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Corporatized Medicine: Time for Physicians to Unionize?

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FEATURES

Corporatized Medicine: Time for Doctor Unions?

How long can physicians maintain meaningful autonomy without a collective bargaining tool? **By Todd A. Zigrang, MBA, MHA, and Jessica L. Bailey-Wheaton, Esq.**

IN 1512, King Henry VIII of England struck a deal with a group of doctors who offered to treat his country's subjects being ravaged by the plague, in return for his endorsement for the creation of the Royal College of Physicians. The deal was a historic compromise—the gift of "[physician] autonomy in return for fidelity."

Since that time, the healthcare industry has experienced a significant and unprecedented amount of change. Physician autonomy and practice have continuously been transformed into an industry enterprise, "...whereby healthcare services have been unitized, protocolized, and homogenized, in order to facilitate their sale in the market, just as if they were any other fungible market commodity, little differentiated from soybeans and pork bellies." In other industries, such as manufacturing and transportation, this imbalance in power between the workers and their corporate employers has spurred the development of unions, so that workers could obtain better leverage to negotiate for better wages and/or working conditions. The popularity of physician unions, however, has not grown at the same rate as in other industries.

"The consolidation and corporatization of medicine over the last several years has contributed to the historic distrust between physicians and hospital employers."

The concept of unions and collective bargaining was born in the labor industry and has been entrenched in American society for centuries. However, the adoption of unions was only popularized in the healthcare sector during the past several decades, beginning with the passage of the *National Labor Relations Act* (NLRA), aka the *Wagner Act*, in 1935, which gave most private-sector employees, including healthcare workers, the right to unionize. Since that time, the NLRA has undergone several iterations that have both directly and indirectly affected the healthcare industry (see "Timeline of Regulatory Changes Affecting Healthcare Labor Unions" on the next page).

Healthcare union membership has steadily climbed over the past several years, including as recently as 2015, concurrent with the healthcare hiring boom. However, these increases do not appear to be a continuing trend. According to the Bureau of Labor Statistics (BLS), union membership has, on average, declined over all industries from 2015 to 2016, including the healthcare industry, despite its employment increases. Although unions have been utilized by various industries over the years, including the nursing profession, to vie for workers' rights, physicians have not followed that same path, in spite of increasing regulation and scrutiny of the medical profession.

Why is Medicine Slow to Embrace Unionization?

The healthcare industry in general, and hospitals and physician practices in particular, have progressively consolidated over the past several decades. This comes in response to a multitude of factors, including the need for greater leveraging power against payors and specialty competitors, and more recently, as a strategy to reduce costs and improve efficiency and quality through economies of scope and scale.

However, the physician population has been slow to unionize, for several potential reasons: (1) regulatory hurdles, such as the NLRA and antitrust laws; (2) lack of incentive due to the availability of other options; (3) historical use of trade and industry associations as a lobbying alternative to unions; (4) the intrinsic autonomy of physicians; and (5) an inherent professional conflict with the use of strikes (refusing to treat patients) as a tool for collective bargaining.

Anti-trust Laws

Physicians have been hesitant to engage in collective bargaining partly because independent practitioners who engage in this activity may potentially run afoul of antitrust laws, such as the *Sherman Act* and the *Clayton Act*. Under antitrust laws, it would be considered illegal for independent physicians and physician groups that are not already affiliated, or financially integrated, to pursue collective bargaining. To do so would be construed as anti-competitive, or as a horizontal agreement among competitors with the potential to restrain trade (by fixing prices).

However, antitrust regulations do not apply to physicians employed within affiliated hospitals or health systems, allowing for the reality of physician

unions in the hospital setting. The growing trend of physician employment (in contrast to the historically large numbers of independently practicing physicians who would be subject to antitrust violations) has allowed physicians the opportunity to participate in collective bargaining.

Surplus of Employment Options

Another reason physicians may be slow to organize is the availability of other options, which may be less onerous, and thus render unions unnecessary. Demand for physician services in the U.S. has remained high for decades, prompting increases in medical school and residency training enrollment, and is expected to remain so, due to changing patient demographics, aging of Baby Boomers and longer life expectancy. The surplus of employment options for physicians allows them to simply leave a position if unsatisfied; it may take an exodus of only a few physicians from a given hospital or system before c-suite executives are convinced to change the organization's policy.

Trade Associations

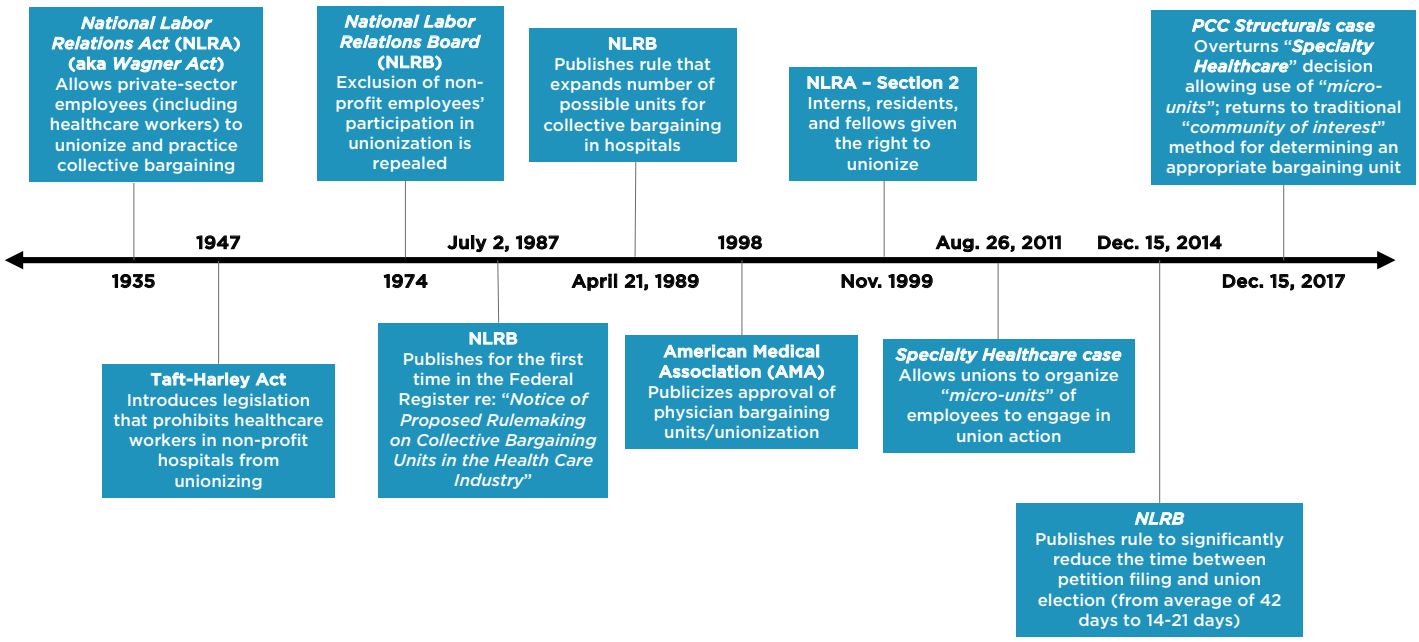
Physicians and residents have relied heavily on medical trade associations to lobby for federal legislation or conduct high-level negotiations. While individual hospitals and organizations have their own individual policies, practices, and idiosyncrasies, many of the sweeping changes to healthcare have occurred on a federal level in the last few years, through the *Affordable Care Act* (ACA).

Medical associations have been the chief voice on behalf of physicians during these federal debates, groups such as the American Medical Association; American Association of Medical Colleges; American College of Physicians; American Academy of Family Physicians, and other physician specialty groups actively opposed the recent attempts to repeal and replace the ACA. Other legislative changes, such as proposed updates to the Quality Payment Program (QPP) under the *Medicare Access and CHIP Reauthorization Act* (MACRA), were also met with contentious debate by various medical groups, like the AMA, the American Medical Group Association, and the Medical Group Management Association.

"Physicians have historically clung to individual autonomy not only in practice, but in voicing their opinions."

Ingrained Individual Autonomy

Even with the use of medical trade associations for lobbying power, physicians have historically clung to individual autonomy not only in practice, but in voicing their opinions. The reason for this is the same as that which underlies physicians' inherent distrust of hospitals and other large employers—the professional oath to practice "medicine...one patient at a time" often seems to be directly at odds with an organization that often must consider the good of "all" over the good of "one." Even the largest physician trade association, the AMA, has felt the backlash of physicians who disagreed with its decisions. For example, in 2016, three physicians wrote a letter to the AMA opposing its support of the nomination of Tom Price, MD, for Secretary of Health and Human Services (HHS), which garnered over 6,000 physician signatures and stated, "the AMA



represents approximately a quarter of physicians in the U.S.—a loud, but minority voice. It certainly does not speak for us."

The "Right to Strike" vs. "First Do No Harm"

Despite the reasons discussed here that may dissuade physicians from joining unions, at the center of the debate about physician unionization is an ethical dilemma: the utilization of the "right to strike." The right to strike has been characterized as a "fundamental human right," and without it, "collective bargaining is reduced to collective begging." Yet the existing professional and ethical concerns related to the "right to strike" are unique to healthcare professionals, particularly physicians. Although striking is allowed within the confines of the NLRA, it is directly at odds with the professional imperative to care for patients and the injunction of "primum non nocere" or to "first do no harm."

"Anti-trust regulations do not apply to physicians employed within affiliated hospitals or health systems, allowing for the reality of physician unions in the hospital setting."

The AMA has asserted that physicians should be free to pursue advocacy and collective action activities, but it warns against unionizing in concert with other workers who "may not share physicians' primary and overriding commitment to patients," such as administrative and support workers within the healthcare delivery system. The AMA further acknowledges the ethical dilemma of engaging in strikes or collective action and has urged physicians to refrain from such activity and consult with legal counsel as appropriate.

The crux of the dilemma behind a physician's "right to strike" is this: will it, or will it not, cause harm to patients? A 2008 literature review found that patient mortality is either unaffected, or decreases, during a strike. The authors list several variables that may explain these unexpected findings, including, but not limited to: the continued provision of emergency services during a strike; the relatively small geographic regions impacted; and the relatively short duration of the strikes studied. It should be noted that given the rarity of physician strikes, there is a dearth of literature concerning this topic and its effect on patient outcomes. Regardless, the right of physicians to utilize striking as leverage in collective bargaining practices, although possibly considered taboo, has not been forbidden.

Not Going to Take It Anymore?

The healthcare industry has undergone transformative change since the cottage industry of Marcus Welby-type practices—when solo physician practices and small community hospitals were the rule, and not the exception. The consolidation and corporatization of medicine over the last several years, as evidenced by the growth in large hospitals and healthcare systems, increasing employment of physicians, and consolidation of payors, has contributed to the historic distrust between physicians and hospital employers. By essentially transforming independent physicians into a regulated and codified labor force, the 1512 covenant that exchanged autonomy for fidelity has been broken, and how to renegotiate that relationship and restore a level of trust between these groups has yet to be determined.

Despite these changes, U.S. physicians have not seen fit to unionize in any significant way, potentially due to one or more of the reasons discussed here. However, given the continuing consolidation and employment of physicians in a healthcare market that is more heavily regulated than ever before, it begs the question: how long can physicians maintain meaningful autonomy without a collective bargaining tool?

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Fireside Chat to Address Physician Unions

ON FRIDAY, June 7, the Chicago Medical Society (CMS) and the American Bar Association (ABA) open the two-day Physician Legal Issues Conference. At 4:45 Friday afternoon, they will be hosting a non-CME session on the formation of physician unions, including why physicians unionize, the potential benefits and pitfalls of unions, and various legal issues that may arise from unionization. The session will also provide practical insight and examples of when physicians have successfully used unions to accomplish their goals and the challenges they faced along the way. CMS and the ABA's Health Law Section urge you to attend this informative chat. The Physician Legal Issues Conference takes place on Chicago's Magnificent Mile at the InterContinental Hotel. For registration details or more information, please call 312-670-2550 or visit: *www.cmsdocs.org.*