

# Do Doctors Need Unions?

By Grace Budrys, Ph.D.

*Dr. Grace Budrys, professor of sociology at DePaul University in Chicago, presented the following remarks during Ramsey Medical Society's Fall Meeting, October 14, 1997.*



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I am very honored to be here. I understand that this discussion carries special significance because you have already confronted and resolved so many problems that doctors in other parts of the country have only begun to address. Furthermore, your state as a whole is considered to be more honest and more forward thinking than many others. Accordingly, the problems you identify, and the solutions you work out, are certain to attract wider attention. The fact that you are interested in discussing physician unionism is particularly noteworthy. In my view, it signals the beginning of a new era in the relationship between the medical profession and the organizations with which medicine interacts. This is not to say that I believe you are prepared to sign up for union cards -- only that you are willing to explore this among other possibilities.

I would like to begin this discussion about physician unionism by noting that ever since I started collecting material on this topic (that's over 20 years ago) I have been hearing the same objections from doctors and from everyone else. First, that it is unprofessional; and, second, that strikes, the only weapon that unions have available to them, are totally unacceptable. This year things have changed. I am now more often asked to list the pros and cons of physician unionism. The latter request does not lend itself to a ready answer. In order to speak to the pros and cons of physician unionism, including strikes, I will first focus on the meanings attached to professionalism.

## The Golden Age and Its Decline

Professionalism carried a great deal more weight during the Golden Age of medicine, roughly the decade of the 1950s until the early 1970s, than it does now. Consider what medical practice was like then. The majority of doctors were practicing under the designation of "physician and surgeon" were located in the community where their patients resided, and had long-standing relationships with patients, and often the whole family. Treatment decisions, as well as charges, were negotiated behind closed doors without much attention to outside parties. Doctors were in a position to do everything they could for their patients. Patients reciprocated with expressions of gratitude and appreciation. Doctors' hospital privileges were determined by colleagues. Most of the decisions doctors were party to were sealed with a handshake. These arrangements

seemed to please everyone. So why did the Golden Age ebb away? Why did the value society attaches to professionalism decline? Or as Dr. Marcus, who is the founder of the Union of American Physicians and Dentists, the subject of my research, puts it: why were doctors pushed off the pedestal?

Several things happened at once. For one, medicine was suddenly becoming more specialized. Second, a massive population shift began which meant that many people were moving out of old neighborhoods to new suburban areas, and other people were moving into the old neighborhoods. Doctors moved too. These two trends in combination caused the dissolution of established doctor/patient relationships. Patients were now seeing doctors who were strangers. That signaled the decline of trust in the medical profession which brought about the malpractice crisis some years later.

Add to this the social activism that ushered in all the legislation of the late 1960s and early 1970s aimed at increasing access to health care, which of course, it did. But all those initiatives also caused costs to rise. So now, in addition to the absence of trust in individual physicians, distrust of the profession as a whole became an issue. After all, somebody had to be blamed for rising costs, and doctors provided a ready target. That is when a new cadre of social critics began gaining ground. They said that medicine was a cottage industry that needed to be brought into the twentieth century. It was obvious that government intervention had been a failure--just look at the costs--it was time for business to step in and bring efficiency to this sector. That, of course, led to the growth of health sector organizations, which have become increasingly more aggressive and competitive.

It is the approach health sector organizations have used to bring medicine out of the cottage industry stage to the modern era, that turns out to be problematic. They have adopted the approach used by factory owners during industrialization. Consider the basic plan: work was divided up; unskilled workers were brought in to replace more independent and expensive craftsmen; foremen, whom management could trust and control, were authorized to monitor others; workers were offered wages on a take it or leave it basis. So that explains how it is that you happen to find yourselves on the factory floor!

I realize that you have dealt with the excesses of for-profit, corporate medicine in Minnesota far better than your colleagues in other states. Unfortunately, having solved that problem means that you must now solve the new problem that decision created: a limited number of very large, controlling, and unresponsive non-profits. It seems that the commitment to organizational efficiency results in very similar structures whether they are organized as for-profits or non-profits.

## **Is There a Place for Professionalism on the Factory Floor?**

Let us return to the Golden Age once again to see what was in it for society that gave it

reason to reward medical professionalism so generously then and not now. In other words, what did medicine offer society in exchange for the high level of prestige, recognition, and rewarding life style doctors enjoyed?

It is not only that patients went to doctors whose offices were conveniently located in the neighborhood during the Golden Age, they also went to doctors whom they knew a great deal about. Patients had little need to worry about doctors engaging in deviant behavior, whether that might involve money, sexual misbehavior, lack of sufficient attention to patients' complaints, or even rudeness. Professionalism was the social arrangement that allowed doctors to enjoy generous social rewards in return for not violating the trust of patients and the community at large. Professionalism worked because everyone believed in it. And, because there were really few alternatives! As long as doctors operated in private offices scattered throughout the community, and when second opinions were regarded as indicating mistrust of a doctors' work, professionalism was the best arrangement that we could come up with.

Economists would describe it a little differently. They would say that the structure of medical practice provided patients with sufficient information so that they could be reasonably informed consumers of the services they were purchasing. That is how economists look at community gossip. The supply of doctors was balanced by demand. They were well distributed. Medicine operated under market conditions, maybe not a perfect market, but close enough.

## **From the Golden Age to Efficiency and Big Medicine**

The Golden Age of medicine ebbed away as these socio-economic arrangements came apart. The Golden Age was replaced by the Age of Efficiency. Medicine's response was to form larger practice groups. This, in turn, brought an important new player into the picture -- the law. Doctors were unprepared for the effect this would produce, namely, having their activities scrutinized by the courts. They are especially disappointed to find their assertions of professionalism not being acknowledged.

From the perspective of the law, medical professionalism does not merit special treatment. Whether doctors choose to uphold standards set by the medical profession is between doctors and the groups, organizations, and associations they join. The law continues to define doctors as it has always done -- as independent contractors. In the past, doctors were treated by the law, as small businessmen. That is still true. Business, whether it is small or large, is governed by anti-trust legislation. Businessmen may not engage in monopolistic practices, compete unfairly, capture too large a share of the

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market, and so on. However, the effort to balance the power of corporate medicine has meant that practice groups have grown much larger. It is these organizations that are being scrutinized by the law -- the group practices, IPAs, PSOs, and so on. All are at risk of being found in violation of anti-trust legislation.

Why now and not in the past is obvious. The structure of medical practice during the Golden Age, and before, came closer to meeting the requirements of anti-trust law.

Medicine operated under conditions more closely approximating a market -- that is, many more independent purchasers and many independent suppliers, far more so than now.

## **The Forced Choice**

My point is this. Doctors now have little alternative but to choose between identifying themselves as: a) business-persons, whose activities will be governed by the same body of laws that governs the operations of Microsoft, General Motors, or Wal-Mart; or b) as workers whose activities fall under labor law. There really are no alternatives! A major drawback in choosing to identify as businesspersons is that an essential part of medicine's claim to professionalism was its success in distinguishing itself from business, which is governed by the caveat emptor principle. Doctors succeeded in gaining their patients' and society's trust because they assured everyone that they could be trusted to put their patients' needs before their own interests. Being sanctioned for violating anti-trust laws puts the basis of that trust in doubt. Yet, the choice is not that easy. Saying one is an employee or works under employee-like conditions is not enough to obtain the protection of labor law. The catch is that managerial and supervisory personnel may not organize against the interests of the employer. Employers invariably argue that physicians are in a position to supervise allied health personnel and participate in decisions with managerial implications. While the law specifically states that professionals are not prohibited from organizing collectively, whether professional responsibilities can be separated from managerial responsibilities, depends on how the court sees it on a case by case basis.

Given the forced choice medicine now confronts, we finally come to the pros and cons associated with physician unionism. Is it worth fighting for the right to establish a union? What will it do for doctors? Isn't it just going to be another bureaucratic organization that will impose more limitations than doctors must deal with already? My answer is that there is no existing model of unionism that medicine must fit into. You cannot assess the pros and cons of an organization that does not yet exist. Choosing to form a union means that you must create an entirely new organization. Therefore, its pros and cons end up being a reflection of the choices its founders make.

## **What About Strikes?**

That still leaves the question of what it is about unions that gives members voice unless

it is the threat of a strike. Behind any question of strikes, there is the lingering discomfort associated with how physician unionism, and the implied threat of strikes, might affect medicine's image. I have a number of observations to make on this point. For one, the largest physicians' strike in this country occurred when physicians who were not unionized walked out in California in response to a 450% increase in malpractice premiums in the mid 1970s. In effect, when the situation gets desperate enough, physicians will apparently act on their frustration without being unionized. Some might say that unionism exacerbates the situation by making it easier to organize a strike. On the other hand, accepting the fact that no one really wants a strike, then a union might also help to prevent impending strikes. Beyond that, there are other ways of capturing the attention of organizations with which one is negotiating. My favorite job action took place in Nevada in the early 1970s when the doctors staged a "white-in." They invited everyone who came to the E.R. to take a bed, and then did not process the paperwork. The hospital capitulated in a day and a half. In short, striking does not mean that you must withhold care.

Physicians across the country have suddenly become more militant. So far, none have resorted to withholding care from patients. In New Jersey, doctors have banded together with the United Food and Commercial Workers Union (UFCW), which represents butchers and bakers among others. The doctors are petitioning the National Labor Relations Board to allow them to vote on representation by the UFCW. Whether they are permitted to vote or not, they have clearly gained the support of that union -- which is no minor matter. The union has made \$250,000 available to the doctors to be used in local commercials exposing the practices the Blue



Dr. Joseph Rigatuso, Grace Budrys and medical students Kathy Woo and Kathy Swenson visit following the Fall Meeting.

Cross Blue Shield HMO uses to restrict patient care services. The more significant impact will come when the union renegotiates its contract. It will insist that the HMO change its practices in accordance with the doctors' demands. It will of course remind the HMO that it can take its entire membership and that of other sympathetic unions to another HMO. The doctors have succeeded in capturing the HMO's attention without any threat to patient care, in fact, just the reverse.

In Tampa, Florida, doctors, led by the orthopedic surgeons, are exploring the possibility of joining the Federation of Physicians and Dentists whose headquarters are in Tallahassee. Their complaint is that they thought they had developed a good relationship with the local branches of several major insurance companies, which encouraged them to establish IPAs to facilitate smoother negotiations. Since then, the

insurance companies have pitted the IPAs against each other. Most recently, the insurance companies have begun to fax contract changes without making any effort to negotiate them, not even bothering to warn doctors that their capitation rates were about to be cut. The doctors believe that taking a united stance will convince the insurance companies to discuss contractual reimbursement rates with no need for further action.

It is also true that doctors in Europe and other western industrialized countries, which have been organized into unions for a long time, do engage in strikes. What determines whether they win or lose is worth considering. It seems that the outcome largely depends on how the public views their demands, because those demands are generally negotiated in a public forum.

## **Physician Unionism And Medical Professionalism**

That brings me back to the meanings associated with professionalism. It is not at all clear what professionalism means these days since doctors are no longer in a position to do everything they can for their patients. As most doctors have come to realize, doctors don't have their own patients anymore. Patients now belong to third parties.

Professionalism carries less weight under these circumstances because the social benefit associated with medical professionalism is no longer so obvious, at least not nearly as obvious as it was during the Golden Age. After all, big health sector organizations have assumed responsibility for monitoring the work that doctors do. And, doctors have not opposed this turn of events until recently. Instead, individual doctors are putting their energies into waging battles on behalf of individual patients in an effort to deliver the kind of care their medical training prepared them to carry out. The flaw here is that patients suspect that doctors really do have the power to convince insurance companies that the disputed test or treatment the doctor is recommending should be covered. When doctors don't succeed, patients often conclude that the doctor did not try hard enough on their behalf. This is, of course, what makes your daily work lives so frustrating.

Having lost the sense that the patients you treat are your own patients, you may want to consider whether you want to do something about that. This is not to suggest that you turn away from individual patients. However, it is possible that taking a stance on behalf of patients in general, not just one patient at a time, would reaffirm the medical profession's historical commitment to quality care. Promoting patients' rights to choose a physician and establish a relationship with that physician may be another worthwhile cause. In short, deciding what professionalism means in the current practice

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environment is important because it can shape public attitudes regarding other objectives.

Medical societies are well suited to achieve such goals. In fact, an Arizona court recently held that this was exactly the role that medical societies should play. In my view, it is probably better to separate such activities from more narrowly defined objectives having to do with reimbursements and other issues that revolve around work and work arrangements. Such concerns are better addressed by an organization devoted to those issues -- that is, unions or union-like organizations.

## The UAPD

With that let me say a few things about the one union that I am most familiar with the Union of American Physicians and Dentists, the UAPD. As the founder of the UAPD, the current president, and the executive director are fond of saying, anyone can join a union. What everyone may not do is bargain collectively.

The UAPD enrolls two kinds of doctors: salaried doctors and those engaged in private practice. It bargains collectively on behalf of those who are employees. Physicians employed by state and local government agencies have been permitted to bargain collectively because California passed a state statute in 1981 giving them the right to do so. The results of such negotiations result in the signing of labor contracts that are running to 75 pages these days. That indicates the number and complexity of issues that are addressed. Whether physicians employed by privately-owned organizations may bargain collectively must be determined by the courts on a case by case basis.

The majority of UAPD members are in private practice. They are independent contractors in the eyes of the law. The union does not bargain collectively on their behalf. It does, however, provide a range of services that the members value. The earliest service it instituted was assistance resolving problems involving reimbursement from the state Medicaid agency, BC/BS, and other insurance companies. It offers examples of the contracts entered into between its members and a variety of contracting organizations, including hospitals, HMOs, and group practice organizations. It offers packages explaining the regulations associated with new state and federal legislation, for example, CLIA, the Americans with Disabilities Act, ERISA, and so on. It monitors state legislative initiatives and assesses the potential impact on physicians, which may or may not lead to lobbying the state legislature. It also enters into legal battles by actively representing members and submitting supporting briefs to the courts. However, the UAPD chooses its court battles carefully because they are so financially draining. One way to sum up what the union does for its private practice

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members is that it turns the work-related challenges encountered by individual members into valuable lessons for the entire membership.

## **Conclusion**

In the end, it is not so much that doctors must decide whether to unionize or not, it is that they must decide how they will interact with large organizations. The difficulty is that large health sector organizations, with resources to match, are legally permitted to set policy and prices. Doctors, by contrast, must enter into negotiations with such organizations on an individual basis, regardless of whether it is an individual patient's treatment or a clause in the physician's contract that is at issue. Clearly, it is the absence of collective and collegial stance that leaves physicians feeling frustrated and powerless. Unionism can provide a platform for developing a collective stance, even if it cannot promise, given current legal constraints, to create a platform for collective action. What such an organization calls itself - - a union, guild or federation, or some such name -- is less important than its ability to develop mechanisms for addressing the work-related concerns presented by physicians given the practice environment in which physicians now find themselves.