

1999

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Recommended Citation

Ellen L. Luepke *White Coat, Blue Collar: Physician Unionization and Managed Care*, 8 *Annals Health L.* 275 (1999).
Available at: <http://lawcommons.luc.edu/annals/vol8/iss1/11>

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White Coat, Blue Collar: Physician Unionization and Managed Care

*Ellen L. Luepke**

INTRODUCTION

Medicine in modern America has changed and continues to change. Gone are the days of traditional medicine, when consumers received health care services paid on a fee-for-service basis by their employers or private health insurance. In the days of fee-for-service, physicians and patients controlled health care decisions and insurers, for the most part, simply acted as payers. Times have changed. Today's health care marketplace is dominated by various permutations of managed care, under which insurers and other payers exercise increasing amounts of control over medical care.¹ The impact of managed care on the changing methods of health care delivery in the United States cannot be understated. In 1995, more than 120 million Americans were enrolled in some type of managed care health plan,² and eighty-five percent of American physicians had a contract with at least

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1. See generally *American Medical Association-Principles of Managed Care* (1998) <<http://www.ama-assn.org/advocacy/principl.htm>> (visited Nov. 14, 1998) (defining managed care as "processes and techniques used by any entity that delivers, administers, and/or assumes risk for health services in order to control or influence the quality, accessibility, utilization, costs and prices, or outcomes of such services provided to a defined population"); see also PETER R. KONGSTVEDT, *Glossary of Terms*, in *ESSENTIALS OF MANAGED HEALTH CARE* 548 (Kongstvedt ed.) (2d ed. 1997) (defining managed care as "a system of health care delivery that tries to manage the cost of health care, the quality of that health care, and access to that care. Common denominators include a panel of contracted providers that is less than the entire universe of available providers, some type of limitations over benefits to subscribers who use non-contracted providers (unless authorized to do so), and some type of authorization system").

2. See Carol J. Simon et al., *The Impact of Managed Care on the Physician Marketplace*, 112 *PUB. HEALTH REP.* 222, 222 (1997). This estimate includes individuals enrolled in health maintenance organizations ("HMOs") and preferred provider organizations ("PPOs").

one managed care plan.³ The increasing influx of managed care into the health care marketplace has profoundly affected the way Americans receive and pay for care. A necessary corollary is that managed care consequently affects the way physicians practice medicine. Whereas medical decisions were once an issue for physician and patient only, the managed care model inserts insurers as an intermediary into medical decision making and the practice of medicine.⁴

Although managed care exists under various structures and organizational models, a few key commonalities predominate. Managed care organizations (“MCOs”)⁵ attempt to achieve economic efficiencies by providing financial incentives for health care providers and implementing case control management and utilization review.⁶ The introduction of these cost-saving techniques has been termed the “corporatization” of medicine through which the corporations conduct careful documentation and review of physician activities and medical outcomes. Some commentators claim the use of managed care cost containment mechanisms gives managed care corporations, rather than individual patients or physicians, predominant influence over health care decisions.⁷ The utilization management process guides a patient’s course of care at all stages of health care decision making, from dictating the scope of covered services and prescribing standardized (and usually limited) lengths of hospital stay for certain procedures, to restricting or controlling a physician’s ability to refer to specialists or authorize medical tests.⁸ MCOs conduct utilization management at all stages of a patient’s health care, including precertification of procedures, concurrent

3. See David Segal, *Doctors Who Dodge a Managed Care Stampede; Fewer Physicians Find They Are Able to Maintain Their Own Fee-for-Service Practices*, WASH. POST, May 20, 1996, at F5.

4. See Simon, et al., *supra* note 2, at 222.

5. This Article will use the term “Managed Care Organization” as a general term describing any type of managed care. For a broad discussion of different types of MCOs and an explanation of their structure and differentiating characteristics, see generally KONGSTVEDT, *supra* note 1; James P. Freiburg, *The ABCs of MCOs: An Overview of Managed Care Organizations*, 81 ILL. B. J. 584 (1993).

6. See PETER D. FOX, *An Overview of Managed Care*, in ESSENTIALS OF MANAGED CARE 4 (Kongstvedt ed.) (2d ed. 1997). Other managed care objectives include promotion of wellness, early diagnosis of disease, patient education, and promotion of self-care. See *id.*

7. See *id.*

8. See John P. Little, *Managed Care Contracts of Adhesion: Terminating the Doctor-Patient Relationship and Endangering Patient Health*, 49 RUTGERS L. REV. 1397, 1407-08 (1997) (citing THOMAS S. BODENHEIMER & KEVIN GRUMBACH, UNDERSTANDING HEALTH POLICY: A CLINICAL APPROACH 42 (1995)).

review while a patient is hospitalized, and finally, retrospective claims review following the course of care.⁹ In addition, MCOs often amass utilization review data to create individual practice profiles of physicians. Managed care organizations use these physician profiles to influence contracting and staffing decisions and as reference in physician credentialing.¹⁰

Many physicians view utilization management and review as MCOs wielding oppressive power over physician decision making at the expense of the physician-patient relationship.¹¹ Often, administrative backlog and complex procedural requirements can delay medical procedures. Additionally, utilization management and review may be conducted by non-physicians, leading one physician to claim, "health care decisions are being dictated by a 'cookbook class' of accountants."¹² The effect of managed care has, at the very least, affected physicians' autonomy over decision making and style of practice.¹³ The most radical physician-based opposition to this trend argues that managed care organizations have taken over health care, destroyed the physician-patient relationship and decreased quality of care, all for the purpose of realizing corporate profits.¹⁴

Physicians have reacted to the changes in medicine brought about by MCOs in various ways. There is a rising degree of unrest among both employed and independent physicians who are banding together to form an organized response to what they perceive as coercive practices by MCOs. This response is taking shape in many forms, from organized medical society advocacy, political lobbying and physician-owned Independent Practice Associations ("IPAs"), to physician unions and collective bargaining units. Of these responses, a growing number of physicians have begun to see formal unionization as a valid and effective response to managed care. Recent success by physician groups around the nation in organizing and forming unions

9. For an in-depth review of utilization management in the managed care context, see generally Peter R. KONGSTVEDT, *Managing Basic Medical-Surgical Utilization*, in *ESSENTIALS OF MANAGED HEALTH CARE* 199-224 (Kongstvedt ed.) (2d ed. 1997).

10. See BARRY R. FURROW, ET AL., *HEALTH LAW* 469-80 (3d ed. 1997).

11. See Robert L. Weinmann, *Afraid to Join a Union?*, <http://www.uapd.com/why_bob.htm> (visited Nov. 14, 1998).

12. See Joyce Riffer, *Physician Unions Fight Loss of Control*, 60 *HOSPITALS* 82, 82 (Jan. 20, 1986) (quoting Sanford Marcus, M.D., former president of the Union of American Physicians and Dentists).

13. See John K. Iglehart, *Health Policy Report - The American Health Care System - Managed Care*, 327 *NEW ENGL. J. MED.* 742, 743 (1992).

14. See Weinmann, *supra* note 11.

presents an innovative and powerful tool to give physicians bargaining power with MCOs. Additionally, this success may provide a needed return to physician and patient control over medical decision making.

This Article outlines and explains physicians' attempts to form labor unions in order to confront what they perceive as coercive practices by MCOs. Part I provides a general history of the rise of physician unions and the reasons for their appearance. It also provides an evaluation of the recent successes and failures of a few physician union initiatives to collectively bargain and pursue other methods of advocacy. Part II provides a legal analysis of the barriers to collective bargaining faced by employed and independent physicians. These legal hurdles involve issues from antitrust and labor law. Part III presents an analysis of the response of organized medicine, particularly the American Medical Association and various state and local medical societies, to the efforts of physicians to initiate collective bargaining with MCOs.

I. THE RISE OF THE PHYSICIAN UNION MOVEMENT IN THE UNITED STATES

A. *Physician Unions Emerge and Wane in the 1970s.*

Physicians seem an unlikely population for unionization. As a group, they are highly educated, generally conservative and bound by a sense of professionalism¹⁵ and a strict ethical code. Unlike traditional unionists such as machinists or factory workers, physicians have long held a position of power, even reverence, in American society. In the past, physicians held almost complete control over the physician-patient relationship, and there was an overriding sense of paternalism in medical decision making.¹⁶ Put simply, physicians recommended treatment, pa-

15. For an in-depth discussion of the rise and fall of medical professionalism in the United States, see GRACE BUDRYS, *WHEN DOCTORS JOIN UNIONS* 32-38 (1997) (pointing to several factors that may have influenced the professional image of physicians, most notably that they gained monopoly over medical knowledge and successfully convinced the public that "medical professionalism was socially desirable").

16. See PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 1-29 (1985) (providing an in-depth discussion of the sociological reasons for physicians' professionalism through social authority and cultural control). Starr argues that physicians historically have used their status as professionals to legitimate their authority, gain a monopoly over medical knowledge, and "achieve solidarity among practitioners." See *id.* at 15. Furthermore, he argues that physicians' authority remains because it has been "institutionalized in a system of standardized education and licensing." See *id.* at 19. See also FURROW ET AL., *supra* note 10, at 454-74.

tients accepted it, and indemnity insurance plans paid the bills. This long-standing, well-defined process changed, beginning with the social upheavals of the 1960s and 1970s. During this period, medicine was among the many social institutions that experienced a decreasing level of public confidence and a corresponding loss of control, autonomy and decision-making power.¹⁷

The nation's oldest and largest physician union was borne out of physician frustration and anger at declining autonomy, decision-making authority and salaries during the early 1970s. The California-based Union of American Physicians and Dentists ("UAPD") was formed in 1972 and headed by Dr. Sanford Marcus.¹⁸ The Union's charter provides valuable insight as to the forces behind its formation and purpose:

We physicians and dentists, in order to provide optimum medical care for people; to insure quality facilities for the provisions of medical care; to enable doctors to give of themselves, unhindered by extraneous forces, for the welfare of their patients; to insure reasonable compensation for doctors commensurate with their training, skill and the responsibility they bear for the life and health of their fellow beings; do establish this Union.¹⁹

During the early to mid-1970s, physician unions experienced a boom in membership, with 16,000 physician members represented by twenty-six unions in 1975.²⁰ Most of the early unions were formed in response to specific actions by hospital administrators or insurers, including perceived unfairness in contracting and control, the influx of managed care and utilization review procedures that physicians found unacceptable.²¹ A poignant example of the discontent firing the early physician unionization movement can be seen in a piece of promotional material produced by the now-defunct Illinois Physicians Union, which was formed in 1973.²² "Professional freedom is rapidly disappearing. Dignity, prestige and respect which are the symbols of medical professionalism have been eroded by insurance carriers and

17. See BUDRYS, *supra* note 15, at 40-41.

18. See *id.* at 8-9.

19. *Id.* at 9 (quoting The Union of American Physicians and Dentists preamble).

20. See *id.* at 11 (citing Mario Bognanno et al., *Physicians' and Dentists' Bargaining Organizations: A Preliminary Look*, 98 MONTHLY LAB. R. 33-35 (1975)).

21. See *id.* at 11-12. The issues spawning collective action included restraints on how physicians spent their time, peer review, and utilization management procedures, as well as contracting issues and the rise of managed care. See *id.*

22. See *id.* at 12-13 (quoting Dr. George Lagorio).

governmental agencies desiring to gain control of medical practice, as well as the biased anti-physician diatribe of the press.”²³

Out of the twenty-six unions in existence at the time of the 1975 study, only two remain, the UAPD and the Doctor’s Council of New York.²⁴ In her book, *When Doctors Join Unions*, Grace Budrys attributes the initial failure of the unions in the 1970s to the perceived tension between medical professionalism and the methodologies typically used by unions, including boycotts and strikes.²⁵ Budrys also cites differences in opinion about the types of problems the new unions should address as well as the methods for resolving these issues.²⁶ As Budrys notes, physicians during that time formed and joined unions in response to specific crises; once the crisis was over, the unions tended to disband.²⁷ Furthermore, early physician unions, much like their modern-day predecessors, were significantly limited by federal and state antitrust and labor law.²⁸

B. *Physician Union Activities in the 1980s and 1990s*

The steadily increasing infiltration of managed care has piqued physicians’ interest once again in collective bargaining carried out by physician union organizations. The UAPD has remained a force as the oldest and most established physician union. Budrys attributes the UAPD’s strength and staying power to the personal efforts of former president and founder Dr. Sanford Marcus, a dedicated leader who hatched the idea to form a physician union, actively recruited members and implemented a formal structure that transformed it from a social movement to a structured, firmly established and recognized union organization.²⁹

The American Medical Association (“AMA”) estimates that 14,000 to 20,000 of America’s approximately 700,000 physicians belong to unions.³⁰ Half of those union members are residents

23. *Id.*

24. *See id.* at 16-17.

25. *See id.* at 17.

26. *See id.* at 58.

27. *See id.* (noting that the unions that did survive — the UAPD and the Doctor’s Council — had influential and dedicated leadership). Another failed union, the Illinois Physicians Union, lasted only as long as its leader, Dr. Lagorio, was willing to maintain it.

28. *See infra* notes 42-55 and accompanying text.

29. *See* BUDRYS, *supra* note 15, at 56.

30. *See CMA Takes ‘Bold’ Step by Proposing Guild Development* [hereinafter “CMA”], MED. IND. TODAY, Feb. 19, 1998.

or interns.³¹ The UAPD currently boasts a membership of 5,000, ninety percent of whom are in California.³² The UAPD recently affiliated with the American Federation of State, County, and Municipal Employees, (“AFSCME”) in order to “reduc[e] the corrosive influence of health management executives over the practice of medicine in the United States.”³³ Prior to the affiliation, the AFSCME provided representation to over 350,000 healthcare workers, including 3,000 physicians.³⁴

The Florida-based Federation of Physicians and Dentists (“FPD”) represents 7,500 physicians, the majority of whom are in private practice.³⁵ The FPD represents physicians in Florida, Connecticut, Ohio, Delaware and Arizona,³⁶ and is affiliated with AFSCME and the AFL-CIO.³⁷ The FPD’s stated purpose is to represent private practice physicians’ interests in negotiations with insurance carriers, to raise public awareness of physicians’ issues through “pro-active litigation, lobbying and constitutional objectives” and to return the practice of medicine to physicians.³⁸

31. It should be noted that residents and interns (collectively known as “housestaff”) have their own separate unions and are embarking on similar attempts to organize and bargain collectively. The efforts of housestaff are beyond the scope of this Article. The Committee of Interns and Residents represents approximately 10,000 interns, residents, and attending physicians. See Mary Chris Jaklevic, *Physicians Find Power in Unions: a Small but Growing Number of Docs are Using Organized Labor to Gain Economic Leverage*, MOD. HEALTHCARE, Oct. 6, 1997, at 104. For a general explanation of housestaff organization attempts, see generally Daniel W. Srsic, *Collective Bargaining by Physicians in the United States and Canada*, 15 COMP. LAB. L. J. 89, 105-09 (1993).

32. See Jaklevic, *supra* note 31, at 104. The UAPD says that it is “equipped to develop affiliates in other states, and, in fact, [is] in the process of doing just that.” Weinmann, *supra* note 10.

33. See Toni Vranjes, *Unions Team Up to Fight Perceived HMO Abuses*, MED. IND. TODAY, Sept. 5, 1997. The UAPD contends that its alliance with the 1.3 million member AFSCME will empower it to “counter the megagreed of HMOs that . . . deprive patients of specialty care and treatment by preventing physicians from practicing the best medicine they can.” See *id.* (quoting Dr. Robert Weinmann, UAPD president).

34. See CMA, *supra* note 30.

35. See Jaklevic, *supra* note 31, at 104. The FPD conducts negotiations for private practice physicians using the “messenger model,” described *infra* note 117-119 and accompanying text.

36. See Mary Chris Jaklevic, *Physician Union Probe: Justice Department Investigating Boycott Charges*, MOD. HEALTHCARE, Feb. 23, 1998, at 6.

37. See Donna Vavala, *Fighting Fire With Fire: Physicians Blazing New Paths to Autonomy*, 21 PHYSICIAN EXECUTIVE 3, 3, Vol. 21, No. 4 (Sat. Apr. 1, 1995).

38. For general information regarding the FPD’s mission and goals, see *Managed Care: Central Florida Physicians Organize to Negotiate Contracts with Insurers*, BNA HEALTH CARE DAILY, Jan. 3, 1994.

Other physician union organizations include the New York-based Doctors Council, which represents 3,000 employed physicians in New York City,³⁹ the Physicians Healthcare Networks Group, with 1,300 members in Naples, Florida⁴⁰ and the Office and Professional Employees International Union, which claims 12,000 podiatrists and 2,100 physician members.⁴¹

II. LEGAL ISSUES SURROUNDING PHYSICIAN UNIONS

The ability of physician unions to represent their members in negotiations with managed care organizations is dictated and restricted by two bodies of law, labor and antitrust, which generally have conflicting goals. Antitrust law, codified by the Sherman Act, seeks to safeguard competition by assuring that market participants do not act to injure consumers by making agreements that illegally restrain trade.⁴² Labor law, on the other hand, embodied by the Clayton Act, is an exception to antitrust law that allows labor organizations to represent their members through collective bargaining.⁴³ The Clayton Act operates by exempting human labor from the definition of a "commodity or article of commerce," removing it from regulation under the Sherman Act and allowing labor organizations to conduct the "legitimate objects" of their organization.⁴⁴ The National Labor Relations Act ("NLRA") defined the labor exception found in the Clayton Act, and created the National Labor Relations Board ("NLRB"), an administrative body responsible for creating, implementing and adjudicating federal labor issues.⁴⁵

The law is fairly clear that employed physicians may bargain collectively under the Clayton Act. However, self-employed or independent physicians are prohibited from collective actions by

39. See Jaklevic, *supra* note 31, at 104. Seventy percent of the physicians represented by the Doctors Council are employed in the public sector. The Doctors Council is not affiliated with a nationwide labor organization.

40. See Debra Galant, *In Person; Organized Medicine*, N. Y. TIMES, Jan. 25, 1998, Sec. 14NJ, at *4. The Physicians Healthcare Networks Group was founded in April, 1997.

41. See *id.* The OPEIU is affiliated with the AFL-CIO.

42. See Sherman Act, 15 U.S.C. § 2 (1997). Violations of Section One of the Sherman Act include "price fixing, bid rigging, horizontal market allocations, and certain types of boycotts," and tying. See Fred E. Haynes, *Cooperative Activities of Physicians and Other Health Care Providers: Antitrust Implications*, C557 ALI-ABI 273, 277 (1990).

43. See Clayton Act, 15 U.S.C. § 17 (1998).

44. See *id.*

45. See National Labor Relations Act, 29 U.S.C. § 151 (1935).

the antitrust laws, and do not fall under the Clayton Act's labor exception. The following section explains the antitrust and labor law elements that shape the boundaries and determine the effectiveness of union representation for physicians.

A. *Employee Physicians*

An estimated forty-five percent of American physicians are employed by hospital systems, HMOs, or other corporate entities on a salaried basis.⁴⁶ To qualify as an "employee" and gain the benefits of the Clayton Act, a person must meet the definition of an "employee" under the NLRA.⁴⁷ The NLRA excludes from the definition of "employee" independent contractors and supervisory employees.⁴⁸

Employee members of recognized labor unions are entitled to avail themselves of the protections of the NLRA, including the right to bargain collectively.⁴⁹ In order to be recognized as a union, employees must petition the NLRB for recognition and the right to form a collective bargaining unit.⁵⁰ A collective bargaining unit defines the class of employees that will be represented by the union. The scope and breadth of a proposed union's collective bargaining unit often is a determinative factor in whether a particular organization movement is successful.⁵¹ The NLRB has defined⁵² and the U.S. Supreme Court has up-

46. See A.P., *Doctors Seeking to Unionize: A Remedy?* CHI. TRIB., Feb. 1, 1998, Bus. Sec., at 10.

47. See 29 U.S.C. § 152(3) (1998).

48. See *id.* In the Taft-Hartley Act, Congress made clear that only those who meet the traditional test of "employees" will be afforded the protection of the NLRA. See 29 U.S.C. § 152 (1974).

49. Refusal of an employer to bargain with a certified union is a violation of the NLRA. See 29 U.S.C. § 158(a)(5) (1998).

50. See Doreen Mangan, *Will Doctor Unions Finally Take Hold?*, 72 MED. ECON. 115, *3 (1995). For a detailed discussion of the definition of collective bargaining units in the health care context, and specifically physician-based collective bargaining units, see generally Michael H. LeRoy et al., *The Law and Economics of Collective Bargaining for Hospitals: An Empirical Public Policy Analysis of Bargaining Unit Determinations*, 9 YALE J. ON REG. 1, 20-23 (1992).

51. See LeRoy, et al., *supra* note 50, at 3-5 (pointing out that management challenges to the definition of collective bargaining units through litigation often can frustrate organization movements by causing delays in certification, thereby impeding the organizers' momentum and delaying representation elections).

52. See *Collective-Bargaining Units in the Health Care Industry*, 54 Fed. Reg. 16,336, 16,336-48 (1989) (codified at 29 C.F.R. pt. 103). See also Jay Greene, *NLRB Issues Guidelines*, MOD. HEALTHCARE, May 20, 1991, at 16 (reporting the issuance of NLRB guidelines processing union election petitions).

held⁵³ eight collective bargaining units for acute-care hospital employees. Two of these designated units represent employee registered nurses and physicians, among other groups of employees.⁵⁴ If a proposed collective bargaining unit falls within the parameters of one of the eight groups of employees in acute care hospitals, as defined by the NLRB, its certification will be granted. For physicians and others not employed by acute care hospitals, the NLRB has discretion to recognize collective bargaining unit petitions based on the facts and circumstances surrounding the representation election and the definition of the collective bargaining unit.⁵⁵

1. The Tucson Example

A recent example of union activity in Arizona demonstrates the ability of employee-physicians to successfully organize a union and bargain with their employers under the protection of the NLRA. On December 5, 1996, physicians employed by the Thomas-Davis Medical Clinic in Tucson voted to join the Federation of Physicians and Dentists/National Union of Hospital and Health Care Employees, an AFSCME affiliate.⁵⁶ The Thomas-Davis medical center is an HMO and group practice that was once owned by physicians.⁵⁷ The physicians sold the medical group and HMO to Foundation Health Corporation ("Foundation"), a for-profit HMO, in 1994.⁵⁸ Thomas-Davis Medical Clin-

53. See *American Hosp. Ass'n v. NLRB*, 111 S.Ct. 1539 (1991) (upholding the NLRB's definition of eight pre-determined collective bargaining units).

54. See *Collective-Bargaining Units in the Health Care Industry*, *supra* note 52. The other designated collective bargaining units include technical employees, skilled maintenance employees, business office clerks, guards and non-professional employees.

55. In cases when employers agree to recognize the collective bargaining unit, its composition is not at issue before the NLRB. See *LeRoy, et al.*, *supra* note 50, at n.10 and accompanying text (citing CHARLES J. MORRIS, ET AL., EDs., *THE DEVELOPING LABOR LAW* 413 (1983)). If there is no agreement, the board must determine the appropriateness of the unit for collective bargaining by analyzing the "community of interests" represented by the proposed bargaining unit. See MORRIS ET AL., *supra*, at 413. This decision "frequently depends on detailed factual analysis on a case-by-case basis, rather than on the simple application of well-settled rules of law." See *id.* at 417.

56. See *Doctors at Tucson Medical Clinic Vote to Join AFSCME Union Affiliate*, BNA HEALTH CARE DAILY, Jan. 27, 1997. See also *supra* notes 35-38 and accompanying text (describing the Florida-Based FPD).

57. See Mary Chris Jaklevic, *Will Doctors Embrace Unions?: Some Predict Rise in Organizing to Counter Managed Care*, MOD. HEALTHCARE, Jan. 20, 1997.

58. See *id.* (stating Foundation purchased the organization for \$720 million).

ics employed 150 physicians in six locations.⁵⁹ In the representation election, ninety-three doctors approved unionization, while thirty-two voted against representation.⁶⁰ The NLRB certified the physicians' bargaining unit as appropriate in a hearing in which Foundation participated, and more importantly, waived the issue of the statutorily supervisory status of the Thomas-Davis physicians.⁶¹

Foundation sold Thomas-Davis shortly after the union vote to FPA Medical Management ("FPA"), a physician practice management company.⁶² After the sale, FPA petitioned to re-open hearings to consider whether the employed physicians were supervisory or managerial personnel. FPA petitioned for rehearing again after the union was certified.⁶³ Because FPA acquired Thomas-Davis after the representation election, however, FPA did not have the opportunity to provide evidence at the representation hearings.⁶⁴ The NLRB held that all of the representational issues raised by FPA were, or could have been, litigated in the previous proceeding, even though FPA was not a party to the original hearing.⁶⁵ The NLRB also held that FPA did not offer any new evidence or special circumstances that would merit reopening the representation hearings.⁶⁶

FPA requested a bargaining unit clarification from the NLRB on February 19, 1997, asking that the collective bargaining unit exclude statutory supervisors and managers.⁶⁷ The regional director of the NLRB denied the clarification petition by letter, stating that the issue of whether the physicians were supervisors or managers had been fully litigated in the prior proceedings.

59. See *Doctors at Tucson Medical Clinic Vote to Join AFSCME Union Affiliate*, *supra* note 56.

60. See *id.*

61. See *Thomas-Davis Medical Centers*, 324 NLRB No.15, 1997 NLRB Lexis 585, *7-8. The collective bargaining unit was defined as "[a]ll regular full-time and part-time physicians, including department chairs, employed by the Employer at facilities located in Pima County, Arizona, excluding all other employees, physician medical directors, assistant medical directors, and members of the Employer's Board of Directors, guards and supervisors as defined in the Act." See *id.*

62. See *id.* FPA is a physician practice management company based in San Diego, California. See *id.*

63. See *NLRB Orders HMO to Bargain with Physicians Union, Company Appeals*, BNA HEALTH CARE DAILY, Aug. 6, 1997.

64. See *id.*

65. See *Thomas-Davis*, *supra* note 61, at *4.

66. See *id.*

67. See *id.* at n.3.

The director upheld the board's decision and certification of the collective bargaining unit as originally defined.⁶⁸

The NLRB ordered FPA to bargain with the union in a decision dated July 24, 1997, finding that FPA had engaged in unfair labor practices affecting commerce in violation of the NLRA.⁶⁹ Although the decision did not contain a formal warning to FPA, as permitted by NLRB rules, FPA attorneys were cautioned for denying certain allegations without good grounds and filing repeated motions to relitigate previously decided issues.⁷⁰ FPA immediately appealed the decision to the U.S. Court of Appeals, D.C. Circuit.⁷¹

The NLRB ordered FPA to bargain with the union upon the union's request.⁷² FPA continued to refuse to bargain in anticipation of their pending appeal. In the meantime, the NLRB sought, pursuant to its Congressionally granted authority, and was granted, an injunction to force FPA to bargain pending the outcome of its appeal.⁷³

After the election of the union, and during the legal maneuvering by FPA to contest the physicians' unionization efforts, FPA made unilateral changes to the physicians' employment relationship. These changes affected the physicians' employment status and the clinics' day-to-day practice.⁷⁴ For example, FPA unilaterally "required bargaining unit physicians to receive authorization before referring patients to other physicians at the medical center," changed the amount of liability insurance required and raised the deductible, reduced the amount of bonuses paid to bargaining unit employees and increased physicians' patient load.⁷⁵

In addition, FPA attempted to manipulate the bargaining unit members by offering them new individual employment contracts with a different compensation level.⁷⁶ The NLRB claimed irreparable injury in its injunctive proceedings, and pointed to the fact that after the unilateral employment changes, nearly half of

68. See *id.* at n.5. See also NLRB Case 28-RC-5449 (holding that the Thomas-Davis employee physicians are not supervisors or managers).

69. See *Thomas-Davis*, *supra* note 61, at n.3, *8-9.

70. See *id.* at *9-10.

71. See *NLRB Upholds Union*, 6 BNA HEALTH L. REP. 1234 (1997).

72. See *Thomas-Davis*, *supra* note 61, at *12-13.

73. See 29 U.S.C. § 160(j) (1998).

74. See Michelle Amber & William Carlile, *Despite Challenge to Union, Talks Proceed Between Arizona Doctors, Clinic*, 6 BNA HEALTH L. REP. 1779, 1779 (1997).

75. See *id.*

76. See *id.*

the physicians in the bargaining unit resigned, and many physicians signed the new individual employment contracts without the benefit of collective bargaining by the union.⁷⁷

In his opinion granting the NLRB a temporary injunction, Judge William Browning held that the union's potential strength and bargaining power was diminished by FPA's unfair labor practices, pointing to reduced attendance at union meetings and numerous physician resignations.⁷⁸ Judge Browning ordered FPA to rescind the unilateral changes in the employment conditions of union physicians and restore employment terms as they were before the December 5, 1996, representation election.⁷⁹ After the issuance of the temporary injunction, FPA finally agreed to negotiate a contract with the union.⁸⁰

The union's battle with FPA, although successful in establishing the physicians' right to form collective bargaining units, resulted in a pyrrhic victory in the end.⁸¹ Although FPA's appeal was defeated in the federal courts,⁸² by the time of the decision FPA had sold or closed all of the Thomas-Davis clinics, forcing former Thomas-Davis physicians to seek employment in smaller practices.⁸³ An equally detrimental effect was felt by former Thomas-Davis patients, some of whom were unable to follow

77. See *NLRB Upholds Union*, *supra* note 71, at 1234 (citing *Overstreet v. Thomas-Davis Medical Centers*, CV 97-488-TUC-WDB (D.C. Ariz. 1997)).

78. See *id.* This example is a clear illustration of litigation by employers that is either designed to or has the effect of frustrating or even destroying unionization movements. Some commentators argue that litigation during the election and start-up period of unions can often quash mobilization efforts. See LeRoy et al., *supra* note 50, at 5-7 (arguing "when litigious hospitals consumed years in appealing Board rulings, ordinary employee turnover often eroded initial organizing gains. In some instances, union supporters were harassed or fired, becoming lessons, perhaps, for the remaining workers"). Although the LeRoy article focuses mainly on non-physician hospital employees, it is interesting to note that the same results occur when physicians comprise the collective bargaining unit, as can be seen in the fact that FPA ignored the NLRB's mandate to bargain with the union, and its unilateral measures affecting physicians' working environment, and employment terms and conditions.

79. See *Amber & Carlile*, *supra* note 74, at 1779.

80. See *id.*

81. See The Center for Studying Health System Change, *Organizational Scenario Number Three, Thomas-Davis Medical Centers*, <<http://www.hschange.com/physconf/thomasdavis.html>> (visited Mar. 26, 1999).

82. See *Thomas-Davis Medical Centers v. NLRB*, 157 F.3d 909 (D.C. Cir. 1998). The court, in affirming the NLRB decision, ruled that it was within the NLRB's discretion to refuse to reopen a previously decided issue and that FPA, through Foundation, had waived the issue of whether the physicians were supervisors. See *id.* at 912.

83. See The Center for Studying Health System Change, *supra* note 81.

their physicians to a new practice and all of whom had to deal with more complex health care systems.⁸⁴

2. The Massachusetts Example

Presented with a more favorable situation, employed physicians in Massachusetts were more wholly successful in certifying a union and gaining a voice in their day-to-day practice than their counterparts in Arizona. In July of 1997, sixty-eight physicians employed at six outpatient centers by Blue Cross Blue Shield of Massachusetts voted unanimously to form a union to be represented by Medical West Physicians Association.⁸⁵ The movement was in response to Blue Cross' plan to sell some of its clinics.⁸⁶ The physicians sought unionization in an effort to influence which of the several bidders would purchase the clinics.⁸⁷ The union was certified by the NLRB without objection by Blue Cross Blue Shield.⁸⁸ In fact, a Blue Cross Blue Shield spokesperson stated that the corporation actually supported the physicians' unionization effort and collective bargaining unit election.⁸⁹ As a result of collective bargaining, the physicians gained the right to evaluate bid finalists and negotiate certain purchase terms⁹⁰ with the eventual purchaser of the clinics.

3. Lessons for Employed Physicians

The Arizona and Massachusetts examples demonstrate the success physician unions can achieve, under the right circumstances, in gaining collective bargaining rights under the NLRA. Although the Thomas-Davis example resulted in a bittersweet outcome, certain conclusions can be drawn from the experience. At the very least, the physician groups in Arizona and Massachusetts have generated nationwide media attention, both in the

84. See *id.* (noting many patients now had to visit multiple office locations for different services and were faced with separate billing and medical management services).

85. See Jaklevic, *supra* note 31, at 100. Medical West Physicians Association ("MWPA") "has been in existence since 1986, when it was formed to negotiate individual employment contracts for doctors at the health centers." See *Plan Doctors Seek Union Representation as Means of Participating in Sales Talks* [hereinafter "Plan Doctors"], 6 BNA HEALTH L. REP. 726 (1997). The group's priority is to "assure that any purchaser [of the clinics] has a commitment to excellent patient care." See *id.*

86. See *Plan Doctors*, *supra* note 85, at 726.

87. See *id.* The union's organizer, Dr. Powers, noted, "Clearly, this was a last option. They didn't want to become a labor organization."

88. See Jaklevic, *supra* note 31, at 99, 100.

89. See *Plan Doctors*, *supra* note 85, at 726.

90. See Jaklevic, *supra* note 31, at 100.

general and health care trade press.⁹¹ Union leaders are touting the success in forming the collective bargaining unit as a great stride in creating inroads for union activities to aid physicians in dealing with MCOs and other employers. Moreover, these examples demonstrate that the NLRB is willing to recognize salaried physicians as employees entitled to protection under the NLRA. The exact boundaries of this protection remain to be seen.

The resolution of the Thomas-Davis case on the waiver issue failed to settle the debate between physicians and their employers over whether physicians can be employees, or whether their position alone puts them in the class of supervisors or managers. Thus far, neither the NLRB nor the courts have provided a definitive answer to the supervisory issue. The Supreme Court has held that professional employees are supervisory and are thus not afforded the protection of the NLRA.⁹² Some have argued that physicians' roles are "inherently" supervisory⁹³ because their position requires them to oversee nurses and technical staff. The NLRB supported this viewpoint when it held in the *Family Health Plan* decision that employed physicians who participated on peer review and other committees possessed managerial duties and were therefore excluded from organizing under the NLRA.⁹⁴ As the Thomas-Davis case shows, however, even the *Family Health Plan* precedent does not preclude all physicians from unionizing.⁹⁵ The Arizona and Massachusetts cases show examples of circumstances under which employed physicians can organize and bargain collectively to reach their goals.

91. Newspaper articles regarding physician unions have recently appeared in the New York Times, Chicago Tribune, and as the cover story in the October 1997 issue of *Modern Healthcare*. See, e.g. *Doctors Seeking to Unionize: A Remedy?*, CHI. TRIB., Feb. 1, 1998, Bus. Sec., at 10; Galant, *supra* note 40, at *4; Jaklevic, *supra* note 31.

92. See *NLRB v. Yeshiva University*, 444 U.S. 672, 684 (1980) (holding that university faculty members, although employees, were sufficiently supervisory and not protected by the NLRA).

93. See Srsic, *supra* note 31, at 108-09.

94. See *FHP, Inc. and Union of American Physicians and Dentists*, 274 NLRB 1141, *3 (1985).

95. Staff physicians were similarly granted the right to organize in *Joint Diseases, North General Hospital*, 288 NLRB 291, *4 (1988). In *Joint Diseases*, department directors were specifically excluded from the bargaining unit. The bargaining unit in *Thomas-Davis* similarly specifically excluded physicians in directorship positions. See *supra* note 61 and accompanying text.

B. *Independent and Self-Employed Physicians*

While it is relatively clear that employed physicians may unionize and bargain collectively to negotiate with MCOs and other employers, self-employed or independent physicians face greater challenges due to the strictures of antitrust law. As noted previously,⁹⁶ employees, including employed physicians, are exempt from antitrust laws under the Clayton Act, and have the right to collectively bargain under the NLRA. Independent, self-employed, or non-salaried physicians do not fall under the labor exception and their efforts to collectively bargain are considered price fixing or unlawful restraint of trade.⁹⁷

The main antitrust barrier applicable to physicians' concerns with managed care involves price fixing. Price fixing is "any agreement among independent sellers aimed at raising, depressing, or fixing the price of a service or product."⁹⁸ Such acts are a per se violation of Section One of the Sherman Act.⁹⁹ Per se violations are considered "so patently anti-competitive that they are conclusively presumed to violate the Sherman Act without proof of unreasonableness in each case," and can subject the actors to criminal prosecution.¹⁰⁰ The Federal Trade Commission has recently reconfirmed the potential for illegal price fixing in the health care context, stating, "It is per se unlawful price fixing for independent health care professionals to collectively negotiate rates with managed care organizations or other [payers] of health care services."¹⁰¹

These regulations create a significant barrier for independent physicians and the unions who purport to represent them. This, despite the fact independent physicians arguably suffer under the same perceived abuses of managed care as employed physicians. Managed care contracts are typically non-negotiable. Additionally, they generally contain strict controls over utilization management, reimbursement amounts, financial incentives and access to specialists. They also may contain termination-

96. See *supra* notes 42-48 and accompanying text.

97. See Haynes, *supra* note 42, at 278-79.

98. See *id.*

99. See 15 U.S.C. § 1.

100. See Haynes, *supra* note 42, at 278-79.

101. See Antitrust: Physicians' Unions, 6 BNA HEALTH L. REP. 1178 (1997) This statement was made by Robert F. Leibenluft, assistant director for health care in the FTC Bureau of Competition, in the course of terminating an FTC investigation of a union of podiatrists.

without-cause clauses or ambiguous contract terms.¹⁰² Many physicians and some legal analysts have argued that typical managed care contracts are actually contracts of adhesion because physicians lack choice and negotiating.¹⁰³

1. Independent Contractors or De Facto Employees?

Common law agency principles generally govern the difference between an employee and an independent contractor.¹⁰⁴ The key factors in the context of independent physicians include the degree of control the employer exercises over the worker, whether the employment is for a distinct occupation or business, an analysis of the type of occupation involved and whether the work is usually done under an employer's direction, the skill required, whether the employer supplies a work place and equipment, and the length of the contract.¹⁰⁵ Other factors include the method of payment and the subjective belief of the parties as to whether an employment relationship exists.¹⁰⁶ The AMA, in a 1997 Board of Trustees Report, concluded that independent physicians are not eligible for the employment exception under the Clayton Act and may not collectively bargain with MCOs or other health plans.¹⁰⁷

Aggressive physicians and union representatives disagree and challenge the notion that a physician whose practice is dominated and dictated by various managed care contracts is not an independent contractor. This group holds the position that the physician is a de facto employee of the MCO. In the first action of its kind, nearly 200 private practice physicians who had contracts with AmeriHealth-New Jersey HMO ("AmeriHealth") petitioned the NLRB for the right to bargain collectively represented by the United Food and Commercial Workers Local 56 in Trenton, New Jersey.¹⁰⁸ Union leaders argued that although the physicians were not salaried by AmeriHealth, the conditions of the managed care contract created de facto employee status. "The issue is not higher fees, but that the HMOs are practicing

102. See Little, *supra* note 8, at 1407-20 (providing an in-depth analysis of these features of managed care contracts).

103. See *id.* at 1422-25.

104. See AMA BOARD OF TRUSTEES REPORT 41, at 216, 221 (June 1997).

105. See *id.* at 222.

106. See *id.* at 223.

107. See *id.*

108. See Mary Chris Jaklevic, *Unions Pursue New Venue, MOD. HEALTHCARE*, Nov. 3, 1997, at 33.

medicine without a license,” commented Dr. Frederick Nahas, a union organizer for the New Jersey physicians in Atlantic and Cape May counties.¹⁰⁹ The group sought to “level the playing field” by regaining control over patient care issues.¹¹⁰ In October 1997 the physicians petitioned the NLRB for representation. Dr. Nahas argued, “These doctors are employees, no ifs, ands or buts. If you don’t follow the rules, you are de-selected.”¹¹¹

The physicians’ petition was dismissed without a hearing on January 8, 1998.¹¹² NLRB regional director Dorothy Moore-Duncan concluded that the physicians were not employees of AmeriHealth because they “also treat patients from other managed-care companies, insurance companies and Medicare, as well as walk-in clients who pay independently.”¹¹³ Moore-Duncan acknowledged, however, that there are a few factors that lend themselves toward an employer-employee relationship, especially the fact that AmeriHealth’s physician contracts are not subject to negotiation.¹¹⁴ However, after balancing the factors that distinguish employees from independent contractors, Moore-Duncan decided that the New Jersey physicians were independent contractors, concluding that, “most significantly, the physicians themselves make the fundamental decisions that determine the profitability of their practices.”¹¹⁵ Another deciding factor, and one argued by the health plan, was that the New Jersey HMO statute, among other state regulations, set the boundaries of the managed care relationship.¹¹⁶ The union immediately announced that it would appeal the decision to the NLRB. Although the dismissal of the petition has no precedential value, the result of an appeal would be precedent-setting and could prepare the stage for increased unionization, or, alternatively, a victory for managed care.

109. See Richard Acello, *Doctors Union Idea is Gaining New Momentum*, 18 SAN DIEGO BUS. J., Nov. 10, 1997.

110. See *id.*

111. See Linda A. Johnson, *Doctors Seeing Labor Unions as Counterweight to HMOs*, CHATTANOOGA FREE PRESS, Jan. 18, 1998, at O4.

112. See *Physician Unionization: Ruling Goes Against Jersey Docs*, HEALTH LINE, Jan. 9, 1998.

113. See *id.* (quoting Dorothy Moore-Duncan’s dismissal decision).

114. See Charlotte Huff, *Doctors & Unions, United they Fell*, HOSP. & HEALTH NETWORKS, Mar. 5, 1998, at 35.

115. See *Physician Unionization: Ruling Goes Against Jersey Docs*, *supra* note 112.

116. See *Doctors’ Bid to Unionize Rejected*, THE LEGAL INTELLIGENCER, Jan. 9, 1998.

2. Alternative Strategies for Physician Advocacy

Union activities on behalf of independent physicians have not always centered on collective bargaining. Unions and independent groups of physicians have developed alternative strategies under existing law to accomplish similar goals for their constituents.

Antitrust regulations prohibit concerted actions that result in unfair competition. However, physicians may negotiate individually with managed care companies for their own independent contracts. In fact, the Federal Trade Commission and the Department of Justice have issued guidelines allowing for a “messenger model” of communication through which representatives from physician networks or unions may act as messengers in one-on-one negotiations between physicians and managed care organizations.¹¹⁷ This technique was first used by “messenger model” PPOs and IPAs. In this model the organization “does not set prices but simply acts as a messenger between the third-party payer and the individual providers, who settle on price terms in separate, individual negotiations.”¹¹⁸

The Federation of Physicians and Dentists has a history of providing negotiation support for physicians using the messenger model. The FPD reviews managed care contracts with physicians, but says that “it is up to the individual doctors to accept or reject a contract.”¹¹⁹ However, the union has recently come under federal antitrust scrutiny for organizing an illegal boycott after reviewing managed care contracts in Connecticut and Delaware.¹²⁰ The Justice Department recently requested documents, alleging that physicians in Connecticut collectively refused to deal with a health plan.¹²¹ Similarly, Blue Cross Blue Shield of Delaware is considering filing a federal complaint after eighty-five percent of the state’s orthopedic surgeons canceled an insurance contract almost simultaneously.¹²² The FPD denies any wrongdoing in either case. Although an investigation is far from an indictment or prosecution, the presence of these investigations indicates the inherent perils of the messenger model. It

117. See *Antitrust: DOJ Cites Price Setting, MFNs as Continuing Antitrust Concerns*, BNA HEALTH CARE DAILY, Apr. 30, 1996; see also Harris Meyer, *Physicians: Look for the Union Label*, 70 HOSPITALS 69, 69 (1996).

118. See Hayes, *supra* note 42, at 295.

119. See Jaklevic, *supra* note 36, at 6.

120. See *id.*

121. See *id.*

122. See *id.*

is clear that the government is aware of private practice physicians attempting concerted actions, and it seems intent on investigating potentially illegal boycotts.

III. THE RESPONSE OF ORGANIZED MEDICINE

Organized medicine, led by the AMA and state and local medical societies, has a history of opposition to unionization by physicians. In 1984, the AMA Board stated that unions' "traditional emphasis on collective action through strict majority rule is ill-suited to professional values of individualism and autonomy. Organizationally and philosophically, moreover, the labor union model comprehends neither of the pursuits that are of paramount importance to physicians organized in professional associations—the advancement of medical science and the promotion of public and patient welfare."¹²³

The AMA's staunch anti-union stance has slowly given way in response to the realities of managed care. In June 1997, the AMA House of Delegates mandated efforts to remove barriers to collective bargaining for physicians.¹²⁴ Although the AMA now supports the right of independent physicians to negotiate collectively with managed care plans, it continues to resist the union structure. Instead, the AMA favors alternative legal structures that will avoid the potential antitrust implications of collective bargaining for independent physicians.

In response to the mandate from the House of Delegates to help physicians negotiate with managed care, the AMA created the Division of Representation to "work with, educate and facilitate the county and state associations or independent groups of physicians to function as physician representation or as an independent bargaining unit."¹²⁵ The AMA presented four strategies that state and local medical societies, with the assistance of the Division of Representation, may choose to pursue in representing independent physicians. The AMA urges medical societies to pursue legislative and judicial advocacy on behalf of physicians using traditional lobbying efforts, a strength of the

123. See BUDRYS, *supra* note 15, at 118 (citing AMA BOARD OF TRUSTEES REPORT (1994)).

124. See Mary Chris Jaklevic, *Wanted: Bargaining Power: AMA Urges Freedom for Self-employed Docs to Unionize in Response to Managed Care*, MOD. HEALTHCARE, June 30, 1997, at 17.

125. See Jeffrey Barg, *AMA Collective Bargaining Program*, PHYSICIAN'S NEWS DIGEST, <<http://www.physiciansnews.com/spotlight/1197.html>> (visited Nov. 14, 1998) (quoting AMA president-elect Dr. Nancy W. Dickey).

organization.¹²⁶ Additionally, the AMA urges medical societies to negotiate noneconomic issues with managed care plans, especially for issues involving medical decision making and quality of patient care.¹²⁷ Furthermore, the AMA urges medical societies to provide individual negotiation services for individual members.¹²⁸

The final and most interesting recommendation the AMA presents is the option of forming a physician-controlled Management Services Organization ("MSO"), IPA, or risk-bearing health plan. Additionally, several state medical societies have introduced their own solutions. In 1986, the Connecticut State Medical Society formed an IPA/HMO because its members were concerned that physicians would lose their voice in medical decision making.¹²⁹ As of 1994, the organization had enrolled 120,000 patients and contracted with 4,300 physicians.¹³⁰ Similarly, the Washington Medical Society created a risk-bearing organization in February of 1994.¹³¹ In early 1997, the Philadelphia County Medical Society vowed to research and initiate a physician's union and a Delaware Valley Health Care Society to provide a stronger voice for physicians in private practice.¹³² In yet another initiative, the Florida Medical Association, citing a sense of urgency, resolved to "seek means to remove restrictions for physicians to form negotiating units" to deal with managed care companies and to garner reasonable fees.¹³³ The UAPD has had an independent non-profit IPA since 1993, which represents 1,260 private practice doctors in

126. See AMA BOARD OF TRUSTEES REPORT, *supra* note 104, at 224; see also *AMA Delegates Direct Association to Find Ways for Doctors to Bargain*, BNA HEALTH CARE DAILY, July 1, 1997.

127. See AMA BOARD OF TRUSTEES REPORT, *supra* note 104, at 224. The report states that recent FTC guidelines "create an antitrust safety zone for medical societies (and other physician groups) to provide medical information to health plans for the purpose of improving the quality of care or the efficiency with which care is rendered." See *id.*

128. See *id.* at 225.

129. See Jim Montague, *Joining the Race: State Medical Societies Try to Beat Managed Care Integrators to the Punch*, HOSP. & HEALTH NETWORKS, Sept. 5, 1994, at 50.

130. See *id.* at 51.

131. See *id.* The Unified Physicians of Washington initially contracted with 2,500 physicians at its inception in 1994. See *id.* at 52.

132. See *Doctor Unions: Philadelphia Physician Seeks Organization*, HEALTH LINE, Feb. 24, 1997.

133. See *Physicians: Florida Group to Form "Negotiating Units,"* HEALTH LINE, July 10, 1997.

California and purports to provide access to 3.1 million patients.¹³⁴

Perhaps the most radical development in organized medicine is the AMA's assistance in a labor dispute in Rockford, Illinois.¹³⁵ The AMA, along with the Illinois State Medical Society, backed a 185-member group of physicians in Rockford, Illinois, in its attempt to obtain certification as a collective bargaining unit represented by the Rockford Physicians' Council.¹³⁶ The Council's goal was to "establish a forum through which physicians could negotiate on administrative issues affecting patient care, staffing, access to medical records and contractual relations."¹³⁷ The AMA provided financial, research, and legal support through its Division of Representation.¹³⁸

The Council filed a representation petition with the NLRB in December 1997, requesting a certification election.¹³⁹ However, the representation process is stalled due to a January 1998 finding by the NLRB that the employer, Rockford Health System, interfered with the Council's efforts to organize by threatening to fire individuals considering affiliation with the Council.¹⁴⁰ Currently, the parties are negotiating a settlement to avoid further litigation.¹⁴¹ This action by the AMA is significant because it is a true departure from the AMA's traditional course of recommending more conservative strategies by traditional organized medicine groups.

A key point of contention that may threaten fledgling union and collective advocacy actions by physicians is the potential for strikes or boycotts traditionally associated with mainstream labor organizations. Although the AMA currently recommends and permits collective action for physicians, it is adamant that it will not advocate or tolerate strikes or boycotts that would jeop-

134. See *Private Practice and IPA Information*, <<http://www.uapd.com/IPA.html>> (visited Nov. 14, 1998); Weinmann, *supra* note 32; see also, *Antitrust: Steiger Outlines Safety Zones for Physician Joint Ventures*, BNA HEALTH CARE DAILY, NOV. 8, 1994 (demonstrating the limitations of the IPA model, in that any one IPA cannot represent more than 20% of the physicians in the geographical area due to antitrust constraints).

135. See Arsenio Oloroso Jr., *AMA Backs Docs' Bid to Unionize: Group Scores Partial Victory in Key Rockford Case*, CRAIN'S CHI. BUS., Jan. 19, 1998, at 4.

136. See *id.*

137. See *AMA Backs Physicians' Campaign Seeking to Bargain at Illinois Plan*, BNA HEALTH CARE DAILY, Jan. 23, 1998.

138. See *id.*

139. See *id.*

140. See *id.*

141. See Oloroso, *supra* note 135, at 4.

ardize patient care.¹⁴² It is clear that employed physicians recognized as collective bargaining units under the NLRA have as much right to strike or conduct other job actions as other employee groups.¹⁴³ However, most physician unions and representative groups have expressed vehement opposition and a promise that they will not resort to strikes.¹⁴⁴ Despite these representations, there have been a few strikes in the U.S., mainly by interns and residents, as well as a few incidents involving HMO employed physicians.¹⁴⁵

CONCLUSION

The reasons offered by union leaders for collective representation center on a response to managed care, but the precise goals go well beyond economic concerns regarding salaries and reimbursement rates. Physicians are concerned about losing control in medical decisions.¹⁴⁶ One fed-up physician recently noted, "We no longer make decisions . . . the mood in the doctor's lounge is one of frustration, depression and anger."¹⁴⁷ Physicians also carry concerns that are not as directly related to patient care, such as timely claims payment and the amount and type of paperwork managed care plans require them to complete.¹⁴⁸ All of this frustration and anger seems to be coming to a head as physicians seek representation among a variety of different organizational models.

It may be too soon to tell what effect the recent movements toward physician unionization and collective action will have on medicine in the long run. Perhaps the most telling indicator that real change is occurring is the response of the AMA, typically a slow-moving, conservative organization. Whatever one's view of managed care, the consensus is that it is here to stay. In the long run, managed care cannot work without the cooperation of

142. See AMA BOARD OF TRUSTEES REPORT, *supra* note 104, at 224, 225.

143. See Larry V. Sobal & James O. Hepner, *Physician Unions: Any Doctor Can Join, but Who Can Bargain Collectively?* 35 HOSP. & HEALTH SERVICES ADMIN. 327 (1990).

144. Those representing commitments not to strike include the UAPD, the FPD and the Doctor's Council.

145. See Srsic, *supra* note 31, at 105-110 (providing a thorough explanation of physician strikes).

146. See *Machinists Union Organizing N.J. Pharmacists, Physicians*, BNA HEALTH CARE DAILY, Feb. 12, 1998.

147. See Galant, *supra* note 40, at *4.

148. See *UFCW Files Petition to Represent Doctors on N.J. HMO Provider Panel*, BNA HEALTH CARE DAILY, Oct. 29, 1997.

its providers, who are an essential element of managed care's product – quality, low-cost health care. The historical and more recent organizational movements may be the first step toward achieving parity in contracting between physicians and MCOs.