

## CEJA Report 9 – A-98 Collective Action and Patient Advocacy

### INTRODUCTION

Interest in organized labor has grown steadily among physicians over the past several years with the rapid emergence of employed doctors and their increasing frustration with managed care. The formation of unions has become a topic of spirited discussion within medical societies and physician groups across the country. It has also become the focus of national media within recent years.

At the 1997 Annual Meeting, the AMA Board of Trustees issued Reports 41 and 42, which provide information on the subject of unionization and call for the creation of a special division of representation within the AMA which will assist in collective negotiations on behalf of physicians and patients. The House of Delegates also adopted policy at the 1997 Annual Meeting to enable this division to move forward vigorously to help state and county medical societies in representing physicians.

In this report, the Council considers the ethical implications of collective action on the part of physicians and offers some guidelines in this area.

### CLIMATE OF UNREST

A sense of powerlessness and disenchantment is pervasive in medicine today. Many physicians seek representation through collective action as a way of voicing their anger over the intrusive control exercised by their employers—in particular, managed care systems that continue to aggressively dictate payment and coverage terms in their contracts with physicians. Physicians have demonstrated frustration at their loss of decision-making powers and their lack of control over the quality of patient care. They argue that it is increasingly difficult for them to serve their patients' interests in an environment which is hostile to these interests. Increased patient loads (and subsequently, less time to spend with each patient); late payments; gag clauses; complicated referral processes meant to discourage costly treatment options; and staff shortages have been offered as only a few of the elements that contribute to sub-optimal working conditions.<sup>1</sup> Physicians have also expressed concern that these systems provide no due process through which their grievances can be heard. The duress created by these developments has led some physicians to organize collectively to seek solutions.

In the case of physicians-in-training, their frustrations are compounded by a predicament of “double jeopardy.” Work conditions that threaten patient care can also mean that they suffer in terms of training and education.<sup>2</sup> Moreover, internship and residency programs are subject to hospital certification, rendering house staff vulnerable to disciplinary measures from administration.

According to the Council on Medical Service, between 1983 and 1995, the proportion of non-federal physicians who are employed rose from 24.2% to 45.4%.<sup>3</sup> An estimated 20,000 of these employed physicians have formed collective bargaining units sanctioned by the National Labor Relations Board.<sup>4</sup> Participation in collective action may allow these physicians to respond to the economic leverage of health care plans with some leverage of their own.

### PHYSICIANS AS EMPLOYEES

With nearly half of American physicians currently working as employees of medical groups, hospitals, or HMOs or other plans, there has been growing acceptance of collective bargaining as an appropriate option for physicians. Historically physicians have been considered independent contractors with claims of self-governance—any collective action on their part would have been prohibited under antitrust laws that bar

individual competitors from banding together to set prices or working conditions. Physicians who are employees, however, fall within the labor exemption to the antitrust laws. Under the protection of the National Labor Relations Act of 1935, physicians may engage in collective bargaining with employers.<sup>5</sup>

In addition, physicians-in-training—represented by the Committee of Interns and Residents (CIR)—recently filed a petition to challenge the 1976 National Labor Relations Board ruling that house officers in private hospitals are not entitled to collectively bargain because they are primarily students.<sup>6</sup> The notion of house staff as employees has also grown more prevalent.

## ETHICAL CONSIDERATIONS

Physicians have a fiduciary obligation to hold their patients' interests paramount. Their roles as employees should neither detract from their roles as professionals nor alter their intrinsic and dominant commitment to serve others in need of their special knowledge and skills.

In light of these professional commitments, collective bargaining should not be sought in a manner that jeopardizes the health and interests of patients. Collective action should never be conducted in a way that preempts the patient's or public's goals in favor of the physician's own.

Furthermore, formal unionization of physicians and physicians-in-training may tie physicians' interests to the interests of workers who do not share the physicians' primary and overriding commitment to patients and the public health. Physicians should not form workplace alliances with those who do not share these ethical priorities.

## WITHHOLDING MEDICAL SERVICES AS A BARGAINING TACTIC

The AMA has long affirmed, in Policy H-405.988, the medical profession's tradition of "not withholding medical services or performing any act that will interfere with the public welfare as a bargaining mechanism."<sup>7</sup> The moral commitment of medical professionals and professionals-in-training is to their patients' needs above their own. This renders the strike unavailable as a means to even the most public-spirited of ends.

A strike is a coercive device on the part of workers who fear that administrators would otherwise be complacent and unconcerned. In the health sector, some argue that a strike might be justified by the argument that it would do greater good for patients and the public in the long run. While it remains possible that strike-threat power can further long-term objectives such as improved patient care, strikes are by their very nature disruptive. No matter how well-coordinated or well-prepared health facilities may be, strikes reduce access to care, eliminate or delay necessary care, and interfere with continuity of care. Each of these consequences is contrary to the physician's ethic.

One economist maintains that strikes follow the rule that victory is "to the strong, not the just" and usually, "the non-combatants suffer most."<sup>8</sup> The cost of strikes can fall most heavily on non-parties to a dispute. The right to protest for one's patient does not warrant sacrificing patient welfare, even on a temporary basis. Those who strike for the sake of patients lose credibility in the eyes of the profession and the public by momentarily threatening the very end they seek.

However there are several activities that may not impinge on essential patient care and that may ultimately improve patient care. In this context, activities that slow productivity and create inconvenience to management might be warranted in some circumstances. A concerted suspension of paperwork is one example that has been given as a potentially successful option of last recourse.<sup>9</sup> Another more controversial strategy is a well-circumscribed slowdown of elective non-urgent care.

In general, the success of physicians' collective action and collective bargaining does not depend on the ability to strike. Physicians and physicians-in-training are capable of using a variety of approaches that do not limit services to patients—e.g. informational pickets, non-disruptive public demonstrations, lobbying and publicity campaigns, collective negotiation. These can all bring political and economic pressure to serve the goals of patient care and health policy.

## PATIENT ADVOCACY

Principle VII of the Principles of Medical Ethics requires that physicians “recognize a responsibility to participate in activities contributing to an improved community.” Indeed physicians should strive to identify, inform themselves of, and speak out on health care matters.<sup>10</sup> Collective action may be one of many ways physicians can fulfill their special political responsibilities, at least on a local institutional level. It may also enable physicians to take a more aggressive role as advocates for their patients.

Physicians have a spectrum of means through which to press for needed reforms, such as the Accreditation Council for Graduate Medical Education for residents or professional societies and political action committees for physicians. Physicians and physicians-in-training who wish to advance their patients' or the public's interests should take full advantage of the tools of collective action which they have available to them.

## RECOMMENDATIONS

The Council on Ethical and Judicial Affairs recommends that the following statements be adopted and that the remainder of this report be filed:

- 1) Collective action should not be conducted in a manner that jeopardizes the health and interests of patients.
- 2) Formal unionization of physicians and physicians-in-training may tie physicians' interests to the interests of workers who may not share physicians' primary and overriding commitment to patients and the public health. Physicians should not form workplace alliances with those who do not share these ethical priorities.
- 3) Strikes reduce access to care, eliminate or delay necessary care, and interfere with continuity of care. Each of these consequences is contrary to the physician's ethic. Physicians should refrain from the use of the strike as a bargaining tactic.
- 4) There are some measures of collective action that may not impinge on essential patient care and may ultimately improve patient care. In this context, activities that slow productivity and create inconvenience to the management might be warranted in some circumstances.
- 5) Physicians and physicians-in-training should take full advantage of the tools of collective action through which to press for needed reforms. Informational pickets, non-disruptive public demonstrations, lobbying and publicity campaigns, and collective negotiation are among the options available which do not limit services to patients. (Principle VII)
- 6) A physician's union activities should be in conformance with the law. (Principle III)

## REFERENCES

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