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PHYSICIAN LABOR UNION FORMATION: ATTITUDES OF 400 PHYSICIANS*

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ABSTRACT

While labor unions occupy a prominent position in the advocacy of other American workers, the medical profession has not embraced labor unions as a means of advocating for the needs and interests of most physicians. This study was undertaken to assess current attitudes about labor union formation among a random sample of physicians.

A survey was mailed to 1200 physicians in two medium-sized New England cities. Four hundred physicians completed the survey. Respondent demographic parameters and answers to survey questions were examined with univariate analysis and multiple logistic regression. One hundred eighty-one (45%) respondents believed it was legal for physicians to form a labor union, while the remainder either did not know (41%), believed it was illegal (14%), or omitted answering (0.3%). Only twenty (5%) admitted consulting an attorney about the legality of a physician labor union. Two hundred seventy-five physicians (69%) stated they would join a union, but only 186 (45%) would participate in a strike that involved withholding elective patient care. Ethical issues were cited as the most important factor in a decision not to withhold services. Specialists and non-U.S. trained physicians were 2.6 ($p = 0.004$) and 2.2 ($p = 0.001$) times more likely to favor joining a union.

*The opinions stated in this article are not intended to represent the views or policies of Baystate Medical Center, Mercy Hospital, or Tufts University School of Medicine.

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Non-U.S. trained physicians, private practitioners, and specialists were 2.0 ($p = 0.03$), 2.1 ($p = 0.04$), and 2.6 ($p = 0.0001$) times more likely to favor participating in a strike.

Current changes in the U.S. health care delivery system have forced physicians to reexamine their roles as leaders in the delivery of medical care. Many physicians feel frustrated by their perceived disempowerment in the management of their patients. They resent increasing interference from nonprofessional sources, including restrictions imposed on patients and referring physicians by health care insurers, employers and state and federal governments [1]. Managed care, while holding the potential to foster more efficient use of health care resources, threatens to compromise physicans' ethics by offering them financial incentives to withhold patient care.

While physicians have traditionally relied on state and national professional societies (e.g., American Medical Association (AMA), American College of Surgeons, etc.) to represent their interests, these organizations have not assumed a leadership role in negotiating business contracts or facilitating resolution of physicians' grievances with third-party payers. As a result, physicians voice little confidence in their national organizations' abilities to represent their interests in these important matters and perceive themselves without effective advocacy [2, 3].

Labor organizations have emerged as dominant entities in the American workplace. They are viewed by the general public as powerful advocates for their membership. While the issue of labor union formation by physicians has been explored in part as one possible solution to the problems of physician advocacy and reempowerment, the movement has not made major inroads with the majority of the medical profession. In the 1970s and 1980s a number of physician labor unions formed; at one time these groups claimed a membership of 50,000 physicians [4]. The impetus was not sustained, and these small unions were able to recruit only a small fraction of the physician labor force. One exception is the Union of American Physicians and Dentists (UAPD). Formed in 1972, the UAPD overcame the considerable obstacles that doomed other physician labor unions and today remains a vital, effective organization [5]. In spite of the UAPD's success, growth of the movement continues to falter because of physicians' fears of violation of antitrust legislation, breach of professionalism, alienation of patients (and the general public), and loss of income. These issues notwithstanding, perhaps an even greater hurdle has been the difficulty in developing solidarity among physicians, a group deeply divided by self-imposed and external barriers. Thus, even when unions began to increase their memberships, they were widely beset by lack of consensus among physicians as to which issues they wished to address and the manner in which to proceed [5]. Another impediment to physician labor union formation has been opposition from the American

Medical Association (AMA) [6]. Recently, however, there have been indications that the AMA may be more supportive of physicians involved in collective bargaining with managed care plans [7]. Concomitantly there has been renewed interest in the movement, and there are reports of new physician labor unions forming [1, 7, 8].

It is possible that the inability of physicians to collectively advocate for themselves is due, in part, to a lack of awareness of how other physicians view labor union formation. The few published surveys addressing physicians' attitudes and beliefs about labor unions have not been written by physicians and, by virtue of their relative antiquity, cannot reflect recent changes in the business and politics of health care [4, 9, 10]. The goal of this project was to provide physicians with a modern perspective by conducting a survey of their peers' attitudes and beliefs about physician labor organizations.

METHODS

Study Protocol

A regional physician directory was used to identify a random sample of 1200 physicians in two medium-sized New England cities. No restrictions regarding type of practice (specialist versus primary care) or practice setting (full-time hospital staff or private practice) were imposed on the selection process. A one-page survey (Appendix A) was constructed to elicit brief demographic profiles of the respondents and to ask five basic questions regarding physician unionization. The survey, along with a cover letter (Appendix B) and a stamped, return-address envelope were sent to each physician. Anonymity of the respondents and authors was maintained to maximize the response rate and minimize bias.

Data Analysis

Descriptive statistics were prepared from the compiled data sheets. Univariate factors in the response to questions 3 and 4 were analyzed with the Pearson chi-square test, with Yates' correction for continuity for two-by-two tables [11], and Fisher's exact test for small unexpected frequencies [12]. For the purpose of analysis, all "don't know" responses were counted as "no" to decrease the chance of beta error in "yes" responses. Missing responses were excluded from the analysis. Additionally, responses of "both" to country of medical education were counted as "non-U.S." Responses of "both" to provider type (some specialists perform primary care, e.g., OB/GYN) were counted as "primary care." "Divorced," "widowed," and "significant other" were counted as "single" (i.e., "not married").

Significant factors on univariate analysis were entered into a multiple logistic regression (MLR) [13]. Estimates were calculated for the regression coefficients using maximum conditional likelihood procedures or a median unbiased estimate when this was not possible [14, 15]. The exact conditional scores test was used to determine the significance of individual factors in the regression model.

In reporting the results of the MLR, significant factors are presented with the regression coefficients (Beta) in the logistic model, adjusted odds ratios and 95 percent confidence limits, and significance levels (p) for each factor. A positive regression coefficient indicates a positive or direct relationship to outcome; a negative coefficient indicates a negative or indirect relationship. The adjusted odds ratio for each factor represents the likelihood of a "yes" response for respondents with the factor present compared to those with the factor absent, after adjusting for other significant factors in the logistic model [16]. Omitting the "don't know" responses from either MLR did not change the results.

ANALYSIS

Twelve hundred surveys were mailed. Twenty-two survey envelopes were returned unopened (e.g., "addressee moved"). Four hundred (34%) completed surveys were returned. The demographic profile of the respondents is shown in Table 1.

Answers to Survey Questions

Responses to survey questions are shown in Figure 1. Most (55%) respondents did not know that physician labor formation was legal, answering either "no" or "don't know." Only 5 percent reported having addressed the issue with an attorney. The majority of respondents (69%) said they would join a union. This percentage was the same (70%) in the subset of respondents who did not know whether physician labor union formation was legal. Responses on participating in a strike were divided, with slightly more respondents saying they would strike vs. not strike (47% vs. 39%). When asked what single issue was most influential in their decision on striking (Figure 2), the majority (57%) cited ethical issues. In a subset analysis (Table 2), physicians in favor of striking cited financial reasons more frequently (37%), with ethical issues being second in frequency (31%).

Demographic Factors in Decision to Join a Union

Results of the univariate analysis and multiple logistic regression of factors significant in the decision to join a union are given in Table 3. Specialists were 2.2 (95% CI 1.4-3.6) times as likely as primary care physicians to answer yes (p = 0.001). Non-U.S. trained physicians were 2.6 (95% CI 1.3-5.7) times as likely as U.S. trained physicians to answer yes (p = 0.004).

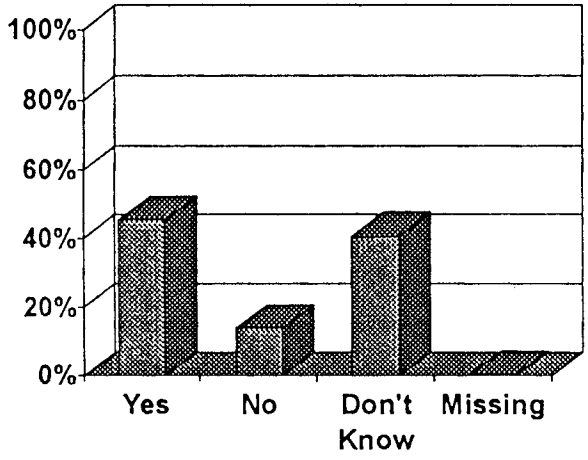
Table 1. Demographic Profile of Survey Respondents

Factor	Number (%)	Factor	Number (%)
Age—years		Country of education	
< 50	222 (55.5)	U.S.	321 (80.3)
≥ 50	178 (44.5)	Non-U.S.	73 (18.3)
		Both	3 (0.8)
Sex		No response	3 (0.8)
Female	54 (13.5)		
Male	338 (84.5)	Type of provider	
No response	8 (2)	Primary care provider	71 (17.8)
		Specialist	262 (65.5)
Relationship status		Both	64 (16.0)
Single	14 (3.5)	Missing	3 (0.8)
Married	359 (89.8)		
Significant other	4 (1)	Type of practice	
Widowed	2 (0.5)	Private practice	301 (75.3)
Divorced	11 (2.8)	Full-time hospital staff	51 (12.8)
No response	10 (2.5)	Both	26 (6.5)
		Missing	22 (5.5)
Number of dependents			
None	56 (14)		
≥ 1	343 (85.8)		
No response	1 (0.3)		

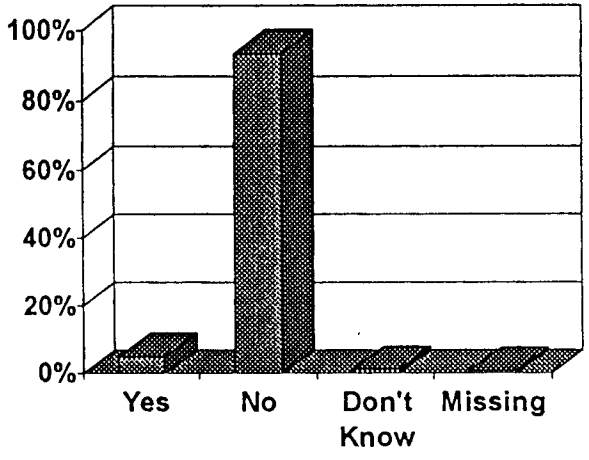
Table 2. Most Important Factors Associated with Decision to Strike

	Would Strike (N = 186)	Would Not Strike (N = 156)	
Factor	No. (%)	No. (%)	P*
Ethical	58 (31.2)	139 (89.1)	0.0001
Legal	17 (19.1)	6 (3.8)	0.055
Financial	68 (36.6)	11 (7.1)	0.0001
Patient opinion	5 (2.7)	17 (10.9)	0.003
Public opinion	12 (6.5)	19 (12.2)	0.088

*Fisher's exact test

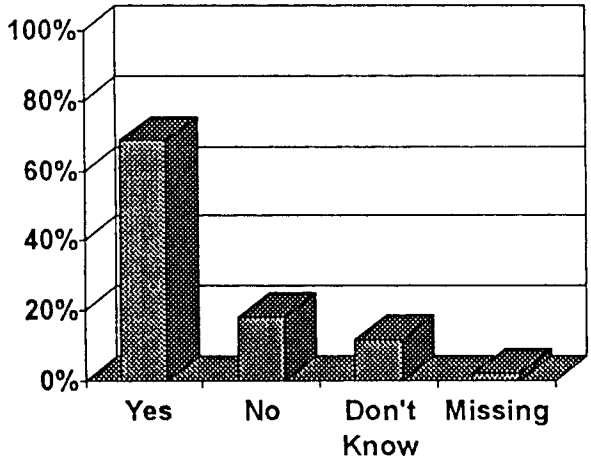


1a. Is it legal for physicians to form a labor union?
(Responses to survey question 1)

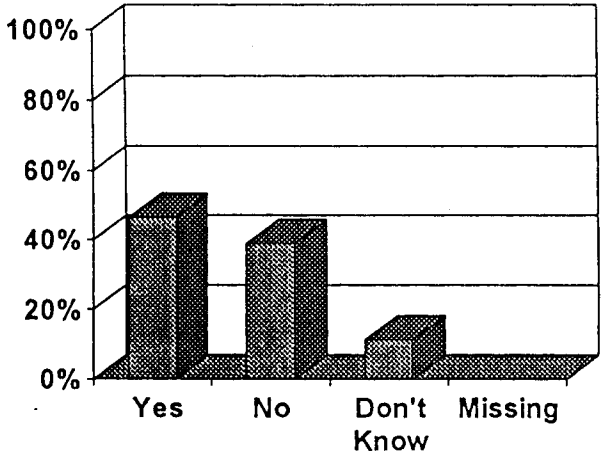


1b. Have you ever consulted an attorney about the legality of labor union formation?
(Responses to survey question 2)

Figure 1.



1c. Would you join a physician labor union?
(Responses to survey question 3)



1d. Would you participate in a strike?
(Responses to survey question 4)

Figure 1. (Cont'd.)

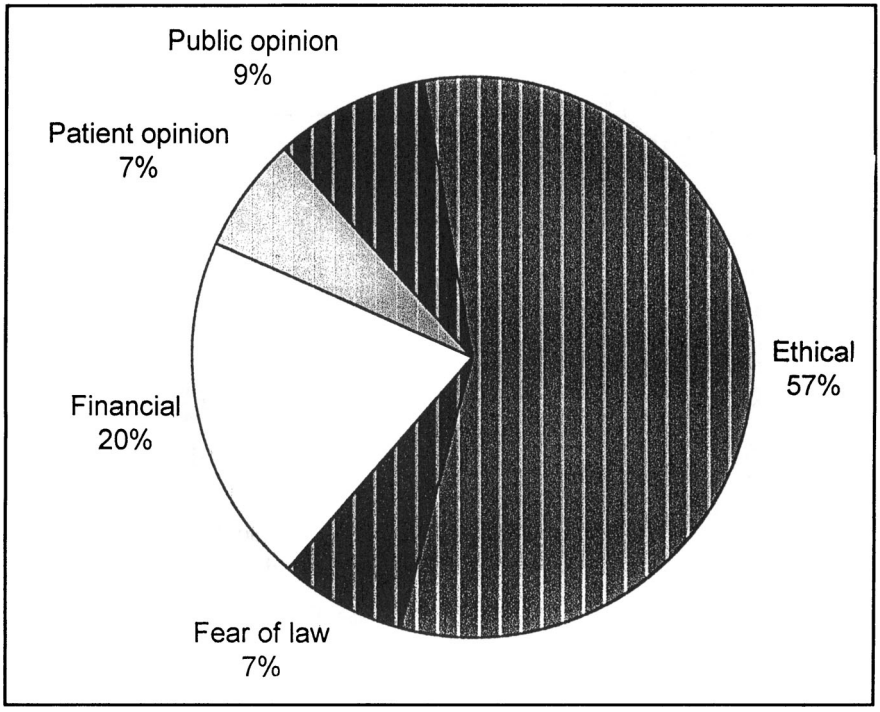


Figure 2. Most important reasons influencing decision about striking. (Distribution of responses to question 5)

Demographic Factors in Decision To Participate in a Strike

Results of the univariate analysis and multiple logistic regression of factors in willingness to participate in a strike are given in Table 4. Specialists were 2.6 (95% CI 1.6-4.5) times as likely as primary care providers to be willing to strike (p = 0.0001). Private practitioners were 2.1 (95% CI 1.0-4.3) times as likely as full-time hospital staff to be willing to strike (p = 0.04). Non-U.S. trained physicians were 2.0 (95% CI 1.1-3.8) times as likely to strike as U.S. trained physicians (p = 0.03).

DISCUSSION

It is legal for physicians to form labor unions [17]. Several currently exist and are active in the United States; others are attempting to form [7, 18]. A lack of precision in defining what is a "physicians union" may well contribute to the

Table 3. Analysis of Factors Associated with Decision to Join a Union

a. Univariate Analysis

Factor	Category	No. Yes (%)
Education	US ($N = 315$)	211 (67)
	Non-US ($N = 72$)	60 (83)
Practice	Private ($N = 297$)	215 (72)
	Full-time ($N = 49$)	28 (57)
Provider	Specialty ($N = 258$)	195 (76)
	Nonspecialty ($N = 132$)	79 (60)
Age	≤ 50 ($N = 216$)	148 (69)
	> 50 ($N = 177$)	127 (72)
Sex	Female ($N = 52$)	29 (56)
	Male ($N = 333$)	241 (72)
Marital Status	Single ($N = 14$)	9 (64)
	Married ($N = 353$)	247 (70)
	Divorced ($N = 11$)	9 (82)
Dependents	0 ($N = 54$)	30 (72)
	≥ 1 ($N = 338$)	235 (70)

b. Multiple Logistic Regression

			95% CI Adj. Odds		
Factor	Beta	Adj. Odds	LL	UL	P
Education*	0.9715	2.6419	1.3169	5.7070	0.004
Provider†	0.7922	2.2082	1.3597	3.5930	0.001
Constant	−1.627				

*U.S. vs. non-U.S.
†Specialty vs. primary care provider/both
LL = Lower limit
UL = Upper limit
P = Probability

Table 4. Analysis of Factors in Decision to Strike

a. Univariate Analysis

Factor	Category	No. Yes (%)
Education	US ($N = 312$)	141 (45)
	Non-US ($N = 69$)	42 (61)
Practice	Full-time ($N = 49$)	16 (33)
	Private ($N = 292$)	152 (52)
Provider	Specialty ($N = 254$)	142 (56)
	Nonspecialty ($N = 130$)	43 (33)
Age	≤ 50 ($N = 218$)	95 (44)
	> 50 ($N = 169$)	91 (54)
Sex	Female ($N = 50$)	18 (36)
	Male ($N = 329$)	164 (50)
Marital Status	Single ($N = 14$)	6 (43)
	Married ($N = 347$)	169 (49)
	Divorced ($N = 11$)	7 (64)
Dependents	0 ($N = 54$)	29 (54)
	≥ 1 ($N = 352$)	156 (47)

b. Multiple Logistic Regression

		95% CI Adj. Odds			
Factor	Beta	Adj. Odds	LL	UL	P
Education	0.7	2.0138	1.0757	3.8443	0.0271
Practice*	0.7229	2.0604	1.0226	4.2879	0.0423
Provider†	0.9728	2.6453	1.5823	4.4853	0.0001
Constant	–3.146	—	—		

*Private vs. full-time staff
†Specialty vs. primary/both
LL = Lower limit
UL = Upper limit
P = Probability

confusion over the legality of physicians forming unions. Traditionally, collective bargaining activities and union formation have been governed by the National Labor Relations Act (NLRA). The primary requirement for union formation under the NLRA is that the physicians be employees. Neither students nor independent contractors may form a union under the NLRA. The primary advantage of physician employees forming a union under the NLRA is that unions under the NLRA are exempt from federal antitrust laws. Conversely, employed physicians with extensive supervisory or managerial duties (e.g., academic physicians) are considered ineligible for protection under the NLRA [9].

Independent contractors may also attempt to come together as a "union" to negotiate terms of payment and conditions of service with HMOs (Health Maintenance Organizations), PPOs (Preferred Provider Organization), and insurance companies. If these physicians are not employees, their bargaining groups cannot be certified as labor unions under the protection of the NLRA. Physicians attempting to bargain collectively outside the aegis of the NLRA may be subject to liability under federal antitrust regulations. Unions may nonetheless effectively advocate for their independent contractor membership by providing expert consultation through professional negotiators who assist the member physicians during contract talks with potential payers [5].

In this study the majority of survey respondents were either unaware of the legality of union formation or believed it to be unlawful. This may stem from highly publicized instances of punitive actions when the actions of health-professional labor unions violated antitrust legislation. Furthermore, since the ultimate "action" of a physician labor union, withholding services from patients, threatens to violate both the Hippocratic oath and the public trust, physicians may be unconsciously biased into believing that physician labor union formation violates civil law as well.

The small percentage of respondents who sought legal counsel about this issue may be explained, in part, by misconceptions as to its legality. Since attorneys have played a considerable role in the development of labor unions in the United States, they would be a logical source for physicians to find information on unionization. However, it is possible that physicians have not reached a point where they are willing to take the first steps to pursue such an option. Apathy and despair, factors that have many physicians prematurely abandoning their careers in medicine, may also dissuade a proactive response to their frustrations.

Over two-thirds of the physicians who responded to the survey indicated they would join a union. This updates and reaffirms the findings of Bumke and Jensen who found that 55 percent and 61 percent of physicians surveyed would join a union [9, 10]. Specialists and non-U.S. trained physicians were more than twice as likely to respond that they would join a union and participate in a strike. Given the current surplus of certain medical and surgical specialists and the diminishing reimbursement for specialty services, this finding is not surprising. Jensen found that while most medical specialists would consider joining a union, surgeons

were the group most likely to join [10]. Similarly, it is possible the responses of primary care providers may be influenced by their improving reimbursement rates and the nature of their relationships with their patients (which stereotypically tends to be more extensive and involved). One can only speculate that the significance of country of medical education might be because foreign-trained physicians find the application of labor union "tactics" to the current physician crisis less offensive than do U.S.-trained physicians. It is possible that hidden, confounding differences in patient volume, reimbursement, and, perhaps, foreign-trained physicians' perceptions of the ethical issues involved in physician labor unions may influence their responses. While Jensen reported that younger physicians were more likely to state they would join a union, age was not a significant factor with this study sample [10].

The finding that private practitioners were more likely to strike than full-time hospital staff was not expected. Since, under current antitrust legislation, hospital employee physicians have the greatest liberty to form a union, this finding carries additional significance. It is possible that hospital staff physicians may be relatively insulated from some of the economic and political pressures that might motivate private practitioners to strike. While these physicians are more likely to be affected by changes in reimbursement for research and educational activities, in many instances the immediate responsibility to react to these changes lies primarily with the administrative and physician leadership, rather than with the individual staff physician.

While a more extensive survey addressing multiple other aspects of physician labor unions was considered, we sought to maximize the survey response rate through an emphasis on brevity, ease of survey completion, and respondent anonymity. Thus, the observed response rate of 34 percent is disappointing and could represent a source of bias if the responses solely reflect the attitudes of individuals who tend to be survey responders. It is unlikely that this influenced the responses about joining a union or striking since nonresponders could be pro-union as well as anti-union. The geographic distribution of the respondents (localized to two midsized New England cities) also raises the possibility that the results are not representative of the U.S. physician population. With this potential bias in mind, the primary focus of this survey is on subgroup comparisons within our sample and on reasons why respondents answered as they did. These comparisons are not subject to the same response bias as the estimation of response rates for the entire sample. This approach assumes that all subgroups are subject equally to the same bias and that subgroup comparisons will be therefore unaffected [19].

No attempt was made to validate the form. External validation was not an option, given the nonfactual nature of the survey. Internal validation of the responses could have been accomplished in a more extensive survey wherein each response was tested via subsequent "hidden" lines of inquiry (that essentially repeat the question). It was felt that in the current survey the purpose of

such redundant questions would be transparent to the reader, rendering them ineffectual and further reducing the response rate.

A longer survey could also provide a more in-depth profile of the responding cohort. Such a survey could evaluate the distribution of response by specific specialty, years in practice (and from retirement), patient volumes, income level, and amount of unpaid debt. A longer survey might also address other potential actions of physician labor unions. These include governmental lobbying, contract negotiations, and boycotting "unfavorable" third-party payers, an action found to be in violation of antitrust legislation.

The limitations of the current survey notwithstanding, its results do offer some insights into the attitudes of a large cohort of physicians. Despite a lack of awareness of the laws addressing physician labor unions, the majority of responding physicians indicated they would join a union. They were less inclined to withhold elective patient services, and this position was primarily influenced by the respondents' sense of ethics. Financial considerations and fear of legal retribution were cited more infrequently. This suggests that physicians continue to maintain a high level of commitment to the needs of their patients (often at their own expense). It remains to be seen whether a higher form of patient advocacy may lie in physicians reclaiming control of their patients' care.

APPENDIX A.
Physician Labor Union Survey Form

Circle most applicable answer

I. SURVEY QUESTIONS

1. It is legal for physicians to form a labor union (or collective bargaining unit)? Yes__ No __ Don't know __

2. Have you ever consulted an attorney to pursue or inquire into the legality of such an action? Yes__ No__

3. If a labor union of *all* physicians were to form, would you join it? Yes__ No__

4. If such a union were to go on strike, withholding all but emergent or compassionate care, would you participate in the strike? Yes__ No__

5. Circle the *one* most important reason influencing this decision:

Ethical issues Fear of legal retribution Financial impact

Your patients' opinions Public opinion

II. RESPONDENT DEMOGRAPHIC DATA

1. Age: less than 50 ≥ 50
2. Sex: female male
3. Relationship status: single married divorced widowed significant other
4. Number of dependents (exclude yourself): 0 ≥ 1
5. Country of medical education: U.S. non-U.S.
6. Primary care provider: Yes No
7. Specialist: Yes No
8. Private practitioner: Yes No
9. Full-time hospital staff: Yes No

APPENDIX B.
Physician Labor Union Survey Cover Letter

Physician Labor Survey
P.O. Box 2550
XXXXXXXXXX

October 2, 1997

Dear Colleague,

I am conducting a research project on physicians' attitudes towards the formation of a labor union of doctors. The survey is being mailed to a large, randomly selected cohort of physicians in the greater XXXXXXX area as a pilot study which might eventually be expanded to survey a greater sample size.

The study should not be construed as an endorsement of labor union formation nor is it an attempt on the part of the author or any of the medical institutions with which he is affiliated to organize such a group.

Please take a moment to answer the enclosed questionnaire. **The individual response forms are completely anonymous and bear no identifying codes.** The data will be analyzed and the results will be submitted for publication in a peer-reviewed medical journal.

Thank you for your participation. For obvious reasons I remain (until the article is submitted for publication) anonymously yours,

John Doe, M.D.
Physican Labor Survey

* * *

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