A Pennsylvania physicians guild

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How should physicians regain control over medical practice?

This question was asked of 101 doctors through a telephone survey designed by the Pennsylvania Medical Society (PaMS). Essentially, a quarter of the physicians polled answered "unionization" and another quarter answered "organize." (Other ideas included "talk to employers" and "focus on efficiency.") Although the data were reported quantitatively, the PaMS has advised that they should be interpreted qualitatively. (In light of this view, no subset data will be cited herein.)

PaMS Vice President for Professional and Corporate Development Denise E. Zimmerman proffers: "While seeking 'organization' is a significant need physicians are expressing, what form that it takes is not clear. None of the research definitively found that physicians desire a union, per se, even though 'unionization' was mentioned from time to time."

I argue that these physicians were clamoring for a union. Those who weren't telling the PaMS to "unionize" by using this word were telling organized medicine to "organize." This is a distinction without a difference. They were calling for some sort of a group-negotiating body to be created to represent their interests, period. Today's doctors want a union.

This clamor is even louder among young physicians, who represent the future of medicine. The chair of the Young Physicians Section of the Philadelphia County Medical Society (PCMS) reported, during the Board of Directors meeting in June, that all of the attendees at a recent

meeting were hospital employees and that all expressed the hope that the PCMS would somehow negotiate for them.

What has organized medicine's response been to the manifest desires of its membership? The response has been threefold: study, more study and still more study. The AMA studies unions; the PaMS continues to study unions; and the PCMS has a second ad hoc committee studying unions.

The PCMS gained national attention during the past year by actually putting forward some concrete plans for forming an affiliation between itself—along with other surrounding county medical societies—and the Organized Professional Employees International Union, a local of the AFL-CIO with which a national podiatrist union has affiliated. This effort generated intense interest—both professional and lay—and a backlash from opponents that was vicious and unrelenting. The problem persists, and festers.

Relegating one's self-image to "labor" may be painful to those who recall medicine's Golden Age. But are you really "management" when you no longer sign the paychecks? Yet, are you any less "professional" because you receive them? And in your daily practice, is it not far more demeaning—whether functioning as either "labor" or as "management"—to be addressed dismissively by administrators, to be controlled by benefit managers, to be placed on hold by insurers, and to be perceived as "waiting on" a patient?

I believe the last, best hope for physicians to regain control over medical practice is by organizing under the protection of the National Labor Relations Act. Whether you call it a union, a guild or a medical society is immaterial. We provide an action plan below. The reader is requested, please, to leave stereotypes and prejudices outside the door.

We should create a statewide holding company that could contract with one or more unions to serve its (physician) members. This organization would be owned by the professional societies that would constitute its governance. Also, functioning as a subsidiary thereof, the Guild could accept as members only those physicians who were concomitantly members of these same professional societies. It could be called the "Pennsylvania Physicians Guild."

Once members of the Guild, doctors could choose to petition for formal representation through a "local" of their choosing, orienting themselves either towards their specialty or towards their institution. Thus, anesthesiologists could either link contractually with other anesthesiologists or with other employed physicians within their hospital. This is an amalgamation of the "AF of L" model (which is specialty oriented) and the "CIO" model (which is industry wide). The AFL/CIO seems to work; so too might the above concept.

Which union(s) would best implement these plans? There has been intense competition recently between the PA Nurses Association and the AFL/CIO for the opportunity to represent non-physician health professionals. The Guild could choose whichever entity it felt strategically to be optimal for its physician members. And governance by independent professional societies would guard against the exertion of undue control by any one unscrupulous force. Influence would be gained by the worker-bee, not the egotist. And such activities would transcend mere

"lobbying."

All this, of course, would be subject to member ratification. But it would occur under the auspices of (and protection afforded by) the National Labor Relations Board. Meaningful collective bargaining could be provided. Contractual rights could be subject to mediation. Specific terms could be subject to negotiation. Disputes (such as the definition of "tenure") would be resolved through defined appeals mechanisms. Is this not what employed physicians are clamoring to be provided by their professional societies?

During the PMS Board of Trustees July Retreat, lawyers representing state mental health employees (doctors, dentists, podiatrists, etc.) related that 90% of their time is spent rectifying disputes, rather than negotiating contracts.

To conservatives, such is a waste of time. To liberals, such is the stuff of individual rights. The physician who is not wedded to political philosophy must ask, simply, whether there is a perceived need for this level of protection.

The AMA opposes unions. When a group of house officers requested support for such an effort, they were rebuffed by both the AMA and the Massachusetts Medical Society. There are limits to what will be done for young physicians.

Instead, the AMA has created a Division of Representation, which is intended to provide individual members the opportunity to have their contracts reviewed. Almost a decade ago, however, the American Society of Internal Medicine initiated a comparable program but found that few internists invoked it. Why? What good is a "review" of a contract, if it’s presented in a take-it-or-leave-it fashion?

Thus, I conclude that review of each doctor’s contract is "piecemeal medicine" and represents little more than an effort to avoid confronting the real-life experience of employed physicians. Patients need an ombudsman—their physician—to ensure they receive the highest quality care. And doctors need an ombudsman—a guild—to help them deal with employers on both a business and a professional level.

Unbridled, the owner will otherwise keep demanding more and remunerating less. The administrator will be less sensitive to patient desires than to ensuring a defined number of patients is seen daily. Norms exist for safe patient care, but they are unlikely to be applied in a one-sided power-structure.

The basic concern of most thinking and feeling physicians is whether striking is inimitable with our Oaths. One way to split-the-difference is to mandate that any motion to strike be limited to non-emergency work and require a super-majority vote, whereas any motion to engage in a lesser "job action" be implemented by simple majority. Regardless of how this "tool" were to be invoked, the fundamental concern is that a guild be the guardian of physicians’ contractual rights. By extension, it would uphold patients’ therapeutic rights, for no one else in the health care delivery system serves so robustly as the ombudsman in this age of cost-cutting and global-denials

as does the educated and dedicated physician.

Those who exclusively advocate the alternative (physician organizations) must face the fact that the (few) successful ones always seem to be purchased by the dreaded hospitals and insurers they were created to combat. They must be confronted with the reality that regaining influence over patient care may very well require implementation of a strategy necessitating court battles and personal lobbying. Only in this way can ethical issues related to referral patterns be liberated from their economic moorings.

Only a guild can protect physician-employees while being, itself, protected from counter-attack from insurers and hospitals. Only a guild will complement existing societies, struggling to reinvent how they will service their members. And only a guild can satisfy pressing and clearly understood needs of young physicians.