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A Reply to Professor Craver: Physicians in Private Practice Already Have Enough Power

By STANTON A. GLANTZ*

SINCE early in this century American physicians have expanded the scientific basis for their work and have argued successfully that, because of the resulting technical complexity, public protection requires that the states give the medical profession broad powers to regulate itself by limiting the number of medical schools1 and that physicians enjoy a near monopoly in the sale of health services through state licensing.2 Medical society control of entry and of professional discipline combined with the fee-for-service payment system allows individual physicians professional and economic autonomy. The individual physician’s independence, however, is diminishing, owing to the rising cost of health care to the public and the rising cost of malpractice insurance to the practitioner,3 both of which one can attribute to the medical profession’s failure to meet its public responsibilities. Congress now requires institutionalized peer review of physicians treating Medicare and Medicaid recipients to see that these patients receive medically justified care.4 For their part, the courts are holding hospitals liable for failing to supervise the medical proce-

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dures carried out within their premises,\(^5\) and the fear of this liability has motivated hospitals to convene peer review committees to maintain the quality of service. The advantages of specialization have spurred the growth of group practice,\(^6\) with its resulting encumbrances. All these changes limit somewhat the private physician's autonomy, but even so, the medical profession and its members enjoy a degree of independence well beyond the reach of other workers. Nevertheless, some physicians see their livelihoods threatened by the encroachments of stronger peer review, group practice, insurance companies, and government regulation, and they have formed unions to protect themselves.\(^7\) Such unions probably are subject to liability under the antitrust laws, and, consequently, Professor Craver argues that the law should be amended or construed to provide physicians in private practice "rights and protections generally available to regular workers."\(^8\)

Craver's arguments overlook three important facts. First, the institutional changes which the doctors denounce merely represent a shift in power from the individual physician to the medical profession as a whole. Second, physicians directly influence the demand for their own services through such actions as instructing a patient to make a return visit, admitting a patient to the hospital, and deciding to administer an extended course of therapy.\(^9\) Third, because society deems the doctors' special skills so important, the state already provides the medical profession with a legally protected monopoly which gives physician "workers" powers far beyond anything a normal union could desire. We have long awaited the changes in our health care system designed to assure better quality and cost control, and it is not in the public interest to amend the labor and antitrust laws to expand the power of private practice physi-


\(^{6}\) See Group Practice Doctor's Income, MED. WORLD NEWS, Feb. 10, 1975, at 111.

\(^{7}\) See, e.g., Alper, Why I Joined a Union, PRISM, May, 1974, at 26; Marcus, A Vote for Unionism, AM. MED. NEWS, Aug. 7, 1972 (letter to the editor); Peterson, Why I Changed My Mind on Doctors' Unions, MED. OPINION, July 1973, at 48-51.


PHYSICIAN UNIONS: A REPLY

November 1975

Physicians to oppose these changes. If anything, the antitrust laws should be strengthened to foster more competition in medical practice.

When one discusses the issue of physicians’ unions, one must distinguish between those physicians who are bona fide salaried employees and those who are independent contractors using an institution’s facilities to earn part of their livelihoods. The former group, which has voluntarily relinquished some of its professional autonomy, already enjoys the benefits of the National Labor Relations Act (NLRA), and rightly so. Like any other employees, they deserve protection from their employers’ capricious actions. The fact that they have given up fee-for-service private practice demonstrates that they have relatively little concern over the questions which motivate private physicians to unionize. Thus, we will focus on the latter group, the physicians in private practice who feel their state-created monopoly does not give them sufficient leverage to protect their own and their patients’ interests.

The actual changes in our health care system to date have been much smaller than Craver suggests. Physician-controlled Blue Cross remains the nation’s largest single third-party carrier, physician-controlled Professional Standards Review Organizations (PSROs) are still in the organizational stages, and not one Health Maintenance Organization (HMO) has yet qualified for federal certification. Public statements by leaders of fledgling physicians’ unions, however, reveal that the leaders expect more drastic changes. A journalist sympathetic with physicians’ views summarized what these leaders fear most:

A nationalized health service in this country would consist of salaried physicians serving in those places, at those times, and in those

11. See generally Colombotos, Kirchner & Millman, Physicians View National Health Insurance: A National Study, 13 Med. Care, May, 1975, at 369 [hereinafter cited as Colombotos, Kirchner & Millman]. The authors’ findings support the proposition that the method by which a physician is paid affects his views on health care issues. For instance, the authors’ survey showed that salaried physicians (hospital-based) favored some form of national health insurance nearly 50% more often than did office-based physicians. Id. at 385.
14. Thanks to the lobbying by various medical special interest groups, the requirements in terms of benefits and rate structures are much more stringent than those that apply to fee-for-service organizations. See Dorsey, The Health Maintenance Organization Act of 1973 (P.L. 93-222) and Prepaid Group Practice Plans, 13 Med. Care, Jan., 1975, at 1, 8.
fashions that they are ordered to serve . . . . The Government would seek to assure what the bureaucrats regard as a proper geographical and specialty distribution of physicians. Precise tables of organization would dictate how many primary physicians, general surgeons, urologists, radiologists, pathologists, and other specialists would be assigned to each community. The procedures each type of doctor might perform would be sharply defined so that primary physicians would not take out appendixes, gallbladders, or even tonsils.

There would be no need for P.S.R.O. as it now exists. Instead, the Government would insist that its physician-employees treat as many diseases as possible by use of specific clinical algorithms—"cookbook medicine" if you please—in an effort to get uniformity of therapeutic approach. Computerized patient records would be relied upon to assure continuity of care, since a nationalized health service with doctors punching time clocks couldn't even attempt to foster, let alone preserve, the substantial degree of personal physician-patient relationship that still remains in American medicine.

For those patients with the right ailments—a simple fracture clearly visible on an X-ray or a pneumonia readily responsive to a specific antibiotic—the care might not be too bad. But for those with difficult, time-consuming problems that resist easy definition or solution, and for those who need emotional support as well as efficiency, this system could seem like a medical hell designed by Franz Kafka.\(^\text{15}\)

With this situation looming on the horizon, some physicians feel that they need a union's economic power in addition to their state-created monopoly, to protect themselves and their patients. Empirical evidence, however, suggests that these fears will not materialize. William Glaser, after studying medical payment systems and organization in every major nation in Europe and the Middle East,\(^\text{16}\) concluded:

Doctors' work is indispensable to the survival and efficiency of people in every social system. Skills and judgment of such a high order are scarce, require much training, and attract general respect from the public and from leaders of the government. Organizations of the profession influence recruitment and prices. In practice, the medical profession acquires a powerful voice in the policies and management of national medical care systems in addition to the clinical services that are its recognized preserve. Consequently, the medical profession eventually manages to ensure that these systems do not operate to its disadvantage in any way.\(^\text{17}\)


\(^{16}\) See W. GLASER, *PAYING THE DOCTOR* 4-5 (1970) [hereinafter cited as GLASER]. Glaser examined the health care systems in Cyprus, Egypt, England, France, Federal Republic of Germany, Greece, Israel, Italy, Lebanon, The Netherlands, Poland, Spain, Sweden, Switzerland, Turkey, USSR.

\(^{17}\) *Id.* at 172.
Thus, while doctors may find their individual autonomy circumscribed in the future, there is little possibility that professional organizations will not adequately represent their collective interests. As for the economic question, Glaser found: "Medicine is one of the highest paid occupations in every country, regardless of whether the medical services are public or private and regardless of the method of payment."\textsuperscript{18}

The Imagined Threat from Health Insurance Carriers

A feeling of powerlessness when dealing with the large health insurance carriers provides one of the strongest motivations for the private practitioner to unionize.\textsuperscript{19} The logic, as Craver points out,\textsuperscript{20} is that an individual physician has no real economic leverage when acting alone against the concentrated power of a third-party carrier. But who are these carriers?

During the Depression, physicians noticed that many people were too poor to seek medical care or to pay their doctor bills. State medical associations developed Blue Shield, for example, so that patients would pay monthly sums to Blue Shield, which would in turn reimburse doctors for their services. Blue Shield insures sixty-five million people for medical and surgical care and handles thirteen million Medicare and Medicaid patients.\textsuperscript{21} Today, state or local medical societies still control most Blue Shield plans. In 1970, two-thirds of all Blue Shield board members were doctors.\textsuperscript{22} Of the twenty-one California Blue Shield directors, nineteen are physicians, and all are nominated and elected by the house of delegates of the California Medical Association (CMA).\textsuperscript{23} Thus, if Blue Shield were as insensitive to the needs of the medical community as the proponents of unionization would have us believe, one wonders why the medical association does not nominate and elect a board more sympathetic to its members' goals.

Rather than arbitrarily setting fees, Blue Shield goes to great lengths to determine each doctor's "usual and customary" fee for a given

\textsuperscript{18} Id.\textsuperscript{19} See, e.g., Alper, \textit{Why I Joined a Union}, PRISM, May, 1974, at 26, 28; Navarro, \textit{Social Policy Issues: An Explanation of the Composition, Nature, and Functions of the Present Health Sector of the United States}, 51 BULL. N.Y. ACAD. MED. 199, 216 (1975); Peterson, \textit{Why I Changed My Mind on Doctors' Unions}, MED. OPINION, July, 1973, at 48-49.\textsuperscript{20} See Craver, supra note 8, at 59.\textsuperscript{21} Bodenheimer, Cumming & Harding, supra note 12, at 584.\textsuperscript{22} Id. at 588.\textsuperscript{23} Id.
For example, in California, the entire payment system is based on reports prepared periodically by a committee of the CMA, whose delegates elect the California Blue Shield directors. These reports, called the California Relative Value Studies (RVS),\(^{25}\) catalogue medical services and procedures along with a code number and a unit value representing the median relative physician charge for each service compared with other services in the same category.\(^{26}\) While the RVS is not a fee schedule, but rather a technique for describing a physician's services, it often serves as a fee-setting guide after an individual physician decides what one relative value study unit of his service costs.\(^{27}\) Within this framework, when a physician under contract with Blue Shield sees a Blue Shield subscriber, he bills Blue Shield, not the patient, by sending in the RVS code with his bill. Blue Shield then pays the doctor his "usual and customary" fee, essentially the lesser of (1) the billed amount, or (2) his median charge for the same service, or (3) the median charge for all physicians in his area for the same service. About once a year Blue Shield recomputes each physician's "usual and customary" fees. Thus, when a physician sends in a bill above his current "usual and customary" fee, although he will not be reimbursed the full amount, he knows he is building a basis for raising his and his colleagues' "usual and customary" fees for the following year.\(^{28}\) No physician, however, has to deal with Blue Shield. If he wishes, he may simply bill his patients at whatever rate he chooses and let them worry about collecting from Blue Shield.\(^{29}\) Since the Medicare bill\(^{30}\) stated specifically that it was not to interfere with the existing delivery system,\(^{31}\) Medicare reimbursement to fee-for-service physicians works according to the Blue Shield formula.

Unlike Blue Shield, the private insurance companies, whose total business is somewhat greater than that of both Blue Cross and Blue Shield,\(^{32}\) contract directly with the patient, not with the physician.\(^{33}\) Generally, these policies reimburse the patient either a fraction of the

\(^{24}\) See id.


\(^{26}\) Id. at 6.

\(^{27}\) Id. at 7, 119.

\(^{28}\) See Bodenheimer, Cummings & Harding, supra note 12, at 588.

\(^{29}\) Id.


\(^{32}\) See, e.g., Bodenheimer, Cummings & Harding, supra note 12, at 588.

\(^{33}\) Id. at 589.
patient's bills (for example, 80 percent) or a set amount, depending on the procedure. Unlike Blue Shield, these insurance companies sometimes do not tie their reimbursement schedules to doctors' fees, leaving irate patients only partially covered.\textsuperscript{34} While this situation has doubtlessly led to friction between patients and physicians because the patients erroneously believed themselves to be fully insured, the insurance contract is between the patient and the carrier, not the physician and the carrier. Thus, the physician is left to set his fees as he wishes and collect as best as he can. Competition with Blue Shield, however, has tended to force the private insurance companies to follow Blue Shield's policy.\textsuperscript{35} Since the physician is not a party to the insurance contract, one is left wondering what role a union would play in negotiating on the physicians' behalf with the private insurance companies. Would the union demand that patient coverage be increased to insure that patients would not have to pay anything and thus to guarantee more reliable collections of the entire fee the physician sets for himself?

\textbf{The Supposed Threat of Government Health Insurance Systems}

Perhaps Medicaid (Medi-Cal in California) provides the greatest source of irritation for the medical community because of its relatively tight fiscal control. For example, although Medi-Cal uses the Blue Shield reimbursement mechanism, the basic rate structure has been permitted only one 2 1/2 percent general rate increase since 1970, although specific increases have been permitted to pass along higher costs. Thus, physicians make less money from Medi-Cal than they would by delivering the same services to regular patients. While this situation may seem unjust, the state does not require anyone to see Medi-Cal patients. Indeed, many physicians have found that Medicaid patients can provide a sort of guaranteed annual income during recessionary periods, when paying patients tend to stay away.\textsuperscript{36}

By fixing payment according to the "usual and customary" fees which the physicians themselves can increase by simply submitting higher bills, the fee-for-service method contains a powerful incentive for physicians to deliver more medical services than the patient's needs justify. Dr. Paul Hawley, while Director of the American College of

\begin{itemize}
\item 34. See \textit{id.}
\item 35. \textit{id.}
\end{itemize}
Surgeons, observed: “One-half of the surgical operations in the United States are now performed by doctors who are untrained, or inadequately trained, to undertake surgery. Inadequately trained physicians are doing an increasing amount of surgery because every insured patient is a paying patient.”

In 1956, the United Mine Workers’ health care program’s benefits for procedures performed by specialists were limited to operations actually performed by board certified surgeons. The union found that surgical rates declined by one-half within three months. In 1972, a New York City union instituted a policy conditioning reimbursement for elective surgery on a second medical opinion that the operation was necessary; their elective surgery rate dropped 17.5 percent. It has been estimated that two million operations (about 16 percent of all surgery) are entirely unnecessary; these operations account for at least 24,000 deaths annually. While these practices are matters of common knowledge within the medical community, neither the medical societies nor Blue Shield (and hence Medicare) require even a second opinion to receive reimbursement for an operation.

Less dramatic, but no less widespread, is the practice of providing unnecessary office and nursing home visits to patients, especially those covered by Medicare and Medicaid:

For example, a fee-for-service group practice comprising Board qualified and certified physicians, a large percentage of whose practice was Medicaid, billed [New York City] for an inordinate number and percentage of referrals to the group otolaryngologist, gynecologist, urologist, pediatrician, allergist, etc. It was standard procedure for the intake group pediatrician to refer to the group otolaryngologist almost every child with uncomplicated acute otitis media. The otolaryngologist received a $20 Medicaid consultation fee which was then presumably pooled in the group’s income.

Similar practices nationwide not only expose patients to risks associated with unnecessary medical procedures, but also cost the taxpayer dear-
ly. In short, Medicare and Medicaid have exacerbated already strong financial incentives for the medical community to perform, at higher prices, more procedures than are medically justified. Physicians on hospital utilization review committees and similar groups who work with fiscal intermediaries have had little effect on costs.\textsuperscript{48}

\textbf{The Exaggerated Burden of Peer Review}

To understand why peer review mechanisms have had little impact on the quality and cost of medical care under government sponsorship and why Craver is incorrect in asserting that utilization review amounts to supervision of medical practitioners,\textsuperscript{44} let us examine how Medi-Cal's physician utilization review works.

Blue Shield, the fiscal intermediary, designates physicians of the same specialty in a locality as a peer group and then flags each provider who, after allowing for the size and nature of each practitioner's patient population, delivers a given service more often than 97.7 percent of his peers.\textsuperscript{46} Thus Medi-Cal utilization review selects physicians with highly unusual practice patterns for additional investigation. In the period of July to September 1974, the 259 physicians who had unusual practice patterns accounted for a substantial amount of money: providers showing unusual practice patterns and having dollar values greater than $5,000 per physician accounted for $1,301,539 in Medi-Cal billings during this period.\textsuperscript{46} Despite the considerable amount of money involved, the review process continues within Blue Shield, with no involvement by state officials, except in those few cases of outright fraud.\textsuperscript{47} A California Department of Finance Report explained that Blue Shield analyzes the report of any provider with an unusual practice pattern and excludes some of these practitioners from further investigation. Reasons for discontinuing the review include insufficient information, prior case information, and other knowledge of the provider.\textsuperscript{48} For those

\begin{itemize}
\item \textsuperscript{43} Panel Discussions on National Health Insurance Before the Subcomm. on Health of the House Comm. on Ways \& Means, 94th Cong., 1st Sess., 12-14 (1975) (statement of Lowell E. Bellin) [hereinafter cited as Bellin statement].
\item \textsuperscript{44} See Craver, supra note 8, at 57.
\item \textsuperscript{45} AUDITS DIVISION, CALIFORNIA DEPT OF FINANCE, A REVIEW OF THE MEDICAL PROGRAM 108 (1974).
\item \textsuperscript{46} Id. at 109.
\item \textsuperscript{47} Id. at 110.
\item \textsuperscript{48} Id. at 110-11.
\end{itemize}
cases the fiscal intermediary decides to monitor, a mechanism is trig-
gerated which flags all claims submitted. These claims are reviewed by
the medical review and audit department of Blue Shield or the local medical
foundation, which belongs to the physicians. This review is defined as
prospective peer review. While the physician is on prospective review,

attempts are made to educate him in regard to program benefits and
limitations. In addition, claims may be denied for excessive services or
the case may be referred to the local medical society for disciplinary
action. On October 18, 1974, there were 233 providers on prospective
peer review.

From information furnished by the fiscal intermediary, the Depart-
ment of Finance could determine the effective date of prospective
review, and it concluded that the average length of time on review was
approximately fourteen months. In some instances, providers had been
on review for as long as five years. The significance of this finding is
that the providers on review continue to treat patients and receive
payments from Medi-Cal even though their practices do not accord with
accepted practice in the area.

Thus, the utilization review process exerts virtually no control on
the practice of medicine by an individual practitioner. Furthermore, an
adverse decision—when one occurs—denies Medi-Cal payment to only
those physicians who are not practicing in accordance with 97.7 percent
of their peers. Like Blue Shield and Medicare, this review mechanism
contains built-in incentives for everyone to deliver more services because
then the scale against which everyone is compared will be pushed ever
higher. Finally, if an individual physician feels strongly about the appro-
priateness of a procedure and cannot convince his peers of its correct-
ness, he can simply bill the patient. In short, existing utilization review
procedures fail not only to constitute "supervision" of individual physi-
cians but also to insure that those treating patients with the public's
money do so in ways consistent with their peers' practices.

These problems are not unique to California. In 1971, the New

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49. Id.
50. Id.
51. Id.
52. Id.
53. Id. at 111.
54. Id. at 112.
55. Id.
56. Id.
57. Id. at 108.
Mexico Department of Health and Social Services was virtually bankrupt owing to overruns in the Medicaid program. To save the program, the department cut back on the scope and duration of benefits for fourteen months so that the projected expenditures would not exceed the state's budget. The department also hired a nonprofit organization of physicians to provide peer review of all Medicaid claims to determine if the services were medically necessary and appropriate.

Far from creating a Kafkaesque nightmare, these steps saved Medicaid in New Mexico. Since 1971, Medicaid in New Mexico has operated within its budget, and the increase in costs, which are attributable to a larger number of eligible beneficiaries, to increased benefits, and to inflation, was only 50 percent, while Medicaid expenditures nationwide have more than doubled. The length of the average hospital stay decreased by 24 percent, at a savings of $2.5 million per year. Use of injections during office visits decreased by two-thirds, at a savings of $200,000 per year. Prescription drug costs were reduced 12 percent the first year and another 5 percent the second year, and New Mexico now spends less on drugs than it spent the year before the new approach was taken, even though drug prices are higher and more people are eligible for assistance.

By institutionalizing physician peer review in a way responsible to the state, not the medical society, New Mexico was able “to provide the opportunity for quality medical care to eligible citizens . . . without bankrupting the State.” These steps were completed without turning all of New Mexico’s physicians into state employees. Again, the change simply reflected a shift in autonomy and responsibility from the individual physician to the medical community as a whole.

Concern over skyrocketing costs in both the public and the private sectors is beginning to produce demands for changing the system. Blue Shield is under growing pressure from consumer groups and some state insurance commissions to add consumers to their boards and use their

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59. Id.
60. Id.
61. Id. at 66-67.
62. Id.
63. Id.
64. Id.
65. Id. at 67.
considerable economic leverage to reduce unnecessary medical procedures. Private insurance companies, concerned about their profits, are also trying to limit cost increases. Perhaps most important, the political alliance between the American Medical Association, the National Association of Manufacturers, the United States Chamber of Commerce, and the Republican Party has been crumbling under the pressures of ever increasing medical care costs. Does the pressure from government, consumers, and business justify permitting the individual physician to unionize? To gain perspective on this problem, let us return to Glaser's study of medicine in Europe and the Middle East:

[A]uthoritarian and evolutionary solutions ultimately end at the same point. Lest medical services be upset and lest they be blamed, the government and sick funds create an administrative structure and system of medical pay that is acceptable to the medical profession. Elaborate concessions are made to the profession's demands for autonomy, resources, and incentives sufficient for future recruitment. Standing consultative mechanisms are created. Shortages of money and malfunctions touch off occasional disputes, sometimes punctuated by extravagant rhetoric and strike threats, but almost invariably the doctors obtain concessions in money and procedure. Since money is limited, doctors rarely get paid as well as they would like, but usually they gain more from the public authorities than does any other private group.

It is against this background that one should examine the passage of legislation establishing PSROs.

In 1970, the Department of Health, Education and Welfare (HEW) asked Congress for authority to establish so-called program review teams of physicians and consumers to monitor federally funded health programs and locate areas of abuse. The AMA reacted by proposing that peer review organizations be established by the state medical societies. Wallace Bennett, a Republican senator from Utah, introduced the AMA proposal that ultimately became the PSRO provision by describing it as

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68. GLASER, supra note 16, at 137 (emphasis added).
70. Professional societies almost never pursue a policy of active case finding of malefactors. At best, professional societies scrutinize only those cases brought to their attention by complaints. This absence of case finding results in ineffective peer review. Bellin statement, supra note 43, at 12.
the best, and perhaps the last, opportunity to fully safeguard the public concern with respect to the cost and quality of medical care while, at the same time, leaving the actual control of medical practice in the hands of those best qualified—America's physicians.71

Today physicians in 203 regions designated by HEW are forming nonprofit corporations; membership in any region's organization is open to any licensed doctors of medicine and osteopathy, and that organization will be recognized as the area's PSRO. Each PSRO will develop standards for practice in its area and review the performance of doctors who treat patients under federally funded programs. Like the current Medicare and Medicaid utilization review system, the PSRO will have little effect on those physicians who do not participate in federal programs.72 In twenty-eight states (and in the District of Columbia) the local PSRO encompasses the state's entire medical society,73 with the result that the PSRO will become the medical society under different initials.74

Of the countries Glaser studied, every one which uses the fee-for-service payment system has an organization similar to the PSRO to gather statistics, and to educate and discipline physicians who deviate too far from established medical practice.75 While the issue of PSROs seriously divided the AMA76 and remains one of the major motivating forces toward unionization, three-quarters of physicians interviewed in a recent survey reacted favorably when asked if, when advising a committee planning a national health insurance program, they would prefer institutionalized peer review similar to that embodied in the PSRO concept.77 The PSROs do come closer to "supervising" physicians in their practices than previous peer review mechanisms, because they are charged not only with flagging those physicians whose practice patterns differ from those of their communities, but also with actually developing standards of care and undertaking studies to highlight local medical problems. The AMA and specialty societies are developing standards and model procedures under contract with HEW, but it will be up to the

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71. Id.
72. See Goran, Roberts, Kellogg, Fielding & Jessee, supra note 4, at 5.
73. Lander, supra note 69, at 7.
75. See Glaser, supra note 16, at 150.
76. See Lander, supra note 69, at 7, 14-15; Reynolds, Is the AMA's Washington Lobby Worth the Money?, Med. Econ., May 12, 1975, at 35. The latter points out that the split is between those opposed to compromise at any price and those urging the AMA to make the best deal possible. Id. at 35.
77. See Colombotos, Kirchner & Millman, supra note 11, at 375-77.
membership in each local PSRO to adopt those standards which it finds most appropriate to its locality. These standards are not legally binding on the individual physician but will help protect him from unjustified malpractice suits, since the law establishing PSROs provides that no physician may be held civilly liable for action taken in compliance with a PSRO's norms provided he exercises "due care."

Each PSRO will monitor hospital admissions and length of stay to guarantee that they are medically justified, and PSRO approval will insure federal reimbursement for a service. Nurses will probably handle the lower level screening process, but only a physician has the authority to challenge the decision of another physician. Most important, HEW emphasizes the educational rather than punitive nature of PSRO activities:

If a physician's pattern of practice indicates that he is delivering excessive or insufficient health care or otherwise improperly treating his patients, his peers in the PSRO will advise the physician and recommend appropriate remedies, such as professional consultation and education. Only in rare cases would sanctions provided by law be imposed . . . .

There is also an extensive appeals structure available to the challenged physician, and the only real sanction the PSRO can employ is denial of payment under a federal program. As with the old utilization review system, the PSRO does not transform individual physicians into employees. Instead, it represents a modest attempt to force the medical community to do a more systematic job of policing itself.

While physicians can be paid for PSRO work, they are often expected to serve on hospital committees without pay to maintain admitting privileges. This expectation has catalyzed unionization movements among many private practitioners because they desire reimbursement for these services. Craver argues that while serving on these committees, the physicians are effectively employees of the hospital. National Labor Relations Board General Counsel Peter Nash, however, denied an unfair labor practice complaint of a group of physicians who claimed that their hospital was not negotiating in good faith on the issue of payment for service on the hospital's utilization review committee. General

78. Goran, Roberts, Kellogg, Fielding & Jessee, supra note 4, at 3.
81. See Craver, supra note 8, at 70.
Counsel Nash recognized that a hospital exercises little control over the actual committee work. Such committee service is analogous to that of scientists who review their peer's work for publication in scientific journals. Scientists consider this activity, for which they are not paid, a reflection of their responsibility for professional quality control. Likewise, physicians should view service on hospital committees as part of a physician's responsibility to his patients, for which the patients pay him, to insure adequate standards at the hospital where he treats them. Finally, Craver and the physicians who wish to force hospitals to pay them for committee work overlook the fact that the hospital makes available, at no cost to the physician, the materials, facilities, and personnel he uses to earn part of his income. At present income levels, unpaid hospital committee service should not cause physicians any financial hardship.

Institutional changes such as the appearance of HMOs and the growth in group practices have little to do with the question of whether or not physicians in private practice should be permitted to unionize. While the payment structure may influence whether or not there is a tendency for excess delivery of medical services, as with a fee-for-service system, or underutilization, as with a capitation system, so long as the organization remains under the control of the physician-owners, no true employer-employee relationship exists. The fact that the physicians surrender part of their professional autonomy to a group to im-

82. General Counsel Hospital Report, 88 LAB. REL. REP. 8, 13 (1975).
83. In 1973 the median net income of all self-employed medical specialists was $41,810. For those in corporate practice the figure was $65,000. The figure for self-employed physicians represents median net earnings (gross income from practice less tax-deductible professional expenses, but before income taxes); the figure for corporate physicians represents median total compensation from practice (salary and bonuses plus corporate profit sharing and pension plan contribution, but before taxes). Owens, How Four Medical Specialties Compare Financially, MED. ECON., Apr. 14, 1975, at 76, 82.
84. Capitation involves the payment of a fixed sum of money per subscriber for medical care during the period of coverage, regardless of the amount of care needed.
85. Nevertheless, organized medicine has secured laws that have discouraged development of prepaid group practices. "A study of state legislation in 1969 found in less than half the states was the situation sufficiently defined to enable prepaid consumer-sponsored group practices to be developed without concern about possible legal restraints. In some states, the law requires a majority of the board of directors of such plans to consist of physicians, and in some there are requirements that all physicians in an area have the privilege of joining the plan should they so desire. Other restrictions hinged on organizational and fiscal requirements of the plans, including questions of limited liability, tax, and insurance." R. Stevens, AMERICAN MEDICINE AND THE PUBLIC INTEREST 423 n.10 (1971). See also Dorsey, The Health Maintenance Organization Act of 1973 (P.L. 93-222) and Prepaid Group Practice Plans, 13 MED. CARE, Jan., 1975, at 1.
prove their working conditions and increase their incomes does not convert them into employees. Of course, were the physicians to become bona fide employees of consumer-run health groups, they would already be covered by the NLRA.

Conclusion

Extending NLRA coverage to private physicians and giving them antitrust immunity would further solidify their control in the health care industry and make it easier for them to keep from the public the information necessary intelligently to select a physician and a mode of delivery. We have already seen how the profession has resisted meaningful peer review and such medically reasonable procedures as requiring a second opinion prior to elective surgery.

The experience of a Maryland consumer group illustrates how organized medicine tries to keep important information from the public. The Public Citizens Health Research Group circulated a questionnaire to the physicians in a Washington, D.C., suburb asking whether or not they were board certified, at which hospitals they practiced, whether or not they made house calls, and what their fees were. The county medical society circulated a letter saying that disclosure of this information would constitute illegal advertising. After receiving responses from 25 percent of the physicians, the consumer group published their guide and filed a lawsuit to overturn the laws under which the medical society sought to prevent its members from disclosing this information. Although the case is still in litigation, it is evident that if the medical society were a union, its legal right to restrain trade would be stronger.

With the movement toward national health insurance, we can expect the cries of anguish from the medical community to grow, despite the fact that 56 percent of physicians recently surveyed were in favor of "some form" of insurance. One study has revealed that physician support for Medicare grew quickly after it was adopted in New York in 1965. While 38 percent supported it before passage, 70 percent were in favor of it a year after passage and 92 percent favored it by 1970. The

86. In 1972, members of group practices earned an average of about $10,000 more than physicians in sole practice. See Group Practice Doctor's Income: Higher than Solo Practitioners, MED. WORLD NEWS, Feb. 10, 1975, at 111.
88. Colombotos, Kirchner & Millman, supra note 11, at 372.
89. Id. at 371. Perhaps their growing acceptance was due to the fact that "the
relatively strong support for national health insurance probably means that when it does arrive, physicians will quickly adjust to the new system. Perhaps, the American medical community is recognizing a seemingly universal fact:

Participation in the decisions of public medical schemes and commitment to the success of these programs will not cause the doctors and the medical association to abandon self-interest. Like every occupation in the public service, they seek higher pay and better working conditions and argue that the nation will benefit through better recruitment and improved performance. As the profession becomes more involved in the management of the public system, the leadership of the medical association changes: the demagogic leaders of a self-centered interest group are replaced by men more skilled in planning and committee work. But when the profession feels it is not paid or appreciated enough, these leaders will again assume the roles of militant and sometimes vitriolic spokesmen for a pressure-group. If they do not, they will be beset by internal rebellions within the medical association and breakaway societies. These occasional outbreaks do not mean the doctors are more self-centered or irreconcilable than other occupations in the public service: their demands and threats are merely more publicized and they are more successful in getting what they want. 90

In sum, the way individual physicians practice medicine in America is, at last, beginning to reflect the growing public demand for better cost and quality control. The changes which have resulted, however, have been and will probably continue to be limited to improvements which involve better policing by the medical community itself. 91 While most physicians seem at least resigned to these changes, only about one-third of the physicians questioned in a recent survey thought that circumstances could ever justify a doctors' strike. 92 If this minority were permitted to unionize, it could, under Local 24, International Brotherhood of Teamsters v. Oliver 93 and American Federation of Musicians

advent of Medicare and Medicaid produced a sharp increase in demand; physicians responded by raising their prices. This price increase, far from inducing physicians to work more, made it possible for them to earn higher incomes while actually working less." V. FUCHS & M. KRAMER, DETERMINANTS OF EXPENDITURES FOR PHYSICIANS' SERVICES IN THE UNITED STATES 1948-1968, at 19 (Nat'l Bureau of Economic Research Occasional Paper No. 117, 1973).

90. GLASER, supra note 16, at 304.
91. Of those interviewed in a survey conducted in Rochester, New York, only about 7% appear to want to remove control of medicine from the physicians; the remaining are equally divided between complete physician control and control shared between physicians and the general public. See Stratmann, Block, Brown & Rozzi, A Study of Consumer Attitudes About Health Care: The Control, Cost, and Financing of Health Services, 13 MED. CARE, Aug., 1975, at 659, 661.
92. See Colombotos, Kirchner & Millman, supra note 11, at 390-91.
93. 358 U.S. 283 (1959), see Craver, supra note 8, at 90.
v. Carroll,\textsuperscript{94} thwart efforts to bring new public accountability to medicine. Most important, the unique skills and training the physician possesses have led the states to give his profession tremendous autonomy in managing its own affairs, and the changes motivating the unionization movement merely represent a shift in authority from the individual physician to his profession as a whole. Dr. Sanford A. Marcus, president of the American Union of Physicians, observed: "[W]e must acknowledge, if sadly, that logic and political persuasion are no longer potent enough for 300,000 physicians to counter the will of 200 million Americans and the entire thrust of recent world history."\textsuperscript{95} His statement eloquently summarizes why Congress and the courts should not facilitate private practice physician unions.

\textsuperscript{94} 391 U.S. 99 (1968), see Craver, supra note 8, at 90-91.

\textsuperscript{95} Marcus, \textit{A Vote for Unionism}, AM. MED. NEWS, Aug. 7, 1972 (letter to the editor).

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