Physician Unions and Organized Medicine

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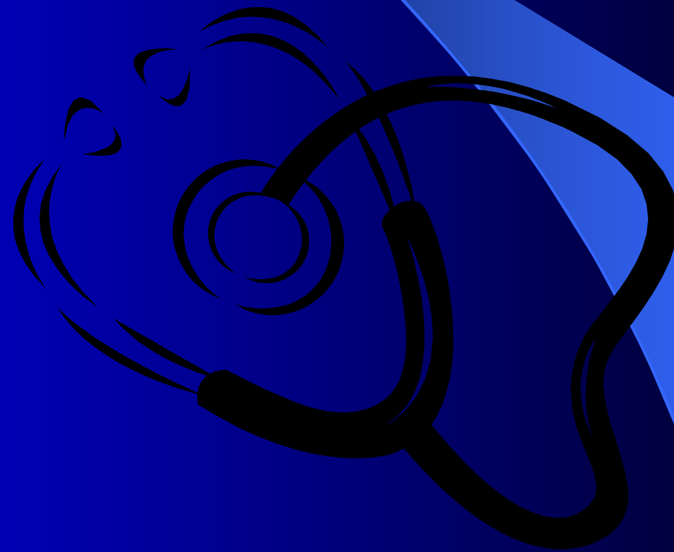
Literature Review

- Grace Budrys. 1997. *When Doctors Join Unions*. Ithaca: Cornell University Press.
- Eliot Freidson. 2001. *Professionalism: The Third Logic*. Chicago: University of Chicago Press.
- Clark Havighurst. 1978. Professional Restraints on Innovation in Health Care Financing. *Duke Law Journal* 303 – 387.
- Carl F. Ameringer. 2002. Federal Antitrust Policy and Physician Discontent: Defining Moments in the Struggle for Congressional Relief. *Journal of Health Politics, Policy and Law* 27(4):543-574.

Physician Unions

- What explains their appearance?
- What have been the barriers to their success?
- What does the future hold?



What Explains their Appearance?

- Economic, social, and organizational disruptions of a post-industrial society
    - manufacturing to a service economy
        - large units of production
    - technological innovation
    - division of labor
    - vigorous competition and profitability
- Ideological shift from regulation to deregulation
- Perceived failure of organized medicine to respond adequately to the situation

Three waves (Budrys)

- **Early 1970s:** response to government legislation expanding access to care and subsequent efforts at cost containment
- **1983-1984:** response to perceived crisis in medical malpractice
- **Current wave:** response to managed care

Perceived failure of organized medicine: typical complaints

- Conservative hierarchy
- Cumbersome procedures and committee structure making it difficult to take quick and decisive action
- Professional associations not structured for collective bargaining –other goals and missions

Perceived failure of organized medicine: broader context

- Collective bargaining did not originate with unions
- Havighurst: "The underlying reason why negotiations between insurers and professional organizations have occurred…is the implicit threat of boycott or related difficulty facing any plan that departed from accepted practice without first securing professional approval." *Duke Law Journal* 1978:381.

Perceived failure of organized medicine: broader context

- Appearance of physician unions in early 1970s was contemporaneous with appearance of foundations for medical care (FMCs)
  - FMCs were sponsored by state and local medical societies
  - Purpose was to protect fee-for-service medicine and deter HMOs from gaining a foothold
  - There were 112 FMCs in or near operation in 1972 with 87,664 participating physicians
  - Principal opposition within medicine came from a relatively small number of physicians who viewed FMCs as bureaucratic and a threat to traditional medical ethics

Barriers to union formation

- Organized medicine
  - Unions a threat to professional unity and antithetical to professional values of individualism and autonomy
  - AMA's formal pronouncement against physician unions occurred in 1973 and was repeated on several occasions until it apparently reversed course in 1999

Barriers to Union Formation

- Professional norms and values
  - Individualism and autonomy
  - Socialization process
  - Union involvement as undignified
  - Opposed to strikes or any disruptions to patient care

Barriers to Union Formation

- Budrys: "The identity long associated with American unions, which is grounded in industrial unionism—organizing by firm, calling for working class solidarity, and restricting individual opportunity in preference for collective security—clearly holds no appeal for physicians."

Barriers to Union Formation

- Legal barriers to collective bargaining (but not to joining unions)
  - Must be employees not independent contractors
    - NLRB: physicians having multiple contracts with HMOs do not satisfy the “right to control” test
    - Antitrust exemption so that independent practitioners can bargain collectively –Campbell bill
  - Cannot be managers
    - Physicians cannot exercise a great degree of control over conditions of work and participate to a considerable extent in organizational policymaking

Barriers to Union Formation

- Legal barriers to collective bargaining (but not to joining unions) (continued)
  - Cannot be supervisors
    - NLRB v. *Kentucky River Community Care, Inc.*, 532 U.S. 706 (2001) (professional employees who use "independent judgment" to direct other employees may be supervisors)
    - Two subsequent regional director decisions of the NLRB have ruled in favor of physicians seeking the right to bargain collectively

Barriers to union formation

- The number of physicians who can engage in collective bargaining is relatively small
  - AMA estimates (1998 data)
    - 325,000 physicians are self-employed
    - 27,000 are supervisors
    - excluding residents and employees of physician-owned groups, the AMA estimated that about 108,000 or 17% of allopathic patient–care physicians could join AMA bargaining group (about one-third of these were academic physicians mostly opposed to union formation)

Barriers to union formation

- Resistance of corporate employers
  - Will use every available means to oppose, including litigation
  - Will discourage physicians from joining
  - Organizing drives can take up to three years and the amount of money involved can be substantial

What does the future hold?

Potential Upside

- Weaker resistance from organized medicine
  - Formation of PRN (Physicians for Responsible Negotiation)
  - Tends to undercut previous arguments opposing union formation based on notions of professionalism
  - AMA Board of Trustees stopped loaning funds to PRN after *Kentucky River* (funding has since been restored), but PRN has a relatively small number of sustaining members
  - Membership in the AMA, as a percentage share of the physician population, continues to decline

What does the future hold?

Potential Upside

- Professional norms and values have been slowly adjusting to the corporate environment, particularly among younger physicians who tend to be more sophisticated in business–related matters
- Trend toward more salaried physicians which some have put at 80% of those in practice five years or less
- Perceived monopsony power of health plans and insurers, the belief that there is an “uneven playing field” and the quest for countervailing power

What does the future hold

Potential Downside

- Future court rulings (on the status of physician supervisors, for example) and the unlikelihood of significant legislation affecting collective bargaining
- Trend toward self-funded employers and direct contracting with physician networks
- Employed physicians tend to be more comfortable with managed care than self-employed physicians
- Patients' bill of rights regulates the terms of managed care contracts in many instances
  - State legislation
  - *Kentucky Association of Health Plans v. Miller* (2003) (ERISA does not preempt any-willing-provider laws)

END