COLLECTIVE BARGAINING AMONG U.S. PHYSICIANS*

Thomas A. Barocci**

WP 1122-80 May 1980
COLLECTIVE BARGAINING AMONG
U.S. PHYSICIANS*

Thomas A. Barocci**

WP 1122-80                        May 1980

*Chapter XIII of Industrial Relations and Health Services, edited by A. S. Sethi (London: Croom Helm Ltd.), forthcoming 1981.

**Associate Professor of Management in the Sloan School of Management at MIT. Special thanks are due to Dale Conway for her invaluable substantive and administrative help in preparing this paper. Also, Katherine Overskei and Daniel Gregorie, M.D., offered insightful research assistance on the legal and practical matters surrounding this inquiry.
The rise of collective bargaining among physicians was a phenomenon of the 1970s. At present (1980), the prospects for survival of those unions that remain in existence can best be described as uncertain. Factors such as physicians' own sense of their professional identity, the legal implications of their supervisory status, anti-trust and labor laws, and income levels that are already among the highest in the country threaten the survival of existing bargaining units. Countering these pressures are trends toward cost containment in hospitals, the possibility of national health insurance, an increasing number of salaried physicians, and collective movements among hospital house staffs (interns, residents, and clinical fellows).

This chapter explores the current status of physicians unions and explains why they sprang up after 1970, the legal and practical considerations responsible for their present uncertain position, and prospects for their future. Fee-for-service physicians, salaried physicians, and house staffs will be discussed separately, because their legal, professional, and social positions in the health care industry are, as we will show, quite different.

Physicians are the highest paid professionals in the United States.¹ Their incomes and perquisites are admired by some, resented by others, and deemed appropriate by most of the general public. In 1976 physicians in the United States averaged $59,544 in net income.² Until
recently, the vast majority of M.D.s were paid on a fee-for-service basis. Over the last 15 years, however, many publicly owned and run health facilities have hired physicians on salary. In addition, private institutions, both for- and non-profit, and including such facilities as nursing homes, health maintenance organizations, and for-profit hospitals, often pay fixed incomes to doctors. This trend has arisen as part of the institutions' cost containment strategies. Not surprisingly, it has served as a motivation for collective organization among physicians.

Among house staff, interns in particular, traditional incentives to organize are clearly present. Internship involves both patient care and educational activities; an internship is necessary for qualification for the examination to practice medicine. (Residents and clinical fellows, the other constituents of the house staff, choose these optional continuations in order to acquire a specialty skill.) Interns are low paid, relative to their skills and importance to the operations of the hospital; they work long hours, often unscheduled and unpredictable; they are subject to both job and educational discipline, since they have not yet attained physician status; and they have little voice in the policies and processes of the hospital. Though they perform many of the same services to patients as regular staff physicians, they are compensated by yearly stipends that are always far less than a staff physician would receive for the same services.

Nonetheless, as with physicians unions in general, there have been only isolated organizing drives by groups of interns (usually with residents and clinical fellows); there is nothing among house staffs or
physicians that could be called an industry-wide drive for unionization. Legislative inconsistencies are no doubt responsible for many of the difficulties facing organizing efforts among physicians and house staffs. Before looking in some detail at the history of these efforts, it is worthwhile to set out the causes of physicians' incentives to unionize.

The initial growth of physicians unions had its roots in the erosion of the fee-for-service role traditionally held by U.S. physicians. Since the mid-1960s, government intervention, third-party health insurance company pressures, and hospital managerial policies have significantly limited the professional and economic independence of the profession. The American Medical Association (AMA), surprisingly and no doubt unwittingly, also played a key role. Professional associations of physicians, such as the AMA, state medical societies, and specialty organizations, have existed for over one hundred years in the United States. Historically, their function was primarily to set and police standards of education and training, encourage professional development, and act as censuring bodies for physicians who did not act in the best interest of patients.

But these associations became more political in nature as a response to the federal government's increasing involvement in the business of health care. This involvement began in the late 1940s, when the government passed legislation to finance capital expansion in hospitals (the Hill-Burton Act); it continued in the 1960s with increased funding for the education and training of physicians, nurses, and other health professionals. But the government's major threat, as perceived
by the medical profession, was its enactment of Medicare and Medicaid legislation, which provides federally sponsored care for the poor and aged.

The AMA, perhaps understandably, was opposed to the enactment of this legislation. Conservatives in the Association were concerned to preserve their heretofore unchallenged economic independence. The AMA finally came around to supporting Medicare/Medicaid on the condition that the fee-for-service principle remain in effect for these federal reimbursements. In this, the Association was successful. However, its adamant opposition to federally sponsored care apparently alienated a great number of younger physicians who were educated and entering practice in the 1960s and 1970s. This cohort, opposed to the conservative stance of the AMA, responded by not joining its ranks. According to the AMA's files, in the 1950s over 55 percent of medical school graduates joined the Association; by the 1960s this percentage had dropped to between 35 and 40 percent; in 1975 only 16 percent of these graduates joined. Though part of this drop is no doubt attributable to the tendency of younger physicians to join specialty societies instead of the AMA, the fact remains that the more liberal young physicians were alienated by the Association's lack of social concern, as evidenced by its bitter, strenuous lobbying against the passage of Medicare and Medicaid.4

Meanwhile, the more conservative among the physician population also turned against the AMA, feeling that their independence had been weakened by the Association's capitulation to this legislation. Ironically, the AMA lost the memberships of both its liberal and its
conservative supporters. Both groups turned their organizational loyalty to local medical associations; a few began at the same time to entertain thoughts of collective organization. Physicians organizations, called unions, federations, or guilds began to form. Bognanno's 1975 survey indicated that at least 16,000 physicians were members in some 26 labor organizations, some of which had National Labor Relations Board (NLRB) certification. These organizations faced substantial difficulties, primarily in the form of legislative inconsistencies posed by the National Labor Relations Act (NLRA) and its regulatory board (the NLRB), as well as from anti-trust laws. Physicians work either as independent fee-for-service professionals or as staff physicians, on salary with a hospital or other medical facility. In order to be protected under the NLRA's provision for union recognition and bargaining rights, organized workers have to fall under the definition of "employee" that exists in the Act and in subsequent judicial decisions. Even the most liberal interpretation of employee, however, could not apply to fee-for-service physicians, and it is very difficult for staff physicians to be defined as employees. The profit motive of some of these bargaining units, and physicians' already high incomes, have also inhibited success in gaining NLRB certification.

For instance, the Union of American Physicians (UAP), which does not have certification, had as one of its goals a $100,000 per year salary for seasoned practitioners. Though it has claimed to represent 8000 of California's 40,000 M.D.s, legal problems have prevented the UAP from representing any fee-for-service physicians. It has been able to offer its members mainly a "grievance procedure," which is simply
an organized force, mainly lawyers, who collect unpaid insurance and Medicare/Medicaid bills. It has also negotiated two contracts for physicians on salary in two small facilities in the state.

Most early organizing drives owed their success to the energy and dedication of strong leaders. Most notable among these are Harold Yount of the American Physicians Guild, Kenneth Burton of the American Physicians Union, Sanford Marcus of the Union of American Physicians, and Stanley Peterson of the American Federation of Physicians and Dentists. However, their efforts often failed to sustain the union in the face of NLRA limitations. A typical experience is the one of a group of physicians on staff at a Nevada hospital. They formed a union in 1972, which, though it did not get NLRB certification, did affiliate with a national union. The efforts of their leader, Dr. Holmes, brought them some successes; most notably they won a $50/hour reimbursement fee for all time spent in committee work. But once Dr. Holmes stepped down, because of illness, the organization dissolved.

A survey by Reynolds in 1976, which was supplemented by a telephone survey we conducted in 1979, revealed that at least a substantial portion of the organizations mentioned in the Bognanno survey of 1975 have disappeared. Those groups that have survived will face difficulty maintaining their legal bargaining status.

Of course, it is not necessary for physicians to be protected by the NLRA in order to organize to act collectively. But recognition under the Act is their only protection from federal anti-trust laws. A collective action by a group of independent contractors or by any intrastate group against an organization with interstate connections
(insurance companies, for example) would be subject to prosecution under the Sherman Act as a "conspiracy in restraint of trade." Only official ratification under the NLRA can protect a labor organization from anti-trust prosecution. Any statewide efforts, even though they were contained within a single state, might still be subject to federal prosecution. Even collective activities that do not cross state lines or involve more than a single employer, and which thus could possibly escape federal anti-trust provisions, might come up against various state anti-trust laws.

Aside from these legal problems, the general tenor in the United States, of imposing constraints on rising hospital costs (which, according to the Consumer Price Index, have been surpassed in cost increases only by oil), also contributes to the public forces opposing collective organization by physicians. Public opinion seems firmly attached to the belief that unionization necessarily increases earnings.

Some fee-for-service physicians have begun to form corporations, combining a number of physicians into an organization that then contracts with one or more hospitals for services of its members. Clearly, these are not unions in the sense of labor laws. Thus they remain a target for anti-trust prosecution, should their pricing policies be deemed in restraint of trade.

Any chance to unionize in the traditional sense of the word falls to the cohorts of physicians who work on salary for a hospital (or part-time with several hospitals) and other health facilities. However, these groups too have recently met with legal setbacks. A recent U.S. Supreme Court decision (NLRB v. Yeshiva University, 78-857) cast a
shadow over prospects for NLRB certification of "professional" bargaining units. Though this decision was made with regard to university professors, the implications for health-care professionals are undeniable. Like professors, physicians supervise and manage workers in their institutions and influence policy and promotion decisions; thus they can be excluded from coverage by the NLRB's jurisdiction.

As we said above, house staffs, especially interns, have many of the traditional incentives to unionize: low pay, long hours, and little voice in policy making. But several factors work against organization. Interns are only temporarily in this uncertain position (usually one year); their prospects for more autonomy and higher earnings are great, and they have a professional identity that has not traditionally been associated with that of organized workers.

Not surprisingly, drives to organize groups of interns have been isolated. They have also come under a great deal of scrutiny by the NLRB and state-level labor sanctioning bodies. In 1974 Public Law 93-360 amended the Taft-Hartley Act of 1974 to remove the exemption of voluntary hospitals from the National Labor Relations Act (1935), thus extending labor relations protection to all employees of health care institutions not under government or public ownership. The question of whether or not the house staff (interns in particular) are students (since they take courses), employees (since they are paid), or managers (since they supervise nurses, among others) has been controversial until quite recently. Unions of house staffs have been formed, certified by state labor boards, and then decertified by the NLRB (based on the fact that these members were students, not employees).
In late 1979 a Congressional committee tried to make clear that it had intended the 1974 amendments to Taft-Hartley to cover hospital house staffs, only to have its amendment defeated by the House of Representatives.

Prior to the passage of the 1974 amendments, the Physicians National Housestaff Association (PNHA) was formed "to organize the house staffs in hospitals throughout the U.S." They met with little success. In New York City the Committee of Interns and Residents (CIR) was formed and represented (as an association, not a union) approximately 5000 house staff in New York hospitals. CIR's primary demands were restriction on hours and "out of title" work. Hospital management, united in the League of Voluntary Hospitals (a loose association of New York hospitals) was opposed to any contractual arrangement. No attempt was made to gain official sanction of CIR as a bargaining agent, though a four-day strike in 1975 led to a compromise settlement. Similarly, in 1975 in Chicago, the 450 member Cook County Hospital Housestaff Association struck and subsequently signed an agreement limiting work hours to 80 per week and establishing a committee to discuss patient care issues.

These organizing efforts of the 1970s began meeting setbacks as early as 1976, when the NLRB dismissed (by a 4-1 vote) a petition by the Ceders-Sinai Housestaff Association in Los Angeles to have their organization recognized by the NLRA. The Board ruled that house staff were not employees, but students. The dissenting vote argued that the relationship between student and employee is not mutually exclusive, since students are not among the exclusions listed from the definition
of employee under section 2 (3) of the Act. Though this gave hope to some house staff organizations, and kept isolated movements toward official recognition alive, the NLRB subsequently ruled against union representation elections in two additional hospitals. In the state of Massachusetts, however, the Labor Commission ruled the other way, allowing an election under Massachusetts law in April 1976.12

Because of the different interpretations by state bodies and the NLRB, the U.S. Circuit Court considered a case in which the issue was whether house staff working in non-profit hospitals in New York could be covered by New York State labor relations law, instead of national law. The Court's ruling was that federal law did not supersede state in this case; house staff labor relations were not within the jurisdiction of the NLRB. In a further turn of events, the U.S. Court of Appeals reversed the Circuit Court's decision. The battle continued with a bill sponsored in the U.S. Congress that would mandate inclusion of house staff under the bargaining laws. Though this bill was expected to pass, it was soundly defeated in late 1979. For now, the issue is settled: house staff will not be considered employees within the meaning of the national labor laws and are therefore excluded from NLRA coverage.

**Summary**

The three separable cohorts of physicians (fee-for-service, salaried, and house staff) have each met legal opposition to any attempts to organize and bargain collectively. Fee-for-service physicians are most clearly outside the criteria for organization,
since they are independent entrepreneurs who could not be represented as a collective unit, according to the NLRA, even if they deemed this route the appropriate method for maintaining their rather privileged positions. Salaried physicians, though possessing a commonality of interest under the definition of an appropriate bargaining unit, have been severely limited by the recent NLRB v. Yeshiva decision of the U.S. Supreme Court, which maintained that professional employees are essentially managers and cannot organize collectively. For house staffs, the recent defeat of a bill to include them under the provisions of the NLRA precludes further attempts to organize in this area.

Though movements for unionization in the medical profession have not been long-lived, they have been significant for pointing out inequities in the treatment of hospital house staff. They have, however, failed to arouse public sympathy for the problems of the salaried or fee-for-service physician; the attempts of these latter groups to organize have met with only fleeting success. The passage of national health insurance in this country is probably the only factor that could breathe life into physician unionization. Unless such insurance becomes a reality, collective organizing will remain dormant, if not moribund, among physicians in the United States.
NOTES


9. See Goldfarb v. Virginia State Bar, 43 U.S.L.W. 4723 (U.S. June 16, 1975), where the court found that state professional societies can indeed be subject to federal prosecution for "conspiring to benefit the economic interests of their members."

10. The physicians dealing with the Kaiser Permanente Health Plan in California operate under this type of organization.

11. Ceders-Sinai Medical Center (Los Angeles, California) v. Ceders-Sinai Housestaff Association, 31-RC-2983, June 10, 1976, 224 NLRB, No. 90, 92 LRRM 1303.
