

Physicians and Unions

Experts say the day is coming when every physician must decide whether to join a union. The issue is controversial and confusing, but it's not going away.

Contrary to rumor, it's not illegal for doctors to join a union—it's collective bargaining that lands most physicians before the Department of Justice.

Welcome to just the first intricacy in a hot topic today's physicians regard as convoluted and controversial: physician unions. "Those not in a union are already behind the times," says Dr. Robert Weinmann, the Oakland, California-based [Union of American Physicians and Dentists \(UAPD\)](#) president and a San Jose neurologist. Yet even he admits that "those behind" comprise 90 percent of the medical profession.

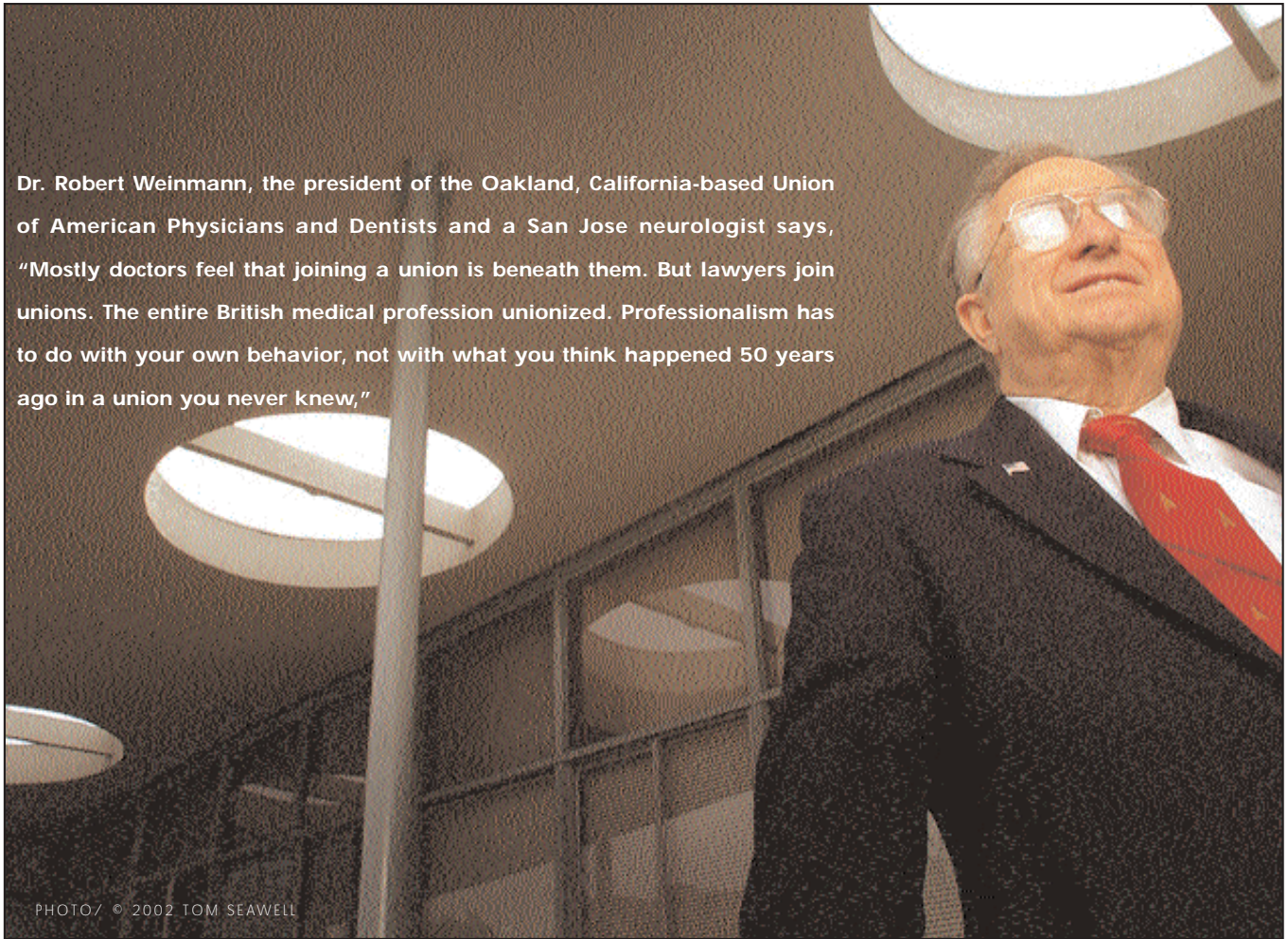
The movement sprang up in the early 1970s, when programs like Medicare and Medicaid alarmed conservative doctors that the government was about to take over, says Grace Budrys, a professor of sociology and the director of the School of Health and Human Services at DePaul University. By the early '80s, it was

malpractice and tort reforms fueling unionization talk. Today, managed care yanks the chain.

"The insurance companies didn't want to deal with one physician at a time, which gave a big spurt to large practice groups," explains Budrys, the author of [When Doctors Join Unions](#) (published by Ilr Press, February, 1997). "But then physicians discovered they could not bargain with managed care organizations because that would be restraint of trade. They're now businessmen who can't join together." Furthermore, her stats show that close to 80 percent of all physicians in practice five years or less are salaried; approximately 45 percent of all doctors work for a set paycheck. The [American Medical Association](#) estimates that number at about 20 percent of all American doctors. No matter how you count it, according to the law, employees may join unions and enter into collective bargaining.

Four unions exist where 20 once competed for attention at the movement's beginning: [UAPD](#); [The Federation of Physicians and Dentists/Alliance of](#)

Dr. Robert Weinmann, the president of the Oakland, California-based Union of American Physicians and Dentists and a San Jose neurologist says, "Mostly doctors feel that joining a union is beneath them. But lawyers join unions. The entire British medical profession unionized. Professionalism has to do with your own behavior, not with what you think happened 50 years ago in a union you never knew,"



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Healthcare and Professional Employees (FPD/AHPE), which is affiliated with the **National Union of Hospital and Healthcare Employees** and the **American Federation of State, County and Municipal Employees (AFSCME/AFL-CIO)** headquartered in Tallahassee, Florida; **Doctor's Council** in New York City; and the **AMA's Physicians for Responsible Negotiation (PRN)**. Their audience: those private practice doctors forbidden collective bargaining options, for now.

Legal wrangling

Legislation bucking this restriction

is no stranger to lawmakers' dockets. Rep. Thomas Campbell (R-California), of Stanford, won the House's vote for the **Quality Health Care Coalition Act of 1999** but failed to find a cheerleader in the Senate. Current House versions call for a pilot project that would amend the **Sherman Anti-Trust law**. So Jack Seddon, the executive director of FPD/AHPE, now lobbies Senate leadership for a Campbelleque version on the assumption that anything they approve has already met the House's approval once.

In 1999, the **Texas Medical Association** sponsored a unique

state law—signed by then-Governor George W. Bush—to allow self-employed physicians collective negotiation privileges under the state attorney general's supervision. When the news broke, the legal and medical communities practically held their breaths waiting to see how the Justice Department and Federal Trade Commission would respond to the heresy. But in reality, the law nixes strike possibilities and prohibits more than 10 percent of physicians in a health plan's geographic area to communicate among themselves to negotiate fees, discounts, and capitation payments.

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STRIKE

Unions' most potent weapon is also its most misunderstood

Mention physician unions to Dr. John R. Aguilar, a Navy captain at the [Department of Defense Health Affairs](#), and he immediately cites his moral and ethical obligations. "Unions look out for the interest of the worker, but we have a third bystander in any kind of conflict: the patient," he says. "The danger is that patients' interests will be subordinated and that's inappropriate." Conflict, of course, is polite code for "strike."

The president of [Health Insurance Association of America](#), Don Young, MD, realizes 95 percent of doctors would never take such drastic measures—movements like the [AMA's Physicians for Responsible Negotiation](#) and Texas state law even forbid this option—but he frets over the minute percent who might. "They could do a lot of harm, especially in rural areas," he points out.

The strike is undoubtedly one of the union's most misunderstood tools, says Robert Weinmann, MD, the president of the [Union of American Physicians and Dentists in](#)

[California](#). "Unions don't cause strikes—members vote for them," he explains. "If doctors don't want one, it won't happen." He even shrugs off the what-if scenario: Physicians merely cross picket lines to get to their patients.

"We understand it's not very smart to strike against the patient. You want to strike against the paymaster to get something done," Weinmann says. The UAPD champions a work slowdown where physicians tend to the sick, but refuse to keep chart notes and other paperwork the hospital needs for insurance reimbursement.

Even that watered-down version holds no meaning for Jack Seddon, the executive director of [The Federation of Physicians and Dentists/ Alliance of Healthcare and Professional Employees](#), which mainly represents non-salaried physicians. "We have no one to strike against," he points out. "And I wouldn't want them to because every state has a medical practices act. If a doctor abandons patients, I can guarantee he won't have a license to practice medicine afterwards." The FPD/AHPE substitutes the strike option with refusal to do business with specific insurance companies. ■

Nor can they touch Medicaid managed care plans or children's health plans. Finally, the Texas term for this process is "joint" rather than "collective" bargaining, because each individual doctor can accept or reject the proposals. Insurance companies can also refuse to come to the table.

Officials at groups like the [National Federation of Independent Business, Small Business United, National Association of Manufacturers](#), and the [U.S. Chamber of Commerce](#) lined up against the concept. Pennsylvania, New Jersey, Maryland, Michigan, Illinois, Alaska, Arkansas, Arizona, California, Connecticut, Delaware, Florida, Hawaii, Missouri, New Hampshire, Rhode Island, Tennessee, West Virginia and DC legislators, on the other hand, began trying to write their own versions. So far, Washington and New Jersey have passed their legislation. But in the three years since Texas stepped out, the Lone Star docs report little has changed, thanks to the layers of rules it takes to organize under this innovative approach.

Instead, the flourishing model—if any archetype can make that claim—remains the third-party messenger. Individual physicians hire a union representative to run the contract between the managed care executives and doctors, reporting each side's views and reactions. In a twist, unions sometimes seed independent practice associations (IPAs) so they then can represent an IPA rather than individual doctors.

Negotiators must tread lightly because the watchword is facilitate, not participate. For instance, unions can compile payment and reimbursement rates data and analyze it for highs, lows, and averages. But they can't use these findings to create agreement—merely to help answer individual physician's questions. "Does that sound like a viable solution to you?" Budrys asks. "It won't last because there's no way to know if physicians discuss the terms among themselves."

UAPD's Weinmann agrees. "It's awkward," he says, "but we've become very adept at it."

Raymond J. Lodise, MD, a former president of the [Philadelphia County Medical Society](#), touts a guild mindset, where the medical members negotiate with insurance companies on businesses' behalf.

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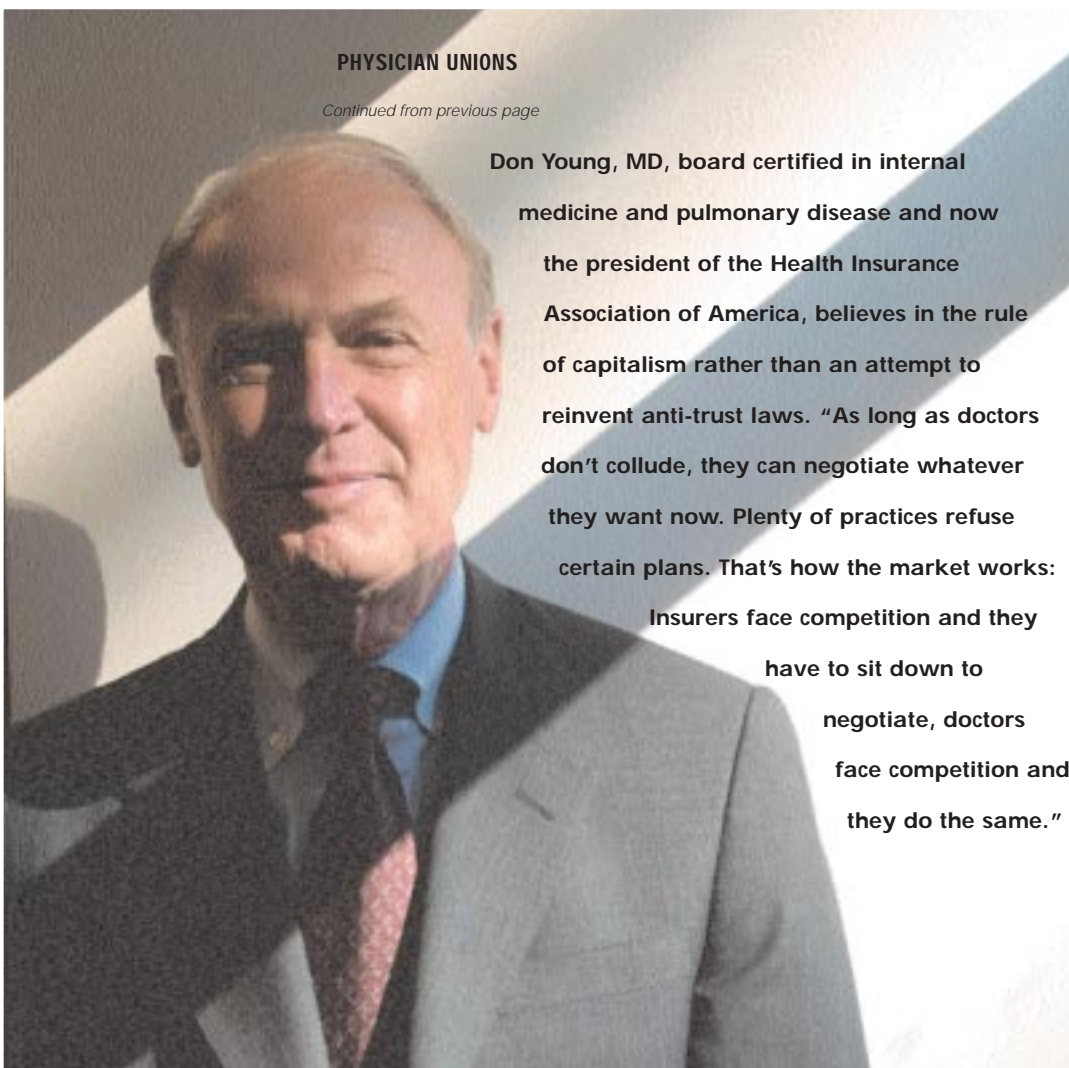
This way, should an HMO rack up a reputation for ignoring doctors and patients' needs, the negotiators could encourage businesses to discontinue working with that plan. "This union would not collectively bargain for reimbursement, because we absolutely recognize that's a market-driven product now. Physicians will get what the public can afford to pay," he told a Delaware Valley publication in 1997.

The AMA's PRN, also launched in 1999, straddles the fence between approving collective bargaining while rejecting unionization.

It reasons that traditional unions focus on the economic well-being of the employee, but doctors prefer to fight for patients' rights more than for themselves. Like the Texas state parameters, the PRN rejects strikes as a bargaining tool—a move traditional unions say tears the teeth from the lion.

"Professional societies like the AMA were formed for educational purposes," says Weinmann. "They don't know how to represent doctors, except in Congress where anybody can testify."

Yet in February 2002, PRN press releases bragged it scored a major victory when the [National Labor Relations Board](#) announced a group of New Jersey physicians represent-



Don Young, MD, board certified in internal medicine and pulmonary disease and now the president of the Health Insurance Association of America, believes in the rule of capitalism rather than an attempt to reinvent anti-trust laws. "As long as doctors don't collude, they can negotiate whatever they want now. Plenty of practices refuse certain plans. That's how the market works: Insurers face competition and they have to sit down to negotiate, doctors face competition and they do the same."

ed by PRN are employees. It clarified a 2001 Supreme Court decision fondly known as [National Labor Relations Board \(NLRB\) v. Kentucky River](#) that led some observers to conclude physicians fall under the supervisor category. "PRN is proud to be the first labor organization in the country to obtain an NLRB determination on which physicians continue to have collective bargaining rights," said then-president Susan Adelman, MD.

Apparently the AMA's Board of Trustees needed more convincing. On April 18, it pulled the plug on additional loans to its labor organization. (The House of Delegates reinstated the funds through 2003 this summer.) When those press releases

hit the media, PRN admitted having only 200 individual and organizational sustaining members, although it was quick to add that "PRN currently represents a group of physicians in Michigan and is in contract negotiations on behalf of a group of physicians in Texas. PRN has two other active cases pending at the NLRB that could set stunning and positive legal precedents for physicians nationwide."

Who's in?

According to Stephen D. Erf, a partner in the Labor, Employment, and OSHA Group at McDermott, Will and Emery in Chicago, the primary factors motivating doctors to organize start with patient care (read

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loss of control over treatment); then move to financial issues like decreased income, slow reimbursement, and patient load increases; and include administrative burdens like specialist referral restrictions and advance scheduling requirements. In other words, money and autonomy.

Weinmann can pinpoint the moment he became a union sympathizer: the day news trickled down of a hospital administrator who sold the medical staff services to an HMO without their input. Malcontents could quit. "In other words, I discovered that independent contractors could be legally sold into involuntary services. The prices were better than yesterday's auction block, so many of the doctors said, 'Well, OK, if that's how it has to be,'" he says.

Budrys sees a slight pattern in orthopaedic surgeons leading the calls for unionization across the country. "That's notable because surgeons aren't usually known for joining together," she says. "But orthopaedic surgeons are the ones who've been infringed on most by managed care organizations—a lot of their work has been transferred to family practitioners." Meanwhile, family practitioners, whom most Americans would guess to be the first on the bandwagon because they command the lowest pay, show the least interest so far.

"The major problem is control over work, and generally the only thing that affects family physicians is they're not allowed to refer out," Budrys explains.

Frank DiCenzo, DO, an ob/gyn in Sewickley Valley, Pennsylvania, says he pays his FPD/AHPE membership

dues to be one step ahead of the pack whenever legislation breakthroughs do occur. "It's the specialists who are told they must get permission for procedures, fill out the paperwork, and the aggravation drives them crazy," he says.

Jeffrey Ali, MD, a solo-practice podiatrist in the Cleveland area, admits his ambivalent attitude when he opened his doors in 1999. Ohio's state podiatry medical association dues included membership in a guild arranged and operated through the Teamster's Union. "That automatically tacked on \$100, which roughly doubles what the AMA charges its members, so I wasn't real excited," he notes. "But I thought, 'Let's see what they can do for us.'" The answer was zilch. He expected to gain more equality in dealing with managed care programs in the city but remained shut out of most rosters in this oversupplied market. Ali applauded when the association withdrew from the arrangement.

Count Don Young, MD, board certified in internal medicine and pulmonary disease and now the president of the [Health Insurance Association of America](#), among those shouting to let capitalism rule rather than attempt to reinvent anti-trust laws. Without this balance, costs soar and the exercise does nothing to improve quality of care, he contends. To illustrate, suppose an ophthalmologist union suddenly bumps the price for cataract surgery from \$2,000 to \$4,000, and demands to have a back-up surgeon involved in every procedure, with both doctors earning the same fee. "Of course, the insurer says those demands are outrageous. Medically, there's no evi-

dence you need two surgeons and that much money," he says. "So every ophthalmologist in town shuts out our plan, holding the insurer totally hostage.

"As long as doctors don't collude, they can negotiate whatever they want now," Young contends. "Plenty of practices refuse certain plans. That's how the market works: Insurers face competition and they have to sit down to negotiate, doctors face competition and they do the same." He also scoffs at the idea patients sit at the forefront of negotiations; he claims all disputes in the real world boil down to fees. "Let's be clear: nothing a health insurer does says the surgeon can't do the procedure. The question is whether it's covered by insurance or if he has to find another route to be paid," Young adds.

Brass tacks

Colleagues like Weinmann are happy to guide the undecided. He claims he once attended a lecture where a former FTC attorney told the audience, "If you want to know how to push the envelope on individual representation without crossing our trade barriers, study the UAPD. They've perfected it." Weinmann's sales pitch centers around the fact that science and biology textbooks don't teach doctors how to deal with bureaucrats telling them to work without payment assurances and threats not to renew business contracts if they continue to defy the insurance company's decisions.

Union representatives are taught such things. According to the FPD/AHPE's Seddon, that organization turned the market rate around

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in Hillsboro, Florida, when doctors there found themselves reimbursed below Medicare rates for commercial products. It influenced three reasonable counter proposals from insurance companies in Utah, a state Seddon characterizes as “controlled by the largest integrated health system in the country.” He’s reportedly looking to file a complaint with the Department of Justice contending Utah’s system has reached monopoly status. “We’ve taken on many an insurance carrier both legally as well as notifying doctors of their rights and teaching them how to negotiate on their own,” he explains. “We have a staff and consultants at work with doctors on a daily basis to work through contract problems.”

Furthermore, union representatives stand ready to step in on peer review meetings, wrongful terminations, malpractice accusations, and other work-related issues. “Doctors can make all kinds of practice arrangements, but none of those are negotiations. They’re just positions or stances,” says Weinmann.

Lawrence Lorber isn’t impressed. “There is nothing magic about a union to do that,” says this partner with [Proskauer Rose LLP](#) law firm in Washington, DC. “For independent physicians, I don’t understand what a union can offer that professional management can’t. When it comes to enforcing contractual rights, management lawyers understand this business and can provide what the doctors legitimately want: responsiveness, payment, approvals, and all the rest.” After all, Lorber adds, when unions take up such causes, they hire these very attorneys, thanks to the law’s specialized nature. Even

Seddon admits an insurance company can refuse to talk to a third-party agent, creating a verbal standoff.

Mike Bissegger, a senior associate with [Epstein, Becker and Green’s](#) senior antitrust group of its national health law practice in Washington, DC, argues the messenger model actually heaps more restrictions on physicians than they bargained for. Here are a few of the dos and don’ts he outlines for doctors who want to avoid appearing before the Justice Department:

- Don’t discuss common issues or positions, or make subjective judgments about particular offers or contracts with colleagues.
- Emphasize to the insurance company that the messenger is not a negotiator.
- Make it clear that either you or the insurance company may bypass the messenger to communicate directly at any time.
- Don’t refuse to negotiate directly if the other side extends the offer.
- Establish clear procedures for the messenger to follow and ensure it does so.
- Have your structure periodically reviewed by antitrust counsel.

That’s why Budrys advises physicians to research thoroughly potential union representation before committing. Read the literature for issues it has tackled, and talk to current members about benefits. Second, sift your desire to join a union through the \$24,000 question: Is my issue big enough? “A lot of groups think they should join a union,” she explains. “But if your beef is that you don’t have locks on the door where you sleep between calls at the hospital,

that’s really not worth it.” However, your response might vary in the case of a faxed contract that dictates a reduction in reimbursements and bears a 24-hour signing deadline or you’re out.

Bissegger advocates practices consider merging as a legal means to the same negotiation power end. You can even opt for a partial integration, as long as the deal structures in some type of risk sharing. “Sometimes doctors think they can share administrative costs and insurance contracts, but that doesn’t involve a risk,” he points out. “Physicians must be financially at risk for their colleagues’ behavior and services usage.” On the plus side, practices typically can merge up to 60 percent of a market’s specialists without triggering collusion accusations.

Of course, every layer of administration you add piles on the overhead fat, Weinmann warns. UAPD delivers these negotiation services for the \$440 annual dues. Not to mention many patients today express distrust with medicine’s big business trend, according to Budrys. “Physicians are in an awkward situation,” she admits.

Brotherhood of patients

The answer, Weinmann contends, lies with good marketing. “The patient should know you belong to a union that fights for you,” he says. “But the person who gets the benefit is the patient, who otherwise would have been stuck with a denial from the insurance company.”

Frank DiCenzo whips out his union card often to make friends among the 25 percent of patients

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who also belong to the brotherhood. “They understand there’s no reason the CEO of a health insurance company should be making \$30 million a year when the doctor receives 30 percent of his fee,” he says.

Seddon agrees. “Doctors discover their patients are their best advocates,” he says. “Many of them are union people who fully understand what the doctor is up against because they live in the same economy. “To further protect your position, post signs stating why you no longer participate with a particular plan, and hand upset patients the phone number to that company’s CEO. And rehearse your reaction to patients who fear you’ll strike against them (see “**Strike**,”).

In the end, old-fashioned snobbery holds back more physicians than process dynamics, in Weinmann’s opinion. “Mostly doctors feel that joining a union is beneath them. But lawyers join unions. The entire British medical profession unionized. Professionalism has to do with your own behavior, not with what you think happened 50 years ago in a union you never knew,” he says.

Chances are, physicians haven’t yet met tomorrow’s union, either. The model emerging won’t resemble the auto workers’ version, Budrys assures, but that doesn’t mean it apes the professional teachers’ group, either. “Doctors can’t expect to step into something that already exists. And it’s hard work creating something that will fit for them. But will it happen? Yes,” she says firmly. ■

Julie Sturgeon is an Indiana-based free-lance writer and a regular contributor.