beckley, *supra* note 1.

3. The AMA reports that about seventy percent of all residency graduates entered salaried positions in 1997. *See* Molly Tschinda, *Nation's Largest Physician Union Forms Under SEIU Umbrella*, MOD. PHYSICIAN, Mar. 2000. The AMA-formed union, Physicians for Responsible Negotiation, placed that figure at nearly ninety percent for doctors completing their residency in 2001. Beckley, *supra* note 1.

4. AmeriHealth, Inc., 329 N.L.R.B. No. 76 (Oct. 18, 1999); Lisa M. Nijm & Bryan A. Liong, *Physician Unionization: White Coats with Blue Collars?*, HOSP. PHYSICIAN, May 2001, at 71.

5. *AmeriHealth*, 1999 WL 963200, at *4; Nijm & Liong, *supra* note 4.

6. *AmeriHealth*, 1999 WL 963200, at *4.

7. *Id.* Approximately thirty-five percent of American insured patients are enrolled in health maintenance organizations (HMOs), which deliver a comprehensive set of health care services through a closed panel of medical providers. *Id.*

8. Diane M. Gianelli, *Delegates Say AMA Must Do More to Foster Collective Bargaining*, AM. MED. NEWS, Jan. 4, 1999; *see* Havighurst, *supra* note 2; Tom Abate, *Doctors Examine Union Option, Physicians Are Beginning to Band Together — and HMOs are Worried*, S.F. CHRON., Sept. 3, 1999.

who operate private practices.[9] Moreover, prior to late 1999, the National Labor Relations Board (NLRB) had construed the NLRA as inapplicable to housestaff — medical interns, residents, and fellows who work in hospitals on an essentially full-time basis as part of their advanced medical training — because housestaff were primarily viewed as students, not employees.[10]

Given the limitations of the NLRA, doctors have pursued their organizing efforts on multiple fronts. Some doctors who fall within the definition of employees have formed their own unions, affiliating with the AFL-CIO and other traditional labor organizations. Also, in response to increasing pressure and vociferous demands by its members, the AMA recently created an independent organization, Physicians for Responsible Negotiation, to organize and assist doctors in collective bargaining using a new model of professional unionization. At the same time, in order to address the needs of the many doctors who fall outside the protection of the NLRA, the AMA has actively lobbied Congress in support of an amendment to the antitrust laws that would permit doctors to collectively bargain with health plan providers and insurers. Finally, the unionization movement is expected to expand dramatically at the housestaff level as a result of a recent NLRB decision which reversed long-standing precedent by holding that housestaff are employees within the meaning of the NLRA.

With the exception of grievances from notoriously underpaid and overworked housestaff, much of the medical profession's rhetoric in support of unionization and collective bargaining rights has focused on patient care issues. Doctors claim that they need to be able to bargain collectively with managed care providers because their excessive and overly restrictive regulations hurt the quality of patient care. However, traditionally collective bargaining has focused on issues relating to wages, hours, and terms and conditions of employment, not consumer safety. Ultimately, patients may derive few benefits from physician unionization.

Section II of this Article reviews the NLRA definition of employee and its application to doctors. Section III addresses the unionization of salaried physicians, while section IV examines the movement for a legislative exemption from the antitrust laws, which would enable doctors to bargain collectively. Section V outlines the cases related to the unionization of housestaff and the implications of the NLRB's recent reversal of position.

---

9. 29 U.S.C. § 152(3) (2001).
10. St. Clare's Hosp. & Health Ctr., 229 N.L.R.B. 1000 (1977).

In conclusion, section VI analyzes the implications of physician unionization in terms of bargainable issues, and the likelihood that bargaining will include patient care issues.

II. APPLICATION OF THE NLRA TO DOCTORS

To distinguish between employees, who are covered by the NLRA, and independent contractors, who do not receive NLRA protection, the NLRB and the courts have borrowed master-servant and agency principles from the common law and have considered a variety of factors.[11] Employee status may be established based on the following: the extent of control exercised over the details of the work; the employment's distinctiveness as an occupation or business; the specialized nature of the work; the skills required; the supplier of the instrumentalities, tools, and place of work; the duration of employment; the method of payment for services (by job or by time); the finding that the work is part of the regular business of the employer; the parties' intent in creating their relationship; and the principal's role in the business.[12] All of these factors must be carefully considered, not just those pertaining to a right of control.[13]

Although conventionally self-employed doctors in individual or group practices have been classified as independent contractors, a group of physicians serving members of an HMO in New Jersey recently challenged that classification, arguing that the controls imposed by managed care providers created a relationship comparable to the employer-employee relationship. In *AmeriHealth, Inc.*,[14] the United Food and Commercial Workers Union Local 56 sought to represent a bargaining unit of 652 primary and specialty physicians serving AmeriHealth HMO members in Atlantic and Cape May Counties, New Jersey. The NLRB upheld a determination that the physicians were independent contractors and thus fell outside the scope of the NLRA.[15]

In petitioning for representation, the physicians claimed that AmeriHealth controlled their access to, and relationships with, their

---

11. N.L.R.B. v. Town & Country Elec., 516 U.S. 85, 93-95 (1995).
12. *AmeriHealth*, 1999 WL 963200, at *26.
13. *Id.*
14. *Id.*
15. *Id.* at *32. The Regional Director had originally administratively dismissed the petition on the grounds that the doctors were independent contractors. Finding that the petition concerned an "important issue of first impression," the Board reinstated the petition and remanded for a full hearing. Following 14 days of hearings in November and December 1998, the hearing officer concluded that the doctors were independent contractors and dismissed the petition. *Id.* at *2.

patients, and argued that they lacked meaningful opportunities to negotiate with AmeriHealth about the terms of their contracts and the fees paid for their services.[16] The Regional Director for NLRB Region 22 found that the record did not support these allegations. With regard to access to patients, the regional director noted that AmeriHealth members comprised a small portion of each participating physician's patient base, that the HMO did not place any restrictions on competition with other health plans or insurers, and that physicians freely engaged in their own marketing efforts.[17] In addition, participating physicians maintained identities separate from AmeriHealth, purchased their own medical malpractice insurance, employed their own staff, made their own business investment decisions, and could structure their practices as they chose, as long as they maintained admission privileges at one participating hospital.[18] Also, the physicians chose their own facilities, equipment, and work hours, subject to minimum standards set by AmeriHealth.[19]

Furthermore, the regional director found insufficient evidence that AmeriHealth regulated the physician-patient relationship in a manner comparable to that of an employer. All participating physicians received a Physicians' Office Manual, which contained practice guidelines for certain types of care that largely conformed with standard medical guidelines.[20] Procedurally, AmeriHealth required patients to obtain a referral from their primary care provider before receiving specialized services and generally restricted referrals to network providers.[21] AmeriHealth also required that certain outpatient services, like lab work and radiology, be referred to capitated providers and that a limited number of procedures be pre-certified as medically necessary.[22] Finally, physicians were expected to comply with a Prescription Drug Formulary for dispensing outpatient medication.[23]

The HMO evaluated participating physicians annually by reviewing their patient records, referral patterns, and compliance with pre-certification requirements and AmeriHealth guidelines.[24] Physicians who failed to meet AmeriHealth's standards would receive improvement plans and their service contracts could be terminated (although AmeriHealth had never actually

---

16. *Id.* at *29-30.
17. *AmeriHealth*, 1999 WL 963200, at *8.
18. *Id.* at *9-10.
19. *Id.*
20. *Id.* at *13.
21. *Id.* at *17, *20.
22. *AmeriHealth*, 1999 WL 963200, at *18-19.
23. *Id.* at *22.
24. *Id.* at *28.

terminated a contract on that basis).[25] Physicians had to be certified by AmeriHealth as meeting minimum standards with regard to medical training and experience and were recertified biannually.[26] The regional director observed that while New Jersey required HMOs to establish and implement a comprehensive utilization management program, to certify and recertify participating physicians, and to maintain performance review procedures, state law did not specify the content of these programs or procedures.[27]

On balance, the regional director concluded that AmeriHealth did not closely monitor and regulate individual physicians' medical practices. He noted that AmeriHealth representatives visited physicians' offices for just a few hours once each year or two to conduct random spot checks of patient records, but that AmeriHealth standards and guidelines did not attempt to control the manner in which medical procedures were actually performed.[28] Similarly, although physicians were required to provide services with the same standard of care, skill, and diligence customary to physicians in the community, AmeriHealth did not attempt to define or enforce that standard.[29] In addition, while AmeriHealth determined the sites for certain services and imposed pre-certification requirements for some procedures, most procedures did not require pre-certification.[30]

Finally, the regional director concluded that participants could negotiate terms and service fees in their contracts.[31] Ten percent of participating physicians had negotiated "special pricing arrangements" with AmeriHealth and between two and five percent had negotiated modifications to certain provisions of their contracts.[32] The regional director observed that the freedom to negotiate did not become illusory simply because some offers to negotiate had been rejected.[33]

The regional director analogized the relationship of physicians with AmeriHealth to the relationship between freelance advertising photographers and an advertising agency, as considered by the NLRB in *Young & Rubicam International*.[34] In *Young*, the NLRB held that highly skilled photographers who rented and maintained their own facilities, invested in expensive equipment, employed their own employees,

25. *Id.*
26. *Id.* at *11-13.
27. *AmeriHealth*, 1999 WL 963200, at *23-24, *28.
28. *Id.* at *28.
29. *Id.*
30. *Id.* at *29.
31. *Id.* at *30.
32. *AmeriHealth*, 1999 WL 963200, at *24-25, *30-31.
33. *Id.* at *30.
34. *Id.* at *31; Young & Rubicam Int'l, Inc., 226 N.L.R.B. 1271 (1976).

incorporated as businesses, advertised to promote their businesses, and received a flat fee from the advertising agency were independent contractors, despite the close monitoring and supervision of their work by art directors for the advertising agency.[35]

The NLRB agreed with the regional director's analogy in *Young*.[36] However, the NLRB minimized the regional director's reliance on the absence of evidence that AmeriHealth exercised substantial control over the physicians' physical conduct and the lack of on-site supervision, finding that it was not customary for the physical conduct of participating physicians to be subject to substantial control and that their performance was monitored using a variety of off-site techniques.[37] The NLRB based its affirmance on its consideration of the factors of the common law agency test, but observed that the holding was "not necessarily precluding a finding that physicians under contract to health maintenance organizations may, in other circumstances, be found to be statutory employees."[38]

Thus, it is still possible for self-employed physicians to secure coverage under the NLRA, provided that they can demonstrate that their contracts with an HMO subject them to additional constraints with regard to patient care issues beyond those identified in *AmeriHealth* and that they have no actual ability to negotiate the terms of their contracts. Without such an extreme level of control by the HMO, however, it appears likely that these physicians will fall outside the scope of the NLRA. In contrast, for those physicians working as staff in hospitals, clinics, and other settings, thereby falling within the traditional definition of employees, unionization is a viable and legally protected option.

III. UNIONIZATION EFFORTS AMONG PHYSICIANS

The unionization movement among doctors dates back to June 1972, when AMA delegates called for a study of the issues involved in collective bargaining.[39] The AMA Board of Trustees recommended that organizing efforts be channeled through medical societies, and the issue remained dormant within the AMA until June 1984, when the House of Delegates called upon the AMA to study means by which physicians could be

35. *Young & Rubicam*, 226 N.L.R.B. at 1277.

36. *AmeriHealth*, 1999 WL 963200, at *1.

37. *Id.*

38. *Id.*

39. Sarah A. Klein, *AMA Board Balks at Bargaining Unit Plan*, AM. MED. NEWS, May 3, 1999.

represented on issues of quality, access, and reimbursement.[40] After several years of study and discussion, the House of Delegates rejected an AMA proposal for the development of a collective bargaining unit and the issue largely died, until delegates to the AMA's annual meeting in June 1997 called for an AMA investigation of collective bargaining for employed physicians.[41]

Managed care's resulting reduction of reimbursement rates and application of job performance measures has fueled physicians' most recent demands for unions as a means to strengthen their negotiating power.[42] This time, in response to increasing pressure, especially from younger physicians and medical residents[43] at its June 1999 meeting, the AMA voted to develop an affiliated national labor organization to represent employed physicians and, to the extent allowed by law, residents.[44]

Despite a June 1998 mandate to develop a union, the AMA Board of Trustees had resisted organizing efforts because of concerns that an AMA-sponsored union was inappropriate and would aversely affect the perception of the public with regard to the medical profession.[45] In a seventy-three page report addressing the collective bargaining proposal, the AMA expressed concerns that a collective bargaining unit could only represent a fraction of AMA constituents because it would not apply to housestaff or self-employed doctors, who are most in need of enhanced

40. *Id.*

41. *Id.*

42. Havighurst, *supra* note 2.

43. Klein, *supra* note 39.

44. Press Release, American Medical Association, AMA Physicians Vote to Form National Negotiating Organization (June 23, 1999), *available at* http://www.ama-assn.org/ama/pub/category/1616.html (last visited Aug. 2, 2002). At that time, controlling NLRB case law precluded medical residents from claiming employee status. *See infra* text accompanying notes 112-19. That decision was reversed a year later in Boston Medical Center Corp., 330 N.L.R.B. 152 (1999).

45. Klein, *supra* note 39.

bargaining strength.[46] The AMA was equally concerned that early organizing failures could ruin the AMA's advocacy image, especially in light of its lack of experience and no-strike policy, and that its reputation as a professional organization would be placed at risk while it endeavored to form a unit that was simultaneously effective and professional.[47]

In an effort to address both of these concerns, despite the 1998 unionization mandate, the AMA House of Delegates voted to continue lobbying efforts in support of legislation that would exempt health care professionals from federal antitrust laws, allowing collective bargaining with health plan providers and insurers. The House of Delegates also voted in support of a directive that all AMA activities regarding physician negotiation maintain the highest levels of professionalism consistent with the AMA's Principles of Medical Ethics and the Current Opinions of the AMA's Council on Ethical and Judicial Affairs.[48] The AMA pledged that its union would be different from a traditional labor union because of its degree of independence, its no-strike pledge, and its commitment to medical ethics.[49]

Following the landmark vote of June 1999, the AMA created an independent labor organization entitled Physicians for Responsible Negotiations (PRN).[50] The AMA also provided an initial 1.2 million dollar loan to support PRN operations through December 31, 2000[51] and a model constitution, which was largely adopted by PRN's governing body (which was initially appointed by the AMA Board of Trustees). The constitution

---

46. Sarah A. Klein, *Board Details Discomfort with Collective Bargaining*, AM. MED. NEWS, June 21, 1999. AMA leaders reportedly estimated that out of the 620,000 doctors directly involved in patient care, a union could assist up to 108,000 (17%) of the nation's physicians. Sarah A. Klein, *AMA to Establish National Collective Bargaining Unit*, AM. MED. NEWS, July 5, 1999; Editorial, *Loud Message in Physician Organizing Vote*, AM. MED. NEWS, July 19, 1999. These small figures are not readily reconciled with other AMA reports estimating that 64% of all licensed physicians in the United States are self-employed, while the remaining 36% are employees (26.6% are employees of hospitals and other medical institutions and 9.4% are employees of doctor owned groups). Klein, *supra* note 39. Nor are the figures reconciled with an earlier estimate placing the percentage of doctors eligible for union members (excluding residents and federal employees) at 43%. Havighurst, *supra* note 2; Sarah A. Klein, *Alliance of Physician Unions Creates New Collective Bargaining Powerhouse*, AM. MED. NEWS, Mar. 15, 1999.

47. Klein, *supra* note 39.

48. American Medical Association, *supra* note 44.

49. *Id.*

50. Press Release, American Medical Association, AMA Announces Next Steps in Creating a National Negotiating Organization for Employed Physicians (Sept. 9, 1999), *available at* http://ama-assn.org/ad-com/releases/1999/prnextstep.htm (last visited Apr. 1, 2002).

51. Report of the Board of Trustees, Regarding Physicians of Responsible Negotiations 13-I-99 (1999).

"stresses an overriding commitment to the promotion of quality healthcare and ties the operating philosophies of PRN" to principles of medical ethics.[52]

Consistent with the AMA pledge, PRN's constitution precludes strikes or other job actions. To further distinguish itself from other traditional labor unions, PRN limits its membership to physicians and disclaims the closed shop model of mandatory union membership.[53] The organizing model developed by PRN calls for an initial education/fact-finding phase to be conducted by the AMA in conjunction with the appropriate local medical society, and is designed to convey to the physician the necessary emotional and financial commitment, as well as the limits of the no-strike model.[54] Those physicians who remain committed to unionization are then authorized to contact PRN for assistance, provided that a core group of physician leaders makes a financial commitment to the organization effort. PRN also assists recognized bargaining units during contract negotiations and contract administration.[55]

PRN initiated its organizing efforts with a group of forty-two staff physicians employed by Wellness Plan in Detroit, a mixed-model HMO that was founded in 1972 to bring state-of-the- art clinics to the urban population following a race riot.[56] In response to two years of significant reductions in state funds and the resulting structural and operational changes, the staff physicians turned to unionization to ensure their say in the plan's future.[57] The issues on the bargaining table included a patients' rights clause, grievance procedures, job security, a joint medical/staff committee structure, and economic concerns.[58] The contract negotiated by PRN was ratified on March 15, 2001.[59]

---

52. *Id.*

53. PRN as Your Collective Bargaining Representative, *available at* http://www.4prn.org/montegiore/prn_as_rep.html (last visited Apr. 1, 2002).

54. Sarah A. Klein, *AMA Bargaining Unit: From Concept to Reality*, AM. MED. NEWS, July 26, 1999; Report of the Board of Trustees, *supra* note 51, at 2.

55. *See Id.*

56. Sarah A. Klein, *PRN Takes on its Initial Bargaining Assignment*, AM. MED. NEWS, Jan. 24, 2000. A petition for representation was filed with the NLRB in late Dec. 1999. *Id.*

57. *Id.* The doctors had been meeting with the United Auto Workers union to discuss organizing before PRN was established and elected to switch to a doctor-based union.

58. Letter from Jill Poznick, Director, Field Operations, to New Jersey physicians (Sept. 25, 2000), *available at* http://www.4prn.org/concentra/index.html (last visited Apr. 2, 2002).

59. *Physician's Union Forges Ahead Successfully, Despite Roadblocks*, PHYSICIAN'S WKLY., Jan. 22, 2001; *AMA Bargaining Arm Wins First Contract with an HMO*, COLLECTIVE BARGAINING BULL. (BNA), Apr. 5, 2001 (on file with author); Tanya Albert, *New York Interns, Residents Get NLRB Nod to Join Union*, AM. MED. NEWS, Apr. 16, 2001. PRN also affiliated with an existing independent labor organization representing twenty emergency medicine physicians

PRN also filed a petition in August 2000 on behalf of approximately nineteen occupational medicine physicians employed at ten Concentra Managed Care, Inc. clinics in New Jersey.[60] Concentra filed various objections to the petition and the scope of the bargaining unit.[61] Resolution of those objections and further organizing efforts among private physicians were delayed as a result of the U.S. Supreme Court's intervening decision in *NLRB v. Kentucky River Community Care*.[62] In that case, the U.S. Supreme Court held that the NLRB had misinterpreted the NLRA and that individuals who "exercise 'ordinary professional or technical judgment in directing less-skilled employees to deliver services'" may be supervisors and are not protected by the NLRA.[63] The *Kentucky River* decision led PRN and others to question whether privately employed physicians would also be considered supervisors and thereby fall outside the scope of the NLRA.[64] Reconsidering PRN's petition to represent the Concentra doctors in New Jersey under the *Kentucky River* decision, the Regional Director for NLRB Region 22 recently concluded that the petitioning doctors were employees, not supervisors.[65] Concentra has requested review of that determination by the NLRB.[66]

While the AMA deliberated over whether to enter the unionization movement, some doctors independently formed their own unions in affiliation with traditional, industrial labor unions. The oldest union of doctors, the Doctors Council, was formed in 1975 to represent physicians, dentists, and podiatrists in the New York City area. On March 1, 1999, the Doctors Council joined a union of medical housestaff, entitled the Committee of Interns and Residents, and United Salaried Physicians and Dentists to form the National Doctors Alliance, a 15,000 member organized

---

in Austin, Texas. *How Much Damage Did Supreme Court Ruling Do to Health Care Unionization?*, MANAGED CARE, Aug. 2001 (on file with author); Trebor Banstetter, *Area Doctors Likely to Unionize Some Experts Say; An Austin Physicians Group's Vote to Join a National Labor Organization is Not Expected to be the Last in Texas*, STAR TELEGRAM, Apr. 17, 2001 (on file with author).

60. Occupational Health Ctrs. of New Jersey d/b/a Concentra Medical Ctrs., Supp. Dec. & Order, No. 22-RC-11944, *available at* http://www.4prn.org/pdf/nlrb_20020131.pdf (last visited Apr. 1, 2002).

61. *Id.*

62. Tanya Albert, *Supreme Court Decision Expands Definition of "Supervisor,"* AM. MED. NEWS, June 25, 2001; N.L.R.B. v. Ky. River Cmty. Care, 532 U.S. 706 (2001).

63. *Ky. River*, 532 U.S. at 713-14 (citation omitted).

64. Albert, *supra* note 62.

65. Occupational Health Ctrs., *supra* note 60.

66. *See* http://www.4prn.org/pdf/brief20020308.pdf (last visited Apr. 20, 2002).

union of salaried physicians and dentists affiliated with the Service Employees International Union (SEIU), AFL-CIO.[67]

Unlike PRN, which actively seeks to disassociate itself from the traditional union model and disclaims a primary interest in worker issues such as pay, hours, and benefits,[68] the National Doctors Alliance and other unions of doctors, such as the Federation of Physicians and Dentists (8500 members) and the Union of American Physicians and Dentists (6000 members), have affiliated with industrial unions and embraced all the tools afforded unions under the NLRA, including the right to strike.[69] These unions concede that patient care is not the sole focus of their collective bargaining efforts. Rather, the agendas include negotiations over salaries, hours, and due process, while patient advocacy is addressed primarily through legislative drives for managed care reform.[70] According to Doctors Council President Dr. Barry Liebowitz, strikes may be appropriate to prevent cost-cutting measures which would affect the quality of patient care, such as the closure of a cardiology or neurology department, but not for purely economic issues.[71]

Thus, at least in principle, PRN represents a new approach to unionization. As discussed in section VI, however, it remains to be seen whether and to what extent collective bargaining can achieve changes in consumer safety matters such as patient care. Ultimately, despite its professed alternative approach, PRN may simply serve as another group through which staff physicians can bargain over wages, hours, and other terms and conditions of employment without utilizing the economic threat of a strike.

IV. ANTITRUST EXEMPTION FOR SELF-EMPLOYED DOCTORS

Under federal antitrust laws, the ability of self-employed private practitioners to organize and negotiate collectively with HMOs and insurance companies is limited.[72] Frustrated with the managed care system and with limitations on their autonomy, these doctors are seeking a

---

67. Diane E. Lewis, *Doctors Join Union to Fight Ills From HMOs*, B. GLOBE, Mar. 2, 1999, at A1.

68. Klein, *supra* note 39.

69. *Id.*; Molly Tschida, *Nation's Largest Physician Union Forms Under SEIU Umbrella*, MOD. PHYSICIAN, Mar. 2000; Abate, *supra* note 8.

70. Klein, *supra* note 39; Lewis, *supra* note 67.

71. Steven Greenhouse, *Doctors' Group Merges With a Larger Union*, N.Y. TIMES, Mar. 2, 1999.

72. 15 U.S.C. §§ 1, 2, 12.

legislative exemption from the constraints of federal antitrust laws for health care providers. Such an exemption was embodied in the Quality Health Care Coalition Act of 1999 (House Bill 1304), which passed the House by a 2:1 vote margin in June 2000, but was never considered by the Senate and died at the end of the session.[73] The AMA pressed for similar legislation in the 107th Congress, and House Bill 3897, the Health Care Antitrust Improvements Act of 2002, sponsored by Congressmen Bob Barr (R-GA) and John Conyers (D-MI), was introduced on March 7, 2002.[74]

As passed by the House, House Bill 1304 granted an exemption from the antitrust laws to health care professionals engaged in negotiations with health plan providers which was identical to that granted to unions negotiating with employers under the NLRA.[75] The bill provided that in connection with such negotiations, the health care professional was to be treated "as an employee engaged in concerted activities,"[76] with the limited exception that the health care professional would be precluded from participating "in any collective cessation of service to patients not otherwise permitted by existing law."[77] In response to criticisms that physicians would use the bill as a vehicle for increasing reimbursement rates that would raise costs for consumers, the bill included a three-year sunset provision and directed the General Accounting Office to conduct a six-month study of the effects of the legislation.[78]

The AMA argues that antitrust legislation is necessary because the market is dominated by a few large insurers and nearly eighty percent of Americans receive their health care coverage from a managed care plan.[79]

---

73. H.R. 1304, 106th Cong. (2000).

74. Tanya Albert, *Collective Bargaining Bill Needs Senate Nod*, AM. MED. NEWS, Jan. 15, 2001; Tanya Albert, *Collective Bargaining Bill Dies; Supporters Vow to Try Again*, AM. MED. NEWS, Nov. 6, 2000.

75. H.R. 1304, 106th Cong. (2000).

76. *Id.* § 2(a).

77. *Id.* § 2(c)(1).

78. *Id.* § 2(d), (h); 146 CONG. REC. H5627, H5639 (daily ed. June 29, 2000) (statement of Rep. Conyers) (citing the three-year sunset provision as obviating the need for any further oversight); 146 CONG. REC. at H5632 (June 29, 2000) (statement of Rep. Pomeroy) (recognizing the Judiciary Committee adopted the sunset provision in response to concerns of rising costs to consumers).

79. AMA Questions and Answers on H.R. 1304, *available at* http://www.ama-assn.org/ama/basic/article/201-561-0.html (last visited Apr. 10, 2002); E. Ratcliffe Anderson, Jr., MD, Statement of the American Medical Association to the Committee on the Judiciary U.S. House of Representatives Re: In Support of the Quality Health-Care Coalition Act of 1999, H.R. 1304 (June 22, 1999) (noting that the Aetna/U.S. Healthcare merger with Prudential will make Aetna one of the three top insurers in nine states and give Aetna control of between 30-59% of the HMO market in certain counties and cities).

The AMA claims that under these circumstances, few doctors can afford not to contract with health plans and are virtually compelled to consent to onerous contract provisions.[80] Such provisions, the AMA asserts, have compromised the ability of doctors to make decisions for their patients. They view an antitrust exemption as the only way to level the playing field.[81] As a further example of disparities in bargaining power, the AMA claims that under the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015, health insurers enjoy a special exemption under the antitrust laws and are permitted to share actuarial data and price information with their competitors, while physicians are precluded from exchanging this type of information.[82]

The Department of Justice (DOJ) and the Federal Trade Commission (FTC), as well as various coalitions of health plan providers, collectively oppose the physician antitrust exemption. The DOJ and the FTC dispute the AMA's claim to need an equalization of power and argue that the public benefits the most from a competitive marketplace policed by the government under existing antitrust laws and measures, such as a Patients Bill of Rights, designed to empower consumer choice.[83] Both government entities disclaim the AMA's assertion that mergers of health plan providers in recent years have resulted in the domination of the marketplace by a half-dozen insurance providers. The DOJ notes that between 1994 and 1997, 150 new HMOs were licensed across the country, and the market share of Blue Cross and Blue Shield, which once dominated the health care industry, has been eroded by managed care plans.[84] As evidence that existing government scrutiny adequately protects the public and health care providers against anti-competitive action, the DOJ cites its intervention in the proposed merger of Aetna and Prudential, where substantial divestitures were required in Dallas and Houston based on concerns that merger in those two markets would lead to market power in the sale of HMO services and the purchase of doctors' services.[85]

---

80. Anderson, *supra* note 79.

81. *Id.*

82. *Id.*

83. *The Quality Health-Care Coalition Act of 1999: Hearing on H.R. 1304 Before the House Judiciary Comm.* (1999) (statement of Joel I. Klein, Ass't Att'y Gen., Antitrust Div., U.S. Dep't of Justice); *The Quality Health-Care Coalition Act of 1999: Hearing on H.R. 1304 Before the House Judiciary Comm.* (1999) (statement presented by Robert Pitofsky, Chairman, Fed. Trade Comm'n).

84. Klein, *supra* note 83.

85. *Id.* The AMA counters that the Aetna merger was the first significant review of a health plan merger ever conducted by the DOJ or the FTC, and asserts that the government has been far

The DOJ and the FTC dismiss the McCarran-Ferguson Act as essentially a red herring, noting that under long-standing U.S. Supreme Court precedent, the Act provides insurers with a limited exemption from the antitrust laws in connection with "the business of insurance" that does not extend to the dealings of insurers with health care providers.[86] The DOJ observes that it has policed insurers' exclusionary or collusive activities with regard to contractual provisions imposed on health care providers.[87]

One of the DOJ's and the FTC's greatest concerns with House Bill 1304 was that it offered no protective mechanisms to guarantee that negotiations would focus on improving the quality of care rather than on the personal financial circumstances of doctors. The entities expressed the fear that the public will ultimately suffer as a result of cost increases that would be passed on to consumers and taxpayers. In their testimony before Congress, both entities cited cases they had investigated, in which doctors jointly negotiating with health insurers had sought significant fee increases (sometimes as much as forty percent), in some cases while professing to be motivated by quality of care concerns.[88] Citing standard economic theory, the DOJ and the FTC noted that an increase in the cost of an input ordinarily translates into a higher output price, and insurers are virtually

---

more ardent in its efforts to police doctors in their exchange of information about proposed health plan contracts. Anderson, *supra* note 79.

86. Klein, *supra* note 83.

87. *Id.*

88. *Id.* The FTC cited the Commission's recent intervention where a group representing 70-80% of the physicians in the Lake Tahoe area were forcing all the area health plans to accept much higher rates than those paid in other parts of California or Nevada or find other doctors with whom to contract. Pitofsky, *supra* note 83. The FTC also cited a consent order settling charges that a group of physicians in Danville, Virginia had agreed on reimbursement rates and other terms of dealing with health plans and had agreed to boycott those plans that did not meet their terms, thereby obstructing the entry of new health care plans into the area. The Virginia case had been jointly investigated with the Commonwealth of Virginia because one of the victims of the boycott was a health plan for state employees. *Id.* The FTC and Virginia collected $170,000 in penalties and damages for the increased costs the state claimed it had to bear in providing health benefits to its employees. *Id.* Similarly, the DOJ cited the Federation of Certified Surgeons and Specialists case, in which 29 doctors comprising the vast majority of general and vascular surgeons with operating privileges at five Tampa hospitals formed a corporation to jointly negotiate higher fees from managed care plans and obtained an average of $14,000 each in additional annual revenues. Klein, *supra* note 83. The DOJ also cited the Federation of Physicians and Dentists case in which it alleges that most of the orthopedic surgeons in Delaware agreed to boycott Blue Cross and Blue Shield after it announced it was going to reduce reimbursement rates, even though those rates were still higher than those paid to orthopedic surgeons in neighboring Philadelphia and were in line with fees paid to other types of specialists in Delaware. *Id.*

certain to pass most of the increased cost of covered services on to consumers.[89] The only alternative to increasing costs is a reduction of covered services, which would be equally detrimental to consumers.[90]

Similar concerns prompted several members of Congress to propose amendments to House Bill 1304 in order to guarantee that negotiations would focus on patient care issues. Proposals by Congressmen Ballenger and Terry would have excluded fee, payment, or reimbursement negotiations from the antitrust exemption,[91] while a proposal by Congressman Stearns required that health care professionals seeking to negotiate first obtain approval from the FTC or the Assistant Attorney General, ensuring that the negotiations would "promote competition and enhance the quality of patient care."[92] All of these proposals were soundly defeated during the floor debate on the bill.[93]

The objections of the DOJ and the FTC appear to stem largely from a concern that was scarcely addressed at the House Judiciary Committee hearings on the bill — the application of the labor law collective bargaining model to negotiations conducted outside the strictures of the NLRA.[94] House Bill 1304 provided that health care professionals negotiating with health plan providers regarding contract terms for the provision of health care items or services were to be treated as "employees engaged in concerted activities," exempt from the antitrust laws to the same extent as

---

89. Klein, *supra* note 83; Pitofsky, *supra* note 83. The DOJ notes that costs for professional services ordinarily constitute 40-50% of a health plan's total costs and for the last few years premiums have closely reflected the costs of insurers. Klein, *supra* note 83. The AMA counters that this is all a smokescreen because overhead accounts for as much as 20-25% of insurance premiums and insurers could absorb more of the costs that they currently pass on to consumers. AMA Questions and Answers, *supra* note 79.

90. *See* Pitofsky, *supra* note 83; Klein, *supra* note 83.

91. H. Amdt. 952, CONG. REC. H5637 (June 30, 2000). The Ballenger Amendment would also have barred negotiations to permit health care professionals to balance bill patients, required health care professionals to develop plans to identify and reduce the incidence of medical errors, required health care professionals to disclose to patients and prospective patients their participation in negotiations and prohibited boycotts. *Id.* The Terry Amendment simply excluded "negotiations over fees" from the exemption. H. Amdt. 955, CONG. REC. H5643 (June 30, 2000).

92. H. Amdt. 953, CONG. REC. H5639 (June 30, 2000).

93. CONG. REC. H5648-51 (June 30, 2000).

94. Testimony submitted by the National Guild of Medical Professionals simply stated that negotiations are not limited to pay-related issues and may "address the entire scope of activities that have resulted in the patient outcry that drives this hearing." Testimony Offered by the National Guild of Medical Professionals, Office and Professional Employees International Union AFL-CIO before the Judiciary Committee of the House of Representatives in Reference to House Bill 1304 The Quality Health-Care Coalition Act of 1999 (June 22, 1999).

those bargaining units recognized under the NLRA.[95] But if such health care professionals are not, in fact, employees, and therefore fall outside the scope of the NLRA, then what does the instruction to treat them as employees engaged in concerted activities mean?

The NLRA provides protected employees with a guaranteed right to organize and engage in concerted activities for the purpose of collective bargaining or for their mutual aid or protection.[96] This right is secured by proscriptions against employer interference with the restraint or coercion of employees in the exercise of their protected rights, including prohibitions against the formation of company unions, employer discrimination, and retaliation against union members.[97] Employers and employees are also required to meet at reasonable times and to negotiate in good faith. The NLRB is charged with ensuring that both parties comply with this obligation, although neither party can be forced to accept any particular provision.[98] The NLRB and the courts have outlined the subjects that are encompassed by the duty to bargain and have designated matters pertaining to wages, hours, and the terms and conditions of employment as mandatory subjects of bargaining that the employer may not unilaterally change without violating the NLRA. Most other matters are permissive subjects, as to which there is no obligation to bargain.[99]

A large body of case law, administrative rulings, and arbitration decisions have evolved over the past sixty-seven years, which interprets and applies these obligations in the labor law context. The result has been a delicate balancing of the economic weapons available to each party, closely policed by the NLRB with the threat of injunctive relief under section 301(a) of the Labor Management Relations Act lurking in the background. When issues arise regarding the construction of the parties' collective bargaining contracts, the courts, and even the NLRB, largely defer to arbitration.[100] The current labor law system is dependent on enforcement

---

95. H.R. 1304, 106th Cong. § 3(a) (1999).

96. 29 U.S.C. § 157 (2002).

97. *Id.* § 158.

98. *Id.* § 155. *See* HK Porter Co. v. N.L.R.B., 397 U.S. 99, 102 (1970) (NLRB cannot require employer or union to agree to any substantive provision in collective bargaining agreement).

99. *See* First Nat'l Maint. Corp. v. N.L.R.B., 452 U.S. 666, 677-78 (1981) (decisions with only indirect and attenuated impact on employment are permissive subjects; decisions that almost exclusively involve an aspect of the employer-employee relationship are mandatory subjects; and decisions pertaining to changes in the scope and direction of the enterprise are permissive subjects, while the effects of those changes are mandatory subjects of bargaining).

100. *See* United Steelworkers v. Warrior & Gulf Navigation Co., 363 U.S. 574, 582-83 (1960) (court will order arbitration where dispute is "susceptible to interpretation" that it falls

and dispute resolution devices to effectuate the protections of the NLRA in the collective negotiating process.

House Bill 1304 and the supporting testimony provided no indication as to the application or enforcement of the duty to bargain when the parties fall outside the scope of the NLRA regulatory structure. The Antitrust Coalition for Consumer Choice in Health Care, a group of employers, health plan providers, and other interested parties, joined the DOJ in expressing concern over the lack of NLRB involvement in this area. The groups observed that the exemption created by the bill would enable health care professionals to remain independent contractors while claiming an antitrust exemption available only to employees, and did so without imposing any of the NLRA obligations and safeguards that apply to all other employees.[101] Several members of Congress expressed similar concerns during the floor debate on House Bill 1304.[102]

While recognizing that the NLRB would have no authority over physicians' negotiations with health plan providers, the AMA contends that such negotiations would not be entirely unregulated because the DOJ and the FTC would continue to oversee the activities of health care professionals.[103] House Bill 3897 adopts a different model for exempting self-employed physicians from the antitrust laws to enable them to negotiate

---

within the context of the parties' agreement); United Steelworkers of Am. v. Enter. Wheel & Car Corp., 363 U.S. 593, 597-98 (1960) (arbitration award will be upheld so long as it "draws its essence" from the contract, and arbitrator need not provide rationale for the decision); United Paperworks v. Misco, 484 U.S. 29 (1987) (courts may not review merits of arbitration award, no matter how improvident or silly).

101. Pitofsky, *supra* note 83; Testimony Offered by the Antitrust Coalition for Consumer Choice in Health Care before the Judiciary Committee of the House of Representatives in Reference to House Bill 1304 (June 22, 1999) [hereinafter Jones Statement].

102. Congressmen Boehner, Pomeroy, and Goodling observed that other groups that have been exempted from the antitrust laws are also subject to oversight by some federal regulatory body, such as the NLRB. 146 CONG. REC. H5630-33 (June 30, 2000). As Congressman Goodling succinctly stated, "[i]t is a flawed labor bill because it grants rights similar to those contained in the National Labor Relations Act, but fails to provide any mechanism to make sure those rights are effective, or fair." 146 CONG REC. H5633 (June 30, 2000). *See also* 146 CONG. REC. H5637 (quoting Sen. Thomas: "What we have got are giving people the rights [of the NLRA] without the responsibilities").

A memo drafted by the Congressional Research Service for Congressman Goodling in response to an inquiry relating to the Judiciary Committee's jurisdiction to consider what Congressman Goodling regarded as a labor bill observed, "though collective bargaining appears contemplated, there is no definition or requirement of a 'duty to bargain,' no mechanism to resolve disputes that might arise during the bargaining process, nor any enforcement mechanism to ensure good faith bargaining, which presumably is the ultimate goal of the exercise." 146 CONG. REC. H5635 (June 30, 2000) (quoting from July 12, 1999 Congressional Research Service memo to Goodling).

103. AMA Questions and Answers, *supra* note 79.

collectively with health plan providers. In lieu of references to the labor law model of collective bargaining, House Bill 3897 modifies the judicial standard for reviewing antitrust claims asserted against physicians collectively negotiating with health plan providers.[104] Under the antitrust laws, such collective action would ordinarily be considered per se illegal, without regard to whether the action has caused harm or is justified by a reasonable business excuse.[105] A prevailing plaintiff in an action challenging such conduct would be entitled to treble damages and attorneys fees.[106] House Bill 3897 precludes a finding of per se illegality in the case of physicians' collective negotiations with health plan providers, and instead provides that such collective action must be judged based on its reasonableness, with regard to factors including "patient access to health care, the quality of health care received by patients, and contract terms or proposed contract terms."[107] The statute would also create a safe harbor, limiting a plaintiff's recovery to actual (not treble) damages if the physicians filed with the Attorney General written notice of their intent to negotiate collectively, and in all cases it would preclude an award of attorneys fees to a prevailing plaintiff absent a finding that the defendant physicians engaged in frivolous conduct during the litigation.[108]

By thus altering the standard for judicial review of physicians' collective action and drastically reducing physicians' potential liability under the antitrust laws, House Bill 3897 (like its predecessor in the 106th Congress) would substantially alter the legal landscape with regard to independent physicians' ability to collectively negotiate with health insurers. House Bill 3897 would also create a minimum of six demonstration projects, under which participating physicians would be exempted from the antitrust laws and allowed to collectively negotiate with health plan providers.[109] Under three of these demonstration projects, physicians would not be subject to any restrictions or oversight with the exception of a prohibition on striking.[110] Under the remaining projects, the collective negotiations would be subject to oversight by the Attorney General, who could intervene and halt negotiations if the physicians were found to have engaged in conduct that

104. H.R. 3897 § 3.
105. *Id.*; Northern Pacific Rwy. Co. v. United States, 356 U.S. 1 (1958).
106. 15 U.S.C. § 15.
107. H.R. 3897 § 2.
108. *Id.* §§ 3, 4.
109. *Id.* § 6.
110. *Id.* § 6(d)(1)(A).

and dispute resolution devices to effectuate the protections of the NLRA in the collective negotiating process.

House Bill 1304 and the supporting testimony provided no indication as to the application or enforcement of the duty to bargain when the parties fall outside the scope of the NLRA regulatory structure. The Antitrust Coalition for Consumer Choice in Health Care, a group of employers, health plan providers, and other interested parties, joined the DOJ in expressing concern over the lack of NLRB involvement in this area. The groups observed that the exemption created by the bill would enable health care professionals to remain independent contractors while claiming an antitrust exemption available only to employees, and did so without imposing any of the NLRA obligations and safeguards that apply to all other employees.[101] Several members of Congress expressed similar concerns during the floor debate on House Bill 1304.[102]

While recognizing that the NLRB would have no authority over physicians' negotiations with health plan providers, the AMA contends that such negotiations would not be entirely unregulated because the DOJ and the FTC would continue to oversee the activities of health care professionals.[103] House Bill 3897 adopts a different model for exempting self-employed physicians from the antitrust laws to enable them to negotiate

---

within the context of the parties' agreement); United Steelworkers of Am. v. Enter. Wheel & Car Corp., 363 U.S. 593, 597-98 (1960) (arbitration award will be upheld so long as it "draws its essence" from the contract, and arbitrator need not provide rationale for the decision); United Paperworks v. Misco, 484 U.S. 29 (1987) (courts may not review merits of arbitration award, no matter how improvident or silly).

101. Pitofsky, *supra* note 83; Testimony Offered by the Antitrust Coalition for Consumer Choice in Health Care before the Judiciary Committee of the House of Representatives in Reference to House Bill 1304 (June 22, 1999) [hereinafter Jones Statement].

102. Congressmen Boehner, Pomeroy, and Goodling observed that other groups that have been exempted from the antitrust laws are also subject to oversight by some federal regulatory body, such as the NLRB. 146 CONG. REC. H5630-33 (June 30, 2000). As Congressman Goodling succinctly stated, "[i]t is a flawed labor bill because it grants rights similar to those contained in the National Labor Relations Act, but fails to provide any mechanism to make sure those rights are effective, or fair." 146 CONG REC. H5633 (June 30, 2000). *See also* 146 CONG. REC. H5637 (quoting Sen. Thomas: "What we have got are giving people the rights [of the NLRA] without the responsibilities").

A memo drafted by the Congressional Research Service for Congressman Goodling in response to an inquiry relating to the Judiciary Committee's jurisdiction to consider what Congressman Goodling regarded as a labor bill observed, "though collective bargaining appears contemplated, there is no definition or requirement of a 'duty to bargain,' no mechanism to resolve disputes that might arise during the bargaining process, nor any enforcement mechanism to ensure good faith bargaining, which presumably is the ultimate goal of the exercise." 146 CONG. REC. H5635 (June 30, 2000) (quoting from July 12, 1999 Congressional Research Service memo to Goodling).

103. AMA Questions and Answers, *supra* note 79.

collectively with health plan providers. In lieu of references to the labor law model of collective bargaining, House Bill 3897 modifies the judicial standard for reviewing antitrust claims asserted against physicians collectively negotiating with health plan providers.[104] Under the antitrust laws, such collective action would ordinarily be considered per se illegal, without regard to whether the action has caused harm or is justified by a reasonable business excuse.[105] A prevailing plaintiff in an action challenging such conduct would be entitled to treble damages and attorneys fees.[106] House Bill 3897 precludes a finding of per se illegality in the case of physicians' collective negotiations with health plan providers, and instead provides that such collective action must be judged based on its reasonableness, with regard to factors including "patient access to health care, the quality of health care received by patients, and contract terms or proposed contract terms."[107] The statute would also create a safe harbor, limiting a plaintiff's recovery to actual (not treble) damages if the physicians filed with the Attorney General written notice of their intent to negotiate collectively, and in all cases it would preclude an award of attorneys fees to a prevailing plaintiff absent a finding that the defendant physicians engaged in frivolous conduct during the litigation.[108]

By thus altering the standard for judicial review of physicians' collective action and drastically reducing physicians' potential liability under the antitrust laws, House Bill 3897 (like its predecessor in the 106th Congress) would substantially alter the legal landscape with regard to independent physicians' ability to collectively negotiate with health insurers. House Bill 3897 would also create a minimum of six demonstration projects, under which participating physicians would be exempted from the antitrust laws and allowed to collectively negotiate with health plan providers.[109] Under three of these demonstration projects, physicians would not be subject to any restrictions or oversight with the exception of a prohibition on striking.[110] Under the remaining projects, the collective negotiations would be subject to oversight by the Attorney General, who could intervene and halt negotiations if the physicians were found to have engaged in conduct that

104. H.R. 3897 § 3.
105. *Id.*; Northern Pacific Rwy. Co. v. United States, 356 U.S. 1 (1958).
106. 15 U.S.C. § 15.
107. H.R. 3897 § 2.
108. *Id.* §§ 3, 4.
109. *Id.* § 6.
110. *Id.* § 6(d)(1)(A).

was intended to substantially harm both competition and the quality of health care received by patients.[111]

The demonstration projects created by House Bill 3897 essentially preserve the labor law collective bargaining model embodied in the 1999 legislation (House Bill 1304) on a test basis, and the antitrust amendments loosen the legal strictures for all self-employed physicians. House Bill 3897 has been referred to the Judiciary Committee and neither the FTC nor the DOJ have expressed their opinions on the legislation thus far. While preserving greater oversight than the earlier legislation, it remains unclear whether House Bill 3897 sufficiently protects the general public from abusive negotiating practices. Without the treble damages and attorneys fee provisions, the costs of litigation challenging collusive practices may be prohibitive and thereby allow all but the most egregious conduct to proceed unchecked. As for the test projects, if they are intended to serve as a model for the future of physician-health plan provider negotiations, it is doubtful whether any conclusions can be drawn from a mere six examples. In the end, the antitrust exemption sought by the AMA to "level the playing field" could potentially grant physicians tremendous negotiating power and could cripple the efforts of the managed care movement to control medical costs.

V. HOUSESTAFF AS EMPLOYEES AND THE BIRTH OF UNIONIZATION

Twenty-seven years ago, shortly after Congress amended the NLRA to extend the jurisdiction of the NLRB to nonprofit healthcare facilities, in *Cedars-Sinai Medical Center*[112] a majority of the NLRB held housestaff—interns, residents, and fellows completing their medical training at healthcare facilities[113] — were not statutory employees because they were primarily engaged in graduate educational training.[114] The NLRB reasoned that the substantial amount of time spent by housestaff on direct patient care was simply the means for effectuating the learning process and did not qualify as traditional employment.[115] The NLRB noted that the patient care activities were coordinated with a variety of teaching and educational activities; and that housestaff received an annual stipend based on their level

111. *Id.* § 6(d)(1)(B).

112. 223 N.L.R.B. 251 (1976).

113. *Id.* Interns are medical school graduates serving an initial period of graduate medical training that is generally required to receive a medical licence. Residency is more advanced training in a medical specialty, lasting from one to five years, and a clinical fellowship is additional training to qualify for certification in a medical subspecialty. *Id.*

114. *Id.* at 253.

115. *Id.*

of medical training, not on the nature of the services rendered or number of hours spent in patient care. The NLRB further noted that the programs were designed to allow the student to develop clinical skills in the student's practice area and not to meet the hospital's staffing requirements; and that the tenure of a member of the housestaff was closely related to the length of the student's training program.[116]

The NLRB reaffirmed and clarified its holding the following year in *St. Clare's Hospital & Health Center*.[117] In that case, the NLRB outlined four categories of cases involving students and placed housestaff in the fourth category, "that in which students perform services at their educational institutions which are directly related to their educational program."[118] The NLRB held that the relationship of these students to their educational institutions is predominantly academic, not economic, and therefore is not readily adaptable to the collective bargaining process.[119]

Following *Cedars-Sinai* and *St. Clare's*, it was widely believed that housestaff fell outside the protection of the NLRA, and that unionization was limited to housestaff working at public hospitals who might be considered protected under state labor laws.[120] In 1997, housestaff at Boston Medical Center (BMC) sought to challenge that position. As a condition to the July 1, 1996 consolidation of Boston City Hospital (a public hospital) and Boston University Medical Center Hospital (a private hospital) to create BMC, the Boston City Council required BMC to recognize the House Officers' Association Committee of Interns and Residents (the Union) as the collective bargaining representative for the 280 former Boston City Hospital housestaff.[121] BMC executed a recognition agreement and, following a card count conducted among housestaff, recognized the Union as the representative for all housestaff and engaged in collective bargaining with the Union.[122] BMC's voluntary recognition could have been withdrawn under the NLRA. To avoid such a possibility,

---

116. *Id.* at 252-53.

117. 229 N.L.R.B. 1000, 1004 (1977).

118. *Id.* at 1002 (citing Cedars-Sinai Med. Ctr., 223 N.L.R.B. 251 (1976)).

119. *Id.*

120. Of the estimated 103,000 housestaff in the United States, only 10,000 currently belong to unions. While protected under state collective-bargaining laws, those laws generally deny public employees the right to strike. Richard A. Knox, *MD Trainees Win the Right to Unionize Decision in Boston Doctors' Case Affects Nation's Private Hospitals*, B. GLOBE, Nov. 30, 1999, at A1.

121. Boston Med. Ctr. Corp., 330 N.L.R.B. No. 30, slip op., at 5 (Nov. 26, 1999). Because Boston City Hospital was a public institution, the housestaff had been able to organize under the Massachusetts labor laws and had been represented by a union since 1969. *Id.*

122. *Id.* at 5-6.

the Union filed a petition with the NLRB in 1997 seeking certification of a unit of housestaff.[123] After a hearing, the regional director dismissed the petition based on the NLRB's holdings in *Cedars-Sinai* and *St. Clare's*.[124]

The NLRB granted requests for review submitted by both parties and subsequently overruled *Cedars-Sinai* and *St. Clare's*. The NLRB held that housestaff are employees within the meaning of NLRA section 2(3), and directed an election of all BMC physicians, including housestaff.[125] The NLRB based its decision on the language of the statute, legislative history, and experience with collective bargaining by housestaff in the public sector. It noted that section 2(3) defines "employee" very broadly and that the exclusions enumerated in the statute do not encompass students.[126] The NLRB observed that the essential elements of the relationship between housestaff and the hospital "obviously define[s] an employer-employee relationship."[127] It cited the facts that housestaff work for an employer covered by the NLRA; receive compensation for services in the form of a stipend that is subject to withholding taxes; receive fringe benefits including workers' compensation, vacations, leave time, and insurance; and spend up to eighty percent of their time engaged in direct patient care.[128] The NLRB held that the status of the housestaff as students "is not mutually exclusive of a finding that they are employees" and analogized their status to that of traditional apprentices, who have been accorded protection under the NLRA.[129]

The NLRB found further support for the application of the NLRA to housestaff in the legislative history of the 1974 Healthcare Amendments. Prior to 1974, private, nonprofit hospitals had been exempt from the definition of "employer" under the NLRA.[130] The NLRB noted that in repealing that exemption, Congress was asked to consider an amendment expressly ensuring that housestaff would not be considered "supervisors" (who are expressly exempt under section 2(11) of the NLRA).[131] The committee report, rejecting the proposed amendment, stated that the designation was unnecessary since under existing NLRB decisions the definition of supervisor did not apply to the individuals the amendment was

---

123. *Id.* at 1-2. *See also* Richard A. Knox, *BMC Residents, Interns Vote to Unionize*, B. GLOBE, Dec. 22, 1999, at B4.

124. *See Boston Med.*, 330 N.L.R.B. at 1-2.

125. *Id.* at 3.

126. *Id.* at 40.

127. *Id.* at 44.

128. *Id.* at 44-45.

129. *Boston Med.*, 330 N.L.R.B. at 45.

130. *Id.* at 52.

131. *Id.* at 52-53.

designed to protect.[132] The NLRB reasoned that the committee report reflected an assumption that housestaff were employees within the scope of the NLRA.[133] The NLRB also cited remarks from the Senate co-sponsor and floor manager of the 1974 Healthcare Amendments referring to the need to protect the notoriously underpaid and overworked housestaff.[134]

Finally, the NLRB cited its "experience and understanding of developments in labor relations in the intervening years since the [NLRB] rendered" *Cedars-Sinai* and *St. Clare's* as a basis for overruling those precedents.[135] The NLRB noted that state courts had recognized housestaff as employees under state labor laws, and that there was no indication that the negative consequences of unionization predicted by earlier opinions had actually occurred.[136] The NLRB declined to address the contours of permissible collective bargaining between housestaff and healthcare facilities, leaving it to the parties (in the first instance) to identify and confront any issues of academic freedom that might arise; then if they cannot resolve it, eventually, it will be litigated before the NLRB.[137]

The contours of permissible collective bargaining remain a matter of considerable debate following *Boston Medical Center*.[138] At the interim meeting of the AMA in December 1999, the Resident and Fellow Section approved a resolution calling on the AMA to study the effects of employee status on education, graduate medical education funding, resident finances, and the formation of housestaff organizations (IHOs).[139] AMA Chair Dr. D. Ted Lewers cautioned housestaff engaged in negotiations against overly emphasizing their employee status, to the exclusion of their academic role, because of the potential implications of such a position on expected Congressional legislation for the elimination of direct funding of graduate medical education to teaching hospitals.[140]

In addition to academic funding concerns, the implications of the decision of the NLRB on the fifty or more IHOs at the nation's four

---

132. *Id.* at 53-54.

133. *Id.*

134. *Boston Med.*, 330 N.L.R.B. at 54-55.

135. *Id.* at 59.

136. *Id.* at 61. The Board especially relied on the lack of any opposition by the AMA to unionization of housestaff, with the exception of its concern that housestaff not be granted the right to strike. *Id.*

137. *Id.* at 63.

138. *Id.*

139. Jay Greene, *Decision "Opens Door" to Unions*, AM. MED. NEWS, Dec. 20, 1999, *available at* http://www.ama-assn.org/sci-pubs/amnews/pick_99/prfb1220.htm (last visited Mar. 16, 2002).

140. *Id.*

hundred major teaching institutions has sparked some discussion. IHOs are representative organizations that enable housestaff to speak as a collective voice in addressing the issues of work hours, wages, and patient care outside of the collective bargaining context.[141] IHO members elect representatives to serve on Graduate Medical Education Committees and work with medical faculty to address housestaff concerns.[142] Prior to the decision of the NLRB, the AMA had worked with housestaff to form IHOs, and had encountered opposition within the medical academic community due to its dual role as founder and supporter of PRN.[143] That opposition increased following *Boston Medical Center* as academics and even PRN attorneys acknowledged that discussions of hospital officials with IHOs would likely be chilled for fear that such talks would be construed by the NLRB as voluntary recognition of the IHOs as unions.[144]

PRN has announced its willingness to assist those housestaff who are interested in the union model with union organizing.[145] While the organization had initially intended to gear-up slowly and to gradually build the infrastructure to compete with established organized groups, concern that housestaff should adopt the PRN organizing model, in lieu of more traditional unions such as the SEIU-affiliated Committee of Interns and Residents (CIR), has led PRN to act more quickly and to target its appeals to those housestaff actively looking to organize.[146]

Despite this initial wave of enthusiasm, since December 1999, when housestaff at BMC voted to be represented by CIR,[147] housestaff at only four other private hospitals have officially requested union representation. Housestaff at three New York City hospitals — St. Luke's-Roosevelt

---

141. Jay Greene, *Resident Organizing Gains Momentum*, AM. MED. NEWS, Aug. 9, 1999, *available at* http://www.ama-assn.org/sci-pubs/amnews/pick_99/pr120809.htm (last visited Mar. 18, 2002).

142. *Id.*

143. *Id.* (citing the AMA's pro-union stance, Montefiore Medical Center rejected the AMA's involvement on behalf of eleven hundred residents seeking to form an IHO).

144. *See id.*; Greene, *supra* note 139.

145. Jay Greene, *Residents Are Employees, NLRB Rules*, AM. MED. NEWS, Dec. 20, 1999, *available at* http://www.ama-assn.org/sci-pubs/amnews/pick_99/prfa1220.htm (last visited Mar. 16, 2002).

146. Vida Foubister, *Deans Say Residents Are Students First*, AM. MED. NEWS, Dec. 20, 1999. CIR had begun a housestaff organizing blitz even before the Board's decision was issued and has targeted its efforts on several northeast hospitals. To counter PRN's emphasis on medical ethics and professionalism, CIR maintains that it will use strikes only as a last resort, and will give sufficient advance notice to allow for safe transfer of patients or arrangements for alternate care. *See* Laura Johannes, *Medicine: Union Efforts Expected to Rise at Hospitals, NLRB Ruling on Resident Authority to Organize Worries Administrators*, WALL ST. J., Dec. 1, 1999, at B8.

147. *Boston Hospital's Union Holds Pioneering Vote*, WALL ST. J., Dec. 22, 1999, at C16.

Hospital Center in Manhattan, Our Lady of Mercy Hospital Center in the Bronx, and Brookdale University Medical Center in Brooklyn voted to join CIR.[148] PRN is seeking to represent approximately 170 residents and fellows at Lutheran General Hospital in Chicago.[149]

The Lutheran General housestaff cited the lack of a formal grievance procedure, the requirement of co-payments for health insurance, low salaries, schedule changes, and other workplace issues as motivating their decision to organize.[150] The housestaff at St. Lukes-Roosevelt and Our Lady of Mercy explained they had sought union representation because of concerns about nursing and other ancillary staff cutbacks, their desire for a voice in the delivery of patient care, and concerns about salaries, meal costs, and other economic issues.[151] In addition to its no-strike pledge, PRN has asserted that it will maintain a "strong and clear separation" between contract and academic issues,[152] while CIR has not made any public statements on this issue. In their first contract with St. Luke's-Roosevelt, the CIR housestaff seem to have avoided academic issues, focusing on wage and benefit issues, housing costs, and the creation of a Patient Care Fund for the purchase of necessary equipment, educational supplies, and other materials.[153] The other unions have not reported the successful negotiation of a contract to date and collective bargaining issues in this context remain largely unresolved.

VI. COLLECTIVE BARGAINING AS A MEANS OF ADDRESSING PATIENT CARE

The AMA attributes its unionization and legislative efforts to concerns regarding patient care, pledging to use the union model as a means of improving the quality of patient care while disclaiming concern over

---

148. Jay Greene, *PRN Files Petition for Union of Residents at Illinois Hospital*, AM. MED. NEWS, Sept. 11, 2000, *available at* http://www.ama-assn.org/sci-pubs/amnews/pick_00/prl10911.htm (last visited Mar. 19, 2002); *Doctors at Two New York Hospitals Vote in Favor of Union Representation*, HEALTH LAW REP. (BNA), vol. 10, No. 13, Mar. 29, 2001, at 513 [hereinafter *Doctors*].

149. Albert, *supra* note 1. The ballots from an election conducted in December 2000 remain impounded pending the NLRB's determination of certain challenges to the scope of the bargaining unit. Beckley, *supra* note 1; *Doctors*, *supra* note 148.

150. Greene, *supra* note 148; *Doctors*, *supra* note 148.

151. Albert, *supra* note 59.

152. Press Release, Physicians for Responsible Negotiation, PRN Offers Representation to Chicago-Area Resident Group (Aug. 16, 2000).

153. *New York Physicians Gain Right to Allocate Funds Set Aside to Improve Patient Caregiving*, COLLECTIVE BARGAINING BULL. (BNA), Aug. 9, 2001, at 91.

payments and related bread-and-butter issues.[154] Some of the patient care issues the AMA has asserted it would seek to raise at the bargaining table are:

- "gag clauses" that prevent physicians from openly discussing alternative treatments that are not considered "medically necessary";
- patient privacy issues;
- restrictive definitions of what constitutes "medically necessary" care;
- "de-selection of physicians who provide 'too much care'";
- unreasonable administrative burdens;
- requirements prohibiting physicians from selectively participating in plans;
- prohibitions on physicians refusing to take new plan participants while accepting other new patients;
- referrals to specialists;
- drug formularies that restrict physicians from prescribing certain types of medications;
- limits on lengths of hospital stay;
- payments for services; and
- patient convenience issues.[155]

With the exception of the buried references to payments and administrative burdens, and perhaps gag clauses to the extent that they might interfere with free speech rights, none of these issues would likely be considered to fall within the scope of terms and conditions of employment, and they would probably not be regarded as mandatory subjects of bargaining under the NLRA.[156] Similarly, if labor law definitions concerning the scope of bargaining were to apply to self-employed doctors collectively negotiating with health plan providers, pursuant to an exemption from the antitrust laws, the providers would not be obligated to address most of the patient care issues identified by the AMA.

Indeed, existing unions of doctors largely refer to the AMA's patient care issues as matters discussed outside the collective bargaining context,

---

154. Bruce Japsen, *Doctors Set Union Course Working Conditions, Not Money, Are Priority*, CHI. TRIB., Dec. 7, 1999, at 1.

155. *See* AMA Questions and Answers, *supra* note 79; Letter from Dr. E. Ratcliffe Anderson, Jr., to the Honorable J. Dennis Hastert (June 25, 1999), *available at* http://www.ama-assn.org/ama/basic/article/201-469-0.html (on file with author); *Egregious Contract Clauses*, AMA Antitrust Relief Literature, *available at* http://www.ama-assn.org/ama/basic/article/201-562-0.html (last visited Mar. 20, 2002); *see also* Klein, *AMA to Establish*, *supra* note 46.

156. To the extent drug formularies and definitions of "medically necessary" care pertain to reimbursement rates, they too might be mandatory subjects.

as to which the collective force of a union may have some persuasive force. For example, a summary of the collective bargaining agreements most recently negotiated by the Doctors Council list terms relating to salaries and benefits, job security, continuing medical education, malpractice reimbursement, and work hours[157] — all of which are consistent with traditional subjects of collective bargaining. In its literature supporting unionization, the National Doctors Alliance (NDA) explains that a union can negotiate wages, hours, benefits, due process protections, and other conditions of employment.[158]

To address patient care issues, the NDA claims that unions grant doctors greater access to key decisionmakers in the government and medical communities, and enable doctors to voice their concerns and provide input on issues affecting them and their patients.[159] Patients may also benefit indirectly from changes to workplace issues that negatively affect patient care, such as existing "unrealistic productivity agreements which reduce the amount of time doctors can spend with patients."[160]

Similarly, the DOJ has observed that patient care issues, identified by the AMA as the purpose for the health care professional antitrust exemption, are not matters that collective bargaining was ever intended to address. Collective bargaining generally focuses on improving the wages and working conditions of union members, but is not considered to be a means of addressing consumer safety issues.[161]

The FTC, the DOJ, and other opponents of House Bill 1304 asserted in testimony before Congress that physicians already have the legal right to jointly present information to health plan providers regarding patient care issues. However, the AMA asserts that this is inadequate because health plan providers are not required to act on the information presented.[162] But if these patient care issues are, at best, permissive subjects of bargaining,

---

157. *Summary of Collective Bargaining Agreement between Doctors Council (NDA) and St. Barnabas Hospital Affiliation at Lincoln Hospital, (1999), available at* www.ndaseiu.com/cb agreement.htm (last visited Mar. 27, 2002); *see also What's New, available at* http://www.doctorscouncil.com/articles/12-01/news.htm (last visited Mar. 27, 2002) [hereinafter *What's New*].

158. *About the National Doctors Alliance/SEIU*, (1999), *available at* http://www.ndaseiu.com/aboutndaseiu.htm (last visited Mar. 27, 2002).

159. National Doctors Alliance, *Frequently Asked Questions*, (1999), *available at* http://www.ndaseiu.com/aboutndaseiu.htm (last visited Mar. 27, 2002).

160. *Id.* Several of the most recently negotiated Doctors Council (NDA) contracts provide for the creation of "Patient Care Committees." Although these committees provide an internal forum to address patient care issues and concerns, NDA does not claim that unionization should be motivated by such concerns.

161. *What's New*, *supra* note 157; Pitofsky, *supra* note 83.

162. *See* AMA Questions and Answers, *supra* note 79.

then even under the NLRA health plan providers would not be required to act on the information presented or to address those issues in a collective bargaining agreement. In addition, the AMA's claims of inadequacy are undermined by its own increasingly active private sector advocacy efforts to empower physicians in their dealings with health plan providers outside the collective bargaining context. For example, the AMA has developed "rapid-response teams" comprised of legal and other experts who work with local medical societies to negotiate contracts with health plan providers to monitor the mandatory use of hospitalists (doctors who work exclusively for an affiliated hospital); to spearhead the AMA's efforts to draw attention to the concentration of health insurance markets, in part through development of supportive economic monopsony theories; and to work with the FTC and the DOJ to expand the situations in which negotiations with health plan providers would be deemed to fall outside antitrust scrutiny.[163]

The FTC has noted that these collective efforts operate within the strictures of existing antitrust laws and enable health care professionals to "engage in collective advocacy, both to promote the interests of their patients and to express their opinions about other issues, such as payment delays, dispute resolution procedures, and other matters."[164] The American Association of Health Plans and the Health Insurance Association of America (which have opposed an antitrust exemption) have cited a variety of devices through which doctors may negotiate collectively and strengthen their bargaining power with health plan providers, including independent practice associations, management service organizations, and provider service organizations.[165] These organizations are umbrella corporations, typically consisting of a few hundred to a few thousand self-employed doctors, that serve as middlemen in negotiating rates for treating HMO patients.[166] As noted by the Antitrust Coalition for Consumer Choice in Health Care, the FTC and the DOJ have issued Health Care Antitrust Guidelines, most recently revised in 1996 to lessen restrictions on these types of collaborative ventures.

The AMA contends that none of these devices are adequate to protect the interests of doctors. Creating operating networks or group practices can be costly and time-consuming, and the size and nature of such groups is strictly confined by the Antitrust Guidelines.[167] The AMA further claims

163. Klein, *Board Details Discomfort*, *supra* note 46.
164. Pitofsky, *supra* note 83.
165. Testimony for H.R. 1304 cited in correspondence with E. Fite.
166. Abate, *supra* note 8.
167. Anderson, *supra* note 79.

that the Antitrust Guidelines are not entirely clear in defining the appropriate level of integration; insurance companies can and do seize on these ambiguities to threaten doctors with antitrust litigation, thus undercutting their leverage.[168] The imperfect nature of these alternatives does not appear to warrant the radical remedy of an antitrust exemption as urged by the AMA. Nor is unionization necessary for doctors who are employees wishing to advocate collectively on behalf of the interests of their patients, as such conduct, within certain strictures, is fully protected by the NLRA.[169]

Ultimately, then, the rallying cry for patient care by the AMA and the PRN seems to be a public relations device designed to win support for unionization among those at the AMA who have historically opposed unionization and with the general public, and is unlikely to bear much fruit at the bargaining table. Indeed, it appears that the DOJ and the FTC are rightly concerned with the implications of an antitrust exemption, and that the AMA's sudden support for collective bargaining is really a device to increase physicians' salaries at the expense of the general public.

VII. CONCLUSION

The collective bargaining model of labor negotiations has made significant inroads within the medical community. In addition to its traditional use for employer-employee negotiations (now expanded to include housestaff), collective bargaining is now being touted as the panacea for the ills of managed care. However, freed of the protections and controls of federal labor law and the constraints of antitrust law, collective bargaining appears most likely to benefit doctors financially. Aside from hollow promises and empty rhetoric, there is little that government, health plan providers, or private citizens can do to ensure that collective bargaining focuses on patient care issues, thereby rendering the passage of an antitrust exemption a very risky proposition.

---

168. *Id.*

169. *See* Eastex, Inc. v. N.L.R.B., 437 U.S. 556, 564-66 (1978). NLRA protects collective activity bearing some nexus to the interests of employers as employees; *see also* N.L.R.B. v. Int'l Bhd. of Elec. Workers, 346 U.S. 464, 477 (1953) (finding that indefensible disloyalty to employer is not protected by NLRA).