



# Physician Unionization: White Coats with Blue Collars?

*Lisa M. Nijm*  
*Bryan A. Liang, MD, PhD, JD*

**T**he impact of recent changes in the health care industry has not been equaled during the past century. Traditional fee-for-service plans, generally characterized by physician autonomy and patient control over care, have largely been displaced by health maintenance organizations (HMOs) and other managed care organizations, which exercise substantive control over patient care and the decision-making process.<sup>1</sup> This displacement of the decision-making hierarchy in health care has caused a significant amount of discontent within the medical community. As a result, a growing number of physicians are turning to unionization both as a way to increase bargaining power and as a method to reassert their role in the medical decision-making process.

## UNIONS AND PHYSICIANS

Unions typically have been used as a vehicle to facilitate the resolution of labor disputes between employers and employees. They were first established to offset the imbalance of economic power between labor and management within society. In fact, most unions primarily operate as a collective bargaining unit on behalf of their members in negotiations with employers on matters relating to wages, hours, terms and conditions of employment, and other important labor issues.<sup>2</sup>

Physician unions are not a new phenomenon. Several unions, such as the Union of American Physicians and Dentists, were first organized in 1974 in response to specific crises, namely large increases in the number and monetary amounts of malpractice claims, more stringent government regulations, and the possibility of national health insurance.<sup>3</sup> Yet, given the limitations on physician unions imposed by antitrust and labor laws, as the urgency of each of these specific crises subsided, union membership dramatically decreased.<sup>4</sup> By 1987, fewer than 50,000 of the nation's more than 650,000 physicians and dentists belonged to the relatively small number of physician unions in the United States.<sup>2</sup> With the infiltration of managed care into the core of the health system,

however, there has been a resurgence of the unionization movement, with an ever-increasing number of physicians now seeking to join unions.

## LAWS REGULATING PHYSICIAN UNIONIZATION

The ability of physician unions to represent their members in negotiations with managed care organizations is governed by federal antitrust and labor laws. Antitrust laws seek to safeguard competition by prohibiting agreements that unreasonably restrict trade or limit competition.<sup>1</sup> Labor laws, on the other hand, create an exemption to antitrust law that allows labor organizations, such as unions, to represent their members through collective bargaining.<sup>1</sup> With respect to physicians, these laws prevent self-employed doctors who are not part of a group practice from agreeing to fix prices or partition segments of the market among themselves. The penalties for violation of these laws range from substantial fines to, in some cases, prison sentences.<sup>1</sup> Major antitrust and labor law principles relating to unions are reviewed below.

### Antitrust Laws

Antitrust laws are based on the notion that true competition in the marketplace will generate improved products and more advanced services at lower prices.<sup>5</sup> The underlying theory is that businesses will likely make modifications or improvements in their products, services, and prices in order to successfully compete with their rivals.<sup>4</sup> Antitrust laws are therefore designed to protect competition by preventing the formation of

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*Ms. Nijm is a third-year MD/JD candidate, Southern Illinois University School of Law and School of Medicine, Carbondale, IL. Dr. Liang is the Arthur W. Grayson Distinguished Professor of Law & Medicine, Southern Illinois University School of Law and School of Medicine, Carbondale, IL; Research Council Faculty Fellow, Instituut voor Sociaal Recht, Katholieke Universiteit, Leuven, Belgium; and a member of the Hospital Physician Editorial Board. Dr. Liang is supported by Katholieke Universiteit Leuven Grant No. F/98/084.*

monopolies or agreements that would inhibit this type of beneficial development in the marketplace.<sup>4</sup>

Typical antitrust issues that arise in health care include the following concerns: (1) price-fixing among competitors, and (2) group boycotts of third-party payers. Regarding the first issue, courts have consistently ruled under antitrust laws that price-fixing is, per se, illegal.<sup>6</sup> Indeed, the justification behind price-fixing is irrelevant.<sup>5</sup> For example, in Arizona, almost 50 dentists collaborated and designed a new fee schedule when an insurance company's reimbursement fees for certain services were less than the cost of those procedures.<sup>5</sup> The dentists simultaneously introduced their new fee schedule to the insurance company with a warning that if the schedule was not accepted, they would refuse to work with the payer. The federal government learned of this "conspiracy" and brought suit to enjoin the dentists from proceeding with any further action. Three of the dentists, who were instrumental in arranging the meetings at which the new fee schedule was established, received criminal convictions for price-fixing, which were upheld on appeal.<sup>5</sup>

The second issue involving group boycotts of third-party payers would come into play if, instead of agreeing on a fixed price, competing physicians were to join together to pressure a third-party payer to set its price at an amount that is acceptable to the physicians; they then jointly would refuse to deal with the payer unless it set its price at that amount. Activity of this kind also is prohibited under antitrust laws, as illustrated by the following case. The US Supreme Court ruled that a dental organization's policy requiring its member dentists to refuse to comply with insurance companies' requirements regarding submission of patient dental radiographs with claim forms was an "unreasonable restraint on trade."<sup>7</sup> The court noted that even showing that the submission of the radiographs did not accomplish its intended purpose was insufficient reason to justify withholding the information from the insurance company and, thus, was a violation of antitrust laws.<sup>6</sup>

Physicians who support unionization efforts have taken several different approaches in their efforts to circumvent these antitrust prohibitions. For example, some self-employed physicians have attempted to work within the limitations of current antitrust law by following a messenger model system endorsed by the Federal Trade Commission and the Department of Justice.<sup>5,8</sup> Under this model, an independent agent, known as a "messenger," corresponds with the third-party payer and then corresponds with the physician separately. The messenger is forbidden from bargaining or making any decisions on behalf of the physician. Furthermore, the

messenger may only relay information between the 2 parties and inform the third-party payer of the average standard fee of the physician for the services and procedures in question. However, the thin line between legal and illegal activity in these situations is difficult to determine, and physicians who engage in such actions might be risking prosecution. In fact, the Department of Justice is currently investigating at least 4 messenger models set up by independent practice associations across the country for potential antitrust violations.<sup>9</sup>

### **Labor Laws**

The predominant legislation regulating the association between employers and employees, including unionization and collective bargaining activities, is the National Labor Relations Act (NLRA) of 1935.<sup>2,10</sup> The federal agency responsible for creating, implementing, and adjudicating labor issues arising under the NLRA is the National Labor Relations Board (NLRB).<sup>9</sup> The Act requires employers and union representatives to engage in fair and open negotiations in order to reach agreements that end labor disputes and stabilize the working relationship.<sup>1</sup>

The NLRA contains several provisions focused specifically on health care organizations.<sup>9</sup> For example, the time period for notification of modification or termination of collective bargaining agreements for health care organizations is increased from the customary 60 days to 90 days prior to expiration of the contract. In addition, the parties are required to advise the Federal Mediation and Conciliation Service as well as any similar state agency within 30 days of any proposed action. The NLRA also forbids a health care labor organization from "striking or picketing a health care institution unless it provides a 10-day written notice, indicating the day and time of strike."<sup>9</sup>

According to the NLRA, only employees are permitted to unionize and collectively bargain on price.<sup>2</sup> To qualify as an employee, one must be working for another individual. The Act specifically states that independent contractors and supervisory personnel are excluded from the definition of an employee,<sup>1</sup> even though commentators have noted the significant control managed care organizations appear to exert over physician activities.

### **RECENT DEVELOPMENTS**

Because of the rules set forth by the NLRA, the vast majority of physicians cannot unionize or collectively bargain on price because they are self-employed and thus classified as independent contractors.<sup>2,4</sup> The Department of Justice and the Federal Trade Commission guidelines

allow joint negotiations only among physicians who "have sufficiently integrated their practices such that they are no longer viewed strictly as competitors for this purpose."<sup>2</sup> Therefore, independent, self-employed physicians are generally not considered employees for the purposes of the National Labor Relations Act or for the labor exemption to the antitrust laws.<sup>4</sup>

The following example illustrates this point. Several hundred private primary care and specialty physicians petitioned the NLRB for the right to have the United Food and Commercial Workers Local 56 represent them in collective bargaining negotiations with AmeriHealth–New Jersey HMO (AmeriHealth).<sup>11</sup> The union argued that, based on AmeriHealth's control over the day-to-day operations of the medical practices, the physicians were not independent contractors but rather de facto employees. The NLRB applied the common law agency test for distinguishing between employees and independent contractors and, focusing on the extent of control exerted by the HMO, ruled against the union and physicians seeking union representation.

Whereas the NLRB acknowledged that AmeriHealth has the ability to control many details of the services physicians perform by specific contract provisions, it emphasized that AmeriHealth did not have considerable control or supervision "with respect to the physical conduct in the [physician's] performances of the services."<sup>11</sup> Specifically, the decision noted that AmeriHealth conducted only relatively few site visits and had no guidelines that attempted either to supervise the manner in which physicians or staff performed procedures or to define standards of care. Moreover, the NLRB stressed that "physicians retain the unfettered right to decide matters as basic as whether they will be sole practitioners or enter into a group practice and whether to become affiliated with 1 or more HMOs."<sup>11</sup> The decision recognized that AmeriHealth's market share of insured patients was only 10% and that almost all of the physicians also had contracted with other insurance companies, including competing HMOs.

However, in late November 1999, the NLRB made a crucial decision that might further the physician unionization effort. In a landmark case, which overturned precedent lasting more than 2 decades, the NLRB ruled that residents, interns, and fellows (ie, house staff) are employees within the definition of the NLRA.<sup>12</sup> Previously, these individuals were considered primarily students and, as such, were not allowed to unionize or collectively bargain.

The NLRB ruled that house staff are encompassed in the broad definition of employee under the NLRA

despite the fact that "a purpose of their being at a hospital may also be, in part, educational."<sup>12</sup> The NLRB examined the nature of the house staff's relationship with the hospital and concluded that all the elements present indicated they were employees of the hospital. The house staff not only worked for an employer (the hospital) but received compensation (including benefits) much like any other employee would, provided patient care for the hospital, and did not pay tuition or fees as traditional students do. This NLRB decision has opened the door to allowing approximately 110,000 physicians nationally to obtain union representation.<sup>13</sup>

Interns and residents at Boston Medical Center were the first physicians to take advantage of this ruling. In late December 1999, by a vote of 177 to 1, the house staff opted for union representation by the House Officers Association.<sup>14</sup> This new bargaining unit became the "first organization recognized by the board as a bargaining representative for interns and residents."<sup>13</sup> Since then, several groups of physicians have organized and received recognition from the NLRB, including a 21-physician unit at Philadelphia's John F. Kennedy Memorial Hospital, a unit of 23 emergency department physicians in Texas, a unit of 40 physicians employed by a Detroit-based HMO, and a group of physicians and dentists at New York Medical College's Metropolitan Hospital.<sup>15</sup>

#### **AMERICAN MEDICAL ASSOCIATION EFFORTS TOWARD UNIONIZATION**

Recognizing the issue of collective bargaining for physicians as a top priority for 2001,<sup>16</sup> the American Medical Association (AMA) also has taken action to further the unionization effort. In response to an outcry from its members to lead the charge for unionization in the 21st century, the AMA funded the creation of the Physicians for Responsible Negotiation (PRN).<sup>17</sup> PRN is a separate entity from the medical association, despite the fact that it is located at AMA headquarters in Chicago and received its initial start-up loan of \$1.2 million from the AMA. The AMA House of Delegates established the organization in response to requests by physician groups to level the playing field with managed care organizations.

PRN's goal is to represent physicians ethically and responsibly.<sup>14</sup> As such, PRN insists that "strikes or withholding of necessary services would never be undertaken as a negotiation tactic."<sup>14</sup> PRN also varies from traditional unions in several other ways. First, the organization offers physicians more of a self-directed organizational structure.<sup>14</sup> Interested physicians receive a

20-page constitution and additional assistance from an external source should they wish to form a collective bargaining unit in their own locale.<sup>14</sup>

Additionally, PRN has recently begun an initiative to affiliate with state and local societies.<sup>18</sup> PRN executives believe that participation by these societies will assist PRN in finding the groups of physicians needing the organization's help. These affiliates also have the ability to provide assistance in the administrative process, thus potentially curtailing grievances at the local level.<sup>18</sup>

Furthermore, PRN has been successful in its initial efforts to obtain bargaining unit status for employed physicians in managed care plans.<sup>17</sup> For example, PRN organized collective bargaining units for a group of 40 physicians employed by a Detroit-based HMO in March 2000 and for a group of physicians employed by Concentra Managed Care, Inc in 10 New Jersey clinics in August 2000.<sup>19</sup> PRN also has been attempting to assist more than 170 residents of Lutheran General Hospital in Park Ridge, IL, to organize after residents approached a union with several concerns, such as the absence of a formal grievance process and "eroding conditions" in their work environment.<sup>20</sup> NLRB-monitored elections were held in early November 2000. However, the ballots have been impounded pending a decision from the NLRB on whether "rotating" residents at the hospital would be allowed to vote.<sup>20</sup>

#### **LEGISLATIVE EFFORTS**

The AMA, together with the National Community Pharmacists Association, also has expressed strong support for legislation that would exempt self-employed physicians from current antitrust laws.<sup>16</sup> The first step toward accomplishing this objective occurred in June of 2000 when then-Governor George W. Bush signed legislation (SB 1468) allowing physicians in Texas to bargain collectively with health plans under an antitrust exemption.<sup>21</sup> The process is supervised by the Texas attorney general, who has the power to grant permission to parties to initiate negotiations as well as the power to approve or disapprove the resulting agreement.

The groundbreaking Texas law restricts the size of a bargaining group to no more than 10% of the licensed physicians in a specific area. Moreover, physicians are able to collectively bargain only with those insurance companies who have a substantial influence on the market. Consistent with the AMA ethical standards, physicians are not permitted under the new law to strike or boycott. To date, more than 18 states have introduced similar legislation regarding collective bargaining and antitrust exemptions for physicians. In most of the states, these legislative efforts have been

unsuccessful. However, legislation is still pending in the District of Columbia, Illinois, Michigan, New Jersey, Pennsylvania, and Rhode Island.<sup>22</sup>

On the federal level, legislation allowing physicians to collectively bargain with insurance companies passed in the House of Representatives but was never introduced in the Senate. The Quality Health Care Coalition Act of 1999 (HR 1304), which would have provided a 3-year waiver of current antitrust laws for physicians, passed the House in June 2000 by a greater than 2-to-1 margin.<sup>23</sup> However, in the face of strong opposition from the Department of Justice, the Federal Trade Commission, and a large coalition of health insurers and businesses, no companion legislation was ever introduced in the Senate.<sup>24</sup> The opposing groups testified that such legislation would "open the door to price-fixing and boycotts"<sup>25</sup> and argued that the bill would greatly increase total spending on health care in the United States.<sup>26</sup>

Although no legislation has been reintroduced to date on the federal level, Rep. Bob Barr (Republican, Georgia) recently announced that he is designing "a strategy for Congress to pass legislation allowing independent health care professionals to negotiate collectively with health insurers."<sup>27</sup> In addition, the AMA has reported working with Sen. Orrin Hatch (Republican, Utah), chairman of the Senate Judiciary Committee, on "the general principles of the necessity to provide antitrust relief."<sup>16</sup>

#### **CONCLUSION**

With the recent changes in the health care system and the move towards managed care, an increasing number of physicians are turning toward unions. The ability of physician unions to form and advocate on behalf of their members is largely limited by federal antitrust and labor laws. Under these laws, a vast majority of physicians cannot unionize because they are classified as self-employed, independent contractors.

However, current developments in law and politics may soon change that. A landmark NLRB decision, overturning 23 years of precedent, has provided an opportunity for more than 100,000 interns and residents to unionize. Furthermore, the groundbreaking Texas law not only has allowed self-employed physicians in Texas to collectively bargain but has also served as a model statute for other states and may serve as a template for future action by the federal government. Finally, even though the Quality Health Care Coalition Act of 1999 did not pass both houses, strong support for unionization from organizations such as the AMA will continue. Thus, with physicians continuing to perceive

managed care as an encroachment on medical decision-making, it is quite possible that physicians in the near future will be wearing a white coat with a blue collar. **HP**

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