

2001

## The Debate Over the Unionization and Collective Bargaining of Private Physicians

Angel M. Aton

Heidi S. Connolly

Follow this and additional works at: <http://scholarlycommons.law.hofstra.edu/hlej>

 Part of the [Law Commons](#)

---

### Recommended Citation

Aton, Angel M. and Connolly, Heidi S. (2001) "The Debate Over the Unionization and Collective Bargaining of Private Physicians," *Hofstra Labor and Employment Law Journal*: Vol. 18: Iss. 2, Article 11.

Available at: <http://scholarlycommons.law.hofstra.edu/hlej/vol18/iss2/11>

This document is brought to you for free and open access by Scholarly Commons at Hofstra Law. It has been accepted for inclusion in Hofstra Labor and Employment Law Journal by an authorized administrator of Scholarly Commons at Hofstra Law. For more information, please contact [lawcls@hofstra.edu](mailto:lawcls@hofstra.edu).

# THE DEBATE OVER THE UNIONIZATION AND COLLECTIVE BARGAINING OF PRIVATE PHYSICIANS

## I. INTRODUCTION

For years many workers in the United States have had the ability to unionize to improve their working conditions. As the industries and the work forces change so will the types of workers wanting to unionize. Doctors are one of those groups that are struggling to change the law to give them the ability to unionize and collectively bargain.

This Note will highlight the current controversy over physician unionization. The problems and issues raised will establish that for physician unionization to be effective, new legislation must be implemented.

Part II begins with a discussion of the background information surrounding the complex facets of the medical profession. The first section explains how groups of doctors can be distinguished from one another and placed into one of three broad categories. Placement in these categories is a reflection of each group's need for union assistance. The next section explains how health plans are similarly distinguishable, and are usually categorized by the method of payment for the health services provided. The final section of Part II discusses existing doctors' unions and examines the different reasons physicians are interested in unionizing.

Many obstacles in the current law hinder or prevent private physicians from joining unions. Some issues arise from antitrust regulations,<sup>1</sup> while others are due to the National Labor Relations Act ("NLRA" or "Act").<sup>2</sup> Part III explains and discusses how these legal issues create potential problems for physician unionization. This Note focuses specifically on whether private doctors can and should be covered under the NLRA. The main question lies in whether physicians

---

1. Congress has passed two different acts addressing antitrust. *See* Sherman Act, 15 U.S.C. §§ 1-7 (1994); Clayton Act, 15 U.S.C. §§ 12-27, 29 U.S.C. §§ 52-53 (1994).

2. 29 U.S.C. §§ 151-68 (1994).

are considered to be employees, independent contractors, or supervisors, and how this determination can affect physician coverage under the NLRA.<sup>3</sup>

Recently, Congress proposed legislation that would remove several of the obstacles discussed in Part III.<sup>4</sup> This legislation attempts to eliminate certain problems by creating an exception for doctors under the NLRA.<sup>5</sup> Part IV discusses this proposed legislation and how its implementation may or may not remove these obstacles.

This Note will show that the current state of physician unionization is in disarray. However, it will be equally apparent that legislation may not resolve this problem and other solutions should be implemented.

## II. BACKGROUND ON PHYSICIAN UNIONIZATION

### A. Categorization of Doctors

When determining if a doctor can unionize, one must first look at the nature of the doctor's employment. As a practitioner, a doctor fits into one of three categories.<sup>6</sup> He or she is either: on staff; a resident, intern, or fellow; or in private practice.<sup>7</sup> Presently, a doctor's ability to join a union and collectively bargain primarily depends on which category he or she is in.<sup>8</sup>

Staff doctors make up the first category of practitioners. Unlike doctors in private practice, they are employees of and receive a set salary from the hospital or clinic that employs them.<sup>9</sup> These doctors are not considered to be self-employed because their salaries are paid by the

---

3. See *id.* at §§ 151-52, 157.

4. See H.R. 1304, 106th Cong. (1999). Currently H.R. 1304 has been put on hold to be dealt with in the future. See Karen Foerstel, *GOP Leaders Order Hyde to Kill Bill on Doctor Bargaining*, at <http://thomas.loc.gov/cgi-bin/query/D?r106:32:/temp/~r1062tXQ0t:e25821>: (Nov. 1, 1999) (on file with the Hofstra Labor & Employment Law Journal). This bill is one of the more complicated bills that has been introduced. See *id.* Other health care bills that were proposed in 1999 include H.R. 2723 and H.R. 2824. See H.R. 2723, 106th Cong. (1999) (enacted) (providing a patients' bill of rights); H.R. 2824, 106th Cong. (1999).

5. See H.R. 1304.

6. See Robert L. Lowes, *Strength in Numbers: Could Doctor Unions Really Be the Answer?*, MED. ECON., June 29, 1998, at 115; Steven Greenhouse, *Unions Find Fertile Ground Recruiting Country's Doctors*, OREGONIAN (Portland), Feb. 7, 1999, at A16, available at 1999 WL 5316354 [hereinafter Greenhouse, *Unions*].

7. See Lowes, *supra* note 6, at 115; Greenhouse, *Unions*, *supra* note 6, at A16.

8. See *infra* Part III.C (discussing protection under the NLRA).

9. See Greenhouse, *Unions*, *supra* note 6, at A16; Montefiore Hosp. & Med. Ctr., 261 N.L.R.B. 569, 571 & n.12 (1982).

hospital.<sup>10</sup> They want to unionize and collectively bargain to improve patient care<sup>11</sup> and negotiate their contracts with hospitals regarding wages and working conditions.<sup>12</sup> Presently, doctor unionization has occurred most frequently among staff doctors<sup>13</sup> since no problems arise regarding their coverage under the NLRA.<sup>14</sup>

The second category of doctors includes interns, residents, and fellows. These are doctors who have graduated from medical school, but are not yet Board certified.<sup>15</sup> Interns are doctors just out of medical school<sup>16</sup> in post-graduate work who experience their first year of supervised practical training (hands-on experience) by rotating through various basic areas of medicine.<sup>17</sup> Residents study under a medical specialist<sup>18</sup> to gain greater knowledge and skill in a particular area of medicine.<sup>19</sup> They treat patients under the guidance of these more experienced physicians.<sup>20</sup> Fellows are doctors that have already completed both an internship and a residency.<sup>21</sup> A fellowship generally

10. See Lowes, *supra* note 6, at 115.

11. See *id.*

12. See Greenhouse, *Unions*, *supra* note 6, at A16.

13. See *id.*

14. See *infra* Part III.C.

15. "Board certified" refers to a physician who passed a specific examination and is now certified as a specialist in that area of expertise. See VERGIL N. SLEE, MD ET AL., *HEALTH CARE TERMS* 75 (3d ed. 1996). The Boards are a national examination given to doctors by the National Board of Medical Examiners. See *id.* The first part of this exam is taken after the second year of medical school. See RACHEL EPSTEIN, *CAREERS IN HEALTH CARE* 28 (Dale C. Garell, M.D. et al. eds., 1989). Usually, passing all parts of this exam results in a license to practice medicine. See SLEE ET AL., *supra*, at 75-76. Some states require additional examinations for a doctor to become licensed. See *id.* at 76; see also *Boston Med. Ctr. Corp.*, 330 N.L.R.B. No. 30 (Nov. 26, 1999), 1999 WL 1076118, at \*3 (NLRB).

16. See SLEE ET AL., *supra* note 15, at 463. Interns are also called first-year resident physicians. See *id.*

17. See *id.*; THOMAS C. TIMMRECK, PH.D., *HEALTH SERVICES CYCLOPEDIA: A COMPENDIUM OF HEALTH-CARE AND PUBLIC HEALTH TERMINOLOGY* 721 (3d ed., Jones & Bartlett Pubs., Inc. 1997) (1982); *Boston Med. Ctr.*, 1999 WL 1076118, at \*3.

18. A medical specialist is a physician who practices a particular area of medicine or surgery. See TIMMRECK, *supra* note 17, at 355, 357; SLEE ET AL., *supra* note 15, at 558. This is different than a primary care physician who, like your family doctor, conducts the initial check-up and then refers the patient to a specialist if a specific problem arises. See SLEE ET AL., *supra* note 15, at 463.

19. After completion of medical school and their internship, these doctors-in-training must choose an area of medicine they would like to specialize in or concentrate on. See TIMMRECK, *supra* note 17, at 650. These specialties range from non-surgical areas such as internal medicine, family medicine, pediatrics, obstetrics, and gynecology to surgical specialties such as orthopedics, thoracic, neurological, and plastic surgery. See EPSTEIN, *supra* note 15, at 32-43. The length of the residency program depends upon the complexity of the specialty area chosen and ranges from 3-5 years. See *id.* at 32, 40, 43.

20. See EPSTEIN, *supra* note 15, at 27; TIMMRECK, *supra* note 17, at 650.

21. See *Cedars-Sinai Med. Ctr.*, 223 N.L.R.B. 251, 251 (1976).

lasts for one year during which time the fellow studies a particular part of the body in the field he or she has chosen.<sup>22</sup> Similar to staff doctors, interns, residents, and fellows are paid by the teaching hospitals that employ them.<sup>23</sup>

For the purposes of unionizing, interns, residents, and fellows are distinguished from licensed physicians. They are referred to as house staff and, as a bargaining unit, have unique concerns.<sup>24</sup> Their main concern is to improve working conditions.<sup>25</sup> While licensed physicians are also concerned with improving working conditions, as discussed below, their concerns are different than those of the house staff.<sup>26</sup> This difference raises the issue of unit determination because if licensed physicians want to bargain, it is unlikely that they will be in the same category as interns, residents, and fellows. The reason for this is that when the National Labor Relations Board (“NLRB” or “Board”) determines a bargaining unit, it wants that bargaining unit comprised of employees with enough in common so that one person could bargain without having to make a lot of trade-offs.<sup>27</sup> This would not be true of a bargaining unit made up of both licensed physicians and house staff because the two groups lack commonality.

When making a unit determination, the Board looks to four factors: 1) whether the employees have similar economic interests (i.e., salary range, hours, benefits, job functions, qualifications, skills); 2) the history of collective bargaining in that field; 3) the extent of employee organization; and 4) if everything else comes out even, the Board will

22. See *id.*; EPSTEIN, *supra* note 15, at 43. Sixty percent of residents studying the area of orthopedic surgery continue on after completing their five-year residency program to study a subspecialty for another year in a fellowship program. See EPSTEIN, *supra* note 15, at 43. Orthopedic subspecialties include concentration on the spine, shoulder, hip, foot, or ankle. See *id.*

23. See *Cedars-Sinai*, 223 N.L.R.B. at 252; see also EPSTEIN, *supra* note 15, at 27. Cf. *Boston Med. Ctr.*, 1999 WL 1076118, at \*3 (noting that interns, residents, and fellows who attend Boston University School of Medicine are paid by both the School of Medicine and Boston Medical Center and receive health, dental, life and malpractice insurance as well as paid vacation and sick leave).

24. See *Boston Med. Ctr.*, 1999 WL 1076118, at \*3; Lowes, *supra* note 6, at 115. For example, a resident’s interests may lie in negotiating the number of hours per week of training while a licensed physician may be more concerned with negotiating over higher quality care for patients.

25. See Lowes, *supra* note 6, at 115. As a part of their training process, residents have a call schedule. See EPSTEIN, *supra* note 15, at 27. If a resident is “on call” Monday night, he would have to work his normal training hours Monday, be “on call” Monday night and still be responsible for his normal training hours on Tuesday, regardless of how much sleep, if any, he got Monday night. See *id.*

26. See THEODORE J. ST. ANTOINE ET AL., LABOR RELATIONS LAW: CASES AND MATERIALS 265-66 (10th ed. 1999).

27. See *id.* (stating that the representative of a collective bargaining unit shall be the sole representative in that unit in bargaining for “rates of pay, wages, hours of employment, or other conditions of employment”).

look to the desire of the employees.<sup>28</sup> When looking at these factors, it is apparent that house staff and licensed physicians do not fit into the same bargaining unit. They do not share the same economic interests, organization history, or desires.<sup>29</sup> It is extremely important for the bargaining unit determination to be proper because an employer who feels that the Board erred in making a unit determination can refuse to bargain with the representatives of that unit.<sup>30</sup>

Until recently, interns, residents, and fellows have been denied coverage under the NLRA.<sup>31</sup> In November 1999, the NLRB overruled prior decisions and for the first time held that interns, residents, and fellows are employees under Section 2(3) of the NLRA and entitled to the rights afforded under the Act.<sup>32</sup> Due to this change in the law, this Note will not discuss the need for interns, residents, and fellows to unionize.<sup>33</sup>

The third category of practitioners is physicians in private practice. Some private physicians affiliate with hospitals in order to perform certain procedures, but their offices are independent and the hospital

28. See MICHAEL C. HARPER & SAMUEL ESTREICHER, LABOR LAW 327 (4th ed. 1996). Sometimes there are restrictions on unit determinations other than the four commonality factors. These restrictions can be found in Section 9(b) of the NLRA. See 29 U.S.C. § 159(b) (1994). It provides that:

The Board shall decide in each case whether, in order to assure to employees the fullest freedom in exercising the rights guaranteed by this subchapter, the unit appropriate for the purposes of collective bargaining shall be the employer unit . . . *Provided*, [t]hat the Board shall not (1) decide that any unit is appropriate for such purposes if such unit includes both professional employees and employees who are not professional employees unless a majority of such professional employees vote for inclusion in such unit; or (2) decide that any craft unit is inappropriate for such purposes on the ground that a different unit has been established by a prior Board determination, unless a majority of the employees in the proposed craft unit vote against separate representation or (3) decide that any unit is appropriate for such purposes if it includes, together with other employees, any individual employed as a guard to enforce against employees and other persons rules to protect property of the employer or to protect the safety of persons on the employer's premises . . . .

*Id.* (emphasis in original).

29. See generally JAN SUGAR-WEBB, OPPORTUNITIES IN PHYSICIAN CAREERS 33, 48, 50, 61-62, 65-66, 68-69, 76, 81 (2000) (contrasting residents' salaries with those of licensed physicians).

30. See ST. ANTOINE ET AL., *supra* note 26, at 301-02 (noting that an employer's refusal to bargain with a union in this situation is a legitimate action).

31. See *Cedars-Sinai*, 223 N.L.R.B. at 253. In *Cedars-Sinai*, the Board concluded that house staff's (interns, residents, and fellows) primary purpose for holding these positions was to gain the requisite education and training needed to become licensed doctors. See *id.* Therefore, interns, residents, and fellows were deemed students and not employees covered by Section 2(3) of the NLRA and not entitled to bargaining rights. See *id.*

32. See *Boston Med. Ctr.*, 1999 WL 1076118, at \*16, 19-20.

33. See *id.*

does not pay the doctors for their services.<sup>34</sup> Rather, their salaries consist of patient payments and health plan provider reimbursements.<sup>35</sup> Many of these doctors also have ownership interests in their practices.<sup>36</sup> Therefore, private practitioners are considered to be self-employed.

It is important to determine which category a doctor fits into when analyzing his or her right to unionize and collectively bargain.<sup>37</sup> This Note focuses on physicians in private practice because it is unclear as to whether they, unlike staff doctors and house staff, have any protection under the NLRA.

### *B. The Different Types of Health Plan Providers*

To better understand why private physicians want to unionize, it is important to learn more about the “other side”—the insurance providers. When paying for medical expenses, an individual may use health insurance. Generally, a person has three options: service plans, indemnity plans, or managed care organization plans.<sup>38</sup> Within each of these plans, people can specifically tailor their coverage to meet their individual medical needs.

With a service plan, payments for medical care are made directly to the doctor and/or hospital by the insurance organization.<sup>39</sup> The beneficiary of a service plan receives services rather than cash.<sup>40</sup> Patients usually have to pay a certain portion of their medical bills before the health insurance service contributes.<sup>41</sup>

Under indemnity plans, medical coverage is provided by insurance

---

34. See generally ALAN G. RAYMOND, *THE HMO HEALTH CARE COMPANION: A CONSUMER'S GUIDE TO MANAGED CARE NETWORKS 1-15* (1994) (addressing the issue of doctor reimbursement).

35. See generally *id.* (highlighting the differences between HMOs and traditional insurance providers).

36. See *Who Can Join Bargaining Unit*, AM. ACAD. FOR ORTHOPEDIC SURGEONS BULL., Aug. 1999, at 15.

37. See 29 U.S.C. §§ 151-52, 157. Under the NLRA, *only employees* have the right to unionize and collectively bargain. See *id.*

38. See generally *AmeriHealth Inc.*, 329 N.L.R.B. No. 76 (Oct. 18, 1999), 1999 WL 963200, at \*4 (discussing the three types of health insurance options); THE NATIONAL DIRECTORY OF MANAGED CARE ORGANIZATIONS I-II (Gwendolyn B. Lareau & Phyllis J. Harris eds., 2d ed. 1998) [hereinafter NATIONAL DIRECTORY] (containing a detailed profile of over 1,800 managed care organizations throughout the United States).

39. See HEALTH CARE CHOICES: FOR TODAY'S CONSUMER 31, 39 (Marc S. Miller ed. 1995).

40. See SLEE ET AL., *supra* note 15, at 67.

41. See HEALTH CARE CHOICES, *supra* note 39, at 32. Blue Cross and Blue Shield is an example of an organization providing this type of coverage. See SLEE ET AL., *supra* note 15, at 67, 72-74.

companies.<sup>42</sup> The insurance company pays a fixed amount for medical care, and if the cost exceeds this amount, the patient is responsible for the difference.<sup>43</sup> Insurance companies interact with the physicians only to discuss payment information.<sup>44</sup> The difference between service and indemnity plans lies with the type of benefits provided.<sup>45</sup> Contrary to service plans, the benefits under indemnity plans are cash payments.<sup>46</sup> These cash payments are sent either to the beneficiary for reimbursement or directly to the health care provider.<sup>47</sup>

The last plan offered is that of the managed care organization (“MCO”).<sup>48</sup> Various organizations such as health maintenance organizations (“HMOs”),<sup>49</sup> preferred provider organizations (“PPOs”),<sup>50</sup>

42. See *AmeriHealth Inc.*, 1999 WL 963200, at \*4.

43. See AGENCY FOR HEALTH CARE POLICY AND RESEARCH, CHOOSING AND USING A HEALTH PLAN: WHAT YOU SHOULD KNOW ABOUT THE DIFFERENT TYPES OF HEALTH PLANS THAT ARE AVAILABLE TODAY (last visited Apr. 22, 2001) available at <http://my.webmd.com/content/article/1680.51357> (on file with the Hofstra Labor & Employment Law Journal).

44. See *AmeriHealth Inc.*, 1999 WL 963200, at \*4.

45. See SLEE ET AL., *supra* note 15, at 67.

46. See *id.*

47. See *id.*

48. See SLEE ET AL., *supra* note 15, at 266. Managed health care arose due to the increasing costs of indemnity insurance after the 1960s. See *id.* at 353-55; see also *AmeriHealth Inc.*, 1999 WL 963200, at \*4.

49. See *AmeriHealth Inc.*, 1999 WL 963200, at \*4; NATIONAL DIRECTORY, *supra* note 38, at I. HMOs have several different models which are characterized, for the most part, by the type of physicians they contract with. See RAYMOND, *supra* note 34, at 6. There are several common models for HMOs. See *id.* at 6-13. The first is staff model HMOs. See *id.* at 7. Staff model HMOs own the health centers and employ the doctors that work there. See *id.* The second type is group model HMOs. See *id.* at 8. In this model, one or more physician practices contract with the HMO and provide medical services for each patient who is a member of that HMO. See *id.* at 8-9. This type of HMO does not employ the physicians. See *id.* at 9. The third type of HMO, the independent practice association (“IPA”), is the fastest growing form of HMO in the United States. See *id.* IPAs are formed by many individual private practice physicians who are combined to form a network of doctors for the HMO member to choose from. See *id.* The HMO pays IPA doctors a fixed amount per patient. See *id.* at 9-10. IPAs are preferred because they have a large selection of doctors to choose from. See *id.* at 10. A downside to IPAs is the hassle of finding a local specialist included in the plan. See *id.* The fourth type of HMO is the point of service HMO (“POS”). See *id.* at 11-12. A member of a POS receives health care from physicians and hospitals within the HMO network or outside of it, all the while receiving coverage. See *id.* at 12. If members choose a network doctor, the only payments they are responsible for is the small co-pay paid at the time of each visit. See *id.* But if a member chooses a non-network physician, that member “ha[s] to share the costs in much the same way as with traditional health insurance coverage.” *Id.* The fifth type of HMO is the Network or Mixed Model HMO. See *id.* at 11. This HMO takes several different HMOs and combines them to form an individualistic HMO for a particular patient’s needs. See *id.*

50. See *AmeriHealth Inc.*, 1999 WL 963200, at \*4; NATIONAL DIRECTORY, *supra* note 38, at II. PPOs are organizations that combine doctors and hospitals in order to provide lower cost health care. See RAYMOND, *supra* note 34, at 13-14. There is no formal organization of PPOs, in fact



exclusive provider organizations (“EPOs”),<sup>51</sup> and integrated delivery systems (“IDS”) or physician hospital organizations (“PHOs”) offer this type of medical plan.<sup>52</sup> MCO plans differ from service and indemnity plans in two ways, payment options and control. Regarding payment, MCOs have two methods of compensating physicians, capitation and fee for service.<sup>53</sup> Capitation is “the fixed amount per patient per month regardless of the number of services or procedures provided to the patient.”<sup>54</sup> Conversely, under the fee for service option, the MCO pays a certain amount of money for each procedure or visit the member has.<sup>55</sup>

The other difference between MCOs and other health plan providers is the amount of control the organization has. MCOs exert varying levels of control over doctors and their patients, the main goal being efficiency.<sup>56</sup> They maintain control by providing a select list of doctors from which their members may choose.<sup>57</sup> The MCOs can also limit which medical procedures a doctor can perform on a patient and when and where the procedures can be done.<sup>58</sup> MCO managers do this by assessing the member’s medical situation and deciding whether the doctor may perform the procedure.<sup>59</sup> Comparatively, insurance companies leave all medical decisions to the doctor’s discretion and only

---

“[t]here is little uniformity among the organization of various PPOs.” SLEE ET AL., *supra* note 15, at 479. “[A] leading PPO consultant, testified at a 1985 Congressional hearing, ‘if you’ve seen one PPO, you’ve seen one PPO.’” *Id.* PPOs were actually designed to compete with HMOs. *See id.* PPOs can be differentiated from HMOs. First, PPOs do not absorb the cost of physician decisions regarding medical procedures while, on the other hand, HMOs do. *See id.* This largely has to do with the fact that PPO physicians are paid on a fee-for-service basis while HMOs will pay their choice physicians an annual salary for each HMO patient. *See id.* Also, a PPO member is not committed to using the health care providers chosen by the PPO. *See id.*

51. EPOs are similar to PPOs. They are “made up of a group of physicians, one or more hospitals, and other providers who contract with an insurer, employer, or other sponsoring group to provide discounted medical services to enrollees.” RAYMOND, *supra* note 34, at 14. These enrollees can receive health care services from another doctor without authorization from their primary care doctor so long as that doctor also participates in the EPO network. *See id.*

52. In the IDS and PHO plans, hospitals, primary care physicians, and specialists bind together and contract with other managed care organizations to provide a combination managed care plan. *See id.* at 15.

53. *See AmeriHealth Inc.*, 1999 WL 963200, at \*4.

54. *Id.*; *see also* EPSTEIN, *supra* note 15, at 20. Because physicians are paid an annual salary per HMO patient, some people are concerned that doctors are encouraged to keep a patient’s medical costs to a minimum. *See* RAYMOND, *supra* note 34, at 3. People fear that the medical care provided will be of a lesser quality since a doctor may skip a test or procedure in order to keep the cost down. *See id.*

55. *See AmeriHealth Inc.*, 1999 WL 963200, at \*4.

56. *See id.*

57. *See id.* at \*5.

58. *See id.* at \*4.

59. *See id.*

interact with physicians on issues of payment.<sup>60</sup>

### C. The Current State of Physician Unionization

Although there are many obstacles to physician unionization, as of 1999, approximately 45,000 doctors in the United States were unionized.<sup>61</sup> However, this only amounted to six percent of the doctors in this country.<sup>62</sup> Until recently, doctors' unions were limited to doctors employed directly by hospitals and clinics.<sup>63</sup> This is no longer true. Private physicians are now joining traditionally blue-collar unions to gain leverage to negotiate with HMOs.<sup>64</sup> Among these unions are the United Food and Commercial Workers ("UFCW"),<sup>65</sup> the International Association of Machinists and Aerospace Workers ("IAMAW"),<sup>66</sup> and the American Federation of Teachers.<sup>67</sup>

To adapt to the changing times, the American Medical Association ("AMA") joined in the unionizing efforts.<sup>68</sup> Its decision to support physician unionization came about in 1997 when the AMA changed its stance concerning doctors' unions.<sup>69</sup> Some observers say that the AMA's involvement reflects the urgency of the situation because while it has always been opposed to labor unions, it has overriding complaints regarding HMOs.<sup>70</sup> The AMA, however, is not forming a typical union, rather, it is trying to offer "an alternative to traditional labor unions."<sup>71</sup>

---

60. See *AmeriHealth Inc.*, 1999 WL 963200, at \*4.

61. See Chris Phan, *Physician Unionization: The Impact on the Medical Profession*, 20 J. LEGAL MED. 115, 115 (1999) (discussing how there are doctors unions in place and that there has been a substantial "surge" recently); Rafael Gerena-Morales, *2 Labor Groups to Form National Doctor's Union*, NEWSDAY (Nassau), March 2, 1999, at A41.

62. See Gerena-Morales, *supra* note 61, at A41. An example of a current doctors' union is the Doctors Council which is a union representing 3,400 doctors, most of them being attending physicians in hospitals (staff doctors) in the New York City area. See Greenhouse, *Unions*, *supra* note 6, at A16. This union has joined forces with the Service Employees International Union to form the National Doctors Alliance which will attempt to organize the 750,000 doctors in the United States. See Gerena-Morales, *supra* note 61, at A41.

63. See Melanie Burney, *NLRB Rejects N.J. Doctors' Union*, ASSOCIATED PRESS, May 24, 1999, available at 1999 WL 17806934.

64. See Lowes, *supra* note 6, at 115; Greenhouse, *Unions*, *supra* note 6, at A16.

65. See Lowes, *supra* note 6, at 115.

66. See *id.* at 118.

67. See Greenhouse, *Unions*, *supra* note 6, at A16.

68. See Tammy Webber, *Doctors' Union Promises No Strikes*, PITTSBURGH POST-GAZETTE, Oct. 12, 1999, at F8, available at 1999 WL 25694161.

69. See Phan, *supra* note 61, at 136. The AMA's change of heart was apparent when it endorsed attempted physician unionization in Rockford, Illinois. See *id.* at 137.

70. See *id.* at 136; Burney, *supra* note 63.

71. Bruce Japsen, *AMA Tells Docs: Organize Unions on As-needed Basis*, KNIGHT-RIDDER

As the AMA promises, this new union, Physicians for Responsible Negotiations (“PRN”), will be different from traditional unions.<sup>72</sup>

The biggest difference stems from the fear of the negative repercussions that always seem to follow failed negotiations.<sup>73</sup> This fear resulted in the AMA assuring that doctors in PRN will never strike.<sup>74</sup> Todd Vande Hey, AMA Vice President of Private Sector Advocacy and a member of the union’s governing body, says striking is not an option and is “unacceptable” to the AMA.<sup>75</sup> Moreover, the PRN will not recruit doctors<sup>76</sup> nor will it petition the NLRB for recognition, leaving that decision to the doctors themselves.<sup>77</sup>

The AMA’s involvement has insurance companies concerned.<sup>78</sup> Currently, under federal antitrust laws, no self-employed doctors can collectively bargain.<sup>79</sup> The AMA is working to have doctors exempted from antitrust law, allowing private doctors to unionize and collectively bargain.<sup>80</sup> The fear of private doctors collectively coming to the bargaining table has some health plan providers attempting to improve relations with doctors.<sup>81</sup> One way they are doing this is by including doctors on committees, giving them a voice in decision making.<sup>82</sup> For example, one insurance company, Aetna Inc., currently hired a “former AMA official to repair its relations with doctors.”<sup>83</sup> These changes are only the beginning; more are anticipated and once more private doctors become involved, the law surrounding physician unionization is more likely to change.

#### *D. Private Doctors and Why They Want to Unionize*

Doctors, as well as patients, have long been complaining about

---

TRIB. BUS. NEWS, Sept. 10, 1999, at 1.

72. *See id.* The name for the union was “chosen with great care.” Webber, *supra* note 68, at F8.

73. *See* Donald Kaul, Editorial, *Docs in Unions? ‘Educational’ TV? What Next?*, ST. J.-REG., July 1, 1999, at 5 (giving an illustration of a patient on the operating table as the surgeon yells “strike”).

74. *See id.*

75. Webber, *supra* note 68, at F8.

76. *See id.*

77. *See* Japsen, *supra* note 71.

78. *See* Webber, *supra* note 68, at F8.

79. *See id.*

80. *See id.* This would leave MCOs with no option but to negotiate with over half a million doctors. *See id.*

81. *See id.*

82. *See id.*

83. Webber, *supra* note 68, at F8.

MCOs.<sup>84</sup> In the past decade, the power and number of MCOs have grown substantially, and with them, complaints about the health care system in this country.<sup>85</sup> Private doctors were able to make independent decisions, but now that MCOs are larger and stronger, most independent doctors are forced to follow the rules and guidelines established by the managed care companies.<sup>86</sup> This often leads to a decline in the quality of service to patients.<sup>87</sup> Some physicians are so outraged by what is happening that they claim “HMOs are trading patient lives and limbs for profits.”<sup>88</sup> This frustration is just one reason compelling many doctors to join, or at least consider joining, a union because they feel it will help them maintain control over the medical decisions involving their patients.<sup>89</sup>

A second reason why doctors choose to unionize is to improve their working conditions. Doctors want a safe and clean environment in which to work, with the necessary staff and equipment, and are unhappy with

84. See *supra* Part II.B (discussing the different types of MCOs and how those differences affect doctors and patients).

85. See Patricia Mullen Ochmann, *Managed Care Organizations Manage to Escape Liability: Why Issues of Quantity vs. Quality Lead to ERISA's Inequitable Preemption of Claims*, 34 AKRON L. REV. 571, 574 (2001).

[M]ore than 125 million Americans rely on more than 2.5 million group health plans for medical coverage. With more than 70 percent of the American workforce and their families enrolled in MCOs, issues concerning patients' rights and the quality of care received under managed care plans affect the majority of the U.S. population.

*Id.* See also Jeremy Lutsky, *Is Your Physician Becoming a Teamster: The Rising Trend of Physicians Joining Labor Unions in the Late 1990s*, 2 DE PAUL J. HEALTH CARE L. 55, 55 (1997).

86. See Phan, *supra* note 61, at 117; Greenhouse, *Unions*, *supra* note 6, at A16 (noting that more than ninety percent of doctors in the United States have at least one contract with an MCO). If the patient is covered by an HMO, the doctor may feel pressure when making medical decisions about that patient. This pressure comes from the fact that if a patient receives many diagnostic tests, procedures, or hospitalization the HMO will have to absorb these expenses since it pays a flat rate to the doctor each year for his or her services. See EPSTEIN, *supra* note 15, at 20. On the other hand, if the patient's medical fees are lower than the annual fee paid by the HMO for the medical services, the doctor may receive an end of the year bonus. See *id.* Since the doctor and the HMO have a contractual relationship, the amount of money the doctor saves or costs the HMO may have bearing on whether or not the HMO renews the contract with the particular doctor for the next term. This can be very important to a doctor with a majority of his patients covered by part of the HMO network.

87. See Burney, *supra* note 63.

88. *Id.* HMOs require the physicians to pack-in patients, thereby limiting the time that can be spent with each one. See Greenhouse, *Unions*, *supra* note 6, at A16. A doctor in California said his HMO expected him to see eight patients per hour, which would limit his time with each patient to seven and a half minutes. See Steven Greenhouse, *Look for the Union Scalpel*, PITTSBURGH POST-GAZETTE, Feb. 7, 1999, at A3.

89. See Phan, *supra* note 61, at 115-17. Often what happens is that if the HMO feels the doctor “order[ed] too many tests,” “use[d] too many resources,” or kept an HMO patient at the hospital for longer than what is considered appropriate, the doctor will be questioned extensively about the reasons for taking these costly actions. EPSTEIN, *supra* note 15, at 22. Many doctors resent being questioned about their medical instincts. See *id.*

the hours expected of them.<sup>90</sup> Long, hard hours are commonly required when doctors work for MCOs and are “bad medicine” and “high-risk for patients.”<sup>91</sup> Many doctors are complaining that an increase in the number of hours they are expected to spend in scheduled appointments leaves them less time for other necessary work.<sup>92</sup>

Another frustrating factor for doctors is the significant bargaining imbalance between individual doctors in private practice and insurance providers.<sup>93</sup> Private doctors rely on these companies to get paid and the providers often take long periods of time to pay the claims that doctors submit.<sup>94</sup> The providers also change the coding system that doctors follow which shows the procedures the doctor used and the diagnosis.<sup>95</sup> The coding system assigns a number to each procedure and diagnosis and requires doctors to list the specific codes pertaining to each patient.<sup>96</sup> The doctors write the codes on a claim sheet and submit claim sheets to the health plan provider for payment. One claim sheet must be submitted for each patient and if the patient is covered under more than one plan, a claim sheet must be submitted to each provider. It is not hard to imagine the chaos that a change in the coding system could cause for doctors.<sup>97</sup> This can result in extra hours of paperwork to resubmit claims for payment. To date, this is one problem that doctors have been unable to

90. See Dan Lawlor, M.D., Commentary, *Voice of the People*, CHI. TRIB., Feb. 7, 1999, at 16, available at 1999 WL 2858376.

91. *Id.*

92. See Greenhouse, *Unions*, *supra* note 6, at A16. Doctors at clinics in Washington decided to unionize after their HMO ordered them to increase their scheduled appointment time from thirty-two hours per week to thirty-six hours per week. See *id.* The doctors say this leaves them very little time to do paperwork and lab analysis. See *id.*

93. See Webber, *supra* note 68, at F8; see also Greenhouse, *Unions*, *supra* note 6, at A16 (stating that doctors in private practice are unionizing to negotiate with HMOs); Lutsky, *supra* note 85, at 89 (discussing how doctors are “feeling powerless in a negotiating sense”).

94. See *Now Hear This . . .*, LEAGUE OF PHYSICIANS & SURGEONS (New York, N.Y.), Oct. 1999 (on file with the Hofstra Labor & Employment Law Journal). There is a law requiring HMOs to pay interest on claims that are not paid in a timely fashion. See *id.* However, doctors are claiming that HMOs are able to get around paying interest on claims by intentionally sending a payment to the doctor that is not in the correct amount, and then, after the doctor complains, sending the payment again, without interest, because the “original remittance was timely.” *Id.* This “self-serving interpretation of ‘timeliness’ should not be tolerated” because it allows “the HMO [to] have its cake and eat it too.” *Id.*

95. See *id.* (discussing how Oxford Health Plans is now comparing its coding practices to the Health Care Financing Administration’s national benchmarks and threatening doctors with “reduction[s] in fee schedules” and “refunds through arbitration proceedings”).

96. See *id.*; EPSTEIN, *supra* note 15, at 19-20.

97. The coding system “specif[ies] which procedures the insurer will cover.” EPSTEIN, *supra* note 15, at 20. Through the coding system, MCOs “limit the payments for the number of days a patient can be hospitalized, the number of tests, and the cost of procedures.” *Id.*

do much about.<sup>98</sup>

Private doctors feel that joining a union could give them the power to negotiate that they lack on their own.<sup>99</sup> Many private physicians would argue that the situation is out of control and MCOs are at such an advantage that they “can refuse contract changes proposed by doctors and simply threaten to lock out any individual provider from a high number of patients.”<sup>100</sup> Unionizing might give doctors, in particular those in private practice, a “chance for meaningful confrontation with a backbone” when negotiating with MCOs.<sup>101</sup> Although doctors have various reasons for joining unions, they can all agree that organizing might be a good way “to get the message out that we [as a society] have to improve health care.”<sup>102</sup> Unfortunately, there are significant barriers hindering private physicians from organizing and collectively bargaining.

### III. BARRIERS TO PRIVATE PHYSICIANS ORGANIZING AND COLLECTIVELY BARGAINING

#### *A. Policy Arguments Against Doctor Unionization*

Today, a tension exists within the medical community. Everyone seems to have an opinion as to whether or not doctor unionization is a good idea. As expected, insurance companies and MCOs are against unionization, but surprisingly enough so are some doctors.<sup>103</sup> Regardless

---

98. Doctors are trying to come up with ways to fight back. One example of how they are attempting to fight the HMOs that send incorrect remittances is by sending written complaints to their representatives instead of protesting directly and demanding prompt repayment with interest unless there is a valid rationale for the offset. *See Now Hear This . . .*, *supra* note 94.

99. *See generally Bargaining Bill Urged to Protect Patients*, AM. ACAD. OF ORTHOPAEDIC SURGEONS BULL., Aug. 1999, at 25 [hereinafter *Bargaining Bill*] (stating that HMOs offer doctors only one choice, “take my business, or go out of business”); *see also* Webber, *supra* note 68, at F8 (noting the AMA’s decision to start a union sends a strong message about how frustrated doctors are, and feel that they need to speak with more than “individual voices”).

100. *Bargaining Bill*, *supra* note 99, at 25. An HMO can refuse to allow individual doctors or clinics to be providers for people covered under that particular plan, thereby “locking them out.” This puts doctors in a compromising position as they are dealing with extremely large and powerful HMOs that require their insured to only see certain providers. *See id.* Therefore, doctors that are locked out would be unable to see what amounts, in certain circumstances, to a large number of patients. *See id.*

101. Lawlor, *supra* note 90, at 16.

102. Greenhouse, *Unions*, *supra* note 6, at A16.

103. *See id.*; Terry Kosdrosky, *Doctors See Unions as Cure for System’s Shortcomings*, CRAIN’S DETROIT BUS., Apr. 27, 1998, at 12, available at 1998 WL 8235809; Lowes, *supra* note 6, at 122.

of who is arguing against unionization, some of the reasons have merit and others seem absurd.

One reason against doctor unionization is that some doctors believe it is unprofessional.<sup>104</sup> According to these doctors, unionizing affects a doctor's image.<sup>105</sup> For some doctors, the fear surrounding physician unionization arises from the stigma attached to the word "union."<sup>106</sup> Due to the history of unions, many doctors perceive unions as traditionally blue-collar, used by skilled laborers, not professionals.<sup>107</sup> Therefore, they believe that joining a union would give them an unprofessional appearance.<sup>108</sup>

Advocates of doctors' unions view this as ludicrous. Dr. Robert Weinmann, the President of the California-based Union of American Physicians and Dentists, agrees: "I know these are things doctors are uncomfortable with. But they have to get over some of the smugness and the view that they are more professional than everyone else."<sup>109</sup> Resistance to doctors' unions puzzles other proponents of unionization. Anthony Tonzola, interim president of the Physicians Union of New Jersey says: "Why shouldn't we be together with people who are hammered by HMOs?"<sup>110</sup>

Another reason some doctors are against unionization is because they feel it conflicts with their Hippocratic Oath.<sup>111</sup> They see strikes as the main and "ultimate" weapon of unions.<sup>112</sup> If doctors were to go on strike, it would be unethical,<sup>113</sup> they would in essence be denying care to

104. See Lowes, *supra* note 6, at 122; see Greenhouse, *Unions, supra* note 6, at A16.

105. See Greenhouse, *Unions, supra* note 6, at A16; Kosdrosky, *supra* note 103, at 12.

106. See Greenhouse, *Unions, supra* note 6, at A16; Kosdrosky, *supra* note 103, at 12.

107. See Greenhouse, *Unions, supra* note 6, at A16. Because the patient is relying on the doctor for his or her special knowledge and expertise, doctors seem to feel that there is something about the doctor/patient relationship that suggests it is special and, therefore, they should not belong to unions. See Phan, *supra* note 61, at 117. To many doctors and critics of doctor unionization, unionizing means the deterioration of this "special relationship." See *id.* at 117-18.

108. See Greenhouse, *Unions, supra* note 6, at A16.

109. Kosdrosky, *supra* note 103, at 12.

110. Lowes, *supra* note 6, at 118, 122; see also Greenhouse, *Unions, supra* note 6, at A16.

111. See Lowes, *supra* note 6, at 122; Greenhouse, *Unions, supra* note 6, at A16. The Hippocratic Oath is an oath taken by physicians entering the practice of medicine. See SUGAR-WEBB, *supra* 29, at 6. At one time it was believed to have come from an ancient Greek physician called Hippocrates, the "father of medicine." See *id.* at 5-6. The oath is comprised of things a doctor promises to do or to refrain from doing. See *The Hippocratic Oath, available at* <http://www.medexplorer.com/hippocratic.dbm> (last visited May 17, 2001) (on file with the Hofstra Labor & Employment Law Journal).

112. See Greenhouse, *Unions, supra* note 6, at A16.

113. "[A]s a physician, I wouldn't think of joining a union . . . . With a union, the ultimate weapon is striking and that's something as a physician, ethically, I'm never going to do." *Id.* (quoting Sheryl Sun, an internist at the Kaiser Permanente Clinic in Santa Clara, California).

patients in violation of the Hippocratic Oath.<sup>114</sup> Therefore, the possibility of a strike has remained a reason why many doctors oppose unionization.

This fear of doctors striking is reasonable. Strikes have happened in the past and there are no guarantees that they will not happen in the future. In 1975, a California physician walkout resulted in a staff reduction of forty percent and losses estimated at 7.5 million dollars for hospitals.<sup>115</sup> However, it is important to keep in mind that only two strikes by nonresident physicians have occurred in the last sixteen years.<sup>116</sup> The AMA has also addressed this concern by announcing it will not permit its union members to use the striking tool.<sup>117</sup> While there are some doctors who are worried that the AMA has given away “one of the bargaining chips”<sup>118</sup> by not considering striking, there are others who still remain reluctant to join a union for the very idea that a strike could occur.<sup>119</sup> This fear, coupled with concern over a professional image, is enough to keep many private doctors from joining a union.

Additionally, some physicians believe doctors should not unionize because there are other alternatives available. They argue that there are already groups in place to address the needs of doctors, and therefore doctors’ unions are unnecessary.<sup>120</sup> These groups include medical societies, which already handle their problems and work to address their needs.<sup>121</sup> In Michigan, doctors have one such group, the Michigan State

---

114. See Phan, *supra* note 61, at 138. In part, the Hippocratic Oath states:

I will use my power to help the sick to the best of my ability and judgment; I will abstain from harming or wrongdoing any man by it. . . . If, therefore, I observe this Oath and do not violate it, may I prosper both in my life and in my profession, earning good repute among all men for all time. If I transgress and forswear this Oath, may my lot be otherwise.

*The Hippocratic Oath*, available at <http://www.medexplorer.com.hippocratic.dbm> (last visited May 17, 2001) (on file with the Hofstra Labor & Employment Law Journal). Both doctors and society take the Hippocratic Oath very seriously. However, it is the sentiment of many doctors that because unions and HMOs did not take the Oath, “[t]hey could care less about the patient’s suffering.” Phan, *supra* note 61, at 138. While the doctors who feel this way recognize that there are alternatives to striking, they also feel that it is always the last resort of unions and this is unacceptable to them. *See id.* Striking, to many individuals, makes unions no better to deal with than HMOs. *See id.* This sentiment is changing rapidly, however, as physicians are beginning to feel that there is no alternative than to turn to collective bargaining to better deal with HMOs. *See id.* at 138.

115. See Phan, *supra* note 61, at 118.

116. *See id.*

117. See Lowes, *supra* note 6, at 122.

118. Webber, *supra* note 68, at F8.

119. See Greenhouse, *Unions*, *supra* note 6, at A16.

120. See Kosdroosky, *supra* note 103, at 12.

121. *See id.*



Medical Society, advocating on their behalf.<sup>122</sup> Recently, it successfully argued a case against an insurance company.<sup>123</sup> Moreover, those who support these societies feel that they are better suited for doctors because patient care is one of their priorities.<sup>124</sup> Further, these societies are not faced with the legal hurdles plaguing doctor unionization.<sup>125</sup>

Advocates for doctor unionization argue that medical societies do not do enough for doctors and that something more is necessary, especially with the increased number of HMOs.<sup>126</sup> Proponents of doctors' unions maintain that "[h]ealth-care unions have led the fight to protect public health care, and they work to support patient advocacy."<sup>127</sup> Their argument is that:

Unions tend to be proactive, taking chances in new areas of employee rights and advocating strongly on behalf of individual members: in contrast, [medical] associations are more reactive. [They] often wait until major issues affect a majority of their membership, then attempt to address those issues on a general, rather than [an] individualized basis.<sup>128</sup>

This is interesting because it is unclear whether medical associations, such as the AMA, are precluded by antitrust law to act as labor organizations and collectively bargain. Therefore, it is hard to understand why it has taken the AMA so long to get involved and why many of these societies are still maintaining their traditional roles.<sup>129</sup>

Apart from doctors, HMOs and hospitals also have concerns over unionization. HMOs argue that unionization will result in higher costs for patient care.<sup>130</sup> They claim that they "have controlled skyrocketing

122. *See id.*

123. *See id.*

124. *See id.*

125. *See* Kosdroosky, *supra* note 103, at 12.

126. *See* Lutsky, *supra* note 85, at 93. Advocates of doctors' unions stress the fact that associations deal with the issues doctors face by giving them general solutions instead of analyzing the particular problem or situation at hand. *See id.* One doctor wrote to two different medical associations and they did not attempt to deal with his particular situation, but instead gave general advice while telling him to "consult [his] own attorney." *Id.* When dealing with the same situation, a union immediately sent a representative to plan a course of action. *See id.*

127. Lawlor, *supra* note 90, at 16.

128. Lutsky, *supra* note 85, at 93.

129. *See id.* One explanation of the AMA's hesitancy is that "[it], unfortunately, has always been a responding type of organization, waiting for the course of history and course of sociology to bypass it, and then responding with sort of studied moderation to things that already happened." *Id.*

130. *See* David Schwab, *MDs Denied Right To Unionize Against HMOs*, STAR-LEDGER, May 25, 1999, available at 1999 WL 2982012; Burney, *supra* note 63.

health costs.”<sup>131</sup> Therefore, if doctors unionize, HMOs maintain that they will not be able to keep a close eye on doctors, resulting in increased fees and the performance of unnecessary tests.<sup>132</sup> AmeriHealth’s Chairman and Chief Executive Officer, G. Fred DiBona, Jr., said: “consumers [will] face[] considerably higher costs in the future”<sup>133</sup> if doctors unionize. Some hospitals are also against unionization for the same reason. The concern is that unionization will result in increased patient costs and lost profits.<sup>134</sup> From a business perspective, inefficiency is created because hospitals will be providing the same quality of care as before, but at a higher cost.<sup>135</sup> However, while the current care provided to patients might be cost-efficient, both HMOs and hospitals are overlooking the lack of quality in the care itself.<sup>136</sup>

Public sentiment also plays a role in the doctor unionization movement. While unions are becoming more enticing to private physicians, with many being persuaded to join their ranks, others still feel that they cannot take the plunge and join a union because the public sentiment seems so strongly against it.<sup>137</sup> The opposition from outside of the medical community stems from the view that doctors are highly compensated and “do not have the right to complain about their incomes.”<sup>138</sup> Additionally, doctors are seen as protectors and guardians, distinguishing them from other employees.<sup>139</sup>

Aside from the reasons mentioned above, critics contend that unionization will not solve the inherent conflict in the relationship

131. Burney, *supra* note 63.

132. *See id.*

133. Schwab, *supra* note 130. AmeriHealth was rated one of New Jersey’s top HMOs by the New Jersey Department of Health and Senior Services. *See id.* G. Fred DiBona, Jr.’s statement was in response to the NLRB’s ruling that doctors were independent contractors and not employees. *See id.* These New Jersey doctors had joined United Food and Commercial Workers Local 56. *See* Burney, *supra* note 63. As a result of the NLRB’s ruling, these doctors are not permitted to collectively bargain with HMOs. *See id.*

134. *See* Greenhouse, *Unions*, *supra* note 6, at A16; Schwab, *supra* note 130.

135. *See* Kosdrosky, *supra* note 103, at 12.

136. *See* Schwab, *supra* note 130 (reporting that doctors are complaining that HMOs interfere with medical decisions by “refusing to pay for expensive procedures” and “forcing patients to leave the hospital early”).

137. *See* Lutsky, *supra* note 85, at 90-91.

138. *Id.* at 91.

139. *See id.* “[T]he medical profession stands alone in the widespread perception that it should not be able to rise up and protect its interests.” *Id.* Movie stars and athletes, who are also highly compensated, have the right to unionize and the public does not protest in the same way that it does when doctors’ unionizing efforts are involved. *See id.* This shows that it is not the high compensation, but rather society’s perception of the role of doctors in the community, that leads to public opposition to physician unionization.

between doctors and health plan providers.<sup>140</sup> If doctors unionize, the unionization will create a “physician monopoly.”<sup>141</sup> When this happens, insurance companies and HMOs will not just sit back and watch; they will fight back.<sup>142</sup> For them to equalize the playing field, the insurance companies and the HMOs will also “band together.”<sup>143</sup> The fear is that a domino effect will result and both sides will end up where they started.<sup>144</sup>

### B. Antitrust Law

In addition to the policy considerations, legal obstacles exist which prevent doctor unionization. The first of these obstacles involves antitrust regulations. There are two laws governing antitrust, the Sherman Act and the Clayton Act.<sup>145</sup> Congress passed the Sherman Act to prevent monopolies in trade and commerce.<sup>146</sup> As a result of the Sherman Act, labor organizations encountered problems bargaining for wages and working conditions with employers.<sup>147</sup> This happened when federal courts held that unions bargaining for wages interrupted the flow of commerce by attempting to create monopolies.<sup>148</sup> Consequently, injunctions were issued against labor organizations for antitrust violations.<sup>149</sup>

Congress passed the Clayton Act in response to problems experienced by labor organizations under the Sherman Act.<sup>150</sup> The Clayton Act exempts labor organizations from antitrust violations by prohibiting courts from issuing injunctions for bargaining about terms

140. See Burney, *supra* note 63.

141. See *id.*

142. See *id.*

143. *Id.*

144. See *id.*

145. See Sherman Act, 15 U.S.C. §§ 1-7 (1994); Clayton Act, 15 U.S.C. §§ 12-27, 29 U.S.C. §§ 52-53 (1994).

146. See 15 U.S.C. § 2. Section 2 states that:

Every person who shall monopolize, or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize any part of the trade or commerce among the several States, or with foreign nations, shall be deemed guilty of a felony, and, on conviction thereof, shall be punished by fine not exceeding \$10,000,000 if a corporation, or, if any other person, \$350,000, or by imprisonment not exceeding three years, or by both said punishments, in the discretion of the court.

*Id.*; see also *Allen Bradley Co. v. Local Union No. 3, IBEW*, 325 U.S. 797, 801 (1945) (discussing the history of the Sherman Act).

147. See *Allen Bradley Co.*, 325 U.S. at 801.

148. See *id.* at 802.

149. See *id.*

150. See *id.* at 803-04.

and conditions of employment.<sup>151</sup> Section 17 of the Clayton Act provides that labor “is not a commodity or article of commerce.”<sup>152</sup> It also makes it lawful for members of labor organizations to engage in collective activities.<sup>153</sup> In *Allen Bradley*, the Supreme Court, taking both the Sherman Act and the Clayton Act into consideration, concluded that bargaining between labor organizations and business employers does not violate antitrust law unless the two sides intend to use the bargaining process to drive out competition.<sup>154</sup> If, as a natural and probable result of the bargaining, competitors are eliminated, there is no antitrust violation

151. See 29 U.S.C. § 52. Section 52 provides that:

No restraining order or injunction shall be granted by any court of the United States, or a judge or the judges thereof, in any case between an employer and employees, or between employers and employees, or between employees, or between persons employed and persons seeking employment, involving, or growing out of, a dispute concerning terms or conditions of employment, unless necessary to prevent irreparable injury to property, or to a property right, of the party making the application, for which injury there is no adequate remedy at law, and such property or property right must be described with particularity in the application, which must be in writing and sworn to by the applicant or by his agent or attorney.

And no such restraining order or injunction shall prohibit any person or persons, whether singly or in concert, from terminating any relation of employment, or from ceasing to perform any work or labor, or from recommending, advising, or persuading others by peaceful means so to do; or from attending at any place where any such person or persons may lawfully be, for the purpose of peacefully obtaining or communicating information, or from peacefully persuading any person to work or to abstain from working; or from ceasing to patronize or to employ any party to such dispute, or from recommending, advising, or persuading others by peaceful and lawful means so to do; or from paying or giving to, or withholding from, any person engaged in such dispute, any strike benefits or other moneys or things of value; or from peaceably assembling in a lawful manner, and for lawful purposes; or from doing any act or thing which might lawfully be done in the absence of such dispute by any party thereto; nor shall any of the acts specified in this paragraph be considered or held to be violations of any law of the United States.

*Id.* Courts can, however, issue injunctions where certain property interests are at stake or where labor practices violate the Norris-LaGuardia Act, 29 U.S.C. §§ 101-15 (1994).

152. 15 U.S.C. § 17. Section 17 provides that:

The labor of a human being is not a commodity or article of commerce. Nothing contained in the antitrust laws shall be construed to forbid the existence and operation of labor, agricultural, or horticultural organizations, instituted for the purposes of mutual help, and not having capital stock or conducted for profit, or to forbid or restrain individual members of such organizations from lawfully carrying out the legitimate objects thereof; nor shall such organizations, or the members thereof, be held or construed to be illegal combinations or conspiracies in restraint of trade, under the antitrust laws.

*Id.*

153. See *id.*

154. See *Allen Bradley*, 325 U.S. at 809-11. It is noteworthy that the Court found an antitrust violation because the purpose of the bargaining in that case was to eliminate competition. See *id.*; *UMW v. Pennington*, 381 U.S. 657, 665-66 (1965).

because the collective bargaining was not aimed at causing this result.<sup>155</sup>

### C. The National Labor Relations Act

A third barrier facing unionizing doctors is federal labor law. The applicable federal law in this area is the NLRA.<sup>156</sup> The purpose of the NLRA is to protect the rights of employees to organize or join a labor organization and to collectively bargain with employers for competitive wage earnings and good working conditions.<sup>157</sup> By protecting this right, the bargaining power between employers and employees becomes equal, limiting unrest within that labor sector.<sup>158</sup> However, federal law creates a problem for unionizing doctors because the NLRA does not necessarily protect their right to organize and collectively bargain.<sup>159</sup> Doctors may run into problems regarding coverage under the NLRA in certain circumstances such as: employee status, unit determination, and multiple role situations.<sup>160</sup>

The NLRA only protects the rights of employees as defined under the Act.<sup>161</sup> It does not give supervisors or independent contractors the right to join labor organizations.<sup>162</sup> As discussed below, the reason for their exclusion is that they simply do not need the NLRA's protection.

Independent contractors work and get paid on a job by job basis as opposed to employees who work for a set hourly wage or annual salary.<sup>163</sup> They negotiate the price for each undertaking and, if dissatisfied, can refuse the work.<sup>164</sup> Their income does not depend on wages, "but upon the difference between what they pay for goods, materials, and labor and what they receive for the end result, that is, upon profits."<sup>165</sup> To determine whether a person is an independent contractor, the NLRB applies the "right-of-control" test.<sup>166</sup> A person is an independent contractor if the hiring party only has control over the

---

155. See *Pennington*, 381 U.S. at 665-66. The Court held that an attempt by the union and employers "to secure uniform labor standards throughout the industry, if proved, was not exempt from the anti-trust laws." *Id.* at 669.

156. 29 U.S.C. §§ 151-68.

157. See *id.* at § 151.

158. See *id.*

159. See *Lutsky*, *supra* note 85, at 63-64.

160. See *id.* at 64.

161. See 29 U.S.C. § 152(3).

162. See *id.*

163. See *ST. ANTOINE ET AL.*, *supra* note 26, at 52.

164. See *id.*

165. *Id.*

166. *Id.* at 53.

end result.<sup>167</sup> If the Board finds that the worker in question does not have any control “over the manner and means by which the result is accomplished[,]” that worker is an employee.<sup>168</sup>

Supervisors, like independent contractors, are not covered under the NLRA.<sup>169</sup> It provides that:

The term “supervisor” means any individual having authority, in the interest of the employer, to hire, transfer, suspend, lay off, recall, promote, discharge, assign, reward, or discipline other employees, or responsibly to direct them, or to adjust their grievances, or effectively to recommend such action, if in connection with the foregoing the exercise of such authority is not of a merely routine or clerical nature, but requires the use of independent judgment.<sup>170</sup>

Normally if people engage in any of these activities, they will be labeled a supervisor and precluded from the protection of the Act.<sup>171</sup> “Where a physician fits into the definitions, and whether she has certain indicia is often a difficult issue and requires careful analysis.”<sup>172</sup> Therefore, when determining whether a physician is a supervisor, the Board has to evaluate each case individually.<sup>173</sup>

Generally, the Board has found private practice doctors to be supervisors or independent contractors so they have not been afforded protection under the NLRA.<sup>174</sup> In some instances, doctors have been categorized as professional employees and their right to organize and collectively bargain was protected under the Act.<sup>175</sup>

---

167. *See id.*

168. ST. ANTOINE ET AL., *supra* note 26, at 53.

169. Under the original Act supervisors were treated as employees and were afforded protection. *See id.* at 54. This changed, however, when employers attacked the original Act. *See id.* With the Taft-Hartley Act of 1947, Congress amended the NLRA by “expressly exclud[ing] from the definition of ‘employee’ ‘any individual employed as a supervisor’ and adopted an apparently broad definition of ‘supervisors.’” *Id.* (citation omitted).

170. 29 U.S.C. § 152(11).

171. *See id.* at § 152(3), (11); *see also* Leigh Anne Flavin, Comment, *The Thomas-Davis Cases: The Appropriateness of Physicians as Bargaining Units and the Possible Implications for Insurance Companies Under the National Labor Relations Act*, 30 ARIZ. ST. L.J. 811, 813 (1998).

172. Flavin, *supra* note 171, at 813-14.

173. *See id.* at 819.

174. *See id.* at 818-21 (discussing different Board findings as to whether a doctor was an employee or a supervisor). *See, e.g.*, AmeriHealth Inc., 329 N.L.R.B. No. 76 (Oct. 18, 1999), 1999 WL 963200, at \*32 (finding that private practice physicians were independent contractors and not employees).

175. *See Montefiore*, 261 N.L.R.B. at 569. Montefiore Hospital and Medical Center is a not-for-profit organization that provides health care services. *See id.* The managerial decisions of the hospital were acted out by the hospital’s extensive administrative structure. *See id.* at 570-71. The

## 1. Can Doctors Be Both Employers and Employees at the Same Time?

In order for private practice doctors to be granted protection by the NLRA, an exception must be created. This is not as simple as it sounds. The exception must provide that these doctors are employees for collective bargaining purposes, but retain employer status in all other work-related circumstances. This conflict may present problems when the physicians negotiate with the managed care organizations.<sup>176</sup>

The following hypothetical is used to illustrate how one doctor could be classified as both an employer and an employee. Assume that an independent private practitioner owns and runs a private medical practice. Twenty doctors work for this practice, therefore, they are employees of the practice. Because the independent private practitioner runs the practice, he or she is the employer of those twenty employees.<sup>177</sup> This practice has contracted with MCOs. These contracts allow it to provide services to patients insured by those MCOs. The private doctors

---

staff doctors' involvement in managerial decisions was restricted to recommendations subject to evaluation by the administration. *See id.* at 571. The main duty of the staff doctors was and still is patient care. *See id.* Therefore, the NLRB determined the hospital's staff doctors were not supervisors, but professional employees whose rights are protected by the NLRA. *See id.* at 569.

176. *Cf.* Memorandum from (name omitted), Attorney at National Labor Relations Board Region 29, to Al Blyer, Attorney at National Labor Relations Board Region 29 (Nov. 20, 1997) [hereinafter Memorandum to Al Blyer] (on file with the Hofstra Labor & Employment Law Journal) (discussing how a problem exists where custodian engineers are not only *employees* of the Board of Education but also are *employers* of other custodians).

An inquiry into the custodian case problem is useful because it deals with similar issues that are likely to arise with respect to private doctors if they are allowed to unionize. First, it is important to understand what the facts are in typical custodian cases because it helps draw out the analogy to doctors. The case that illustrates this analogy is *In re Sch. & Library Employees Union, Local 74*, N.Y. Pub. Empl. Relations Bd. (March 8, 1976) (No. D-0087). In this case, there was a custodian engineer who worked for a particular school but was employed by the Board of Education. *See* Memorandum to Al Blyer (providing a helpful recitation of the facts). His duties were to oversee the other custodians and make sure that they were performing their duties. *See Sch. & Library Employees Union* (No. D-0087). The custodian engineer has complete control over the hiring and firing of the other custodians. *See id.* In fact, he issues the paychecks of the other custodians and cleaners. *See* Stip. ¶ 6, *Sch. & Library Employees Union* (No. D-0087). The custodian engineer was covered as an employee under a collective bargaining agreement between the Board of Education and his union. *See* Memorandum to Al Blyer. Yet, that same custodian engineer was represented by the same union in his role as the employer of the other custodians and cleaners. *See id.* In other words, Local 891 acts as a union by representing the custodian engineers in their collective bargaining with the Board of Education, but also as a multi-employer association by representing those same engineers as employers of cleaners. *See id.* Therefore, the custodian engineer and the union are playing multiple roles.

177. Think of the owner as the head partner of a law firm. The head partner at a law firm is still an attorney, but he or she makes more money than others at the firm and is in charge of most major decisions. The head partner also "runs" the firm. The owner/doctor in our hypothetical "runs" the practice and the other doctors are his or her employees.

would want to organize to form a union to collectively bargain with these MCOs for better working conditions. Here is where the confusion surfaces. In our hypothetical, the doctors at the clinic, if unionized, would collectively bargain with the MCOs. However, the owner-doctor is the employer of the other twenty doctors. There are going to be issues the doctor will bargain for, as the business owner of the practice, that will conflict with the issues the other twenty doctors are concerned with, such as considerations for better patient care.

Society is already concerned that doctors want to unionize to raise their profits. The argument is that if in a position to negotiate, doctors will use that ability solely to increase profits. The problem illustrated by the hypothetical, doctors simultaneously acting as employers and employees, exemplifies this societal concern. Because the owner of a clinic/private practice is in a position to negotiate with the MCOs, he or she is also in a position to make deals with the MCOs that may compromise the best interest of the patients. These deals might adversely affect the interests of the other doctors in the practice as well.<sup>178</sup>

Aside from the aforementioned policy concern, legally, there is a problem with unit determination.<sup>179</sup> As discussed earlier, the Board determines the proper bargaining unit.<sup>180</sup> Although the previous discussion is in the context of private physicians not fitting into the same bargaining unit as housestaff (interns, residents, and fellows), the same problem arises here. It is not clear that owner-doctors should be placed in the same unit as the doctors they employ because of the possibility of diverging interests. Once the Board establishes a bargaining unit, no collective bargaining can take place outside of that unit.<sup>181</sup> If the Board determines that all private physicians are part of the same bargaining unit, it is likely that the owner-doctor's interests will supercede those of his or her employees. Then arises the concern that patient care might be sacrificed as well.

---

178. In the hypothetical case, the owner-doctor is going to be concerned with not only patient care, but also running a business and maximizing profits. There is a possibility that the business interests of the owner-doctor make his interests so different from those of the other doctors that together they do not make an appropriate bargaining unit.

179. Interview with Richard Bock, Attorney for the National Labor Relations Board, Region 29, in Hempstead, N.Y. (Feb. 15, 2000).

180. See *supra* notes 28-30 and accompanying text.

181. See *ST. ANTOINE ET AL.*, *supra* note 26, at 265 (discussing how employers can bargain only exclusively with the representative unit).



## 2. Multiple Employer Problems

### a. Single Employer Units

If private physicians are given the right to collectively bargain with MCOs, then there are some issues that arise regarding the parties involved in the negotiations. Going back to our hypothetical, three parties are involved: 1) the owner-doctor; 2) the physician employees; and 3) the MCOs. The physician employees, arguably, have two employers. This leads to some of the same issues raised when determining proper bargaining units.<sup>182</sup> In some situations, it might be appropriate to consider multiple employers as a single employer unit for collective bargaining purposes. In our example, the single employer unit would be the MCO and owner-doctor.

The question becomes whether the MCO and owner-doctor are two separate entities sufficiently integrated as to constitute a single employer. To determine this, the Board must evaluate: "(1) functional integration of operations; (2) centralized control of labor relations; (3) common management; and (4) common ownership."<sup>183</sup>

When looking at these factors, it is unlikely that owner-doctors and MCOs would ever be considered a single-employer unit by the NLRB. It is clear that MCOs and owner-doctors do not have any type of functional integration of operations. They only interact with one another for approval of patient care and payment for services. While the doctors may feel that the MCOs have "management control," the inner workings of the doctors' offices are only controlled by the owner-doctors and their staff. If the owner-doctor no longer wants to deal with a particular MCO, the owner-doctor can decide to forgo future contract deals with that MCO after their present contract expires.

In *Radio & Television Broadcast Technicians Local Union 1264 v. Broadcast Service of Mobile, Inc.*,<sup>184</sup> the NLRB found that WSIM, the local radio station and the Holt Broadcasting Service were a single-employer unit because WSIM was owned and operated by Holt.<sup>185</sup> Therefore, looking at the structure of the two corporations, WSIM was essentially a subsidiary due to its substantial integration with Holt

---

182. See *infra* Part III.C.1 & 2.b.

183. *NLRB v. Browning-Ferris Indus.*, 691 F.2d 1117, 1122 (3d Cir. 1982); see also *Radio Union v. Broadcast Serv. of Mobile, Inc.*, 380 U.S. 255 (1965).

184. 380 U.S. 255 (1965).

185. See *id.* at 256.

Broadcasting.<sup>186</sup> As can be seen, a private doctor's office has a completely different relationship with an MCO.

#### b. Joint and Multi-Employer Bargaining Units

Another difficulty arises for society when private practice physicians have to contract with several different MCOs. The doctors' unions will have to negotiate and bargain with each MCO individually, which is both onerous and inefficient. As a result, doctors' unions will have to abide by many different collective bargaining agreements. Normally, when this problem arises in other contexts, the solution for the negotiating parties is to consent to multi-employer bargaining.<sup>187</sup>

To illustrate the concept of multi-employer bargaining, consider this example. There are three MCOs: MCO-1, MCO-2, and MCO-3. Each contracts with the union representing the private physicians. If they were to bargain as a multi-employer unit, the union and the MCOs would negotiate and bargain together to reach a collective agreement binding all parties.<sup>188</sup> After consent to this arrangement has been given and negotiations have begun, no party may withdraw from the negotiations until an agreement is reached.<sup>189</sup> If the parties have bargained to the point of impasse, each side has tools it can use to facilitate further negotiations.<sup>190</sup> The union may, for example, engage in a whipsaw strike.<sup>191</sup> In a whipsaw strike the union will choose one of the employers in the multi-employer unit and have its employees strike.<sup>192</sup> If the impasse remains beyond this first strike, the union will continue down the line striking each employer in succession.<sup>193</sup> To combat the striking efforts of the union, the employers may institute a lockout.<sup>194</sup>

However, multi-employer bargaining units are not attractive to society. The tools used to break an impasse will likely result in an MCO monopoly over the entire health plan industry. As noted earlier, physicians striking is unacceptable to both doctors and society due to

---

186. *See id.*

187. *See* Douglas L. Leslie, *Symposium on the Law and Economics of Bargaining: Multiemployer Bargaining Rules*, 75 VA. L. REV. 241, 241-42 (1989).

188. *See id.* at 241.

189. *See id.* at 242.

190. *See id.*

191. *See id.* at 242-43; *see also* ST. ANTOINE ET AL., *supra* note 26, at 282.

192. *See* ST. ANTOINE ET AL., *supra* note 26, at 282-84 (discussing Charles D. Bonanno *Linen Serv. v. NLRB*, 454 U.S. 404 (1982)).

193. *See id.*

194. *See id.* at 282; Leslie, *supra* note 187, at 243.

their commitment to watch over patients. Without the striking tool, however, doctors would be at the mercy of the MCO multi-employer unit. MCOs, on the other hand, are in the business of making money. They do not take an oath to provide health care to the sick, therefore, they would have no objection to utilizing the lockout tool. By locking out doctors, MCOs would essentially be locking out patients, denying them patient care in much the same way a doctors' strike would. From a business perspective, joining a multi-employer bargaining unit is great for the MCOs because they can all band together and fix health care prices. This leaves the customer-patients without the ability to shop around for the best health care coverage at reasonable prices. Consequently, society should be wary of these MCO multi-employer bargaining units as a response to doctor unionization.

#### IV. THE ELIMINATION OF OBSTACLES THROUGH LEGISLATION

##### A. *House of Representatives Bill 1304*<sup>195</sup>

In this country, the ongoing debate over health care has people urging Congress to get involved.<sup>196</sup> Congress has been unable to get much accomplished because of the disagreement over the proper solution. The result has been a series of proposed bills submitted by different members of the House of Representatives.<sup>197</sup> None of these bills, however, have proven sufficient in accomplishing anything significant, other than more debate amongst our representatives.

The most recent bill, however, proposes a change in the law dealing specifically with the organization of physicians for the purposes of collectively bargaining with HMOs and other insurance companies.<sup>198</sup> The proposed bill's stated purpose is

[t]o ensure and foster continued patient safety and quality of care by making the antitrust laws apply to negotiations between groups of health care professionals and health plans and health insurance issuers in the same manner as such laws apply to collective bargaining by

---

195. H.R. 1304, 106th Cong. (1999).

196. See generally *Bargaining Bill*, *supra* note 99, at 25 (stressing doctors' concerns over the current health care situation).

197. See H.R. 1304; H.R. 2723, 106th Cong. (1999); H.R. 2824, 106th Cong. (1999).

198. See H.R. 1304; see also *Bargaining Bill*, *supra* note 99, at 25.

labor organizations under the National Labor Relations Act.<sup>199</sup>

Essentially, the proposed bill attempts to provide for an antitrust exemption for all health care professionals in the limited context of bargaining and negotiating with health plan providers.<sup>200</sup> House Bill 1304, also known as the Campbell Bill,<sup>201</sup> states that in these negotiations, the physicians, even private doctors, should be treated the same way as employees who are covered under the NLRA.<sup>202</sup> This is an attempt to bypass the finding that physicians in private practice are independent contractors, managers, or employers, *not* employees covered by the NLRA.<sup>203</sup> Proponents of the bill argue that this would help level out the playing field between physicians and health plans.<sup>204</sup> Furthermore, H.R. 1304 eliminates concern over physician strikes through an express limitation prohibiting such strikes.<sup>205</sup> This limitation states that “[t]he exemption provided in subsection (a) shall not confer any right to participate in any collective cessation of service to patients not otherwise permitted by law.”<sup>206</sup> Although this anti-strike provision makes the bill look attractive, due to strong lobbying by MCOs, Republican leaders in the House of Representatives have put the bill aside.<sup>207</sup>

### *B. Preventing Strikes Through State Law*

Striking continues to be a major source of discomfort for those promoting doctor unionization.<sup>208</sup> Although H.R. 1304 attempts to solve this problem, there are state laws that offer valuable solutions. For example, many states prohibit public employees from striking.<sup>209</sup> The purpose of these anti-strike laws is to provide a way for public employees to organize and collectively bargain over working conditions while protecting the community’s health and safety by disallowing

199. H.R. 1304.

200. *See id.*; *see also Bargaining Bill, supra* note 99, at 25.

201. The Bill is referred to as the Campbell Bill because it was introduced by Representative Tom Campbell, a Republican from California. *See* H.R. 1304.

202. *See id.*

203. *See id.* (stating that physicians “shall not be regarded as having the status of an employer, independent contractor, managerial employee, or supervisor”).

204. *See Bargaining Bill, supra* note 99, at 25.

205. *See* H.R. 1304 § 3(c).

206. *Id.*

207. *See* 160 CONG. REC. S13599 (daily ed. Nov. 1, 1999) (statement of Sen. Graham).

208. *See* Greenhouse, *Unions, supra* note 6, at A16.

209. *See, e.g.,* N.Y. CIV. SERV. LAW §§ 200-214 (McKinney 1999).

cessation of service.<sup>210</sup> Public employees that have been prevented from striking include police officers, firefighters, and teachers.<sup>211</sup> Employees of state or municipally owned utilities such as: electrical workers, water and sewage workers, transit system workers, and port facility workers have also been prevented from striking.<sup>212</sup> While the majority of these employees are blue-collar workers, their jobs involve caring for the public. Police officers and firefighters, in particular, care for the public in a way that makes striking seem reprehensible. Doctors striking would have the same effect, if not worse, than a strike by public employees.

Anti-striking laws have not prevented these public employees from effectively organizing and negotiating over working conditions.<sup>213</sup> These same laws also provide alternate methods for resolving negotiation disputes.<sup>214</sup> The public employees' union is required to negotiate with the employer until impasse.<sup>215</sup> Upon reaching the point of impasse, the union and employer have several options. First, the employer and the union can choose a neutral arbitrator to come and mediate the situation to reach a comparable resolution of the terms of the collective bargaining agreement.<sup>216</sup> Second, the employer and the union can turn to the Public Employment Relations Board ("PERB"),<sup>217</sup> which can appoint a mediator to resolve the dispute.<sup>218</sup> Lastly, if an impasse still exists, the Board will make a recommendation to resolve it by deciding the terms

---

210. See Bernard T. King, *The Taylor Act-Experiment in Public Employer-Employee Relations*, 20 SYRACUSE L. REV. 1, 3 (1968).

211. See, e.g., *Warwick Sch. Comm. v. Warwick Teacher's Union Local 915*, 613 A.2d 1273, 1275-76 (R.I. 1992) (teachers); *City of New Orleans v. Police Ass'n of La., Teamsters Local No. 253*, 369 So. 2d 188, 190 (La. Ct. App. 1979) (police officers); *Syracuse Hancock Prof'l Firefighters Ass'n, Local 1888*, 494 N.Y.S.2d 191, 193 (App. Div. 1985) (firefighters).

212. See *City of Pana v. Crowe*, 316 N.E.2d 513, 515-16 (Ill. 1974) (water and sewage workers); *Hanson v. Commonwealth*, 181 N.E.2d 843, 847-48 (Mass. 1962) (transit system workers); *City of Alcoa v. IBEW Local Union 760*, 308 S.W.2d 476, 482 (Tenn. 1957) (electrical workers); *City of Wilmington v. Gen. Teamsters Local Union 326*, 290 A.2d 8, 13 (Del. Ch. 1972) (port facility workers).

213. See N.Y. CIV. SERV. LAW § 209. See, e.g., Matthew Carolan & Raymond J. Keating, *Don't Blame Island's Cops for Their Lofty Salaries*, NEWSDAY (New York, N.Y.), Sept. 5, 2000, at A26 (confirming that the Nassau County police officers' union has successfully negotiated high salaries, \$90,000 on average, without the use of a strike).

214. See N.Y. CIV. SERV. LAW §§ 205, 209.

215. See *Inc. Vill. of Lynbrook v. N.Y. State Pub. Employment Relations Bd.*, 48 N.Y.2d 398, 402 n.1 (1979).

216. See N.Y. CIV. SERV. LAW § 209(2); *Niagara Wheatfield Adm'rs Ass'n v. Niagara Wheatfield Cent. Sch. Dist.*, 44 N.Y.2d 68, 71 (1978); *County of Broome v. Deputy Sheriffs Benevolent Ass'n*, 395 N.Y.S.2d 720, 721 (App. Div. 1977).

217. See N.Y. CIV. SERV. LAW § 205(1).

218. See *id.* at § 209(3)(a).

and conditions of employment.<sup>219</sup>

Doctors' unions should be held to the same anti-striking laws as public employees. Prohibiting the use of strikes allows doctors to collectively bargain and organize without having to worry about harming the community's health and safety.

## V. CONCLUSION

It is apparent that there are many problems that must be resolved before private physicians can organize and collectively bargain with MCOs in an effective manner. Even if legislation resolves the legal problems, such as antitrust regulations and the applicability of the NLRA, other issues, the biggest being the striking tool, arise that must be addressed. One question that must be answered is: will doctor unionization be effective if doctors waive the right to strike, the most powerful and threatening of all union tools? The answer is unclear, but one thing we do know—doctors' strikes are unacceptable as a matter of public policy.

Although recent proposed legislation seems attractive, there are valid concerns that it would lead to a shift of power resulting in physicians raising their fees.<sup>220</sup> These costs would then be passed along to the patient through the insurance companies and MCOs.<sup>221</sup> This is problematic because if doctors conduct and charge MCOs for unnecessary tests or charge more for services, all of the costs will be passed on to the patients. So, what can be done?

While attempts at unionization and negotiation with MCOs are forthcoming and some doctors' unions have been established, perhaps the answer lies in MCO contract negotiations. Doctors should focus on strengthening their medical societies by having them work with MCOs to establish a contract negotiating clause that would allow both doctors and MCOs to continuously argue for terms that are important to them. These contracts should also include provisions that guide the parties if negotiations fail. Since MCOs are heavily opposed to doctor unionization, this alternative might be the answer. They should focus on the fact that this option, while not as favorable for them as the current system, is clearly better than dealing with doctors' unions.

The contracts should be structured to utilize alternative dispute

---

219. See *id.* § 209(3); *County of Niagara v. Newman*, 481 N.Y.S.2d 563, 564 (App. Div. 1984).

220. See *Bargaining Bill*, *supra* note 99, at 25.

221. See *id.*

resolution (“ADR”). ADR includes arbitration and mediation and consists of bringing in a third party to arbitrate or mediate disputes that arise between the parties. This would allow conflicts arising between health care providers and MCOs to be handled out-of-court. The parties would agree to submit disputes to mutually chosen mediators and arbitrators for resolution, emphasizing patient care as the main concern and profits as secondary. For this very reason, the public will have more faith in the resolutions. It is good for the parties because it is more cost-effective than going to court and does not take as long to resolve. It also eliminates the need for tools like striking and lockouts, and facilitates negotiations and communication between doctors and MCOs.

A variation of this ADR model would involve doctors’ unions and MCOs submitting disputes under collective bargaining agreements to mediation or arbitration. In this context, if an impasse is reached, MCOs and doctors’ unions will turn to a neutral mediator or arbitrator for a binding resolution. A clause in the collective bargaining agreement between the MCO and the union will provide guidance in these situations. Currently, many public employees such as firefighters, police officers, and teachers are prohibited from striking, yet have successfully negotiated with their employers. However, if negotiations fail, the parties turn to the arbitration/mediation process outlined by state law. State legislatures should implement analogous legislation for private physicians.

It is apparent that if MCOs continue to grow more powerful, private physicians must be given sufficient power to negotiate with them. Implementing a solution, such as the options discussed above, will establish better relationships between MCOs, private physicians, and, most importantly, patients.

*Angel M. Aton\* and Heidi S. Connolly\*\**

---

\* First and foremost, I would like to thank Heidi Connolly for her dedication and friendship. I would also like to thank the editors and staff of the *Journal* with special thanks to Marc Mory, Bill Duffy, Amy Vitacco, and Phil Goldstein for their input—this Note is better because of their efforts. The guidance of Professor Grant Hayden and Richard Bock was instrumental to the development of this Note and is greatly appreciated. I wish to thank my parents, Ron and Michele, and my siblings Kate and Joe, for their love and encouragement. Finally, I thank Deni Bogoev for his love, support, and devotion through not only this endeavor, but through all of law school.

\*\* Angel, it has been fun. Thank you for all of your hard work. Phil, Amy, Bill, and the entire *Journal* staff, thank you for your comments and suggestions. To Marc Mory, Professor Grant Hayden, and Richard Bock thanks taking time out of your schedules to help us through this Note. To my two best friends, I love you both. You have kept me sane these three years. I cannot imagine life without you. Mom and Dad, if it were not for the two of you I would not be where I am today. There are no words to say to make you understand how much I appreciate all you have done for me.