

✓ California University, Institute of Industrial
Relations (Berkeley) Center for Labor Research
and Education, ✓

✓ / "DOCTORS' UNIONS AND COLLECTIVE BARGAINING", ✓

REPORT OF PROCEEDINGS ,

CONFERENCE SPONSORED

BY

✓ UNIVERSITY OF CALIFORNIA, BERKELEY,
✓ Center for Labor Research and Education, ✓
Institute of Industrial Relations

and

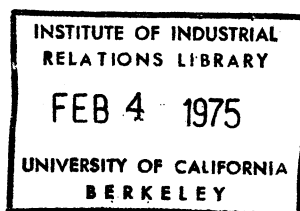
✓ AMERICAN FEDERATION OF PHYSICIANS AND DENTISTS
(AFPD) ✓

Philip R. Alper, M.D., Conference Reporter
and Editor of Proceedings

Hotel Claremont

Berkeley, California

April 27 and 28, 1974



✓ Berkeley, 1975 ✓

TABLE OF CONTENTS

	<u>PAGE</u>
WELCOME TO PARTICIPANTS	1
REMARKS by Donald C. Meyer, D.D.S., Permanent Chairman	5
PHYSICIAN UNIONIZATION AND THE FUTURE OF AMERICAN MEDICINE by Dr. Harry Schwartz	9
COLLECTIVE BARGAINING IN MEDICINE, by Anthony Bottone, M.D.	23
AFTERNOON SESSION	40
THE LEGAL FRAMEWORK FOR PHYSICIANS AND DENTISTS COLLECTIVE BARGAINING, by Walter Kintz, Attorney at Law	40
ORGANIZING FOR COLLECTIVE BARGAINING, by Sanford A. Marcus, M.D.	61
REMARKS by John D. MacCarthy, M.D.	73
QUESTION AND ANSWER PERIOD	78
EVENING SESSION	87
THE PROFESSIONAL STANDARDS REVIEW ORGANIZATION - PSRO, WHAT IT MEANS, by William I. Bauer, M.D.	89
SUMMARY OF THE WORKSHOP ON PROBLEMS OF SALARIED PROFESSIONALS	108
SUMMARY OF THE WORKSHOP ON GRIEVANCE PROCEDURES AND PROCESSING FOR THE PROFESSIONAL	111
SUMMARY OF WORKSHOP ON ORGANIZING, THE PROFESSIONAL SOCIETY AND THE UNION	114
SEMINAR SUMMARY, CONCLUSION AND FUTURE DIRECTIONS by Philip R. Alper, M.D.	116
PARTICIPATING ORGANIZATIONS AFFILIATED WITH AMERICAN FEDERATION OF PHYSICIANS AND DENTISTS	125

P R O G R A M

Saturday, April 27, 1974

8:00 a.m.	Registration
9:00 a.m.	Welcome: Professor George Strauss, and Dr. Stanley S. Peterson
9:20 a.m.	Remarks: Permanent Chairman of Seminar, Dr. Donald C. Meyer
9:30 a.m.	The Case for American Medicine, Physician Unionization and the Future of American Medicine, Dr. Harry Schwartz, a socio-economic overview of the American medical profession. Author: <i>The Case for American Medicine</i> , McKay, New York
10:30 a.m.	Break
11:00 a.m.	Collective Bargaining in Medicine, Dr. Anthony Bottone. A historical perspective, summary of collective bargaining efforts in which physicians and dentists have engaged, the goals they sought and the successes and failures of these efforts.
12:00 - 1:15 p.m.	Luncheon Break
1:30 p.m.	The Legal Framework for Physicians and Dentists Collective Bargaining. Mr. Walter Kintz will discuss the possible form and content whereby physicians and dentists may engage in collective bargaining, as related to the dynamic field of labor law, custom and practice.
2:45 p.m.	Break
3:00 p.m.	Organizing for Collective Bargaining. Dr. Sanford A. Marcus will discuss the role of the professional society and the union in building an organization with muscle.
4:00 p.m.	Question and Answer Period
6:00 p.m.	No Host Cocktail Hour
7:00 p.m.	Dinner meeting. Chairman--Dr. Stanley S. Peterson. The Professional Standards Review Organization--PSRO, <i>What It Means</i> . Speaker: Dr. William I. Bauer.

P R O G R A M

(CONTINUED)

Sunday, April 28, 1974

9:00 a.m.

Workshops

Grievance Procedures and Processing for the Professional. Panel:
Dr. Ervin, Mrs. Skiber, Mr. Glass.

Problems of Salaried Professionals. Panel: Dr. Bottone, Mr.
Gordon, Mr. Amundson, Mr. Shechtman.

Organizing: The Professional Society and the Union. Dr. Marcus,
Dr. Meyer, Dr. Anderson, Dr. Lustig, Dr. Edwards, and Mr. Bond.

10:30 a.m.

Break

11:00 a.m.

Symposia-Reports, Dr. Alper, Conference Reporter, Editor of
Proceedings

12:00 p.m.

Adjournment

FACULTY

Philip R. Alper, M.D., Union of American Physicians Member; Editor, California Society of Internal Medicine *Newsletter*; Contributing Editor, *Medical Economics*

William W. Anderson, M.D., Director of Organization/Membership, Union of American Physicians

William I. Bauer, M.D., Former Director, Office of Professional Standards Review (PSRO), U. S. Department of Health, Education and Welfare

Anthony Bottone, M.D., Executive Director, Committee of Interns and Residents of New York City

James O. Edwards, D.D.S., President, Santa Clara County Dentists Union, California State Federation of Physicians and Dentists

Clinton V. Ervin, Jr., M.D., Director, Insurance Grievance Department, Union of American Physicians

Walter Kintz, LLB, Supervising Attorney, National Labor Relations Board, Region 20

Gerald J. Lustig, M.D., Vice President, American Federation of Physicians and Dentists; President, New York State Federation of Physicians and Dentists; President-Elect, Richmond County Medical Society

Sanford A. Marcus, M.D., Vice-President, American Federation of Physicians and Dentists; President, Union of American Physicians, California State Federation of Physicians and Dentists

Donald C. Meyer, D.D.S., First Vice-President, American Federation of Physicians and Dentists; President, Doctors Association of the City of New York

Stanley S. Peterson, M.D., President, American Federation of Physicians and Dentists; President, Missouri Physicians Guild

Harry Schwartz, Ph.D., Economist, Author, Visiting Professor of Medical Economics, Columbia University, New York

George Strauss, Ph.D., Professor, Acting Director, Institute of Industrial Relations, University of California

ADVISORY

Norman E. Amundson, Coordinator of Labor Education Programs, University of California

Thomas M. Bond, Coordinator, Union of American Physicians, Assistant to President

Marion Goldfinger, Administrator, Doctors Association of the City of New York

Joseph G. Glass, Esq., and William E. Glass, Esq., Counsel, Doctors Association of the City of New York

Murray A. Gordon, Esq., Counsel, Committee of Interns and Residents of New York City

Judith Skiber, R.N., Insurance Grievance Advisor, Union of American Physicians

Ronald Shechtman, Esq., Counsel, Public Health Physicians Association

Max Lilley, Esq., General Counsel, American Federation of Physicians and Dentists

James C. Paras, Esq., General Counsel, Union of American Physicians

P R O C E E D I N G S

The Conference of Doctors' Unions and Collective Bargaining sponsored jointly by the University of California, Berkeley, Center for Labor Research and Education, Institute of Industrial Relations, and the American Federation of Physicians and Dentists (AFPD) was called to order at 9:12 o'clock a.m. in the Churchill Room of the Hotel Claremont, Berkeley, California on Saturday, April 27, 1974 by Professor George Strauss, Acting Director, Institute of Industrial Relations, University of California.

WELCOME

Professor George Strauss and Dr. Stanley S. Peterson

ACTING DIRECTOR STRAUSS: Good morning, greetings, welcome. On behalf of the Institute of Industrial Relations I want to welcome you to this Seminar on Doctors' Unions and Collective Bargaining. I not only welcome you, but I should like to say a few things.

This is not the kind of talk that I would give to most unions because most unions would be sensitive to criticisms about their mistakes. You still have your mistakes ahead of you. I shall speak frankly.

From the point of view of the Institute of Industrial Relations and maybe from your point of view too, this is a very controversial congress. We are used to controversy, but we have gotten a little bit more than the average number of criticisms with regard to our participation. Different kinds of criticism, but all very relevant.

Just at the beginning of last week, for instance, we got three nasty letters from three different points of view. One letter came from the right and it was addressed to our boss: the Board of Regents of the University of California. It accused us of running a one-sided Conference which made no room for dissenting voices, particularly those of the thousands of physicians who felt that unionism was inconsistent with professional values and patients' welfare. I am sure that you have heard of this point of view. Anyway, I answered that letter.

The second letter came from the left. It suggested you were a pretty crummy group for us to get involved with; we should be out there organizing the patients, not the doctors who milk them; and in any case organized labor

and organized medicine had too many differences, too many areas of conflict, for our Institute trying to be playing both sides of the streets at once.

The third letter is too detailed for me to discuss at length, but it presented instances of what it alleged to be, shall we say, questionable organizing and campaign practices in which one of the organizations represented here allegedly engaged.

Even at worst, let me say that these alleged practices have been hal-
lowed by the President of the United States and also have been engaged in by many other unions. But I could see that in your case, those who were not already convinced of the justice of your cause might feel that these were questionable, and especially questionable for people who think of themselves as scientists.

All this, I think, is to make the obvious point: You have a problem; organizing doctors is not the same as organizing steamfitters. In the first place of course, there is this question of public image. Doctors are not farm workers. If you go out on strike, nobody is going to run any benefit parties for you. There is a national stereotype that doctors overcharge. After all, very few people become voluntarily sick, and it adds insult to injury to have to pay a doctor. For a doctor to go out on strike or even ask for more money is the worst form of heresy.

A related point. One of your biggest consumers is labor. If you raise your fees, directly or indirectly, it comes out of workers' wages. Labor traditionally has been in favor of keeping medical costs down and recently labor has raised some very fundamental questions as to what it feels is a wasteful and undesirable use of medical resources. Labor may be delighted to have you organize, but many of its relationships to you will be as adversary rather than as brothers in arms.

Or another related point. No one expects a bootlegger or even a teamster to be an idealist or to put the public interest first or the interest of his clients first. But doctors are expected to do this. And that makes it harder for you to exercise your muscle, if any.

I suspect that if you ever got professors on strike, they would immediately start scabbing on themselves by going back to work -- their arguments of course being that this is to help their graduate students or to continue their research. I suspect that you folks also suffer from this same internal inhibition which prevents you from using your real power. But even if you tried to exercise this power, the public would rise up in arms against you. It's OK for bricklayers to threaten to strike as a matter of course, but your weapons are more dangerous and society will allow you to use them only with the greatest of caution. Like Israel, I don't think the Big Powers will ever permit you to win an all-out war. They know very well that you have no intention of going into all-out wars. And I know that you yourselves are concerned with the questions of: What are our legitimate weapons? What are

our techniques?

Let's look some more at the question of image. The middle-class American has learned to coexist with union people, but he doesn't want his daughter to marry one. Semantics are important here. I have always argued that the Hospital Workers Union would have a much easier time if they called themselves The American College of Hospital Workers and if they denied accreditation to hospitals which failed to adhere to "professional" economic standards.

Take, for instance, a typical labor-relations term: "demand." This is a perfectly normal term in the lexicon of a blue-collar union. But the smart white-collar union organizer recognizes that it turns a lot of people off. The smart white-collar union makes "proposals," "requests," "suggestions," "arguments" -- but never "demands." They have "representatives," not "stewards." They have "professional standards," not "work rules" or "makework rules." And so forth. The effect may be the same, but the image is important.

I suspect that there is another issue which will come up here in the next two days. This relates to differences in objectives. Some of you see doctors' unions as a means of advancing medicine and of promoting the general welfare, especially for lower-income patients. Others of you may look upon it as a means of fattening your pocketbooks. Probably most of you have both objectives in mind. You hope to help yourselves and you hope to help your patients and society at the same time.

In this you are not really unique. Other unions, even the Teamsters or the Boilermakers, have specific economic objectives as well as objectives related to the general welfare. But with other unions, when it gets down to the nitty-gritty the person's selfish objectives come first. Is this what you intend? If not, how do you stop it from being so? Why should you be different from other unions?

To conclude, you face numerous problems. Assuming you succeed in organizing, it is not even clear with whom you are going to negotiate. Maybe legislative developments on the national level will resolve this question. But right now is it with insurance companies? The government? Individual patients? With whom?

What are your legal rights? What can you get away with? You will have some legal advice here today.

How do you use your muscle? Can you use this muscle once you have it without hurting patients; the very people you presumably want to help? Or is this matter of helping patients just a matter of public relations mouthwash?

What can you do about the public's perception that the medical profession makes too much money? Or do you care? If teamsters don't care, why should you care?

How do you organize your profession? How do you deal with the mounting third-party concern in this area? Some people feel that just as wars are too important to leave to generals, health problems are too important to leave to doctors. Specifically, how do you relate to PSRO's?

These are tough questions. I know that they are not new questions. I know that other people have raised them in even nastier language than I have, although I am pretty nasty. (Laughter) I know also that there are answers of various degrees of quality. But in this Conference we are going to look just not for answers but for good answers, for the best-possible answers that we can get. Because these issues are really too important for shoddy thinking and too important for sloganeering.

With this I hope I have provoked quite a few of you. I hope as the meeting goes along there will be arguing and screaming. By this afternoon I hope everybody will know where we are.

(Applause.)

DR. PETERSON: Dr. Strauss, you managed to aggravate me. I am breaking a long-standing rule. Whenever anybody has insulted me in an organization for the last five years, I have stood up and challenged it at the time. I am breaking that rule this morning. I expect that I shall probably get around to answering your questions a little later.

So much for that. I guess you have accomplished your purpose. I want to welcome you too.

ACTING DIRECTOR STRAUSS: He's a nice guy!

DR. PETERSON: Yes, I am. And, you know, one of the things that I have found out recently is that nice guys are winning. That's what the people want: people who are right, willing to stand for it and then go to it.

But that isn't what you came to hear this morning. You are here today for a Seminar that is sponsored by the American Federation of Physicians and Dentists in association with the University of California. The Chairman, who you will meet pretty soon, is from New York. I am from Springfield, Missouri. The people who have done all the work are in San Francisco and Berkeley. And I think they ought to know right from the beginning that we are appreciative of all the work that has been and is being done, because maybe we will get so busy with other things later that we won't be able to find time to say so.

We are in perilous times, as you all just heard. But the times really aren't as bad as you have heard. Not all people think doctors make too much money, contrary to what has been said. In fact, we have people worrying about that. We have even got the Federal government worrying that they will do too much to our income and get us into trouble. So, officially or unofficially, that's not it.

But of course that is not our problem today -- and you know it. About the image. We will worry about that a little later today, but the American Federation of Physicians and Dentists was formed because of a need. If there hadn't been a need, we would have been out of business by now. Our only problem as an organization right now is finding enough time and energy to get around to the people who want to talk to us. And we are really going! And of course the reason we are going is because our local organizations are doing well. It is not because just a few of us are working hard. We have lots of people working in this area. They are thinkers. Thinkers. Spelled with a T. Sometimes that gets us into trouble. But this occasion is not one of them.

Some time ago, actually at a meeting in San Francisco, Dr. Donald Meyer came up with the idea that we should have a University Seminar on physician unionism. Like any good executive, I said: "All right. You do it." And this is the result.

I want you all to know that we laid down some certain ground rules in San Francisco that day. We have passed the first one in attendance. We have passed the number of people we had set our mind to, to have to hope to have a successful conference. So Dr. Meyer, being the Chairman of this organization, gets an A for that. How the rest of the day goes I don't know, but it promises to be all right.

This will be the first of several conferences designed to do what we hope this one does. We shall have another one in October on the East Coast and then we shall see where we go from there.

I think that with that our ground rules have been laid down pretty well, our challenges have been more than adequately put forward for us, and in view of that I shall let the rest of my speech go for the time being.

We are certainly in pleasant surroundings. We have lots of work to do. And I guess that we had better get at it.

(Applause.)

REMARKS

Dr. Donald C. Meyer, Permanent Chairman

CHAIRMAN MEYER: We shall introduce Dr. Peterson more formally later this evening at our dinner.

I want to thank Professor Strauss and Dr. Peterson for their remarks.

My name is Donald Meyer and I am from New York. I am a dentist and I am the Chairman by acclamation, as you heard from Dr. Peterson, of this Seminar. And I want to welcome you also.

Significantly enough, we have people here from very interesting places. For example, we have doctors from Canada; we have doctors from the East Coast, doctors from the South -- and I think we even have one from downtown Burbank. (Laughter.)

At the outset of this Seminar, I want to make an announcement because what I will mention has been happening very often at conferences -- not necessarily such as these, but to many conferences, some even on television. And that is that if anybody has any idea of streaking this Seminar, be advised that you will probably receive a bill for a physical examination from at least 100 physicians and, if you open your mouths, at least 10 dentists. But if you decide to do it, there are a few lawyers here who will be glad to defend you for a fee. (Laughter.)

Now I have a few prepared remarks which, I hope will serve as a keynote for what this Conference is all about. The Conference was entitled, "Doctors' Unions and Collective Bargaining." And if we get anything across today and tomorrow, it will be some idea of what the thinking is of people who are interested in this area.

I might point out that, as you have heard already, not everybody, even who is attending this Conference and paying his way, is friendly to the idea of doctors' unions and collective bargaining. But everybody is welcome here.

This, we hope, will be an open discussion. Maybe some minds will be changed one way or the other. Maybe some things will be learned.

At the outset I wish to invite everybody to pick our brains, whether for the benefit of doctors' unions or even against doctors' unions. That's our purpose in being here. Let me say this:

Doctors are people. Doctors are citizens. Doctors are workers, highly educated and skilled workers, with awesome responsibilities -- but workers nevertheless.

Traditionally, in our society, even though the physician and dentist clearly earn their livelihoods as a result of their labors, they have not been considered by the public or by themselves for the most part as part of the American labor force. Perhaps the most prominent reason for this has been the doctors' respected "professional" status as well as his traditional "doctor/patient, strictly private practice" image.

To quote the title of a popular song, "The Times, They Are A-Changing." Increasingly doctors are accepting full- and part-time salaried positions in hospitals, medical and dental schools, and health maintenance organizations, to name a few areas where many thousands of doctors are employed.

With the growing intrusion of third parties such as insurance companies,

hospitals and government, for example, Medicare and Medicaid and the Cost of Living Council and their pronouncements, is there any doctor who can truthfully say that he and all of his patients still enjoy a strictly two-party, completely confidential doctor/patient relationship?

When National Health Insurance comes into being (and there can no longer be any doubt that it will), third-party influences will seep into every aspect of American medicine and dentistry.

The merits of and drawbacks to changing our present system of health-care delivery have been, are being and will be discussed over and over. In the myriad of rhetoric about health-care rights, the right of the consumer to participate and even control, the right of government to inspect and regulate, the right of each citizen to quality health care, what has been overlooked is the right of the doctor to have the final determination in all facets of medical and dental practice which affect the health and well-being of his patients. Under any health-care system, if the patient is to receive the best care available, only the doctor, by virtue of his education, skill and experience, must practice his profession. Computers do not practice medicine. High-speed air turbine drills do not practice dentistry. Government, insurance companies, hospitals, nurses, assistants and all categories of ancillary personnel may aid the doctor, but if they are allowed to control or to take over medical and dental and dental practice, the "high quality health care for all" dream of the idealists will never materialize.

Clearly in the interest of protecting his patients from those forces -- political, financial or otherwise -- which would destroy quality health care, the doctor must assert another of his rights. As the skilled dispenser of health maintenance and treatment he has every ethical, moral, legal and human right (perhaps "obligation" rather than "right" would be more appropriate) to fight for his beliefs in how his skills can be utilized most effectively.

This advocacy in behalf of his patient and himself in dealing with government, hospitals, insurance companies and the like is called "bargaining" in labor jargon. If two, three, four or four hundred and fifty thousand physicians and dentists band together and demand an input into the rules, regulations and legislation that affect their professional lives, this is called "collective bargaining."

There can be no question of the doctor's right to bargain individually or collectively. The only question is whether or not this right will be exercised fully before it is too late to prevent what has happened in so many other countries from happening here.

We are all aware of the thousands and thousands of doctors who have sought professional refuge here. The American doctor and his patients have no place to go. The fight is here, the time is now, and the bargaining must begin.

That is my keynote. I am sure that there will be controversy about that. But now I want to introduce someone whose introduction, at least, cannot be controversial.

I am privileged to introduce to you at this time a gentleman who happens to be a neighbor of mine back East. And he happens also to be the author of a book a copy of which you will find in your brochures: The Case for American Medicine. His name is Dr. Harry Schwartz. He is a Visiting Professor of Medical Economics at Columbia University and a member of the New York Times editorial board.

At this time I would like to welcome Dr. Schwartz, who will address us on the topic "The Case for American Medicine."

Thank you. (Applause.)

PHYSICIAN UNIONIZATION AND THE FUTURE OF
AMERICAN MEDICINE

by

Harry Schwartz

Let me begin by stressing that I am stating only my own views, and do not speak here for any past or present employer. Let me also say that I speak as one who is a member of two unions -- the American Newspaper Guild and the Civil Service Employees Association of New York. It is my deep conviction that it is inevitable that the doctors of the United States will be unionized. In Great Britain, today, the British Medical Association takes it for granted that it is the union which negotiates for the physicians of that country. Some day there will be some equivalent American organization, perhaps a transformed American Medical Association or perhaps one of its present rival organizations. Strong societal trends are profoundly changing the organization of American medicine. In the process they are undermining all past assumptions about the physician's work, his status, his independence and his political and economic role in the system of American health care. Since these societal trends aim squarely at reducing and weakening physicians' positions, physicians will increasingly become aware that they will have to accept collective bargaining on a union or quasi-union basis with the profound changes this implies.

Despite the title of my book, I am not going to argue the case for American medicine today. In a sense that case has recently been implicitly admitted by Senator Edward M. Kennedy, the author of the well known book, "In Critical Condition. The Crisis in America's Health Care." All of us here who are parents undoubtedly were shocked and empathized with Senator Kennedy several months when he got the terrible news that his beloved twelve year old son had cancer. That was a terrible blow, and the Senator and his son had the sympathy of all Americans. What is relevant here is that Senator Kennedy, seeking the finest possible medical care for his son, turned to American physicians and American hospitals for that care. It would be superfluous to discuss the implications of that decision from perhaps the most articulate and influential critic of American medicine.

I would also like to call your attention to two important journalistic confirmations of the high regard the American people hold for the medical care they receive. Earlier this year the New York Times and the Washington Post independently studied public opinion in their circulation areas. The basic conclusions of these two independent surveys were similar: namely, the great majority of Americans are quite satisfied with their medical system

and their medical care; are confident that they can get good medical care when they need it; and don't really regard change in the system of medical care as a matter of great priority or interest.

The New York Times study used a particularly interesting device. The individuals questioned were given a list of twenty subjects about which they might have complaints. In effect, they were asked to list the areas of their greatest concern in descending order. The outcome was illuminating. In this list of 20 potential subjects of concern or worry, medical care came out sixteenth. It was fourth from the bottom.

The statistical record helps explain these findings. The most frequently cited indices of national health are the rate of infant mortality and life expectancy at birth. The rate of infant mortality has been plunging downward rapidly this past decade and in some months this year has been close to 16 deaths per thousand live births, roughly a 40 per cent decline since 1965. Similarly life expectancy has been setting new high records annually. Unfortunately, however, these positive facts are almost never mentioned in the public discussion where -- either because of ignorance or other causes -- the focus of attention is almost always on the negative. The health field has few more important objectives than seeking to get the public discussion of medical care back to a level of objectivity in which all key pertinent facts are presented for discussion, not merely some carefully selected data that distort the reality.

My main purposes in this talk are two. First, to illuminate the changing status and work position of physicians which leads me to believe that doctors unions are inevitable. Second, to suggest major topics of concern for unions of physicians. In all this my only assumption is that physicians have the same right and the same incentive to combine for advancement of their common interests as do all other categories of workers. I do not mean to imply, obviously, that demands raised by physicians' unions are or always will be correct and justified. There is no reasons why physicians' unions should differ from other unions in stating maximum demands, even thoroughly unreasonable demands at times, as part of their bargaining tactics. I am also aware that physicians' strikes can have more serious consequences than strikes by less essential workers. Unfortunately, candor requires me to point out that the precedents already set by strikes of hospital workers and nurses in different American cities have probably weakened the moral and other restraints against future strikes by physicians.

Let us look first at the changing pattern of physician employment and the rapidly rising supply of doctors available in this country. I shall focus upon the five year period 1968 to 1973. In this period the population of the United States increased 4.5 per cent, a small rise which reflects the rapid recent decline in the national birth rate. But in this same period the number of physicians in this country increased by 16 per cent, or almost four times

as rapidly as the rate of population growth. This far more growth in the nation's physician supply as compared with population also, unfortunately, goes normally unmentioned in most public discussion. Presumably it would be too jarring for those who see only a "doctor shortage." As a footnote, I might mention that the net increase in the number of doctors in this country between 1968 and 1973 was 50,000. But both in 1968 and in 1974 one hears frequent references to the 50,000 doctor shortage. Fortunately, as we shall see in a moment, one high government official has introduced a note of realism into the discussion, one which takes account of the facts more than of the stereotypes.

But the most interesting statistics for our purpose are those depicting the changes over 1968-1973 in the main categories of physicians, particularly in the category of hospital-based physicians -- interns, residents and attendings, doctors who are normally salaried employees, not independent businessmen.

Just between 1968 and 1973, the number of hospital-based physicians has increased from about 77,000 to 94,000, an increase of 22 per cent. There are of course other salaried physicians, for example employees of prepaid group practices, as well as medical teachers and medical researchers. But the category of hospital-based physicians undoubtedly includes the bulk of salaried doctors. Over the same five year period, on the other hand, the number of office-based physicians -- and this is where most entrepreneurial physicians are to be found -- increased only by 9 per cent. In short, the trend is plain enough. More and more American physicians are moving toward becoming hired workers, rather than being as in the past primarily and overwhelmingly small businessmen. Already, in other words, there are tens of thousands of physicians who are entitled under the law to form unions and bargain collectively as do other hired workers.

Along with this should be noted the fact that the independence of the solo physician in small group practice is also being eroded rapidly. A rapidly proliferating body of laws, administrative regulations, court decisions and pressures from alleged consumer representatives are increasingly reducing his freedom of action. A similar impact is resulting from the already large and still growing role of third-party payers -- private insurance companies and the government -- who are increasingly moving to supervise and scrutinize the physician's actions as though he were an employee, not an independent contractor.

Taking these two trends together -- the rapid increase of physicians who are simply hired workers and the increasing loss of independence of physician-entrepreneurs -- the conclusion seems indicated that we are in the midst of a process of collectivization of American doctors, one aimed at a reduction of their status and of their economic well being and perhaps eventually at their full proletarianization. Though not often referred to, much of the dynamic behind the process is what the London Economist once called the politics of envy. All this is related to the egalitarianism now rampant in

influential intellectual circles -- an egalitarianism, however, which has not yet chosen to attack the extraordinary incomes and life styles of popular athletes, entertainment personalities and the like. Related also is the feeling in some circles that medical care is somehow a human right that should be available without charge. Thus while it is proper to pay a plumber for fixing the sink faucet, it is somehow improper to pay the doctor who saves one's life. The ideology of health care as a human right demands that all health care be "free" and that whatever sacrifices are required of physicians, nurses, etc. to realize this medical Communism be imposed upon them. The advocates of these ideas, of course, rarely discourse upon the related subject that people who claim rights must acknowledge responsibilities.

But on a more practical level we have the terrible problem that in any democracy demagoguery is often an extremely effective political tactic. At the extreme it is represented by the perhaps not so mythical Congressman who votes for all appropriations and against all tax bills. In the medical field, the analogy is the legislator who enthusiastically backs legislation to expand the area of "free" medicine, but who then becomes highly indignant when the bills start coming in. Moreover -- as is almost inevitable in an era of inflation -- those bills usually turn out to be far higher than the often deliberately minimized estimates presented when the legislation for "free" medical care was first being adopted.

Increasingly the trend in the market for medical care is for the government to become a monopsonist -- the sole buyer -- in the health care field. Just as a monopolistic seller can exploit his divided and competing customers, so a monopsonistic buyer can exploit the divided and competing sellers with whom he is faced. The United States Government is not yet the monopsonist in the American health care field, but one must be blind not to see the trend toward that situation. That trend is reaching its high point in the increasing likelihood that Congress will pass into law a comprehensive national insurance bill.

As the government pays a larger and larger share of the nation's growing health care bill, it becomes more and more concerned with minimizing those bills. The means which it employs for that purpose naturally create problems for all in the health care field, and they also furnish appropriate subjects for concern to unions of health care providers, including physicians' unions. The list of phenomena presented below are not necessarily bad; many have positive aspects. But if only because of the fact that they are being unilaterally imposed upon the medical system through the superior power of government, they must raise questions from the point of view of physicians. Government's unilateral authority to tax, to subsidize, to make past illegal actions legal and past legal actions illegal gives it fearsome power.

First we may consider the discriminatory provisions applied against physicians, dentists and the like during the recent and current period of wage price control. Fee limitations of 2 1/2 per cent annual increase, for

example, were less than half the percentage wage increases decreed as legal for workers represented by unions. There has even been discussion that with the scheduled general disappearance of wage and price controls over all other areas of the economy, tight controls should still be maintained over the health care field.

Second, the government has moved rapidly and effectively to increase the number of physicians in this country. This has been done domestically by financing an increased number of medical schools and encouraging existing medical schools to expand their enrollments. Moreover, there has been a wholesale removal of earlier barriers to the immigration of foreign-trained physicians. The first results have already been seen in the data cited above regarding a 16 per cent increase in the number of physicians during the past five years, when population rose less than one-third as much. I am not trying to argue that there has been no case for increasing the number of physicians. I am simply trying to point out that one hope of those behind this policy was that an increased number of physicians would produce greater price competition among them. It is understandable that government should desire this end. It is equally understandable that an effective union of physicians might have some reservations on this matter. What is ironic now is that the flood of physicians has become so great that even high government officials such as Dr. Charles Edwards, Assistant Secretary of HEW, are expressing apprehension and predicting a physician surplus if present trends continue. My own view, I might add, is that the nation already has a physician surplus in many ways, and that the real problem is the geographic and specialty maldistribution of physicians. On the latter point there is already talk of employing the coercive powers of government to correct these maldistributions in an arbitrary manner by employing the stick far more than the carrot. If this policy is carried into practice, it too would become a suitable subject of concern for physicians' unions.

A third government tactic is the encouragement, legalization and subsidization of numerous diverse programs to train and produce cheaper personnel who can partially replace physicians. Nurse practitioners, physicians' assistants, midwives, Medex, and emergency care paramedics are among the many categories in this effort. Some physicians seem to have the naive idea that these new personnel will always simply work under physician supervision in a continuing hierarchical relationship similar to what presently exists. Such naivete is best dispelled by viewing the energetic campaign of organized nursing for nurse-physician equality or even, in some situations, nurse primacy. The new paramedics will want a bigger share of the turf, and will introduce a new complicating factor in the already tangled politics and economics of health care personnel. My point simply is, however, that as these partial physician replacements and physician extenders increase, they will give growing competition to physicians and present problems appropriate for union consideration and action.

A fourth expedient now being used by the government in its attack on medical costs is what some of my friends consider a medical equivalent of

a Soviet collective farm. These new health maintenance organizations now being subsidized and otherwise encouraged by government agencies have an interesting rationale. It is argued by their proponents that since they operate within rigid income constraints -- determined by the capitation payment per subscriber -- they create useful incentives for medical economy. It is further held that since patients in HMO's are not deterred from seeing the doctor by any need to pay any fee, or more than a small fee, the HMO's can practice preventive medicine, catch disease in an early and curable state, and the like. The great economy pointed to in reciting the HMO liability is always the lower number of hospital days used by, say, Kaiser-Permanente subscribers as against, say, subscribers to conventional Blue Shield-Blue Cross medical insurance. The truth of these arguments may or may not be accepted. As an economist, however, what strikes me as the central feature of the HMO is that for short run profit maximization those who operate this organization have every incentive to deliver as little medical care as possible. All this was summed up to me the other day by a bright young would-be HMO organizer I met who confessed he often dreamed about having his own HMO in which 20 per cent at least of his subscribers were devout, practicing members of the Christian Science Church.

More and more physicians are now being pressured or bribed to join HMO's and to leave independent fee for service practice. Certainly in large HMO's physicians are for all practical purposes hired workers, whatever the formal contract may say about "partnership." Physicians' unions would seem to have a useful future role in negotiating for HMO doctors in these emporia of mass medicine. Just what the ethics are of putting doctors into positions where they can profit by doing as little as possible for their patients is a problem I leave for other and perhaps wiser heads. I should also think physician unions might press in the future for less inequality in HMO competition with fee for service physicians. This inequality is implicit in a situation in which fee for service physicians pay taxes to a government which uses its revenues to subsidize their HMO competitors.

Finally, the government realizes that it will take years to put all American medicine into the HMO straitjacket, assuming that final consummation can ever be realized. Since Washington can't wait to get tighter control over medical costs, it is putting into effect a major change that is in principle even more sweeping than the HMO mode, the Professional Standards Review Organizations, or PSRO's. This is in a sense the ultimate cost control mechanism for it provides a means for rationing medical care. The rhetoric, of course, is now in terms of assuring high quality care and preventing overutilization. But the reality is that the government has provided itself with a means for deciding -- for all those whose care is paid for through government funds -- who shall enter the hospital and who shall not, who shall get a kidney transplant and who shall not, who shall be put into the coronary care unit and who shall not, etc. I know that in this early stage the emphasis is upon the idea that physicians will staff and run PSRO's and that all that is involved is a formalization and strengthening of traditional peer review. We are all adults, however, and we all know there is

no Santa Claus. Over the next few years, I venture to predict, PSRO will increasingly be taken out of the hands of local practicing physicians and will become the domain of a new medical police force whose sole or major measure of merit will be how much it has helped reduce or slow the growth of medical care costs. Physicians, I suggest, will need unions to defend themselves and their patients against the rationing activities of the future PSRO police apparatus. And in that activity it will be extremely important for physicians and their organizations to enlist the support and cooperation of patients and patients' organizations. To say this is not to deny that peer review has its uses nor is it to deny that there is a small minority of physicians who abuse the medical mechanism in order to profit from overutilization of one sort or another. But my suspicion is that such scoundrels will find ways to circumvent the PSRO safeguards, while the remorseless pressure for maximum economy in the delivery of "free" medical care will be a potent source of conflict in which individual physicians will need help from their organizations.

Let me conclude by repeating that as I view these trends, I am convinced that they must inevitably persuade physicians that they need militant union protection as much as do journalists, college professors, or auto workers. The question it seems to me is merely who will provide the needed vehicle. Will it be an American Medical Association changed and revitalized to meet the needs of a new era, or will it be one of the newer, militant groups now aspiring to fill the gap created by the AMA's reluctance or inability to meet the needs of a very new time?

Thank you very much. (Loud applause.)

CHAIRMAN MEYER: I am sure we all want to thank Dr. Schwartz for his presentation. We shall now entertain questions.

DR. LOUIS G. BRENNAN (Stockton, California):

Dr. Schwartz, is there a plan by the government that is being followed, sort of a protocol? It almost seems like a conspiracy.

DR. SCHWARTZ: Let's not be paranoid. I did not mean to imply that there was in any way a conspiracy in government. Government is so fouled up that if they had a conspiracy, they couldn't carry it out. [Laughter and applause.]

This is not a conspiracy. The facts are simple: great promises have been made, great expectations have been raised, but the taxpayers really don't want to pay the bill to fulfill those expectations. Hence there is the need to look for scapegoats. And the scapegoats available are the doctors and the dentists and podiatrists and all others engaged in health care. They are the ones who are going to be squeezed, you see. Because obviously nobody can say that Congress made promises or arrangements that are impossible to fulfill given the temper of the American people.

So there is no conspiracy. But the forces at work are such that it is inevitable that we are going to get results which might have arisen from a successful conspiracy.

DR. ANTHONY W. ORLANDELLA (South Laguna, California):

My question is: If the AMA is composed of very conservative men who believe in free enterprise, how did they ever allow HMO's and PSRO's to get to the point where they are today?

MR. SCHWARTZ: The AMA does not control what happens. Its influence is exaggerated by friends and foes alike. They had a traumatic defeat over Medicaid and Medicare back in the mid-60's. They still haven't recovered from that defeat.

All its other weaknesses are accentuated because the AMA is rent by internal feuds of all kinds.

This meeting is being held really because the AMA is not a very good union. It doesn't even think of itself as a union. And that is the reason that others are now trying to create organizations that will function as doctors' unions.

DR. JOHN T. RANDALL (Fremont, California):

Some days ago I believe I read that the cost of administration of Medical in California was 52% of the budget. Have you any idea what will be the cost of administration of the National Health Insurance? Wouldn't that completely negate any saving on medical care in the country?

DR. SCHWARTZ: I think that that is too serious a question to be answered very simply, but I am perfectly willing to answer it sort of flippantly.

Regardless of what the cost of administration may come to, if you deny enough medical care to enough people, you can probably end up with a net saving. That's a joke, but only partly a joke.

The truth is I really don't know so I don't want to make a dogmatic answer. But certainly it is clear that trying to administer fairly and honestly and generously a National Health Insurance scheme would be a very expensive thing, even if the best computers were used.

DR. DANIEL GORMLEY (Los Angeles, California): My name is Dan Gormley of Los Angeles.

In discussing the problem of oversupply of physicians, it seems that one potential culprit in the scenario is the academic system or the academic doctors. Because in the academic world, if you want to do this, you create

a big department. That means that you get a lot of residents, you train a lot of people. And I don't know whether this is true or not, but it is my impression that it is going their way without regard to their impact of the growth of certain specialties on the health-care scene.

I wonder if you had had a chance to discuss this with academic physicians or if you had any feedback.

DR. SCHWARTZ: Yes. I spent last week with a bunch of academic surgeons in Hamilton, Ontario. They are very conscious of the problems here.

I point out that if you go to the Pennsylvania Medical Center at Hershey, Pennsylvania and ask, "How many neurosurgeons are being trained by Professor Richard Bergland?" who is the chief of neurosurgery there, the answer would be: "Zero."

Professor Bergland wrote a very interesting article last year assailing neurosurgery for having produced too many practitioners and he has announced that he is following a one hundred per cent abortion policy in his department.

So there are changes taking place in the academy, too. But remember that the academicians are under tremendous pressure to provide service now; and for service they tend to think that you have got to have more residents and that you have got to have more interns. So pity the poor academician. He is under a crossfire, too, these days. And he has money problems as he faces the demands on him for education and research plus service.

DR. VINCENT CANGELLO (University of California, Berkeley):

Would I be correct in presuming from your presentation that the forces that are upon us are not to be rolled back; therefore the solution as you see it is for us to join forces in order to deal with the force that cannot be stopped? Would that be a fair statement?

DR. SCHWARTZ: Well, I don't want to exaggerate my ability to foresee the future. What I am saying is that as far as I can see with my fallible vision, in the long run these forces are going to win out. But I could be wrong and I certainly don't want to discourage anybody who wants to fight these forces, if that is what he wants to do. But I am saying that even if I am wrong, the trends in motion already are so great that I think you people have every incentive to combine in unions or in other self-defense organizations like the great bulk of American working men. I think you people are working men as I am a working man; and if I am entitled to belong to a union, I don't see why you shouldn't be.

DR. WILLIAM BARTLETT (Klamath Falls, Oregon):

I was struck by your comment that the people list health as the 16th from the top.

DR. SCHWARTZ: In this specific New York survey I am talking about.

DR. BARTLETT: But yet Senator Packwood and Congressman Ullman of Oregon and others feel apparently that health care is the No. 1 priority and that it has to be solved immediately or the next year.

Would you comment why the representatives seem to have such a desire for imposing this health care upon us when the people don't seem to feel the need?

DR. SCHWARTZ: The real people you should ask are Senator Packwood and Representative Ullman. But since you asked, I can only do a certain amount of speculation. And the speculation is based on the size of medical practice in the United States.

Last year apparently there were one billion patient/physician contacts outside the hospital. God knows how many more occurred in the hospitals. I haven't counted them. But if there were one billion patient/physician contacts outside the hospital in a year, it comes close to three million patient/physician contacts a day. Three hundred and sixty-five into a billion. Say two and a half million a day.

I don't care what percentage of dissatisfaction you figure on: one-tenth of one per cent; one-hundredth of one per cent. Obviously there are cases of dissatisfaction with the medical system. There are doctors who are incompetent; there are doctors who are thieves. You know, all kinds of things happen in this world. And anything you say about the American medical system is true of somebody or something or some facility at some time with that huge volume of activity. What I am simply saying is that whatever small percentage of dissatisfaction there is (and there is dissatisfaction) you translate it into letters to Congressmen, it means there are going to be hundreds or thousands of letters to Congressmen.

One of the characteristics of our life is that people who are satisfied take good work for granted. In every organization in which I have ever worked the slogan is: "If the boss doesn't talk to you, thank God! You have done a good job. He only talks to you when there is something about which he is unhappy." And I think the same thing is true here. The people who are happy (and the great majority is -- I use The New York Times and The Washington Post as my witnesses) don't write letters. The people who are unhappy, for good reason or bad, do write letters. And so sitting in Washington at the receiving end of these letters it is very easy to get the idea: "My God! everybody out there is screaming!"

But, you see, you have to have a certain amount of statistical sophistication to understand this, that the volume of complaints is a function of the size of the enterprise. Unfortunately it is only very rarely that all those satisfied people out there say out loud: "My God! it is pretty good and we are happy." How many people here know who Louis Russell, Jr. is?
[No response.]

Raise your hand if you know who he is. [No response.]

Louis Russell, Jr. [No response.]

You see, you are even worse than the usual audience. Usually one or two will be able to identify him.

UNIDENTIFIED VOICE: The son of Louis Russell, Sr.!

DR. SCHWARTZ: OK. Louis Russell, Jr. is a black man. He's a black man who is a vocational teacher of what? Industrial arts in Indianapolis, Indiana.

Is it beginning to percolate now?

He is the man who is now approaching the sixth anniversary of the implanting of somebody else's heart in his chest. He is the longest-lived transplant patient in the world. And when I talked to him last August on the fifth anniversary, he sounded great. He told me that he was making three speeches a week typically and he was doing fine. He is probably the greatest single example of what modern American medicine can do -- and nobody knows him.

Do you see my point? The success stories we don't pay any attention to. OK?

DR. EUAN HORNIMAN (Surrey, B.C., Canada): My name is Euan Horniman and I come from British Columbia, Canada.

What I would like to ask is: What percentage of the medical care in the United States is provided by HMO's and at what rate is it increasing?

DR. SCHWARTZ: To this time HMO's constitute a small percentage of the American system. The largest figure that I have seen is that even now, at the peak time, there may be six million people enrolled in HMO's. If that is true, then they are responsible for less than 3 per cent of the medical care in the United States. Six million. But it is intended to expand them; and there are a great many HMO's now in preparation in the United States. The subsidies promised by Congress are attracting many ambitious and hungry entrepreneurs.

DR. CHARLES C. HENDERSON (Auburn, California):

Over the years we have experienced the loss of the individual decision in medicine. In our hospital committees make decisions as to whether the patient should or shouldn't be a hospital patient.

The most discouraging thing to me is to bring the PSRO's into the

picture because of this one-billion-patient visits that you discussed. Whether or not it is for a monetary reason, it will certainly influence the medical care in this country.

Do you have any idea of where this concept originated in our culture or in these forces that we are talking about?

DR. SCHWARTZ: Well, look! let's be fair about it. There are two things that have to be said and said pretty plainly.

First of all, there are abuses in the medical system. By no means are all MD's good guys. You are not far from Sacramento where John Nork played his little games. And if you don't know about John Nork, you ought to know him. And the John Norks of the world really give one pause. This doctor testified under oath that he had committed a number of needless operations -- and operations which he was incompetent to perform, by the way -- and he left a number of people crippled for life.

And so there are abuses in the medical system and that can't be denied. And I think in part you people have asked for some of your troubles because you haven't done a good enough job policing your own ranks. The Tissue Committee and utilization review in many places have been pretty perfunctory; and having failed to do a job, you are finding other people moving in to do it. Well, you should have anticipated that.

But the second part also has to be said. Medi-Cal and Medicare are financed by public funds. All of us pay for them in taxes.

There is an old and well-established principle that anybody who gets public funds has to be accountable for them. And the accountability requirement is going to be there.

My own view is that PSRO quite clearly will not only seek accountability, but it is also ultimately going to be rationing. And what it comes down to is that when you decided to accept public funds, you accepted along with it, whether you know it or not, all kinds of controls and reporting requirements that have to come inevitably.

That is the reason that I say there are no conspiracies over here. I don't want to encourage any paranoia, but there are certain inevitable forces at work.

DR. FRED KRUEGER (Stockton, California):

Dr. Schwartz, I get somewhat a hollow feeling when I hear these comments about the number of doctors that do create problems, and yet I can't help but feel that many of our ILWU members, our longshoremen, our automobile

workers, certainly have problems in their individual ranks. But they still are not getting imposed upon their ranks like we are in ours. And I somewhat get disturbed about this at times.

DR. SCHWARTZ: You know, it is perfectly true. But, you see, if an automobile worker forgets to turn a couple of screws in the assembly line, there are a couple of cars that will show in dealers' or customers' hands which are defective in one way or another -- and fortunately those defects don't usually cost a life. But when a doctor makes a mistake it can cost a life. You are more important to society (than most people) in the work that you do. Which is one of the reasons for your having great public respect and one of the reasons for your large incomes. But you also have to expect greater public scrutiny. You can't have one without the other.

DR. ROBERT MEAGHER (Sacramento, California):

I have watched the union movement now for the last several years and one of the concerns that I have is the small number of physicians who are members out of the total of 365,000.

My question is: Should physicians attempt to stand on their own as a union -- or would it be advantageous for them to consider affiliation with one of the larger unions?

DR. SCHWARTZ: I think Dr. Strauss made a very good point: namely, that most American labor unions regard their interests as being opposed to that of physicians. They don't understand physicians as workers.

I think that the alliance of physicians has to be with patients. I divide the world into three groups, if you will:

Physicians, using that for the professionals engaged in health-care delivery.

Patients. I think that there is a very strong affinity between a good physician and a patient. Because a patient is sick and is worried about it, and he wants to be well.

Non-patients. But most people at any given moment are well; and when we are well, what most of us are concerned about is minimizing the cost of medical care for those who are sick. Our viewpoint changes dramatically when we get sick or our loved ones get sick.

CHAIRMAN MEYER: Unless there is a burning question now, I would like to thank Dr. Schwartz for his presentation this morning. However, he is not getting away so easily.

During the luncheon period we are seating Dr. Schwartz and other faculty members at specified tables. There will be placards on the tables

and you are invited to join them for lunch -- and then you can have informal discussions with those whom you think might interest you.

We shall convene the Seminar again at 11:15 o'clock

[Short recess.]

CHAIRMAN MEYER: It is now my privilege to introduce a speaker who is probably the single medical authority on collective-bargaining efforts of physicians and dentists in this country. In addition to functioning actively as a physician and as immediate past Executive Director of the Committee of Interns and Residents of New York City -- probably the largest organized union-type group of interns and house staff in the country; he is also a candidate for a doctoral degree here at the University of California in the History of Collective Bargaining of Physicians and Dentists, and is now about to undertake a psychiatric residency.

He is a friend of ours from 'way back, somebody who is deeply interested in the doctors' union movement.

I would now like to present Dr. Anthony Bottone. [Loud applause.]

COLLECTIVE BARGAINING IN MEDICINE

Anthony Bottone, M.D.

DR. BOTTONE: Thank you very much.

Briefly, what I am going to discuss today are essentially the different phases that brought about the growth of collective bargaining in medicine primarily among the interns and residents, although I should add that more recent developments have involved other physicians to a considerable extent, ranging from medical faculty to individuals who are in private practice, as has been accomplished here in San Francisco through the work of Dr. Sanford Marcus.

The first slide, please.

One of the things in medicine which we often overlook is our heritage. This slide depicts one of the early publications in 1937 of an organization which had attempted to engage in some form of negotiations which I am defining loosely as collective bargaining in order to improve certain things. The publication is called The Intern. And as you can see, there are a couple of doctors standing up in white suits. There is one doctor testifying before the Board of Aldermen in New York City about being paid \$15.00 a month as interns.

Here they are standing out in the front of the City Hall with Alderman Burke in the center, who has supported them in their efforts to obtain a pay increase. What he wanted to do actually was to go as high as a thousand dollars a year for interns.

In those days the interns were in a really desperate state. I say this because one cannot discuss the development of the intern organizations without referring to the climate which gave rise to them.

The next slide, please.

With the advent of the depression in 1929 there developed a tremendous strain on hospitals and outpatient clinics. To go back a bit further, prior to 1929 a commission was appointed by President Hoover to report on the cost of medical care. It was headed by a physician, Dr. Ray Lyman Wilbur. Dr. Wilbur was formerly President of Stanford University, President of the AMA, and also Secretary of the Interior, (during which time he performed an appendectomy in a national park on someone who was too ill to be transferred to a medical facility).

In 1932 the Wilbur Report appeared. The Report recommended various changes in the structure and financing of health-care, including the promotion of group practice and a form of national health insurance. This is one of the things which helped to give rise to some of the aspects of the labor movement in medicine.

Another factor was the impact of the depression upon students and upon different youth groups and the related influence of solutions that were developed by the government. We saw the appearance of the Civilian Conservation Corps, which had about 500,000 young people working in it throughout the country. Many different student groups also came into existence. Some were conservative and some were more radical. From this student movement, there appeared an organization known as the Association of Medical Students, which was primarily interested in a change in some features of the delivery of medical care and also in improvements in the teaching of medicine.

The third aspect of the '30's besides the youth movements and the health movement was the activity of labor. Certain labor laws that were passed. Their importance is not so much in how they affected medicine as how these laws reflected the attitude of the times.

It was during this period of time that the National Labor Relations Board developed in its original form. And that was under the NIRA (National Industrial Recovery Act), which was declared unconstitutional in 1935, at which time the National Labor Relations Act was passed. It is otherwise known as the Wagner Act.

The Wagner Act gave the sanction of government to promoting the organization of industry. And the purposes behind it were primarily twofold:

1. To provide for an increase in the salaries of workers and therefore stimulate the economy.
2. To bring peace to an area of industrial strife.

Almost at the same time, a group was formed among interns which was known as the Intern Council of America. Its objectives were primarily twofold:

1. To obtain increased salaries, workmen's compensation and other types of monetary benefits, either direct or indirect.
2. The second was loosely related to health care and especially included improvement in the quality of training at many of the medical institutions.

At that period of time the AMA, of course, was accrediting internships; the interns, as they are doing today, obtained the recommendations for approved internships and residencies. When they surveyed the hospitals, they found that most of the hospitals were not in compliance with the recommendations.

The Intern Council attempted to win increases in salary which at the time went from zero dollars a day up to a maximum of about twenty-five dollars a month. They also lobbied for workmen's compensation.

In those days interns rode the ambulances. The intern's seat was in the back of the ambulance and was uncovered, out in the open. Frequently, the ambulance would spill, the drivers being as reckless as they are today. When injuries occurred, the ambulance driver would be compensated, but the intern who was not earning any wage, was not subject to any kind of workmen's compensation. The Intern Council managed to get a law passed which covered them for workmen's compensation.

The interns, by the way, did receive free room and board. And one of the issues in those days (as today) was the quality of food served by the institutions.

Meanwhile, the medical students were also quite active, idealistically seeking to promote various social aspects of medicine. Ironically enough, the two groups merged because of World War II. The interns and the medical students joined in lobbying for exemption from the draft so that they could complete their training. And this action brought about their merger in 1941. (This is interesting because to a certain degree the Vietnam War also brought some interns and some medical students together again in the period around 1969, where they worked together on peace marches, and so on.)

What resulted in 1941 was the formation of the Association of Interns and Medical Students. During the War the organization remained fairly dormant. But in the postwar period, it became more involved not only in lobbying for economic benefits but also, (what with the medical students now being associated with the interns), in much more of a thrust towards the solution of health-care problems and in particular promoting national health insurance, which was then not in existence.

The next slide, please.

To a certain degree this took on the appearance an anti-AMA stance. In this picture you see a man who is labelled as Old Guard running away from a WAVE called Medical Progress.

This cartoon appeared in one of their publications, along with other photos and cartoons depicting how, for example, a wolf called Medical Anarchy was going to be put at the wayside and a new era where a type of well-structured, well-planned form of medicine would be introduced. Some of the idealistic theories of these persons were very much influenced by the five-year and ten-year plans of Soviet Russia. They were impressed by the progress that had been made by the provision of medical care in Russia, particularly because medical care for these idealistic physicians was not just the provision of adequate X-ray and laboratory facilities and good medical care, but it was also the provision of food, lodging and other things.

I would just like to remark in passing that a young physician who is now the president of one of the large oil companies (Occidental Petroleum) had gone to Russia in the '30's, and he was very much impressed by the fact that his services as an intern were not needed by the Russians. What they

needed was food. So he arranged to barter, getting ships to bring over grain to Russia in exchange for various goods from Russia. And because of that he became very closely aligned with the Russian people; he then gave up medicine and devoted the rest of his life to enterprises. He is Dr. Armand Hammer.

In any case, around 1948 the Association of Interns and Medical Students came out for national health insurance. During this period of time, by coincidence the AMA decided to investigate them as being a "communist-tinged" or "communist-front" organization. A report was presented some time around 1950 wherein it was stated that they could not definitely establish any affiliation with known communist organizations. However, they did suspect that because many of the leaders and other activists were somewhat oriented towards the ideals of communism, the organization was "definitely leftwing."

Also at that time Medical Economics published an article which labelled the organization as being "communist-front." The President of the AMA circulated the article to all of the intern and medical students in the country, and simultaneously an independent movement developed, supported by the AMA, called the Student Medical Association in 1950.

The next slide, please.

The next slide essentially is a flow sheet of what happened.

On the top left you see the Association of Medical Students founded in 1937; in the lower left the Intern Council of America, founded in 1934. They merged in 1941, bringing together the idealistic strain and the pragmatic strain to form the Association of Interns and Medical Students. That died in 1951, at which time the Association of Medical Students was founded.

May I have the lights, please.

During the 1950's the Korean War and McCarthyism put very much a damper upon any kind of activities by any student groups that were in any way radically oriented. And by "radical" you could be anything and everything.

Subsequently, in the late '50's McCarthy was censored and, in addition, the civil rights movement began to develop.

Now, the civil rights movement to a great degree replaced the other youth movements that had taken place in the '30's that were primarily centered around things like the Oxford Pledge, anti-war activities and concerns with the economy of the country.

The youth movements of the early 1960's were oriented towards civil rights. At the same time a new attitude was developing among hospital workers, who were gradually beginning to organize. And during that period of time, the first type of intern/resident organization that was somewhat

union-like developed in New York City. That was the Committee of Interns and Residents which was formed in 1958. And that organization went on to become quite active going on to become recognized as the collective-bargaining agent for house-staff in New York City. And simultaneously counterpart groups began to spring up across the country--somewhat independently, somewhat related.

These organizations survived and began to grow in a much different way from the earlier period of time. During the next few minutes I would like to discuss some of the special characteristics of the medical student and intern/resident population of those days.

May I have the next slide, please.

For one thing, medical student expenses had increased. This chart shows on the left side expenses of medical students in 1963 and on the right side expenses in 1967.

I do not have data on earlier periods of time, but you can imagine that the difference between 1963 and the '50's was probably quite great.

Among the greatest increases was tuition at school (the top bar). Board and lodging also increased quite a bit. All other expenses were not significantly increased.

The next slide, please.

Another thing that also happened to medical students which was not characteristic of the '30's is that they got married. In the '30's, if you were married you were often denied an internship. If you were married, you would lie about it. If you got married during internship, you might be bounced out. By way of illustration, one doctor told me that he had his wife give up her child because he was afraid to marry her while he was an intern. And so they gave up the child for adoption--and then after he finished his internship they got married.

Now, with the appearance of married interns, there was more of a stress put upon them for family support when they had children. But even without children there were new problems.

The next slide, please.

I think all of you probably remember the film, "Not As A Stranger." The book was written by a physician. The title, by the way, comes from the name of the early Egyptian god of medicine, Imhotep, whose name meant a person who does not come as a stranger.

As you can see from the chart, married students depended upon their spouses for 50% of their income. And in, "Not As A Stranger," I think it was Robert Mitchum who depended upon his nurse-wife, who put him through medical school.

You can also see that single students depended to a great degree upon their families.

Now this brings up an interesting question: How did these medical students in the '60's feel as men to be dependent upon women for a source of income?

That was not socially accepted at that time. That was probably something which was felt by them as an embarrassment.

The next slide, please.

This is taken from a study that was performed by an economist of the Committee of Interns and Residents back around 1969 or 1970; and to a degree it is valid for certain things that had taken place in an earlier period of time--namely, in the '50's.

In the late 1960's we see that interns were earning quite a bit less than other professionals. Interns at that time were earning \$10,300. They had requested \$15,000.

This, by the way, was for a work-week that could vary from sixty to one hundred twenty hours. In contrast:

An architect: 40 hours a week, \$18,696.

Law clerk: \$17,356.

Geologist/physicist/scientist: \$16,931.

Psychologist: \$16,580.

Education. The intern, M.D., four years of postgraduate training in a medical school, is earning less. A law clerk, three years of law school, is earning considerably more. If he were to work a 40-hour week, the law clerk would earn seventeen-three; 45 hours, twenty-five; 60 hours, twenty-eight nine; 75 hours a week, thirty-three thousand plus.

Interns were not unaware of these things. They were not unaware of the fact that they could qualify for welfare. They were not unaware that the janitor might be earning more than they were earning. And this produced a considerable strain. There was another important thing that happened.

The next slide, please.

What happened is that a competitive market developed for interns and residents. This chart shows residencies, top column, 1941; internships, bottom column.

We shall just ignore the internships and concentrate primarily on residencies.

In 1945 there were about eight or nine thousand residency positions. And they were all filled by American graduates. When the Korean War came

along, by 1949 the number of positions exceeded the available supply of American graduates. The difference: about two or three thousand.

In 1950, the number of available residencies had increased to about 19,000. The gap between availability and supply increased further.

The foreign medical graduates--a form of reverse foreign aid where medical care in this country has been literally subsidized by foreign countries, which train physicians, send them over to the American states and where they work for periods of time, where they then either go back or they stay in the United States--now began to fill vacant residency positions.

And so, as you can see, as we move through this period of time where the difference between supply and demand continued to increase, the number of foreign doctors increased. A dip occurred when the AMA introduced an examination system for foreigners in order to improve the quality.

This was attacked at that time, but only briefly. The move by the AMA was a very wise one. Because many of the persons who came into the country could not speak English and posed considerable problems in patient care.

Nevertheless, in 1970 there were 40,000 residencies in this country. Of those, only about 26,000 were filled by American graduates. The rest were foreign.

With reference to internships, in 1970 there were over 15,000 positions available; there were about 3,000 that were not filled. Of the number of internships, approximately 8,000 were American and the remainder were foreign.

There had been a tremendous mushrooming in the number of residency positions, a tremendous demand placed upon the available personnel; and in addition residencies had become more attractive. The longer period of residency training made organization more practical. It is very difficult to organize when you are only in an internship for one year or maybe two years. There is very poor continuity.

The number of specialty boards also had increased. Up to 1929 there were only two specialty boards in this country. From 1930 to 1939, 13 were founded. From 1940 to 1949 another four were created. And it was during this period of time that you see the development of more of a demand and less of a supply. And finally, since 1949 only one medical board has been created. That was for family practice in 1969.

May I have the next slide, please.

Here I would just like to briefly go over some of the events related to house-staff that took place from the period of approximately 1958 to the present.

During this time, the Association of American Medical Students became independent. Then in 1965 a radical movement developed among medical students which was similar to the Association of Medical Students that developed in the 1930's. This group then influenced the Association of American Medical Students and caused it to become much more involved with other activities, such as, for example, the different health-care programs that took place in Appalachia. And so we see once again the development of a strongly idealistic medical-student organization.

During this period of time the economic worth of the intern and the resident was quite low. A civil-rights movement was going on, with people demanding their rights. There were freedom riots in 1961. The Students for a Democratic Society appeared in 1962. Workers were organizing around the clock. America could afford enough money to start a war as was made clear by the Gulf of Tonkin Resolution in 1964, and this event was not lost on interns and residents.

So one finds that in Los Angeles the first heal-in occurred in 1965. The Los Angeles County heal-in was one of the first job actions in which interns and residents had undertaken to improve their salary levels.

This was followed in 1967 by the Boston City Hospital heal-in.

Meanwhile the CIR, without engaging in job actions, was improving the salaries of interns and residents. In 1958 they did it in a fashion that was similar to the one used by the Association of Interns and Residents: by lobbying; by just making the Assemblymen aware of how little interns and residents were earning.

The CIR also was engaged in other activities that were related to improving the quality of medical care. In 1959, for example, they published a report demonstrating that the death rate at some city hospitals was much higher than in other city hospitals; they showed that this was associated with the lack of supervision of the interns and residents at the so-called nonteaching or unaffiliated city hospitals. And this brought about the affiliation system in New York City which has resulted in a dramatic improvement in medical care. First, because there were now teachers and other hospital personnel to watch over the interns and residents; and secondly, because better teaching hospitals attracted a much better group of interns and residents. So the CIR from the beginning was involved in broader issues than salary negotiations.

But in the meantime certain legal events occurred which began to change the status of interns and residents. In 1968 and 1969 various decisions of the New York State Labor Relations Board, responding to the work of the CIR attorney, Murray Gordon, who will be speaking later on, recognized that interns and residents were no longer just students, no longer just so-called apprentices but were indeed workers; and that as workers they were entitled to negotiate for salaries and be recognized as workers. With this, the situation changed dramatically, especially in New York City.

It did not happen as much in other cities. The reason for this was that the Taft-Hartley Act excluded nonprofit hospitals and governmental hospitals, the very institutions in which the largest number of interns and residents were to be found. Despite this, there were sporadic uprisings. But the only place where there was real continuity was in New York City, which had a favorable climate from the point of view of local labor laws.

Around 1969 there was a peak, a crest, of student activism in the United States. In 1970 there was also a peak of certain forms of house-staff activism in the United States. A lawsuit against Los Angeles County Hospital was lodged in January of 1970; while at the same time a separate organization was negotiating for a salary increase. They got the salary increase and they also got some publicity from the lawsuit, which was later dropped.

The lawsuit was interesting. It challenged the overcrowding of the county hospital wards. And the reason it was launched in Los Angeles was that there was a health-law program in the area which had given the house-staff legal expertise; they used this expertise when a medical ward was closed down causing some of the patients to be cared for in hallways. So they launched the lawsuit which had some impact, but not a continuing one.

At the same time in 1970 the interns and residents at Wadsworth Hospital attended hearings under Senator Cranston. They described deficiencies in the medical care of veterans in the VA hospitals. That too generated tremendous publicity, reaching the front page of Life Magazine. It too resulted in only limited changes and not in a permanent, basic change in the VA hospitals. And as you can see with recent events in the Veterans Administration, the organization is still beset by problems.

At the same time another significant event took place at the District of Columbia Hospital, D. C. General in Washington, D. C. For the first time, interns and residents undertook to effect hospital changes through the vehicle of hospital accreditations hearings. The President of the House Staff Organization had gotten the JCAH to hear complaints of the house-staff as well as from the community about some of the deficiencies in medical care at D. C. General. They took the position that the hospital should not be accredited until those problems were overcome. This action, over a period of time, has helped bring about many changes in the accreditation of hospitals and perhaps has contributed to a certain degree to the present ability of the federal government to bypass the JCAH if they so desire.

Finally, we see the development of the first National House Staff Conference. This took place primarily because of the efforts of a former president of the Student American Medical Association. So once again you see this interplay between the students and the interns. Which is only a very natural interplay because medical students graduate and they become interns.

Let's just briefly discuss some of the practical aspects of organizing among interns and residents.

First of all, when low salaries are paid to interns and residents it is very difficult for someone who comes from a ghetto family that has to support him when he goes to medical school and when he goes through his internship and residency. This is reflected in this 1967 study (next slide) which shows firstly that while two percent of the population earned twenty-five thousand dollars or more, twenty percent of the medical students came from those families. On the other hand, while forty-one percent of the population earned between five and ten thousand dollars, only twenty-eight percent of the medical students came from that group. So the wealthier the background, the better the chance of becoming a medical student and making it through.

The next slide, please.

Therefore, collective bargaining compliments the development of more physicians who come from a different socio-economic background. And this covers a broad range from race to other groups.

There is also the responsibility of collective bargaining. Interns are a lot more willing to negotiate and get involved with the idealistic issues. So they are changing the concept of collective bargaining. You don't find this in industrial relations in other industries.

Here is a pamphlet which is printed in Spanish for the Spanish-speaking population in San Francisco, telling them why the interns were going out on strike.

And this is a pamphlet calling for support of the interns because, as it says on the top, "Community people and San Francisco General Hospital workers have joined in a coalition with striking interns."

You don't often find this approach in strikes by other organizations. Certainly, for example, community support for the teachers' strike in New York City, in Brownsville, was absent. But you find that interns and residents try to enlist support from the community and also are interested to a certain degree in the community's problems.

The next slide, please.

This shows that the goals of doctors are different when they get to the negotiating table. Why were these interns going out on strike? Because they were seeing you, the people, sitting in our X-ray rooms for two or three hours waiting; and it goes on with a whole list of problems that they were trying to remedy through a strike.

Now, this brings us to consider three important aspects of collective bargaining. The first, that collective bargaining will have an impact upon the nature of the physician. The second, that collective bargaining will be influenced by interns and residents as they have more idealistic goals and closer ties with community groups. And the third thing: that strikes should not take place if there is collective bargaining.

The reason the San Francisco strike took place was because these interns were not organized. They didn't know anything about collective bargaining. They just got together and didn't even tell their lawyer that they were going out on strike. They got upset about something and so they decided to walk off the job. And they did. They were not recognized as a collective-bargaining agent, and they did not even know how to engage in negotiations. They tried to bring everyone they could into the room to negotiate. They engaged in personal insults upon doctors, the mayor, and so on--and it was pandemonium. And when you get collective bargaining of that type, no decent labor relations mediator or individual who is skilled in labor relations is going to have anything to do with any such thing. He could not be responsible, because he would not be sure that his membership would back up a commitment. So collective bargaining is for organizations that show a certain type of maturity; and collective bargaining can help avoid strikes.

The next slide, please.

We see the development of the national house-staff organizations in medicine. There was the National House Staff Conference to which I referred. That was in 1971. There was a second one in 1972. A coalition was set up, as a by-product. At the same time the AMA organized its own interns and residents section.

As the AMA set up its own house-staff organization in 1972, the Interns and Residents formed an independent organization, also in 1972, which they called the PNHSA--Physicians National House Staff Association.

Meanwhile, on January 15, 1972, a conference was held at the Institute of Industrial Relations of the University of California on Collective Bargaining in Medicine. It was probably the first conference of that type in the country. Dr. Sanford Marcus attended the conference and, partly through the contact he had, went on to develop the Union of American Physicians. The UAP has been very successful here in Northern California, particularly in servicing the needs not only of the membership but also of the patients when they find they aren't getting paid by insurance companies when they should be. And so the UAP has acted not only as a physician advocate but also as a patient advocate. This is frequently overlooked.

In 1972 the Nevada Physicians Union was formed as a division of the Service Employees International Union of the American Federation of Labor-CIO.

The last slide will show what happened to the interns and resident organizations and how they began to merge.

First of all, the AMA's group was formed. Then there was the PNHSA, formed later on in October of that year. As a result of the Conference on Collective Bargaining in Medicine, the attorney who was with the CIR at that time, Murray Gordon, became involved with the Physicians National House Staff Association. During the same period of time the Student American

Medical Association, which helped subsidize the formation of the PNHSA, also helped get a type of subsidy for the PNHSA through the provision of an insurance program from Minnesota Mutual. This had the immediate effect of an influx of money, plus an influx of legal talent.

The AMA, seeing that its own organization was not going anywhere, and possibly afraid of a takeover of their organization by the other group, formed a separate group known as the Council of House Staff Affairs, which was appointed by the Board of Trustees and reported to the Board of Trustees.

The PNHSA in a massive attack at the AMA's Anaheim meeting literally took over the AMA/INR business session. They also won many seats in the Council of House Staff Affairs. And at the same time they rallied around some of the problems facing interns and residents who lacked due process.

At the Duke University training program in North Carolina the interns and residents were made to sign a statement that they would not engage in moonlighting. Some doctor sent an anonymous letter saying: "We should be permitted to moonlight since there are other doctors, like in the Department of Radiology, who moonlight and here are their names:" Whereupon their chief called them in and gave them slips of paper to say that those who were named could resign without being fired. One of the doctors resisted and he was fired. Whereupon the Committee of Interns and Residents and the PNHSA joined together to fly him out to Anaheim. And there, right next door to Disneyland, he began to see a new type of American Medical Association begin to emerge. A resolution recommending due process for interns and residents was passed. The talents of Murray Gordon, who is perhaps the most knowledgeable attorney in the labor relations in medicine and the health-care field, were applied to the development of a universal contract that will hopefully provide this benefit to all interns and residents.

In the meantime the American Federation of Physicians and Dentists was developing, which became widely involved in many types of organizing activities around the country. We will probably hear more about that, particularly from Dr. Marcus.

What is in line for the future? I have here on the last slide "PSRO," but I should also add "HMO" and "National Health Insurance" plus many other things which I just cannot foresee which will influence the development of collective bargaining in medicine.

I envision several possible trends. I think that the unionization of faculty members will probably increase as it has in New York State and elsewhere, like in New Jersey. Interns and residents will probably engage in collective bargaining on a broader scale. How this will relate to any of the national organizations I mentioned, I just don't know.

I think that interns and residents are going to benefit because Professional Standards Review Organizations, by federal mandate, will be required to have intern and resident participation. In areas where there

are more or almost as many interns and residents than as private practitioners, a PSRO may be challenged if it doesn't have more interns and residents in the PSRO: For example, in Los Angeles, I am told that the Los Angeles County Medical Society is boycotting the formation of a PSRO. Instead, the interns and residents are going to proceed and form their own PSRO. And if they are the only one submitting a grant application, they may very well get it.

In New York City, the situation is different. The medical societies are actively engaged in forming their own PSRO's and the CIR, in lieu of competing with them and forming their own, is working with them in order to jointly form PSRO's in which interns and residents are involved.

I would like to leave the remaining minutes for any questions that there might be.

CHAIRMAN MEYER: As we did before, we shall take questions from the audience. Please identify yourself as you are called.

DR. JOHN D. MACCARTHY (Merced, California): Would you give us an estimate of how large a proportion of house officers are actively engaged in activities which would represent legitimate union activities?

DR. BOTTONE: In formal collective bargaining organizations which are certified, I would say approximately twenty-five percent. In informal organizations, it's very difficult to estimate. I would say that a safe estimate would be about 50% of the rest. And there may be more. In some organizations you just have a weekly chat and you present your gripes. This is very unstructured. On the other hand, there are other organizations which are separate, independent and have their own headquarters and are certified as unions. So it is hard to really say how many house-staff organizations there are which are actively engaged in union activities because many of them you just don't hear about. But I would say, at least 75% of the residents and interns in the country are engaged in some way in these types of discussions.

DR. FRED W. RIO (Saugus, California): Dr. Fred Rio, Saugus, California.

Did I understand you correctly? Did you say that because the Los Angeles County Medical Association moved to not engage in PSRO's, the Interns and Residents Association is going to provide us with the PSRO? If they are, who are they going to review?

DR. BOTTONE: Let me just cover that.

According to the PSRO laws, you must represent, I think, at least 25% of the physicians in the community. If the interns and residents have their own PSRO, they must do it independently. They must develop an independent board of trustees. They will have no funding at the beginning except what may be given by out of pocket or from the organization. And they must submit a grant application to the federal government. If the grant application is accepted, then the organization will receive funding.

Now, I am not too clear about the subsequent activities. I think the interns and residents must then seek representation of all the physicians in the community.

DR. WILLIAM I. BAUER (Former Director, Office of Professional Standards Review [PSRO], U. S. Department of Health, Education and Welfare): I thought that I might help to explain this.

CHAIRMAN MEYER: I shall not introduce Dr. Bauer formally now. He will be speaking to us this evening.

DR. BAUER: The legislation says that more than one organization from any particular area may apply in this initial planning stage for money to be designated eventually as a PSRO. All you have to show is that you have the potential to have 25% of the licensed practicing physicians in the area be members of the organization. At the present time you don't have to be incorporated. You don't have to have any other qualifications. But you have to show potentially that you can eventually get at least 25%.

And so it would be possible that the Los Angeles County Medical Society and the interns both could apply for planning contract money as of the close-off date. Which is April 30. And they might both be funded. Then at the end of the six-months period, which would start on the first of July, in one of the organizations there would have to be some kind of election. And of course all it takes is ten percent petition to require an election. And then if more than 50% vote that that is not the organization that they want, then they cannot be designated. But this is the procedure that would go on in the six-months period.

DR. BOTTONE: Thank you for the clarification, Dr. Bauer.

I would like to add that in those areas where you have more than 50% of the physicians as interns and residents, they could provide a tremendous impact. And that is the case in the County of Kings (or Brooklyn), New York City and also in Queens.

DR. BEN EDMUND (Interns and Residents Association, Los Angeles): Dr. Bottone, you inferred that interns and residents may be more successful through collective bargaining than through past efforts in striking, going through publicity, and so on.

Could you give us your reasoning for that?

DR. BOTTONE: Yes. First of all, the striking by the interns in San Francisco was not effective because they did not first try to achieve their goals through any of the normal channels and they did not try to achieve them through collective bargaining. So they didn't engage in any kind of meaningful negotiations.

The second thing is that the problem with the Los Angeles County House Staff Association in January 1970 was the fact that they had two separate organizations functioning. One was ad hoc and one was one-man.

The president of the organization got in touch with an attorney and drew up a petition recommending that interns be given an adequate salary level. This was in the Winter of 1969.

This was presented to the Board of Supervisors in Los Angeles and they were due to report on it in January.

However, some time in the Winter a medical ward was closed down and the patients were transferred to another facility--they were literally standing in the hallways because they had no other place to go. The residents in internal medicine got together with a law group and about 50 of them sponsored a lawsuit which they presented to the Board of Supervisors at the same time that the salary issue was coming up.

So what you had is that the Board of Supervisors approved the settlement of the salary issue and the medical residents stepped back from really pushing the lawsuit.

Now, even if the lawsuit were to be pushed, it might not be totally successful because litigation is tremendously slow, it is very expensive, and the primary impact is usually the kind of publicity that the unions get. And then if measured over a long period of time, you begin to gradually see some impact. For example, the CIR, which engages in collective bargaining separately, also got the Health and Hospitals Corporation to sue the city of New York for additional funds which the city had not paid the corporation and which was required by state law. The lawsuit failed. And I am just a bit sceptical about the success that one may have with legal methods in improving the funding of some of the city hospitals.

Now, through collective bargaining various changes can be made, but here there is an impact upon the rights of management.

Now, briefly let me go over some of the things that have been achieved in collective bargaining.

I think it was in 1968 that the CIR negotiated two points:

1. Two voting representatives on the medical boards of the hospitals and also on committees, so that they could have a direct input into the decision-making body concerning itself with medical care.

2. A grievance mechanism governing out-of-title work where interns and residents who felt that they were doing the work of a janitor or of a messenger could seek redress and ask that additional ancillary personnel be added at the hospitals.

More recently the Los Angeles County House Staff Association as well as those in the University of Michigan have also negotiated clauses in their contracts relevant to the improvement of equipment that is available at the hospital so that there would be adequate equipment. Also clauses providing for adequate staff and things of that nature.

The problem with all of these is the following:

1. Let us say that you have a grievance concerning lack of EKG machines. Do you have binding arbitration to which you can appeal? And if not, then how far can you really be able to go?
2. The problem of getting interns and residents to bring a grievance, because a lot of times a doctor will find it to be more expedient to do the job than to get a grievance going.

Now, for example, out-of-title work. We had a resident in obstetrics who was rushing a woman to a delivery room since there was no messenger around, and going around a curve he suffered a crush injury of his hand.

I happened to talk to him and I said: "Well, it looks like there aren't enough messengers in your hospital and not enough ancillary personnel to help transport patients to other areas. Would you be interested in raising a grievance?"

He said: "No." He felt embarrassed; he felt that it was part of his job; that he shouldn't have let it happen, and he didn't want to stand out.

So there has to be support from the other interns and residents, an attitude which would permit them to go ahead and push those things that they can negotiate in a collective bargaining contract.

Lawsuits you think may be effective, but in some areas, as in altering the funding of hospitals, I don't think that they have been too successful.

CHAIRMAN MEYER: I shall entertain one more question.

DR. HARRY J. CAMPBELL (Los Angeles, California): Dr. Harry Campbell from Los Angeles.

Dr. Bottone, what do you see for the future for the Physicians and House Staff Association? Will it become a collective-bargaining unit on a nationwide basis--or will it continue to act as a resource for smaller collective-bargaining units on a local basis?

DR. BOTTONE: I think that the latter would be more likely. First of all, the organization probably will remain a fairly loosely structured coalition. With the hundreds of organizations that are represented, it would be very difficult to develop a national kind of thrust with regard to collective bargaining. Also there are doctors from parts of the country who are very much anti-union and who would not at all approve of any kind of collective bargaining in the normal sense; there are other doctors who are militantly pro-union. I don't think that the organization would survive for a long time if it took upon itself to impose either of those two alternatives upon their membership. More likely it will remain a loosely structured coalition.

CHAIRMAN MEYER: I think that we all owe a debt of thanks to Dr. Bottone for his splendid address. [Loud applause.]

And now, ladies and gentlemen, under the auspices of Dr. Gerald J. Lustig, the President of the New York State Federation of Physicians and Dentists, a luncheon-for-learning program has been organized. Thank you.

We shall resume this Seminar at 1:30 in this room.

AFTERNOON SESSION

... The Seminar was called to order pursuant to luncheon recess at 1:50 o'clock p.m. by Chairman Meyer. ...

CHAIRMAN MEYER: I want to welcome everybody back. Our next speaker, Mr. Walter Kintz will discuss, "The Legal Framework for Physicians and Dentists Collective Bargaining."

Mr. Kintz is an attorney. Since October 1959 he has been employed by the National Labor Relations Board, 20th Region, San Francisco, California. Currently he is the Supervising Attorney of the National Labor Relations Board, Region 20. Mr. Kintz.

THE LEGAL FRAMEWORK FOR PHYSICIANS
AND DENTISTS COLLECTIVE BARGAINING

Walter Kintz, Attorney at Law

MR. KINTZ: Thank you.

I always make a disclaimer--not so much because I want to, but because it is required of me. With that introduction I must make it clear that I am here personally. This is not my government-compensated day. This is my day off. And the opinions that I express here and the remarks in general are my personal opinions and do not represent the National Labor Relations Board in any way.

By making that disclaimer, I can deal more frankly with any of the questions and the matters that you might want to ask about.

Let me also say that I would prefer the maximum level of informality. I risk, like any speaker, boring the audience. One of the surest ways to preclude that is that you feel free to interrupt if you have any questions. I shall also attempt to leave enough time at the end so that if you are further confused by my remarks, we can make at least some effort to remove that confusion.

I would like to discuss with you the subject of labor law, perhaps in general terms that I believe from what I am able to deduce are areas that you might like to know a little bit more about or that I think that you ought to be interested in knowing a little bit more about.

I don't know much about medicine and I am assuming (and I hope that I am not patronizing you ladies and gentlemen) that you don't know a great deal about labor law. In order to understand any professional field, it seems to me that one of the basic steps is to talk about definitions. Labor lawyers use some terms very basically, and they are all generally understood and well understood by the professionals in the field. If you

are going to become interested in this field and have responsibilities in the field, you are going to have to start at least with the definitions. And so that is where I propose to begin my remarks.

Labor-law definitions are really the embodiment in statutes and court decisions of traditional concepts. I am not going to go into all the intricacies involved in interpreting these statutes and decisions, but I shall merely try to lay out these basic concepts and try to point out to you along the way how I think that they may become important to you.

To me the most important question for a doctors' union is: Can it function? Are there enough doctors who are employees? And that is a very important term: the term "employee." Because a union exists to represent employees in their employment relation with their employer.

So it is basic to ask: Are you employees? Are you employees now? Is there a serious and growing potential for you to become employees in the future? Or are you some other kind of an animal?

An employee is traditionally an individual who works for another person under substantial direction as to the time, place and hours of performance, and the manner and competency in performance of some job or service for that other person.

In some situations that is going to fit your idea of the kind of work that you do; in other cases it is not going to. Let us examine the term "employee" and try to define it a bit more by contrasting it with some other terms that are common in labor law.

For instance, "employee" versus "supervisor." Going back to 1935, in the Wagner Act the term "employee" was distinguished from the term "supervisor," a supervisor being an agent of management who is not free to engage in organizational or union activities without his employer taking reprisals against him in contrast to an employee who does have those statutorily-protected rights. The supervisor is a person who has the authority to responsibly direct the work of another person.

That might sound as if it were applicable to an awful lot of you. Physicians very commonly direct the work of nurses, less-experienced physicians, other medical personnel, technical personnel, X-ray technicians. I am sure you know a host of examples.

Does that definition, then, automatically make almost all of you supervisors and thereby preclude the opportunity for real and substantial collective bargaining?

I suspect not. I know that the California Nurses Association, which is a professional association engaged in the medical field, has established that it is a labor organization and gained bargaining rights on behalf of many of its members from hospitals both legally and extralegally. I mean,

both under the aegis of the federal labor laws and outside the aegis of the federal labor laws. I do know that they have a tremendous problem, though, with regard to the subject of supervisor versus employee and that in many of the "established units," as we call them in the labor-law field, a great many of the nurses have been found ineligible to participate in government elections because they supervise the work of non-nursing personnel.

With that background and with doctors moving newly into the field, who knows what will happen?

The area has been confused greatly by a very recent decision which I read only yesterday. The National Labor Relations Board handed down a decision in which they said that a supervisor is a person who responsibly directs the work of another employee and has authority to hire and fire another employee in the same bargaining unit, that is the same group of employees.

If this decision ultimately becomes well-established law and pervasive in the field, it broadens the opportunities for collective bargaining for physicians considerably. Because if we are talking about a group of physicians as the bargaining unit (and I shall come back and discuss a little bit more about bargaining in the future); if a group of physicians, let us say, employed by a hospital organization like we have here at Kaiser Foundation Hospitals would form a labor organization, demand bargaining rights, claim that the group of doctors as they are constituted is the appropriate group to bargain with their employer, excluding the nurses and the other professional personnel, then they could probably avoid the danger of the supervisor problem I have pointed out because they probably do not supervise people within that bargaining unit. And so they would be able to exercise all of the rights guaranteed and protected for employees under the federal law.

It is an interesting area of development, and I call it to your attention. It is certainly a clouded area as it stands right now.

Perhaps equally important to you as physicians is the question of employee versus independent contractor. I think that probably is even a more basic question than the one of employee versus supervisor. So many physicians, as I understand the practice of medicine, have a relationship with the hospital which might be under traditional labor-law concepts characterized as that of independent contractor rather than employee.

There is a lot of law in every industry from trucking to construction about what is an independent contractor versus an employee, and there is practically nothing at all in the medical field. There is practically no precedent in the field.

It doth behoove this organization if it is serious about representing doctors to start off its trip into the business of collective bargaining by a well-selected case establishing with good facts a precedent that

the physicians involved are employees rather than independent contractors. I am insufficiently informed concerning the practical, day-to-day relationship of the doctor and the hospital in the traditional practice of medicine to make what I consider to be a reasoned opinion on that subject. Even if you wanted my opinion, under these circumstances I would be reluctant to give it. But I can point out to you some of the factors that have been traditional in labor law in deciding whether an individual is an employee or an independent contractor--remembering always that the reason why we are interested in this subject is that an employee has rights guaranteed by the law and an independent contractor does not share those rights.

All right. Some of the things that the courts and the National Labor Relations Board have looked at include the extent to which the master or the superior party, that is the employer, exercises control over the individual acts that the person performs, whether he directs him point by point as to how he is going to accomplish his tasks; when, where and how; whether he determines the standard of quality of performance of those on an individual-job basis or whether he merely decides at the end: "Well, that man did a poor job for me. So I won't hire him to paint my house again."

If you hire a man to paint your house, you recognize that he is going to paint your house and he isn't going to let you tell him: "Now I want you to start here by the door and I want you to proceed in this direction. I want you to get this far in this length of time." He is going to tell you that, "It is eight hundred (or a thousand) dollars to paint the house. I'll get it done in three weeks. And how, when and how many people I use is my business and none of yours."

This mentioning "how many people I use" is another factor. Whether the individual rendering the services is rendering the services personally or employing others to render the service is a factor that might help you as physicians because you generally render your own service. The question, of course, in the physician situation to me boils down to whether you have the opportunity to maintain your professional standards and to act in your particular discretion in rendering the service and still conform to the idea of being an employee. Can you perform as an employee under the supervision of the hospital and still meet what you consider to be the requirements of your professional standards in the practice of medicine?

I really think that the extent of control is the single most important factor that there is to talk about in determining whether an individual is an employee or an independent contractor. If you read through the cases and do a lot of research, you can come up with lots of other factors. I would say that the other factors don't really weigh as heavily as the degree and nature and directness of the exercise of control. I have seen cases that consider such factors as whether income-tax withholding is made, (probably in a belated effort to get all the various federal agencies to view the employee-employer relationship the same way). Because I think the idea there is that if the IRS is going to say that, "You are an employee," then

the National Labor Relations Board is a little bit reluctant to say that, "You aren't an employee." However, there is no legal compulsion for there to be orderliness in this field or for there to be orderliness in application of all of the various statutory regulations. Indeed, the concept that Dr. Marcus applies may well not be that which the National Labor Relations Board will apply. Maybe that is something that you ought to be looking forward to changing. Maybe you ought to be prepared to make a compelling argument both in terms of legislative lobbying and in terms of a case of legal proceeding that you are entitled to equality of treatment. If you are going to be an employee for one purpose, you ought to be an employee for another purpose.

Other factors that have been considered in determining this question of employee versus independent contractor are whether the individual employee is engaged in the business, whether there is one business in which the employee is engaged and another business in which the independent contractor is engaged.

This hurts you too, I think, because the physician, again in most cases I believe, in the practice of medicine probably has an office practice and in addition practices at a hospital. This seems in the traditional labor-law concept to make him sound something like the contractor who paints your house. He is not in the business of merely working for you at your house. He has his own, independently established place of business, and he is willing and able to paint houses for you and others.

And of course this gives you a clue to another kind of area where this individual sells these services to various persons. And in the practice of medicine I am not well-enough informed to say whether a physician practices at more than one hospital and could enter into an employer-employee relationship with more than one hospital at the same time.

These factors go on and on and on; and they even include the individual skill and professionalism that are involved in the occupation. If you apply that one too stringently, you will find that no professional could be an employee. But there are cases which hold to the contrary. So I won't belabor that anymore.

As I see it, I would point out that we are in a field where the nature of the practice of medicine is changing and your principal opportunity to effect the employee relationship, if you want to accomplish that, is to influence the direction in which the practice of medicine changes to that result. If you want to be employees, I think it is time to use your political and economic power to influence the development of medical care in this country and the manner of delivery of medical care so that the physician is in an employee relationship with those agencies which will provide and deliver the medical care.

DR. LOUIS G. BRENNAN (Stockton, California): Mr. Kintz? I have two questions, if I may.

MR. KINTZ: Go ahead.

DR. BRENNAN: 1. How does the barber fit into the definition of an employee, since he has been unionized for many years? And

2. Let's further muddle the picture and take the case of a professional corporation and particularly the solo type of medical corporation where the physician is president of the corporation and also an employee.

MR. KINTZ: OK. The second one is certainly a lot easier than the first one.

Under the traditional legal concepts anyone who is a supervisor or above (and that would take you on up through management) is deprived of all of the rights of an employee and all of the protections afforded an employee. So even if he holds two hats, he basically is not going to have the protection. The president of a professional corporation who pays himself a salary is, I think, the classic situation that you are talking about. He is not going to be entitled to the protections generally afforded to employees, simply stated.

Returning to the question of barbers. Most barbers in fact are not employees as defined under the National Labor Relations Act and are not afforded protection. Most barbers are independent businessmen or partners. And in that respect they are parallel to the way that the learned professions are practiced.

By the way, most barber shops don't meet the jurisdictional standard of anything but the local state authorities. But answering your question, unless you want to talk about a large facility like a barber shop on a military installation where fifty barbers cut the hair of ten thousand recruits in a day, you don't have employees. The neighborhood barber shop is generally owned and operated by one man.

Now, there is a Barbers' Union--and I think that perhaps that is what is disturbing you.

I may be answering a question you don't want answered, but I will anyway.

There is a Barbers' Union and it is a labor organization. And that is, by the way, the next definition to which I was coming. It is a labor organization as defined in the federal labor law because it includes among its memberships persons who are employees and it represents some people who are employees. It also happens to represent a lot of people who are employers or independent businessmen without employees. But it gets to be a labor organization because there are some situations in which its members are employees and it does represent them in collective bargaining.

If an organization exists in whole or in part for the purpose of representing employees (I have already told you what an employee is) it is a labor organization, that is, when it represents them with respect to their employment. And that's all there is to it. The definition is remarkably easy to satisfy. With the signing of one collective bargaining agreement and the admission of one employee to your membership you are very clearly a labor organization as defined in the federal law, with the rights and, I must now emphasize, the responsibilities appurtenant thereto.

OK. Though I have covered my next definition, that of a labor organization, I did miss one point that I wanted to make. There was one inherent confusion, I think, in my answer to the gentleman's question, and that is this: that a doctor might very well be an employee on one job, in one situation, and might very well be an employer or an independent contractor in another situation on the same day. They are not mutually exclusive when they involve different employers.

Let me illustrate this. A physician might work in a clinic owned by a group of physicians and operated for profit. He might be employed there to render medical services four hours a day, three days a week. Here is an employee.

All right. He might also have an office in a medical building downtown which he operates independently and where he sees his patients another few hours a day. And indeed he might have still a third relationship with another hospital across the town where he goes on a consultant basis, where he goes periodically merely to make use of their facilities. In this way, he could have manifold different relationships in one given day. So the concepts about which we have talked are mutually exclusive only in one employer-employee relationship.

MS. SYLVIA ULRICH (Miami, Florida): If you were an employee of a professional corporation, would you be denied voting privileges in the area of collective bargaining?

MR. KINTZ: If you are an employee of a professional corporation of which you are not an officer or a supervisor, you will be entitled to vote with respect to collective-bargaining rights at that establishment.

MS. ULRICH: And what if there were two or three employees, all of whom are officers?

MR. KINTZ: All of them would be deprived of any right to vote under any of the basic legal statutes concerning collective bargaining rights vis-a-vis that practice you are talking about, but not necessarily if they were employed someplace else.

Are you more confused now, madam?

MS. ULRICH: Yes.

MR. KINTZ: All right. What I was trying to make clear is that when we talk about the disqualification for independent contractors or supervisors or managers from employee rights, they are disqualified only in that employee situation where they have that supervisory or managerial or independent-contractor position. They are not disqualified from the exercise of the rights of an employee if they have some other job relationship someplace else with some other party where they are in fact employees.

Is that clearer?

MS. ULRICH: Right.

MR. THOMAS M. BOND (Coordinator, Union of American Physicians, Assistant to President): Aren't you, though, talking about areas coming within the National Labor Relations Act versus areas outside the National Labor Relations Act?

MR. KINTZ: Yes. I hope to get on to cover them and distinguish between them. I am also talking about federal employment, however, and probably to a large extent about most state employment to which the test of independent contractor and supervisor will probably be engrafted. And to a general extent, Mr. Bond, I am even talking about private relations outside the jurisdiction of the National Labor Relations Board in most states that have a systematic regulation of labor law. So the principles, I think, are fairly broad.

There are many no-man's-land areas where there aren't going to be any rights that belong to employees to be protected. That much is clear.

DR. EUGENE E. NORTHCOTT (Stockton, California): I am incorporated in my private practice. I have also a clinic in which I am a legal partner. The clinic is a partnership, and acts as consultant for three hospitals.

Now I would like to know: What am I and where?

MR. KINTZ: That calls for a manifold answer.

Obviously, in a professional corporation you are not an employee and under no system that I am aware of would you have any right to exercise the rights of an employee.

With respect to those other relationships, the clinic where you are a partner, I think the answer appears to be the same pretty clearly. With respect to the other relationships, I am not sure that I know enough about them to be able to give you a very intelligent answer.

The point I was trying to emphasize which it sounds as if you don't like, was that because you are not an employee in those two instances doesn't prevent you from being one someplace else.

DR. SILVIO B. MARGOULIS (San Francisco, California): In a situation where I am providing medical service, but I am not billing the patient, I am rather billing some governmental agency, some insurance company, where somebody else is compensating me for the services rendered, am I or am I not an employee?

MR. KINTZ: You are an independent businessman; you are not an employee merely because you don't receive payment from the person to whom you render the service.

That is not one of the factors that I mentioned and it really does not do anything, as I see the general tendency of labor law, to make you an employee merely because you are not receiving compensation directly from the person to whom you render the service. The question rather, Doctor, is: Does that agency from which you receive your compensation determine the hours, the place, the circumstances, generally control the manner in which you render that service--or does it merely just pay you for it? It is the extent to which they control the times and circumstances, whether they provide the tools (maybe I should say the "instruments"), the facilities and your supporting personnel. Those are the questions. Just paying you is not going to make you their employee. If the facts change as I indicated, then you may become an employee.

DR. SANFORD A. MARCUS (Vice President, American Federation of Physicians and Dentists): I think that Dr. Margoulis leads us to the point where the greater portion of one's practice will be under the complete governance of a governmental agency which will not only set fees but which will delimit the extent of the services that can be rendered.

Granted one may be considered an independent contractor in being free to turn down such an arrangement, but the alternative may well be starvation one day if one chooses to do so in the absence of any other workable area. And the question then comes up: If an illusion of private practice is maintained in the initial steps of a governmental health program, is it going to be considered an independent-contractor arrangement where the free marketplace, which the antitrust laws were designed to protect and where the labor laws were designed to give parties at least the right to have input into the determination of the quantity and quality of the care that they render, does not exist?

In other words, we can foresee a situation where we are being given all the disadvantages of being a private contractor, all the disadvantages of being an employee and the advantages of neither.

MR. KINTZ: I think that that is a substantial possibility. That is what I intended to point out in my answer. And I also intended to suggest that to you when I remarked initially that as the private practice changes, I think that you ought to be aware of its significance. Merely by losing what you regard to be your economic independence is not going to make you an employee. And if you think it is, you are pursuing a false hope. So you had better make some other plans along the line.

DR. HARRY J. CAMPBELL (Los Angeles, California): I have two questions:

1. Would the National Labor Relations Board view an intern and resident in training as being employees? And
2. Are there any precedents in the area of interns and residents in training being determined to be employees as established by the courts?

MR. KINTZ: There is some confusing law in the field, to say the least. I don't regard the National Labor Relations Board as really having put the question to bed in any way. I think that there is a high probability that they will not be regarded as employees. Because, if I understand the nature of interns in the practice of medicine, basically they are involved in completing an educational requirement by being interns. And if that is the case, the National Labor Relations Board has generally excluded from the appropriate bargaining units individuals who are performing a service for money which was also incidental to an educational requirement.

Going directly the other way, there are some state-court decisions finding them to be employees.

DR. DANIEL GORMLEY (Glendora, California): Is it not true that interns and residents have been denied many advantages of students and fellows while for tax purposes they are treated as employees?

How it can be one way in one area and not in the other.

MR. KINTZ: I shall repeat the admission of Ralph Waldo Emerson: that "consistency is the hobgoblin of small minds." It is also not a particular hobgoblin of the federal government structure or of law generally.

You are correct. It doesn't make any sense.

I tried to point out that very factor out to you: that you could be left with the worst of both halves. And I think that that is distinctly possible.

DR. JOHN D. MacCARTHY (Merced, California): In a hypothetical situation where there are 50 doctors in a geographical location and one of them becomes an employee for two hours a week at a local medical institution. Can they all be union members?

MR. KINTZ: There is nothing wrong with them all belonging to the union.

DR. MacCARTHY: Can the union represent them?

MR. KINTZ: Well, the union can only represent them if they are employees someplace, if they are entitled to employee representation. That is the only way that the union is going to gain the various statutory aids in representing

them. The union may do a fine job in representing them by lobbying on their behalf, by persuading people with whom they deal to give them certain benefits, but they are not employees who are entitled to employee protection. That is a very important point.

All I have undertaken here, in obviously a very unclear area, is to help you to understand what an employee is and what rights flow from being an employee.

You can join a labor organization if you are not an employee. The National Association of Manufacturers, in the commonly understood use of the term, represents many large manufacturing corporations. It doesn't represent them in their employment situation. It represents them by lobbying in Congress, in the state legislatures and in a host of other ways.

And by the way, that is also an important function of every labor organization that is worth anything in this country. They do a lot of lobbying--very active and aggressive lobbying--before every kind of public body.

MR. GARY RADINE (California Dental Association Staff, Los Angeles, California): Sir, I cannot understand your answer about barbers. I am sorry.

MR. KINTZ: I will go over that again.

Most barbers are independently employed businessmen. They employee themselves either in a partnership or individual, entrepreneurial business much like a doctor or a lawyer who has an office. There are, however, some barbers who work in a large barber shop owned by one man who employees fifty men to cut hair. Those are employees. Merely because they are barbers they don't cease to be employees. They would cease to be employees if they were owners of the establishment. And their union is a union because it does bargain for wages, hours and working conditions on behalf of those people who are cutting hair for someone else.

In addition (and by the way, I point this out to carry the analogy one step further and relate it back to the previous question), it also lobbies for prices and legal regulations on behalf of the entrepreneurial barbers. It makes its weight felt in the legislature with regard to the terms and conditions under which the work of the entrepreneurial business of barbering will be practiced. And so it represents them too. It does not represent them under the protections that the law affords to employees.

DR. DANIEL GORMLEY (Los Angeles, California): My question has to do with the supervisory classification. Would it be possible to have the faculty, the supervisors of the interns and residents, in the same collective bargaining unit with the interns and residents?

MR. KINTZ: Not if it is under the jurisdiction of the National Labor Relations Act or not if it is in federal employment.

By the way, these questions are kind of skipping ahead. I know the group is confused, because I want to go on and explain that a little bit more.

But as a general proposition you could not gain the bargaining rights through a government-conducted election. However, if you have got the muscle to get the bargaining rights for supervisors and nonsupervisors together and you are not in an area where the federal law prevails, you can get them. It is a question of muscle.

Let me point out that if you walk over to the water front, the ILWU represents a great many supervisors on that water front. It also represents a great many guards. And there is a provision in the National Labor Relations Act that the National Labor Relations Board won't put guards in the same unit with nonguard employees. It is just a parallel provision to the one that we talk about with supervisors. But they have the muscle, they have the economic power to make people listen. And it doesn't violate the law to have them in. It does violate some of the state statutes and it violates federal government regulations with regard to interns who are federal employees. But in the private sector, if you have the muscle to make the employer take the supervisors and nonsupervisors together, you can do it.

The import of what I have said is that the true power of organization is extralegal rather than legal.

That is not a euphemism for something that is dishonest--and I don't mean to imply that it is.

CHAIRMAN MEYER: I would like to ask a question. I am here to learn also.

On the question of the barbers, I am not sure that what you say is what you really mean. And I would like to ask a question for clarification.

The statement has been made that since the Barbers' Union represents employee barbers, that gives them the authority to establish fees not only for the barber employee but to establish fees for self-employed barbers.

Is that not correct?

MR. KINTZ: No. If that is what I said, it certainly is not what I meant. It doesn't give them the legal authority. It may give them the economic power to do it. And you have to distinguish between the two. It gives them no legal authority to bargain on behalf of the entrepreneurial barbers, to set the fee for the entrepreneurial barbers, how much he will charge for a haircut. It gives them no legal authority to do that. But it may give them the economic power to meaningfully affect the price that is charged for a haircut.

CHAIRMAN MEYER: The question is a matter of practicality. Those of us who still go to barbers occasionally find that there is a posted schedule of minimum fees that applies to anyone in that barber shop who is practicing barbering, whether he is the employer or not. If that be the case, I would ask you if these barbers have ever been accused of violating any antitrust law.

MR. KINTZ: They have been in California. In California they were accused of violating the Cartwright Act.

CHAIRMAN MEYER: And what happened?

MR. KINTZ: They managed to beat it, as I recall.

The point is very well taken. And that was the point that I intended to convey rather than that there might be some magic in being a union that gained the right.

DR. RICHARD W. SWITZER (Tucson, Arizona): Since PSRO legislation intends to regulate the correctness and the nature and the degree of practicing medicine, has it in effect made physicians employees?

MR. KINTZ: It has taken a big step in that direction. I am not really authoritative enough to give you what I consider to be a reliable legal interpretation, but it certainly is a step in that direction. Each step that tends to control the manner, the method, the facilities, the things that I have mentioned, tends to create the employee relationship. And insofar as that is a fluid area, I am telling you that it is an area where you have some power to affect your ultimate destiny.

DR. GENOVESE FLICK (Sacramento, California): I would just like to say that a doctor who is employed by the hospital in a limited capacity would be an employee for that particular job. Is that not correct?

MR. KINTZ: That is correct.

MR. LOUIS BAKER: (Los Angeles, California): In recent years the Joint Committee on Accreditation of Hospitals has promulgated a series of bylaws. In these bylaws, there is the premise that the hospital board is ultimately responsible for the quality of medical care. Some hospital administrators have interpreted this to mean that the physician is no longer an independent contractor, but in a sense is an employee of the hospital and the board.

Does this have any effect on your status as an independent contractor vis-a-vis the hospital?

MR. KINTZ: Yes, it does. I think it is one of the factors that if you wanted to establish you are an employee, you would point to.

I might also point in a related field to the question of tort liability. I think it is the Darling Case which comments upon the master-and-servant concept of the hospital and physician. And the extent to which the hospital is the master and the doctor is the servant is the extent to which the doctor is the employee of the hospital.

DR. PATRICK M. SHAUGHNESSY (Newhall, California): I hate to beat this thing to death.

What you were saying is that no one really knows what the answer to this question is? Until we have a test case we are not going to know?

MR. KINTZ: That's right.

DR. SHAUGHNESSY: But you don't know and you can't refer to someone who does.

MR. KINTZ: That's correct. Absolutely correct.

Also one more thing I am saying is that you still have a lot of capacity to affect the ultimate outcome of this question; and I am trying to give you some hints about how and where and why you might affect the outcome.

DR. VINCENT CANGELLO (University of California, Berkeley): May I take that question a step further?

Would it be fair to surmise that the AMA has resisted any attempt or even hint at calling a doctor an employee?

Now, as trends develop, being an employee may tend to have some benefits which heretofore the doctor didn't have. And I am beginning to suspect that if the AMA were to take the position of wanting doctors to become employees, they wouldn't have an awful lot of trouble getting it done.

MR. KINTZ: There are about two questions there and a few speculations, Doctor.

But let me say that I don't know much about the policies of the American Medical Association and I don't expect you to know a great deal about the policies of the American Bar Association. But certainly an organization of that power and prestige and capacity to effect change in the field has profound power to affect the outcome of whether a doctor is an employee or not--if that answers your question.

I think a lot of confusion as a result of my remarks has come about by the fact that we got into many questions before I developed all the ideas. I know I disturbed Mr. Bond a great deal because I didn't get the opportunity to explain to you what I consider to be the four main areas in which labor law operates. I started with these definitions, but they don't mean much unless we talk about the four main areas in which labor law operates. You must be aware of these.

The first to which I would like to call your attention is the traditional area of the employees and an employer in a private business--corporate, partnership or entrepreneurial private business.

Now, the medical profession is engaged in private business in the sense I am using the term. When a group of doctors operates a clinic or a medical facility for their profit, they are treated for the purposes of labor law generally speaking (and I say "generally speaking") like any other business, just like manufacturing trucks or automobiles. If they meet certain interstate-commerce standards, they are subject to the National Labor Relations Act and their employees have all the protections guaranteed employees under the National Labor Relations Act. Which are (and by the way, now we are getting to the significance of the term "employees" finally) the right to organize; to form, join, labor organizations of their own choosing, free from interference by their employer by way of restraint, threats, coercion or discrimination in job tenure or assignment.

Now, those are the basic protections that an employee of a private business in interstate commerce is granted under the Wagner Act and has had since 1935.

Excluded from Wagner Act coverage are private, nonprofit hospitals. However, I see an authority in the field in the back of the room who may know a great deal more about this, but I hear rumors continuously (and they are getting louder every day) that there is going to be an amendment to the National Labor Relations Act to put private, nonprofit hospitals under its jurisdiction. Which would then afford these protections to all such entities should that amendment come. They are presently not covered.

DR. SHAUGHNESSY: Does this also apply to privately owned, nonprofit, health-delivery organizations, like free clinics and things like that?

MR. KINTZ: The answer to that question is muddy. I think that if it is operated by a charitable organization such as the Roman Catholic Church as part of its religious activities, they would be exempt from coverage by the National Labor Relations Act. If it was operated otherwise, as a community organization, private, nonprofit, but not part of a religious or charitable institution, then jurisdiction would be asserted just as it would over any private business.

OK. Once we have lined out that area and we understand it, we know that that is where the primary protections for employee and employee organizational and union activity exist.

By the way, the protections extend beyond union activity to merely concerted activity. Any two employees working together to improve wages, hours and working conditions are protected just as is union activity. So you don't actually, formally even have to have a union to be afforded the protection.

Now, that is the first major area. That is the area under the jurisdiction of the National Labor Relations Board.

The second major area consists of employees of the federal government. By Executive Order 11491, an identical scheme of protection is provided to all employees of the federal government. And there is an internal agency of the federal government to protect these rights of federal government employees.

Many physicians who are employed by the United States Government would be interested, of course, in this aspect of it. It is fairly narrow, but it is also a fairly clear area where we can answer most of your questions.

The third area to me, I would say, is state, county and municipal, where under the Meyers-Milius-Brown Act and other sections of the California Government Code (if you want to look them up, they are 3501 to 3510 and 3525 to 3526 primarily) the basic right to organize and form, join, labor organizations, to be represented, is protected for state, county and municipal employees. There is, however, no complicated, bureaucratic method of redressing those rights and basically you are involved in lawsuits when you seek to do in those areas, but the rights are there in California.

I know you folks come from many states and I have not the foggiest idea of what the various other states provide. Some states have similar legislation, some states have more comprehensive legislation, and a great many states have none at all. If there is none at all, you are really in a no-man's land when it comes to the protection of employees in the right to organize, when they do seek to form unions. There it is almost exclusively a matter of economic power.

The fourth area is the no-man's land where no one affords any particular protection. For instance, in California all businesses which do not meet the jurisdictional standards of the National Labor Relations Board fall into this. Most states do not have a statute comparable to the National Labor Relations Act. Many of the industrial eastern states do. Many states have what California has: a general statute which says that employees are free from coercion in selecting their bargaining representative. And that is basically what Section 93 of the California Labor Code says.

If that section is violated, you are going to have to go to court and file a lawsuit to redress the violation. Also it is an area where your economic power is very important because that is your principal protection in those areas.

And so when we apply the significance of the definitions I gave you earlier, we have to apply them keeping in mind the four main realms of labor law that exist in the United States. And I regret to state that I am not well-informed enough about the various states so that each of you could ask me what your situation is in your respective state. I suggest that your union can probably assist you there. One of the things that an organization like

a physicians' union can do is to be aware of what the various statutory regulations in each jurisdiction are that protect the right to organize, define employees and go into the details of these as they apply to each of you.

We have talked a little about the benefits of employees and we have talked a little bit about the areas of labor law that exist in this country, and I pointed out some of the major regulatory schemes. I think there are a couple of points that bear some emphasis, one that I have not discussed at all.

If you are a labor organization, that is, if you meet the statutory definition (an organization existing in whole or in part for the purpose of representing employees), you have both the benefits and the liabilities of a labor organization. You can violate the National Labor Relations Act. For instance, the National Labor Relations Act prohibits a union from coercing a self-employed person to join a union (Section 18(b)(4)(a) of the Act.)

I call that to your attention before you get too enthusiastic about encouraging private practitioners in a partnership situation or an entrepreneurial situation to join your union. By the threat of economic action against them you run a serious risk of violating the law if you are a labor organization--a risk that you do not undertake if you are not a union.

You may be familiar with the grape-boycott legal issue in California; and you may know that ultimately the Farm Workers Union escaped responsibility under the National Labor Relations Act for secondary-boycott conduct because it was able to establish that it was not a union because it did not admit any person defined as an employee to membership. So there is that other side of the coin I point out to you. When you undertake to gain the benefits of a union, you also undertake the risks. However, on balance, the risks seem to be far less than the benefits. That is my personal appraisal. And I leave you to make your own appraisals, of course.

Similarly and obviously, if you are a labor organization (and by the way, only a labor organization or an employee, for instance, can violate the National Labor Relations Act), you could engage in a secondary boycott. If you are in an association of physicians that is not a labor organization, you cannot engage in a secondary boycott, just by the same tactic that, I pointed out to you, Cesar Chavez' Farm Workers have employed.

UNIDENTIFIED REGISTRANT: Can you define secondary boycott?

MR. KINTZ: It is one of the more complex sections of the federal labor law. I can give you a brief idea.

It is putting economic pressure on a neutral employer to force him to cease doing business with another employer with whom you have a dispute. In other words, it is going to some employer that is not involved in your dispute

and putting economic pressure on him, getting him to cease doing business or change the manner in which he does business in order to put pressure on the person with whom you have the grievance.

UNIDENTIFIED REGISTRANT: Will you repeat. Who can have the right to have a secondary boycott and who cannot?

MR. KINTZ: Only a union is liable for engaging in boycotts. They cannot do it. But if you are not a union, you can engage in the very same conduct without the same result. On the other hand, there are antitrust exemptions for a union that do not exist if you are not a union. So it is a factor to balance back the other way.

MR. EUAN HORNIMAN (Surrey, B. C., Canada): What you are saying is that a doctor cannot put pressure on his patients to influence a third party who is not paying him.

MR. KINTZ: No. I am not saying that at all. I am saying that a labor organization may not put economic pressure on one party because he has an economic dispute with a third party. I repeat, only a bonafide labor union is subject to the secondary-boycott provisions.

By the way, this does not apply in your country, sir, and I have no idea what the law is there.

DR. MARCUS: The question of secondary boycotts has interesting ramifications. Most of us are aware that a certain insurance company took the liberty a year or two ago of notifying its beneficiaries of its policies that in individual cases they deemed a physician's fee to be too high, that they were going to pay according to a profile that they unilaterally and arbitrarily determined to be fair; and that if the physician determined that he was going to pursue the patient for the unpaid balance of this bill, the insurance carrier would assist the patient in legal representation.

It immediately became apparent to many of us that it would have been prudent or possible for us to post in our waiting rooms a notice that before any service was rendered to any patient it must be understood by the patient that if they were insured by that particular insurance company, they would not be assisted by the physician in the filling out of any forms of that carrier--in effect, negating the coverage of that patient.

What would be the legal ramifications of that particular action carried on (A) by a physicians' organization and (B) by a physicians' union?

MR. KINTZ: Let me say first of all to make sure that we don't get confused here that the insurance company in engaging in this conduct cannot be engaged in a secondary boycott because it isn't a union and you have to be a union to be engaged in a secondary boycott. So we aren't going to be able to use that weapon against the insurance company. No conceivable violation of the secondary-boycott provision is had by the physician in

taking the response certainly on an individual basis. If the organization of physicians is not a union, then it cannot be engaged in any secondary boycott. Whether or not it is a secondary boycott if it is a union I am in serious doubt. I am inclined to doubt that it is.

It is a difficult question. It is a unique one, I must say.

All right. In pointing out these things I am not trying to make judgments for you. I am rather trying to show you some potential benefits and some potential pitfalls. I want you to have the awareness of what it means to be a labor organization and what it means not to be a labor organization.

I don't have the time to go into antitrust provisions at any length, but there are a few other areas on which I would like to touch before I conclude my remarks.

I have tried to make it clear that I think that muscle is really what unions are about in spite of all this talk of legal protections. Labor organizations as I have known them in 15 years succeed or fail not in terms of their ability to make use of the statutory protections, not in terms of the various statutes which happen to be applicable to their realm of endeavor, but rather to the extent to which they have the wholehearted support of the unified and enthusiastic, disciplined membership that seeks to accomplish certainly economic gains for them.

Labor organizations in this country have achieved a great many of their goals at the ballot box, in the legislature, on the picket line, and in a host of other places outside the courtroom, outside the National Labor Relations Board and far away from lawyers' offices. They have achieved their power through economic and political strength.

When you make your decisions, I think that they should be dictated primarily by these considerations, avoiding the legal pitfalls along the way. For instance, should the doctors seek representation in a collective bargaining unit limited to physicians? I would suspect that every one of you in this room would say: "Obviously. We wouldn't want to combine with other than physicians."

But before you jump too quickly to that conclusion, recognize the strength that lies in joining together with the nurses or other medical-care personnel both professional and nonprofessional.

Recognize the protection of solidarity (an old-fashioned trade-union term: "solidarity") with other people who together with you may wield economic power to achieve common goals. The larger the base of your economic worker power, even for physicians in your lofty professional positions, the more power you are going to have. The more alienated and alone you stand, the more you are going to be subject to social, political and economic attack for whatever you do to pursue your ends.

And so think about what kind of bargaining units you are going to be arguing for. Think about whether you are going to be going the route of asking the government to conduct an election where the government has jurisdiction or whether you are going to try to make use of your economic power to make sure that supervisors, as we have discussed here, are included in your bargaining units. Because the supervisors may be the key to your economic power in the situation.

Remember also that the Teamsters Union, for instance, enters into collective bargaining agreements with employers that set the wage rates for employees and independent contractors and have been able to do this successfully despite legal attack on the procedure because they have been able to show that if the independent contractor is allowed to cut the rate at which his services are sold to the trucking industry, it will obviously have an effect on employment by employees in that industry.

There are interesting independent-contractor law cases involving the Teamsters Union and its contracts representing employees which also set minimum-fee schedules for independent truckers who are independent contractors in terms of our discussion here today.

So there is a potential for economic power in the independent contractor. And by our definition discussion at the outset of these remarks I did not want to push the whole question of independent contractors too far to the background but, rather, counsel you to look to what the Teamsters have done in that area.

Remember that distinction between illegal and extra-legal. Remember that if you are talking about union organization in the terms that I know it, the ultimate question you are asking is not all these legal issues that we have been struggling so hard with today, but muscle.

And good luck to you! [Loud applause.]

CHAIRMAN MEYER: Thank you very much, Mr. Kintz. That was a very stimulating discussion.

There will be a short break now.

[Short recess.]

CHAIRMAN MEYER: Would you kindly take your seats, please.

I come now to a very pleasurable part of the program, for me personally: the introduction of our next speaker.

There is a little history involved here. I hope the history does not repeat itself. And I shall explain that.

Twenty years ago Sanford Marcus, our next speaker, and I were neighbors in South Carolina and we were working for the same employer. We both wore the same uniform. It was the federal government who employed us: specifically the United States Air Force.

We lost track of each other until a couple of years ago when it turned out that we were both active in the doctor-union movement--Dr. Marcus on the West coast primarily and I over in New York.

We started out knowing each other as employees of the federal government. I just don't know whether we are going to end up the same way.

Dr. Marcus is a graduate of the University of California with a Master's degree in physiology and an M.D. from the University of Pennsylvania. He is a Diplomate of the American Board of Surgery and is a practicing surgeon in Daly City, California--right outside of San Francisco. He is President of the California State Federation of Physicians and Dentists, President of the Union of American Physicians and Dentists, and Vice President and Secretary of the American Federation of Physicians and Dentists. His topic today will be Organizing for Collective Bargaining. Dr. Marcus will discuss the role of the professional society and the union in building an organization with, as Mr. Kintz referred to it, muscle.

Dr. Marcus! [Loud applause.]

ORGANIZING FOR COLLECTIVE BARGAINING

Sanford A. Marcus, M.D.

DR. MARCUS: Thank you, Dr. Meyer.

I never stop to think about that going full circle: namely, starting in uniform and ending up there. But it is something that will probably give me nightmares for the next week or so.

It is indeed a pleasure to see this meeting gathered here today. It is a plateau, a certain bringing to fruition of ideas that started hesitatingly and cautiously only two years ago for myself. As you have heard today, there are organizations represented here that date back fourteen and sixteen years, respectively. We are the neophytes. Two years ago I attended a seminar under the same auspices (The Institute of Industrial Relations of the University of California) on the subject of Collective Bargaining and the Young Physician. It dealt primarily with the role of the intern and resident at that time. And I listened with rapt admiration from the audience to what these young doctors had done, what they had taught us.

On the program were many people who are here today: Dr. Bottone, who was instrumental in organizing that program; Mr. Kintz, who was again one of the legal lights who graced that program.

As I sat and listened to Mr. Kintz this afternoon I was truly impressed with the evolutionary process that had taken place in Mr. Kintz himself. At that time he pointed out that there were certain green pastures to which we aspired that were forbidden to us and which this afternoon he dangles before us as a prospect to which we might, with muscle, be near.

The fact of the matter is that I have learned much, I continue to learn much and I have most of what remains to be learned ahead of me. What I have learned so far is this:

That what we propose is an honorable program. We represent an ancient profession. As such we have a rich and long legacy of human service behind us. We have the oath of Hippocrates and a record of dedication that no politician or muckraking author or malpractice attorney can either legitimately attack or certainly hope to emulate himself. Accordingly, I don't want to be in a defensive posture.

My father was a physician. When my father walked down the street, gentlemen tipped their hats to him. Nurses (God bless them!) stood up when he walked into the chart room.

At the present time we find ourselves, however, under attack from a variety of sources; and I have stepped back a pace or two and have tried to wonder why.

We heard this morning about the "politics of envy," we heard about the "age of egalitarianism," and of course we heard about the right to medical care.

The evolution of that concept itself is worthy of a parenthetical glance because it started from the notion in which all of us enthusiastically share that no one shall be denied access to the best of medical care because of an inability to pay for it. This has been paraphrased and foreshortened into "right to medical care." And that notion itself has been bent and perverted into the idea of free medical care.

With this acting, as it does, as an historic sociologic wage, successively one country after another has adopted the notion of government involvement in both the financing and distribution of health care. It ill behooves any of us to fight the lost battles of 1935 against the ogre of socialized medicine.

We come here today to talk about realities if not faits accomplis. We talk about something that is happening and will happen. What we are talking about is how best, in an eclectic manner, we can extract those aspects of health care that are worthy of defense and protection and see that they are protected during this period of on-rushing tidal wave of socio-economic change in our profession.

As we look at this and as each of us has been touched more and more intimately by these changes, a desire to lash back has overcome us. But merely talking or grouching or grumbling; merely defying, as in "The Last Angry Man" shaking his fist at the moon, is no longer enough.

I am the recipient of a legacy. I belong to a proud profession. Something has been handed to me as a baton in a relay race. I have two of my own children who profess an interest in entering the field. I am old enough to say that I could "cop out," get out of it while the getting is good and to hell with what comes later! But I feel a responsibility to protect a noble profession. And that is what brought me into this at considerable personal cost in time, treasure and, with the indulgence of the loveliest wife in the world, time with my family.

What we see now is the following:

There is emerging in Congress at the present time the format for what will come. Within the next two or three weeks representatives in this room will be testifying before the House Ways and Means Committee in the area of what we think should go into the new National Health Insurance Act. We do not intend to say it should be stopped at all costs. If we are asked our personal feeling, we must say in conscience that it does far more than any act should reasonably be expected to do. It should, as Dr. Schwartz pointed out, protect those who are unable to take care of themselves, not those who are disciplined to take care of themselves. However, I am certain that that

type of argument will fall on deaf ears and be simply a quaint, historic anachronism.

What we intend to do is to ask -- demand, if you will, to use contemporary rhetoric -- that physicians have the right of any honorable workman to have a determining voice through the mechanism of collective bargaining in the determination of what is good for our patients.

We shall be faced by the unalterable fact that there are budgetary stringencies that will limit the availability of funds, but we do not wish to assume the mantle of being bookkeeper and doctor. We are in an adversary position, make no mistake about it. We have at the present time three groups of adversaries. We have insurance carriers. You have heard reference to that. We have hospitals, with which the dental members of our group do not often come in contact but which are gaining increasing governance over the carrying out of our day-to-day activities -- and ultimately we shall have one hundred per cent control by government.

Setting aside the employer/employee relationship, I must tell you that the American physician and dentist compositely has a tremendous amount of power -- far, far beyond the 40,000 numbers that were cited to you, which look puny indeed against a population of perhaps 210 million, but which exert a tremendous amount of control over the day-to-day activities of everyone in this country. Acting together, with solidarity -- "muscle," if you want to call it that, although it is a nasty word to "nice" doctors -- we can achieve certain things.

In the course of my own education I glanced at the labor movement I was attempting to emulate, dismissed for the moment the fact that we could possibly get Jimmy Hoffa to represent us, enjoined as he is from participating in union activity, and defending myself all the while against the fact that perhaps I might turn out to be a Tony Boyle. And I set up a dialogue with The Air Line Pilots Association (I liked that). Air line pilots are rich. Air line pilots make three times as much per hour of work as I do. And this immediately made them attractive. Mr. Gary Greene, who is the counsel of the Air Line Pilots Association, has been my mentor for a considerable period of time. He directed my attention to a volume called The Air Line Pilots Association, a Study in Elite Unionization, published by the Harvard University Press in 1971 and written by George E. Hopkins. In that volume there is the clear story of the evolution of The Air Line Pilots Association from a bunch of disjointed, hot-shot Charlie Barnstormers, with leather helmets and scarves thrown rakishly over their shoulders, to a very tight-knit, proud professional Union that has not only won great material benefits for its members but which has had the controlling voice in the emerging picture of the entire transportation industry of America. They have won for themselves virtually a protected position under the law as it has evolved -- and they remain proud and they remain noble and they remain clean.

The notion of professionalism that collective action is undignified is the one educational barrier I had to overcome. And that, I find, is the one that is most difficult to overcome in the minds of the people with whom I speak. But I shall tell you this: the air line pilots, through their solidarity, through their dignified but concerted action, have not only won material benefits for themselves but have insured the preservation of their professionalism.

So using that as a model we embarked upon this great odyssey of setting up unions for physicians. Many preconceived notions had to be set aside: doctors are "rugged individualists;" doctors can never be made to work together, and all the rest.

I have told this repeatedly: that there is very little that I with my puny personal powers of persuasion can do to induce any physician to abandon this pathway of individualism and enter the field of collective action. However, when my chief recruiter gets through with him, he'll be damn glad to join! My chief recruiter is Senator Edward Kennedy.

Senator Kennedy, I think, serves a very valuable purpose in the role that he has chosen in that he has highlighted and legitimized the real fears that physicians have about what is going to happen to them. Accordingly, he is indeed my chief recruiter. And within the next few weeks he and others who jump on his bandwagon, I think, will have a very significant impact on the membership rolls of our unions.

To organize a union, as Mr. Kintz pointed out, one merely needs a meeting of minds, a sharing of grievances, the agreement to work together. Again, based on what he said, it is not what you call yourself but what you do that determines how you are treated. But again we as physicians have walked on tip toes so as not to be in violation of this strange ogre of the law.

The deeper we get into this, the more we realize that many respected unions do not trouble themselves with the law or with the possibilities of treading on some of its more remote ramifications, but simply try to conduct themselves honorably and gather muscle.

It is important that those of you who are interested in furthering the cause of physicians' unionism remember this fact: that we are in a ridiculous posture at the moment. We are building an ark on top of a dry mountain. People are laughing at us. "Who ever heard of a bunch of rich doctors needing a union?" But après le déluge! When those flood waters start to rise, there are going to be an awful lot of people anxious and willing to clamber aboard this "ridiculous" ark.

We have to get the ear of the existing medical groups. I have addressed innumerable county and state medical associations. I have been on a panel before the Leadership Conference of the American Medical Association in Chicago.

The thrust of that meeting in Chicago was: What can a union do that the AMA can't? The repeated plaintive response was that "Anything you can do we can do better."

I pointed to the insignia of the AMA and said: "You have had a century to do it." The present posture of the American Medical Association is a far cry from that that they presented 25 years ago. The image at that time was that this was the strongest union in America. But it took a succession of defeats, based I believe on a lack of social perceptiveness on the part of the AMA, to label the American Medical Association in the political arena as an ex-champ.

I happen to have admired Joe Louis during my youth and watched this wonderful fighting machine during some of his magnificent triumphs. He became the personal champion of all of us. And I remember with tears in my eyes how I saw him getting utterly clobbered during the days when he was washed up, a "has-been" trying to make a few bucks to work his way out from under an insupportable tax burden.

I think that the American Medical Association has great dignity. I think that it can afford to continue as the pinnacle of aspiration of any physician based on its achievements in the scientific, ethical, professional, educational areas in which it has operated to bring the standards of American health care to the highest of anywhere in the world. Resting on those laurels alone and continuing in this same pattern we support the AMA one hundred per cent and we urge our members to continue to support the American Medical Association and all of its component branches. God knows we have enough enemies outside the profession not to go courting enemies inside the profession!

But the American Medical Association in attempting to get off the ropes and put on these socio-economic boxing gloves that have seen so much blood is, I believe, trying to do a task that it is no longer equipped to do. It could have done it; it chose not to do it.

On January 31, 1972, in its own magazine the AMA came out with the headline (and I quote): "THE AMA IS NOT AND CANNOT BE A UNION."

As we looked about us for what vehicle might possibly provide the framework for some sort of socio-economic defense organization for ourselves in the stormy days that lie ahead, we naturally looked towards unions. We thought initially that we would latch onto the AFL-CIO. I wrote a letter to George Meany at one point long before I formed this Union, and I said: "Dear Mr. Meany: ..." And I outlined some of the problems we faced. "Why don't you form the doctors of this country into a union?" And I got back a letter that you might have expected: very courteous and very well-thought-out. It read:

"Dear Mr. Marcus:

"The AFL-CIO has traditionally represented employees vis-a-vis their employers; and accordingly, at the present time, since physicians are defined as entrepreneurs, it would be inappropriate for us to represent you."

However, he went on to say: "In five or ten years, when most of you will be employees, we will be very interested in you."

This to me was not a humorous reply. I think that George Meany is not given to humorous replies. And I think that that was and may still be his honest appraisal of the situation. However, in pressing the matter we found that COPE, the political-action arm of the AFL-CIO, had a director named Mr. Barkan, who has a canned speech that he uses up and down the land which he refers to as his "Come to Jesus" speech and in which he labels doctors as "bloodsuckers" and accuses them of capitalizing on the misfortune of others in order to enrich their personal pockets. And I felt it somewhat inappropriate at that point to climb into bed with someone who obviously was so un-enlightened as not to be aware that physicians had problems and grievances of their own.

For the moment, therefore, we are totally independent of them. We hope that their education will develop as ours is and that some day we may possibly talk otherwise. We could not see embracing the organization that has been the prime mover in the development of the Kennedy-Griffin Health Bill, which most of us feel is the most severe and repressive of all the health vehicles that have been proposed. And therefore we feel that the time is not ripe for more than arm's-length dialogue.

We have formed our own Union. I have spoken with a great many groups. These groups have been provided with packets of information detailing the need to observe the responsibilities of labor law, as Mr. Kintz pointed out. This is not something that we are going to approach frivolously. We have expended tens of thousands of dollars in legal fees defining the limits of what we can properly and cannot properly engage in. And let me assure you that, if anything, we are leaning on the side of being overly-cautious. But this has not dimmed one whit our determination to push the case that we believe is necessary.

When we go to Washington, it is our intention to obviate some of this legal hassle that you heard here today about the employer/employee status by asking simply that in the writing of the new law that definition of physicians as employees be included. That will save us the trouble of a court test to legitimize this status. But we firmly intend through the organization and the resources that we are accumulating to go this route if it is necessary.

I would personally if I were a legislator feel that it is probably better to deal with the physicians on a conciliatory basis, hoping to make

this somewhat controversial National Health Bill more palatable and more workable by wooing those who ultimately must make it work rather than legitimatizing them and cementing them into an adversary position where nothing but strife can result and where the ultimate loser must be the American public, our patients.

Can a medical society become a union?

Yes, it can. I believe that because of the many problems that it has, the many other hats that it is forced to wear, if it were to become a union and carry on the socio-economic activity, there would be areas of conflict that would somewhat deflate its legal force. It has been interpreted to us by our legal consultants that it is better to form an entirely new organization without any financial commitments or interlocking directorates with the medical societies and do this socio-economic work as a separate function.

Again we are not in conflict with them. We feel that it is no more incongruous for us to belong to a union and to a county or state association or American Medical Association than it is for us to belong to an AMA and an Academy of General Practice or an American College of Surgeons. We are talking about division of labor; we are talking about the performance of separate functions. I do not believe it behooves us to enter into any of the areas of prerogative of the existing societies. I think they through their proclamation that they are not and cannot be a union have created a vacuum into which we must properly enter.

What can a union do for me?

It is very hard when you have nothing to sell but an idea and you collect money and you get a certain amount of enthusiastic commitment -- and then nothing happens and people say: "Maybe I was carried away." Obviously there must be slain dragons to present because without these the enthusiasm of your membership wanes.

We perceived this. And under the extremely expert guidance of Dr. Clinton V. Ervin, who heads our Grievance Committee, and his excellent staff headed by Mrs. Judith Skiber, both of whom are here today, we set up a mechanism whereby we as the union might represent our union members in dealing with insurance carriers in matters where they had unilaterally and arbitrarily and often capriciously withheld payments for services already rendered by us to our patients. We adopted a mechanism of addressing ourselves through the Union, under the Union letterhead, to these carriers demanding that they explain the terms of the coverage of that particular patient's policy and the basis upon which they determined that their liability fell short of what we felt the patient was entitled to receive.

We have been singularly unsuccessful in obtaining extracts of patients'

policies because in almost every instance by return mail either to the patient in cases of self-insurance or to his physician in the case of assignment the check for the unpaid balance comes in full. Within the past twelve-month period we are near the half-million-dollar mark in what we have been able to recover for our members and our patients in funds previously held by insurance carriers under the notion that if they held these funds long enough they could pocket the interest gained therefrom. And we now have pipelines, not into the claims department of insurance companies, but into the offices of the vice presidents and presidents of the companies, where our letterhead carrying this "terrible, terrible" perjorative phrase "Union" enters with far more respect than the hat-in-hand approach previously tried by our professional associations. That is one thing that we have done.

Here in California, we are dealing at the present time with the workmen's compensation carriers who have chosen to accept a so-called minimum-fee schedule for work-related injuries as being the fee schedule that they will honor. In these inflationary times, and without decent adjustment, sometimes the compensation approaches a ludicrously low level. We have talked to the carriers and we are presently in conversation with the American Arbitration Association. We have not yet entered into a formal relationship with the Arbitration Association, but we feel that they are a proper vehicle for us to use in resolving this problem of why work-related injuries in California are considered to be second-class injuries in terms of compensation and range of coverage. We shall have more to say about that later.

We have involved ourselves in legislation. You have received copies of cards indicating the tremendous disparity in what is paid physicians in different sections of California based on someone's computerized notion of what they will accept. This has worked great injustices in certain areas such as Merced County, California, where doctors have the lowest profile in the State, where physicians doing exactly the same work and with certainly the same degree of competence are paid in many cases one-third to one-half less than others in the State.

We have intervened in this situation; and while we have not completely resolved it, we have at least gotten the State to study its inequities. And once it gets out of the long succession of governor's commissions and study groups, we hope that we shall have had a real input into the rectification of these injustices.

Setting aside the doctor's position as employee for the moment, I will tell you that, as Dr. Meyer said in his opening statement, the times are indeed changing. We have a situation in hospitals where through the Darling decision referred to by Mr. Kintz and the Nork decision in Sacramento referred to by Dr. Schwartz, the lay board of the hospital has been invested with the ultimate responsibility for the enforcement and maintenance of professional standards in that hospital. This can be reduced to a total absurdity when you stop and think about it. If a physician practices at the only hospital in a community, it is obvious that his entire livelihood is wrapped up in the

ability to bring patients to that hospital is totally and without right of appeal or input from him to be governed by those who in many instances are not equipped by training or professional expertise to judge him, the ingredients of great injustice are present.

It can be said that those of you who belong to staffs of hospitals really are not on hospital staffs at all. You belong, rather, to a company union. Those of you who are familiar with the sad litany of what company unions represented back in the days of the coal fields of Western Pennsylvania and West Virginia and the like realize that the company union is a yoke of enslavement that the employer can place around the necks of employees, one that will govern the total earning of their livelihoods and make them totally beholden to the employer. If through legal interpretation this can be made to stick, obviously this changes the notion that we patronize hospitals much as we would patronize supermarkets and that we are, in fact, in a subservient position. If we act in concert against those hospitals, can it be criminal syndicalism any more than it was criminal syndicalism for someone in a sweatshop similarly to band together a half a century ago or longer?

With reference to insurance carriers, indeed we can argue about fees. We walk with great trepidation in the area of setting minimum-fee schedules, but in the myopic, tunnel-vision-type interpretation of the American Medical Association, all we talk about when we talk about physicians' unions is setting up minimum-fee schedules. We are skirting that issue immediately because even the astute attorneys through their bar associations have not been able to tiptoe their way through those mine fields and neither can we until they do our dirty work for us.

We can, however, in dealing with insurance companies (and you can infer from the questions that I asked Mr. Kintz) indicate to our patients that they are getting unilaterally "taken" by the insurer with which they deal. We can recommend that they change their carrier. We can communicate with labor unions that deal through one carrier and state that they would be better serving their membership if they dealt with another one because we intend to throw up certain obstacles to that coverage.

Oh yes, this will make us guilty of collusion and that sort of thing. We are prepared for the legal defense incident to the law suit that is certain to follow. Ultimately, however, when we talk about insurance carriers, we are talking about a transitory, interim-type factor because I believe that it is the intention of the government simply to usurp the entire insurance field, leaving perhaps only the crumbs of the basic coverage or some such thing to them, and for the government to get into the insurance business itself. It may not do it in the first wave of National Health Insurance. They may look upon this as a graded sort of activity. But it will be certainly the plan of those who are pushing for government medicine to prove that not only are physicians unable to police their own professional standards, but also that insurance carriers cannot do the job efficiently.

This has a built-in failure factor that will be determined by the tremendous wave of overutilization that will immediately follow the enactment of National Health Insurance. And when that comes government will say: "It has failed. The health insurance field is hereby defunct and we are the only carrier in the business."

What happens when you deal with the only carrier in the business? Well, they set your fees. There is no right of appeal from their setting of your fees. To your Medi-Cal or Medicaid patients you cannot render a supplemental bill. Oh, you can refuse to take those patients. At the present time they represent a relatively small percentage of the patient population, unless of course you happen to be a Black physician -- in which case you are already totally beholden to the government plan because almost all your patients are on Medi-Cal or Medicare. The Black physicians in many instances have been our mentors and they have told me much about what it is like to practice under a total system of government medicine. They don't like it as we will not like it, but they are the sharp, cutting edge and they are taking an awful lot of knocks in their effort to find their way through the obstacles that have been thrown up before them.

When the government becomes the only carrier, you will comply. If you will not comply, you have this euphemistically termed Professional Standards Review Organization, which has been sloppily referred to as a "peer-review group," that will tell you that you must comply. The PSRO's, despite the fact that Dr. Bauer is in this room and has espoused this avenue, have a built-in failure factor that will enable them not to survive, I would estimate, beyond a two-year period because what they are asking the physician to do is to become schizophrenic. The physician in his obligation to this patient has the need to render care to the individual patient to the full extent of his ability. The Professional Standards Review Organization (and I have already had six legislators introduce bills that will change the name of this to Cost Control Review Organizations) has the function of cutting down or monitoring, if you will, the amount of money that will come out of the rigidly circumscribed budget that will be allocated for health care. Accordingly, the PSRO's initially are going to be asked to treat the thin line between how much you can cut down on the cost of health care and the impossible task of coping with the wave of overutilization on the part of the walking well, the hypochondriacs and the "little old ladies in tennis shoes" who will make demands on the system that will certainly overload it. The PSRO's charged with cost control are going to be forced to turn on their own codes of medical ethics and professional standards of expertise and cut down and cut down and cut down and compromise until they are nothing more than shattered clerks. At that time the Secretary of HEW (and this is all etched in stone on the H.R.1 Act) will step in and say: "We gave you your chance" -- and it will be taken out of the hands of the PSRO's and then the power blocs will be clearly established.

We have been enticed into this dual role under the notion that somebody is paying respect to our professionalism and our knowledge, but in point of fact it is an impossible task. And I would counsel anyone to defy the law by refusing to sit on or vote for the establishment of a Professional Standards Review Organization because ultimately it can only reflect great discredit on the medical profession, and we are going to end up in the same place anyhow. It is better to get the mud out of the waters and define our terms at the beginning. PSRO's are cost-control review organizations and they are the enemy.

Not going to jail has been official union posture. However, we do not feel that the record of civil disobedience, especially against oppressive or bad legislation, in recent years has been that bad that we might not be inclined to study this further.

Health maintenance organizations. Do the unions have a posture with regard to them? Surely. They are here. We are neither for, nor against them. They are one way of delivering health care. What we do care about is that within the health maintenance organization, just as with government salaried physicians in the armed forces or those working for insurance carriers or any other form of health-care delivery, the physician in his capacity as the one expert in the matter of delivering health care to his patient is not denigrated to the role of a public functionary. We will fight for our HMO union members as vigorously as we fight for our private-practice (if that is what you still insist on calling it) union members.

I believe that health maintenance organizations (and this is a private observation and not construed as the policy of the Union) have a built-in failure factor too. Perhaps one of the most successful of these groups (the Kaiser plan here in California) operates successfully and I believe renders good quality medical care because it can be highly selective in the clientele it serves. They serve essentially a younger, employed group of people. They almost certainly where possible exclude the elderly, the chronically ill, the poverty groups. If Kaiser were, through legislation, obliged not to be selective but to take in every one within a certain geographic radius, by tomorrow afternoon they would be broke. They would cling for a little while to financing to operate, but what would happen to Kaiser is essentially what has happened in British medicine where the norm is the three-minute office visit and where hernia repairs often take three or four years to get on a surgery schedule. The sheer overload in work that would impinge upon them would impoverish the plan.

And so I think while we are talking about health maintenance organizations at the present time, they are something of a quaint, interim phenomenon too. They are foredoomed to failure in the wave of overpromising to the American public that has been done for the last quarter century or so and they too shall pass away.

I think that I have rambled on long enough. I would like to tell you that the road ahead, based on the nice, clear legal opinions that we have

gotten and on the great wave of enthusiasm we have been able to muster in the medical profession, is going to be free of pitfalls and we are going to emerge in the brave new world of tomorrow's medicine triumphant.

There is much that has to be done, there are many fights in which we have to engage. And it is tough to tell a genteel and refined profession that it must peel off its coat, roll up its sleeves and fight. There is abuse, personal and professional opprobrium that have been heaped upon us. If we keep our eye on the ultimate goal, that we are not self-seeking but that we are perhaps the last defenders of a noble profession with the longest legacy of dedicated public service, through our unions we will indeed emerge triumphant, if not unscarred.

I thank you. [Loud and sustained applause.]

CHAIRMAN MEYER: I am sure that we all want to thank Dr. Marcus for his inspiring remarks.

Before we get to our question-and-answer period, which will include questions for Dr. Marcus and our other prior speakers, I have been asked to give the floor to Dr. John D. MacCarthy, who will present a brief paper.

Dr. MacCarthy!

REMARKS

John D. MacCarthy, M.D., Merced, California

DR. MacCARTHY: Thank you.

Dr. Marcus is a hard man to follow after such an inspiring discussion.

If you will turn to the information in the kit that you were handed, you will find a card which describes the Level III Medi-Cal payments to physicians for various geographic areas in the State of California.

You will notice on one side there are many counties and on the other side only a few counties and many districts in Los Angeles.

My discussion is going to be confined to fees for medicine. We consider these to be particularly important because they relate to the bulk of services by primary physicians. You will notice that payments vary: at the low end, there is a group of counties here receive payment at a unit rate of only \$5.12 as opposed to the highest rate in the State, which is in one of the Los Angeles districts, at \$7.68.

I am calling your attention to this table and I ask you to keep it handy if you want to make reference to it later.

You also received a statement labelled "Table IV," which refers to population statistics of the counties which receive the lowest Level III payments by Medi-Cal.

The material I am presenting has been submitted for publication. My associate, Dr. Feehan,* and I did a brief study to attempt to correlate some of the factors which contribute to the failure of rural areas to attract doctors -- and we feel that we have pinpointed one of them.

"In 1966 California established a statewide program for reimbursement of private physicians which was supposed to solve most of the problems of both the recipients and providers of medical services. California's program was called Medi-Cal and it developed almost simultaneously with Federal Medicaid.

"When the Medi-Cal program was begun, two options were discussed with the California Medical Association. These were a statewide fee schedule and an individual profile system. The California Medical Association recommended a profile system. Please note that Dr. Thomas Elmendorf, immediate past president of the CMA, has said that since the origin of the program the State has given little attention to CMA recommendations for updating.

*Dr. Edward B. Feehan

I might as an aside say that I think you will find a number of items in this paper which will suggest areas for collective bargaining by a physician's union.

"On May 20, 1970 Dr. Earl Brian, then the Director of the Department of Health Care Services (now Department of Health) wrote to the President of California Blue Shield to inform him of the Department's decisions as to how Medi-Cal payments would be made after July 1, 1970. The California Legislature did not seem to have a direct say in their payment policies, but rather they were based on administrative decisions. Some brief definitions from this letter are essential in order to understand the tables and discussions that follow."

I am sorry that I have to bring statistics and definitions from this never-never land of bureaucratic manipulation to a group of scientifically trained people. But it is important that you make an attempt to understand what we are talking about.

If you are not confused when I am finished, call your local bureaucrat. Perhaps he can confuse you further. And if all else fails, you can try the Director of the California Department of Health. The telephone number is (916) 445-1248.

"Level I [is] the usual fee for the service charged by the individual physician during the six-month period preceding January 1, 1969.

"Level II [is] the 60th percentile of the range of fees charged for the service by the physicians in the designated area during the six-month period preceding January 1, 1969.

"Level III (and this is the Level, a copy of which you have) is the 60th percentile of the range of fees charged by physicians in a designated area for the broad band of services during the first quarter of 1967.

"The fees that were considered in developing the value of these levels were those that were submitted to Blue Shield of California, the fiscal intermediary for Medi-Cal. Input included Medi-Cal, CHAMPUS and private standard Blue Shield billings, according to the Department of Health. Only a cost control bureaucrat could explain why two different base periods were used.

"Most of our discussion will concern Level III, which is also known as the area profile, because it is these Level III payments that are received by all physicians opening a practice since 1968, either solo or in a group formed after '68. It should be interesting to residents that board certification does not affect the level of payment an individual receives and thus it is possible and does happen that (as Dr. Marcus has said) in the same community a board-certified individual may receive a lesser rate of payment than his colleague who is not board-certified.

The Committee on Relative Value Studies (formerly the Committee on Fees) of the California Medical Association has been active in the field of relative value studies and the California Relative Value Studies are considered a progenitor of such studies elsewhere. The Fifth Edition of the California RVS was published in 1969 and a Sixth Edition is expected in 1974. The Third Edition of the 1964 study is the one used by California Blue Shield and the State in calculating Medi-Cal factors.

In the 1964 California RVS one medi-cal unit was equivalent to one surgical unit and also to one radiology unit and one anesthesia unit. It is essential to understand this concept when looking at the tables that we are presenting to you. One medical unit is equivalent to a brief office visit on an established patient. Three units would be a simple consultation from any kind of a specialist.

Now, the point that I want to stress is that if you take a figure for a single-office visit from the lowest-paid areas, it will be \$5.12 for a brief office visit, whereas in the highest it will be \$7.68. The difference is significant.

But these sums don't represent pure profit. If the current value of one medical unit, that is, a usual and customary service, is \$8.50 and it is subject to a 50% overhead cost (and I think everyone in private practice would agree that this is not unusual even in a group practice), then the overhead cost per visit is \$4.25. Thus, based on Medi-Cal payments, the net earnings for a brief medical office visit would be \$.87 in the area of the lowest factor and \$3.43 in the area of the highest factor. If a \$5.00 minimum overhead were used, of course you would only get \$.12 as opposed to \$3.40.

The differences in rate affect visits to complicated hospital cases as well as office-patient visits. If the difference in profit unit is multiplied by many visits a day, it is readily apparent that this would represent a sizeable difference in income for any physician or group.

The reason that the Level III figures are in such odd amounts is that in November 1972 there was a three per cent across-the-board increase. Which is the only adjustment that has ever been made.

In actual practice most California physicians are probably paid about \$1.00 per unit more than the Level III value because most California physicians were already in practice and therefore established Level I profiles in the last six months of 1968. However, physicians who first began billing after that time are paid at Level III. Also, all physicians are paid at this level for any service for which they submitted less than six billings on profile patients, that is, Medi-Cal, CHAMPUS and private Blue Shield, during the base period. Thus, it is possible for a surgeon to be paid less for performing a cholecystectomy with exploration of the common bile-duct than he would for performing a simple cholecystectomy. This would occur if he had not performed

the cholecystectomy with exploration of the common bile-duct during the base period.

If "Big Brother" isn't watching you, at least his computers are.

My reason for going over this material is that we believe that the effect of the area-profile situation is to accentuate the existing maldistribution of physicians in California. The population in Table IV tends to support this belief. It might be argued that the State had a unique opportunity to improve physician maldistribution at the beginning of the Medi-Cal program by making payments to providers in low-physician-population areas equal to or higher than those in physician-surplus areas. Instead, it appears that the State's policies have resulted in a worsening of the physician distribution problem as shown in a comparison of the physician to population ratios for 1969 and 1971 for the areas having the lowest medical factor. We have chosen to present the figures for the eight counties having a medicine factor (which is the one most commonly used for primary care) of 5.12, which is the lowest in the State. All but one of these counties have fewer than 50 physicians. And thus it is Merced and the counties that constitute Area II which appear in Table IV. The supply of physicians is expressed as a ratio of physicians to 100,000 population.

We regret that demographic information for years subsequent to 1971 is not yet available. Our impression is that the longest time span would present even a greater adverse effect. Only two of the counties show an improvement in the physician to population ratio. The Glenn County Chamber of Commerce explained to me that the apparent increase in the ratio was due to an actual fall in the population due to increased job opportunities and to an error in the census.

Contrast this general decline in the areas having the lowest medicine factor with the record in the San Francisco-Oakland Metropolitan Area. In the eight-year period ending in 1972 this area had an increase in its physician to population ratio of 18.9%. The general trend on a statewide basis was for the physician to population ratio to increase. It should be mentioned at the same time that there is also a trend for patient usage to increase even if the ratios do not change.

It is also the impression of the authors, who practice in the largest of the areas with the lowest medicine factor, that the average age of the physicians who have remained in these areas has increased during this period of time. Further, we believe that if the figures were available, the ratio of primary physicians to population would be even more seriously affected than the figures in Table IV already indicate for physicians as a whole.

One of the authors' hypotheses is that physicians are only slightly less responsive to economic incentives and disincentives than are other

segments of the population. We contend that a drastic payment revision by third-party agencies such as Medi-Cal could to some extent overcome the other disadvantages which have caused physicians to congregate in metropolitan areas.

The Department of Health has admitted that there are inadequacies in the present payment system for Medi-Cal. Public hearings have been held and the Department is conducting a study and preparing recommendations for modification of the payment system. The authors hope that the Department of Health will take the potential effect of their recommendations upon the physician maldistribution problem into consideration when formulating recommendations for changes. The authors further hope that this paper might be useful in other states so that the mistakes made in California, often referred to as a bellweather state and also as an area of interesting sociological experiment often, might not be repeated elsewhere.

Finally, I would like to thank the Union of American Physicians for two things:

1. It is the only organized group of physicians that has jumped in to help us with our own personal problem in Merced; and

2. It has offered us our first forum to expose the dangers of bureaucratic inflexibility to the patients of a disadvantaged area.

Thank you. [Loud applause.]

CHAIRMAN MEYER: Thank you, Dr. MacCarthy.

And now the Chair will entertain questions, provocations and discussion from the participants in the Seminar. I shall be happy to moderate, referee, explain, elucidate.

QUESTION AND ANSWER PERIOD

DR. ANTHONY J. DiCROCE (Point Pleasant Beach, New Jersey):

I want to ask a question about the payment of union dues from professional corporations.

Is that legal -- or does it have to be paid separately as an individual?

CHAIRMAN MEYER: Mr. Kintz is no longer here. I think he alluded to that, but he is not here.

DR. MARCUS: We have some interpretation on it. We have been advised by our legal counsel (we have the document which we can send to you) that it is not proper for the professional corporation to pay the dues of its members; the employee physician must pay his union dues out of his salary.

DR. HAL D. McCONNAUGHEY (Visalia, California):

The dues to the union are tax deductible, are they not?

DR. MARCUS: Yes.

CHAIRMAN MEYER: Correct.

UNIDENTIFIED REGISTRANT: Does the Union agree with the AMA position of not raising fees when price controls expire next Wednesday?

DR. STANLEY S. PETERSON (President, American Federation of Physicians and Dentists): For several months now we have been talking at some length about the fact that it was not equitable that all of the rest of the economy should be going up and doctors should be restrained from keeping pace with the economy. So the position of the Union is not to hold the line. It is not to hold the line.

Now, I shall also tell you as my friend that you must look at what you are doing and be able to justify what you do. Because we are going to catch hell anyway. So you must be able to justify what you do. But we cannot in good conscience on one side decry the fact that we are being held down unjustly and then the day after controls expire say: "Don't raise fees."

We have got enough already."

But do it right, gentlemen. Do it right. Also don't do it before you hear the official notice that controls are off. They aren't off yet. [Applause.]

CHAIRMAN MEYER: I could point out that I think Dr. Peterson is saying that we are going to be damned if we don't and we are going to be damned if we do.

I suspect, as Dr. Marcus has indicated above, that when PSRO fails (and Dr. Marcus's opinion is that it will, and I think that that is shared by many), we will be blamed for not having let it work even though there was a failure factor built into it. If the cost of medical care, and physician and dentist fees in particular, rises, that will be the excuse to hasten the National Health Insurance to roll back the fees that we charge and perhaps to get us into a different system.

MR. JACK LIGHT (California Medical Association Staff, San Francisco California): Is there any antipathy against or affinity between the union and the foundations for medical care?

CHAIRMAN MEYER: Dr. Peterson.

DR. PETERSON: Depending on what your foundation is doing. If your foundation is active (we will get the easy one out of the way first) and if they are an insurance broker pure and simple, then probably your union may be representing you in conversations with them about your fee. If your foundation is a review organization which is working for the insurance companies, reviewing your charts and giving them the benefits of your indiscretions, then they are hardly on your side and your union may have a little bit of discussion in that area. If your foundation is working for you and you are both going the same direction, then there is no problem there.

There is no direct yes or no answer to your question, but I think that those examples will probably put it in the proper area. Again this is one of those situations where we ought not to be fighting among ourselves. We need all the help that we can get. We ought to stay friends within our own organization.

CHAIRMAN MEYER: Dr. Marcus wanted to comment on this also.

DR. MARCUS: I believe that the greatest single impetus to the development of foundations is exactly the same as that which has impelled unions: namely, that in unity there is some sort of strength to be gathered. I think that the problem is that foundations tend to become involved in the insurance business, which, as I indicated to you, by its very nature is committed to pay out the least in benefits and collect the maximum in premiums; and therefore they are attempting to work both sides of the street

to the detriment of both.

I would feel that at this particular time the unions would be well advised not to attack the foundations for the very reason that Dr. Peterson pointed out: that we don't need enemies inside the profession. I think that the foundations have by their track record proven that they too are a passing phenomenon and that they too shall pass away.

In the San Joaquin Valley, the prototype foundation (and that is the one that has been pointed to as being the model throughout the country), the San Joaquin Medical Foundation, in its dealings with the State just came up with a \$500,000 short payment from the State. The net effect of this will be that the members of that foundation who rendered medical care in good faith will have ended up working two free months within the last fiscal year for that foundation.

I know of no labor organization that would permit its members to work without compensation. I think that the foundations represent an extension of the traditional posture of the doctor: that he wants more than anything in the world to prove what a nice guy he is in working to keep costs down; and that this "nice-guy" image is forcing him into positions of compliance that no honest workingman would brook for one second.

Again, if the prototype foundation is in trouble; if this year they lopped off two-months' payment for their members and two years ago the members were obliged to rebate ten percent of all that they had received from the foundation within a one-year period in order to keep the foundation afloat, this is not performing the function of a union.

I think that we shall let the foundation alone. We shall let them flounder. We shall let their loss experience tell the members where they can best be represented.

CHAIRMAN MEYER: I would like to interpose some thoughts here. You can't always treat a patient democratically. When you have two physicians giving different opinions about a case, that's one thing. And just because three physicians decide not to operate and the fourth one says "Operate", you don't necessarily go by majority opinion in the democratic sense. But among attorneys I think that it is even worse. Attorneys, as you know, are committed to advocate and to present cases for things in which they may not even believe. They are required as officers of the court to defend the innocence of someone who might have been standing with a knife in someone's back. This is the way our system is set up.

I am alluding to this because after Mr. Kintz's discussion today, I overheard some of the attorneys in this audience disputing some of the things that were said by Mr. Kintz. And I am just wondering if there are any of these distinguished gentlemen who would very briefly like to comment

on some of the statements that were made earlier today.

MURRAY A. GORDON, Esquire (Counsel, Committee of Interns and Residents of New York City): I would like to comment.

CHAIRMAN MEYER: Murray Gordon is counsel for the Committee of Interns and Residents of New York City, which is a component of the American Federation of Physicians and Dentists.

MR. GORDON: The image of a contentious lawyer defending his client who was caught with a dripping knife is not what prompted me to come up here, nor is it necessarily any profound disagreement with Mr. Kintz. I want to give this group the benefit of my own research and experience in areas which were discussed by Mr. Kintz. And I don't particularly want to put it in the context of agreeing or disagreeing. I shall tell you what my own experience has been.

First, the context of any discussion on the subject has to be whether one is entitled to have mandated collective bargaining. An employee who comes within the jurisdiction of a labor-relations act can compel his employer to sit across the table and negotiate with him on matters of concern and within the scope of the employment relationship. And obviously, if physicians as well as anyone else could compel, could mandate, bargaining, it is leverage of considerable importance, although it is not indispensable. Because I think if one listened to what Dr. Marcus has to say here and the kind of negotiating posture and service which has been rendered to physicians whether they are or are not employees, it is clear that there is a function to be performed by a union of physicians even if you don't reach the exalted status of an employee.

Second, I must say that in my judgment house staff officers are employees. And that extends to all hospital-based physicians who are on salary basis -- interns, residents, fellows, salaried physicians. And tomorrow it will be the medical students who are the externs.

This has been so for purposes of voting residence, workmen's compensation, Internal Revenue, and in every jurisdiction which has considered the question for labor-relations purposes as well.

This is a function not only of the law in the State of New York where in two adversary proceedings interns and residents were deemed to be employees within the scope of the State Labor Relations Act; and in Pennsylvania and in Michigan as well there have been clear determinations to that effect.

That is not to denigrate the didactic component of a training program. It is there, it is acknowledged in these cases. But it is to say that there is a recognition of a heavy service component; and in that aspect

of a training program one is an employee. And that is sufficient to render him an employee for all purposes under the Labor Relations Act, including prohibition against strikes on the part of the public employees.

Thirdly, it is my judgment, too, that a house staff officer is not and will not be deemed to be a supervisor for purposes of the supervisory exclusion under the National Labor Relations Act or any other state act which prohibits mandatory collective bargaining in the instance of supervisors.

And let me make this clear: In the medical profession there is a collegial relationship. Which means that someone is always watching someone else in how he performs his job. That is supervision to an extent. The first-year resident supervises the intern. The second-year resident, if he is around, supervises the first-year resident. And the fellow, if he is around, or the attending is likewise supervising. But that supervision when it is in the performance of the professional mission rather than in the interest of management is not deemed the kind of supervision which is excluded from coverage under a labor-relations act. And in that regard I should report to you that the passage of an amendment to the National Labor Relations Act in the current session of the Congress so as to extend the National Labor Relations Act to salaried employees of charitable institutions such as voluntary hospitals is imminent. I have been working with the offices of those senators concerned with that legislation and there is currently issued by the Senate Labor Committee a report which is a negotiating report, at least on this subject, specifying that the understanding of the Senate is that the supervisory exclusion does not apply to salaried physicians at hospitals when they are supervising in the performance of a professional mission. This is based upon a whole series of decisions by the National Labor Relations Board involving nurses in proprietary hospitals, which have been within the jurisdiction of the National Labor Relations Board for several years now. And that is precisely the distinction which has been made in the cases.

Fourthly, in my judgment too (here I agree with Mr. Kintz) I think it is quite clear that the private practitioner today cannot be deemed an employer for purposes of labor-relations coverage. That doesn't render you wholly ineffective or ineffectual (I am now harkening back to what I said at the beginning), but that particular modality is not available to you. And here on somewhat more tentative ground, I think that I would say that it is somewhat unlikely that adoption of the PSRO structure is going to change that for legal purposes. There are many businesses in the American economy that are very closely regulated. They have to maintain records of prices and sales and have all manner of regulation under which they may have to live as much as you surely do -- and that has not converted them into employees. And as a matter of fact, if you do become an employee by reason of PSRO or any subsequent extension of it, you will be at best a

federal employee, who has some very limited collective-bargaining rights. Very limited.

So that I do not see that this is an important direction for you to be pursuing. It is appropriate in some circumstances. And there is a substantial number of employees in this Union, and on their behalf you can function in the most conventional way.

And finally I would say that for purposes of the antitrust laws and the activities in which the union is engaged in fighting for fair fees and fighting for fair treatment in connection with fees, the antitrust laws contemplated a relatively unhampered market in fixing the price and rates and the like. By a hypothesis here, the defense provided by this Union is in a regulated market. The stimulation for your efforts is the circumstance that there are rates being fixed now and you want some input in influencing how those fees and rates are being fixed. It is as if an industry came before the Cost of Living Council and presented its case for a fair price increase. No one has suggested that to be a violation of the antitrust laws. Where all you are seeking to do is fairly influence that agency of government which assumes the right to fix rates or fees, I would think it to be very tenuous to suggest that that constitutes a violation of the antitrust laws.

Thank you. [Applause.]

CHAIRMAN MEYER: Dr. Marcus wanted to make a comment before we go back to the floor.

DR. MARCUS: To show you how thoroughly confused is this entire area, our own local Union has been involved in a case, which we paradoxically find ourselves on the side of the Internal Revenue Service, which has defined a hospital-based physician in California who thought he was an independent contractor with the hospital as an employee. The IRS is asking for back taxes that should have been withheld, and is asking for FICA (Social Security payments). They have stimulated the State of California to go after back taxes too, and they are attacking this physician who has set up a Keogh Plan believing himself to be an independent contractor, an entrepreneur, stating that his Keogh Plan is invalid because in fact he is an employee. Now, as Mr. Kintz pointed out to you, you can properly see how a very substantial number of hospital-based physicians (radiologists, anesthesiologists, pathologists, emergency-room physicians and all the rest) can very well find themselves in difficult circumstances if this definition holds. We of course are taking the position that it does. If it does hold, we as a Union have already indicated to the county hospital concerned that if this doctor is indeed an employee, we want the whole package of employee benefits that were available to all the rest of the employees to be paid to him in terms of overtime services, health insurance, and the like.

Now, we may compromise on the issue of just getting the county hospital simply to pay the back taxes and let it go at that in a gesture of great generosity. But if you wonder, What can a physicians' union do? this is one small area.

DR. JOHN RANDALL (Fremont, California): Does the Union have any representation on the relative value committee?

DR. MARCUS: We have not sought it. We don't know whether any of the committees contain members of the union.

MR. JEFFREY A. BERMAN (Los Angeles, California): My name is Jeffrey Berman and I am a hospital employer labor lawyer, of the firm that represents the Hospital Council of Southern California.

I agree generally with the comments made by Mr. Gordon. However, there is one point that Dr. Gordon did not address himself to.

When you are dealing with nonhospital-based physicians in concerted activity of boycotts of hospitals, refusal to admit patients and refusal to sign medical forms, you might be in serious danger of the antitrust laws.

CHAIRMAN MEYER: We appreciate your warning us. We thank you.

I didn't mean that facetiously. Dr. Marcus has indicated and we have agreed that there will be cases and there are sometimes controversies that will have to be taken up as they come. And we appreciate legal comment.

We have been in this business in New York since 1961 and we have had legal advice that this could be done and that could be done. Well, sometimes it works and sometimes it doesn't.

I must point out, by the way, that the American Federation of Physicians and Dentists is what it says it is at this point. It is a Federation. There are state chapters and there are local chapters that have been there prior to the existence of the AFPD; and we find that many of the actions that are taken are taken by our local group with advice from the national. And we have within our own group a number of attorneys, and behind the scenes we are not always in agreement. But I think that what has to be understood is that in the whole history of law and in the whole history of this country there are many times that what has become law now and accepted was not law before or was thought to be illegal. The Supreme Court has come all the way around on several different issues. Sometimes it is going to be a matter of confrontation and what the times are and what you can and cannot do. I think it has to be based on what happens locally, what local laws are, what the sentiment of the local population is.

DR. BRENNAN (Stockton, California): I have the dubious distinction

of belonging to the medical foundation alluded to by Dr. Marcus. The current hierarchy of the San Joaquin Foundation is actively engaged in establishing a PSRO, which I understand is one of five actively being established out of 22 in the State of California.

The other thing they plan to do is to discontinue peer review for the foundation program and to use the PSRO to do their review.

I just bring this out as a point of information.

My question is directed to Dr. Marcus. He has explained the UAP posture on the PSRO.

What I want to know specifically is: What can we union members and sympathizers do about the establishment of this current PSRO in Stockton?

CHAIRMAN MEYER: Do you want to answer that at this time, Dr. Marcus?

DR. MARCUS: I think that I would rather answer that in the discussion group tomorrow when we have time to discuss it.

DR. ALBERT E. YELLIN (Los Angeles, California): My question is going to be along the same lines.

Dr. Marcus, if you are saying that you don't want to associate with PSRO's, Dr. Schwartz has indicated that certainly cost accountability is going to be necessary. We need some alternative plan.

DR. MARCUS: I think it is fatuous of any physician or physicians' group to believe that we can escape from accountability when the funds do flow through government channels. Accountability is burdensome, but it is here and it will increasingly be a part of our existence.

What I attempted to do in my remarks and what I hope will be done through law is to separate the notion of a review of professional standards from the idea of simple cost containment.

I think that dealing with these organizations would be infinitely simpler if they were set up as cost-control review organizations and left aside the idea of a review of professional standards, with its implied notion that serious enough abuses in the past now warrant the setting up of this police mechanism over us.

Once that semantic objection is taken care of, yes, we can sit down and bargain with these groups. We can say that under no circumstances can we go beyond a certain point in limiting or constraining certain norms of medical care because to do so would be to run in the face of the principles

by which medicine by its very nature functions. We are being asked essentially to be Solomon-like-wise in an area where computerized norms, holes in a punch card, will increasingly become our masters.

The first thing that must be done is to say: "Doctors, we have got to cut down on costs" -- and then we discuss it. And as long as the adversary position remains; as long as the bargaining posture can be set up in that way, fine and dandy.

I do happen to believe that we keep too many people in hospitals for too long, and I have said as much at staff meetings and elsewhere. And I think that once we get out of the rarified financial atmosphere of hospitals, we will do much to alleviate a lot of this pyramiding health care, health-cost crisis.

But actually right now, within the framework of the PSRO mechanism, I don't think that there is anything that can be done.

Back to the preceding question: What can we do once the thing is set up? We can attempt to obstruct it at every turn. We can make every possible pitch for the maintenance of confidentiality of our records. We can refuse to fill out forms. We can do all the rest. Which may in essence cut down on our own individual incomes, but this is what any striker risks whenever he makes a strong economic pitch for what he believes in.

I think if we can obstruct the system to show at the outset that it cannot work in the form in which it has been contrived, certainly a more realistic idea can be developed.

I must tell you here that when Dr. Schwartz and I attended the Leadership Conference of the AMA a year ago in February, I suppose Senator Bentsen, the junior Senator from Texas, who was the guest speaker at that meeting, made a Freudian slip. He thanked the American Medical Association for its support in the drafting of the PSRO legislation.

I hope indeed it was a mistake, as they claimed it was. But I don't believe that sufficient thought was given to the pejorative notion that doctors selectively as a profession, especially in these Watergate days, needed a review of their professional standards when the bill was drafted. [Applause.]

CHAIRMAN MEYER: Unless we are prepared to use our muscle against other labor people, we are being forced out of this room at this time. We will recess until our evening session. Thank you.

EVENING SESSION

DR. MEYER: Welcome to the evening session of this seminar. I should mention that after this seminar, which is officially sponsored by the University of California, you will receive a certificate of completion which will be sent to you at a future date.

It is hoped that we will be having another conference in October in New York City in conjunction with the Cornell University School of Industrial Labor Relations. And I would hope that those of you who are interested would plan to attend.

Now, I would like to get on with the formal part of the Program. I next have a task which I find most pleasurable, and that is to introduce Stanley S. Peterson, M.D. He is a very interesting person.

Dr. Peterson makes his living practicing internal medicine. He is the senior partner in a 43-man group in Springfield, Missouri. He has been president of his own county medical society. He has been the Speaker of the House of Delegates of the Missouri State Medical Association. He is at this time a delegate to the Missouri State Medical Association from his home county. He has been a delegate to the American Medical Association for five terms. Just recently--three weeks ago, as a matter of fact--an election was held again. There was some talk of "Should a man who is active in the union movement be a delegate to the House of Delegates of the AMA?" Dr. Peterson was re-elected. There was no opposition. He is the Chairman of the Commission on Governmental Relations and Third Party Mayors of the Missouri State Medical Association. He has been involved in various state advisory groups with regard to welfare, hospitals and nursing homes and multiple civic groups.

With all these responsibilities and achievements, Dr. Peterson has undertaken physician-union responsibilities that have taken him all over this country. If he were to give you a copy of his schedule, you would see that he has covered just about the entire country, criss-crossing back and forth, one-night stands all over, preaching doctors unions.

I would now like to formally introduce the President of the American Federation of Physicians and Dentists, Dr. Stanley S. Peterson.

[Applause.]

CHAIRMAN PETERSON: Thank you, Mr. Chairman. It is pleasant to be here. We don't quite answer the stereotype of a union organizer these days. And I think that is rightly so. One of the reasons I like to get those credentials in there is that everybody likes to say that doctors really aren't interested in unions. "It's just a few of those kooks over on the corner that are interested in unions."

Well, we now have credentials. We don't have to be unusual people any more. We now have credentials, and these credentials are getting better all the time. We don't have to apologize for union activity. We never have, but people have for us. So I think that it is important that we look at this.

In a few minutes we are going to hear the main speaker of the evening. Tonight our speaker says that he will be glad to field any questions that you would like to hand to him after he gets done speaking. He has the dubious honor of having caught a good amount of hell, either directly or indirectly, before he even made his speech. So just remember that he is all signed up and ready for you. We spoiled his appetite tonight. He couldn't eat very much. But that is all right. That is the price you pay for the honor of coming to talk to us!

Our speaker is an internist. He has practiced internal medicine for some 16 years in Colorado and around and about. He has a list of credentials, which I am not going to read. This is the back sheet. It's half full.

This is the middle sheet. It's full.

This is the front sheet. It's full. Plus all the notations we have added to it.

Let us just say that he really does have a pedigree which entitles him to speak from the position of a physician as well as from the position of a bureaucrat. I have known him kind of casually off and on for several years, but my first real contact with him more than "How are you?" "Fine." was at the time he was the Director of the Office of Professional Standards Review, Office of the Assistant Secretary for Health in the Department of Health, Education and Welfare. We had a long conversation. He is a regular bureaucrat, with one exception. He said: "I'm ready and willing to see that PSRO goes in." At that time I didn't realize, or I wasn't listening very well and I didn't hear that next word called "able." He didn't say he was able. I don't know whether he was or not. But shortly after that he moved out of the office.

I hope that it was because of the committee that met with you and pointed out the error of your ways that you moved out of that office! That would be one positive effect that we had in this situation, anyway! So he moved out. He moved out in October of '73. He stayed on as a special assistant and finished up a year's service for the federal government by March of '74, and then in April of 1974 he really had seen the error of his ways and moved right on out into a situation where he is now a private consultant for PSRO. That means if you all want him to come down and set one up for you, he will do it for a fee.

Now, in addition to that, he is a clinical assistant professor in the Department of Medicine at Georgetown University.

He is going to now tell us why PSRO, how PSRO and what is going to happen with PSRO.

I give you at this time William I. Bauer, M.D.

THE PROFESSIONAL STANDARDS REVIEW ORGANIZATION - PSRO, WHAT IT MEANS

William I. Bauer, M.D.

DR. BAUER: Thank you, Dr. Peterson. We did meet, and it was for about two hours. We discussed PSRO; we discussed HMO and we discussed a lot of the other things that have been talked about here today.

Today has been a very interesting day for me. I have learned a lot. And I think it has been particularly interesting because of the contrast between this particular meeting and the meeting that I attended in the early part of this month in Washington which was called by the American Association of Foundations for Medical Care. At that meeting they had a very large registration. I believe it was upwards of 500. And at this meeting there was no mention about repeal of the legislation, there was no mention about dissatisfaction with the legislation. This was a meeting of foundation people who had come to Washington under the direction of HEW to see how the PSRO program should be implemented.

I have here for those of you who may be interested the first seven chapters of the PSRO manual. The manual to establish the various types of PSRO's was published about the 25th of March. This is a document that is going to help the PSRO's in their development. This is a 17-chapter manual. The first seven chapters, as I mentioned, are here. The last ten chapters are either not available or not completed in their final form.

Some very interesting chapters have yet to be developed. "The Financial Management of a PSRO Program," "PSRO Data Needs," "Disclosure of Information," "Statewide Professional Standards Review Councils." All of these and a number of others have not been put out in final form.

I did want to comment a little bit on some of the things which inspired me about some of the previous speakers.

First, to Dr. Marcus. I didn't write the legislation. As you know, it was written by Senator Bennett and Jay Constantine and Jim Mangan. They are supposed to have been the gentlemen who were responsible for the legislation. And I have heard Senator Bennett on a number of occasions state that the basis of this legislation was the legislation proposed by the AMA with some modifications. The modifications, as he discusses them, were primarily over whether these should be state-controlled organizations or whether they should have local involvement.

I also see the foundation movement as probably the greatest single implementing force at the present time to get this legislation implemented and to get it functioning. Dr. Schwartz brought up an interesting concept--an HMO made up of Christian Scientists. I thought this was a fascinating concept. This legislation mentions this. Section 1170 of 249(f) specifically states that the PSRO shall not apply to Christian Science sanatoria. It is always a good section to get to in the legislation because it is the last section and you know, when you arrive there, you are through reading!

Dr. Peterson and I have talked the last couple of days about the many different ways we might approach the subject tonight. And, as he has mentioned, I think I will talk a little bit about the background, some of the things that have happened in the past year, the present status, and then some of the future predictions. And then I will be glad to answer any kinds of questions.

Certainly PSRO has been mentioned today. Almost every speaker, I think, kind of towards the end of their talk seemed to build up to something about the PSRO legislation. And certainly I think this legislation has the potential, as Dr. Schwartz mentioned, of having a tremendous impact, perhaps more than any other legislation that has yet been passed, on the practice of medicine. And certainly we are going through a time when the whole health care system, and particularly the physicians, in this country have been under a tremendous amount of pressure for change. I see this coming from all sides. It has certainly been mentioned with national health insurance. I think we can realize, perhaps in just a small way, some of the potential changes that may be taking place. The public is very concerned about the constantly increasing cost in all areas of health care. And I think the medical profession has been designated for special consideration.

Dr. Peterson pointed this out in a news release on February 8th, in which he discussed the government's wage-price action. And it has certainly been mentioned several times in various ways today. People are certainly concerned with the access to medical care.

Dr. Schwartz mentioned his experience in an emergency room. And if you really want to know the whole story, get him to tell all the chain of events that occurred that evening. It's very fascinating.

There is concern about the quality of medical care, about the distribution of care, about the necessity and the appropriateness of care once it has been delivered. And this concern has no doubt led to the development of many legislative programs.

We have talked today about the health maintenance organization, about the various health planning authorities. There have been programs for control of drugs, for medical devices, for various quality assurance programs. Another program which has this evening, or today anyway, received only slight mention--I think it was by Dr. Schwartz--has to do with end-stage renal disease. The final regulations in the end-stage renal disease program have just been announced.

This end-stage renal disease program sets up a network for the treatment of renal disease. This will include a transplant center; this will include secondary facilities and the primary care areas. This will be a network that has on the outside various places that renal dialysis can be performed, then secondary centers and then, finally, these will be attached to a facility that can do renal transplants. This is the regulation of

care through a network approach with limiting the number of facilities by a specific diagnosis, end-stage renal disease.

In New York City there are, I believe, 18 institutions now doing kidney transplants. The criteria specify that to be eligible the center that is going to do a kidney transplant should have done a certain number. I haven't followed it recently, but the number was approaching the range of 15 to 25. And eligibility is also on a population basis so that a 2,000,000 population can support a transplant center, 500,000 can support a renal dialysis center, and so forth. This means that in some areas, like in New York City, they may restrict the number of institutions being allowed to do renal transplants to 5 or 6. They don't restrict them in that they can't do transplants. It is just that the entire funding of the renal transplant program will be from the federal government and they will have to be certified as being qualified to participate in this kind of care.

There certainly have been various other quality assurance programs which have developed around the country. Some of these were mentioned this morning and certainly are not limited to the federal government. We have had TAP programs and QAP and CHAP and CAP and many others that have been rapidly progressing without this phase of PSRO and government intervention. And then along in the fall of 1972, relatively unknown--and certainly the significance of this was not realized--Section 249(f) of the Social Security Amendment was passed. The PSRO legislation.

I think it is worth a moment to talk about why the legislation was passed if we are going to understand what is anticipated out of this legislation. I want to read you a few sections out of the report of the Senate Finance Committee.

"According to recent estimates, the costs of Medicare hospital insurance programs will overrun estimates made in 1967 by some \$240 billion over a 25-year period. Medicaid costs are also rising at precipitous rates. The rapidly increasing costs of these programs are attributable to two factors. One of these is an increase in the unit cost of services such as physicians visits, surgical procedures and hospitalization. The second factor which is responsible for the increase in costs of the Medicare and Medicaid programs is an increase in the number of services provided to beneficiaries. Aside from the economic impact, the Committee is most concerned about the effect of overutilization of health care on the aged and the poor. Unnecessary hospitalization, unnecessary surgery are not consistent with proper health care.

Witnesses testified that a significant portion of health services provided under Medicare and Medicaid are probably not medically necessary."

This comes from the first two paragraphs of the Senate report. The Committee concluded that the present system of assuring proper utilization of institutional and physicians services is basically inadequate:

"In the light of the shortcomings outlined above, the Committee believes that the critically important utilization review process must be restructured and made more effective through substantially increased professional participation. The Committee agrees with the principle of peer review enunciated in the report of the President's Health Manpower Commission issued in November of 1967 that states that peer review should be performed at the local level with professional societies acting as sponsors and supervisors. Assurance must be provided that the evaluation groups perform their tasks in an impartial and effective manner and emphasis should be placed on assuring high quality of performance and on discovering and preventing unsatisfactory performance.

"The Committee has therefore included an amendment which authorizes the establishment of independent professional standards review organizations by means of which participating physicians would assume responsibility for establishing standards of care and for reviewing the appropriateness and the quality of services provided under Medicare and Medicaid."

So PSRO came into being.

When I first considered taking the position as Director of PSRO a little over a year ago, this was certainly a virtually unknown subject, and particularly so among practicing physicians. Few had ever heard of PSRO.

In June of 1973 Dr. Schwartz and I were on a program in New York City. I spoke first, and he followed with an excellent talk concerning, "Is there a Place for Compassion in PSRO?" And he took, as he did this time, an article in the morning paper. It had to do with a mother who had been ill and went to the hospital. This left her child at home with no one to care for her. So the child was admitted to a hospital for custodial care until the mother was well. There was no question that the child needed the care, but Dr. Schwartz raised the point: "Would this care have been given under PSRO? And, if it wouldn't, would the child simply be left without care?" Thus: "Was there a place for compassion in PSRO?"

To answer the question: Yes. There can certainly be socioeconomic indications for hospital admission or for extending lengths of stay in a hospital.

At that time, however, I did ask: Was this the place for custodial care? Shouldn't society develop some less expensive way of providing this type of care?

Well, a lot has happened since June of 1973. First, the PSRO areas were designated. The problem during the summer had to do primarily with the single state versus the multiple area designation problems. At that time the AMA was very active in working for the single state in contrast to the multiple state areas. But I do not remember at that time that there

was any particular movement about whether or not PSRO should be implemented. It had to do more with the method of implementation. However, I was at Anaheim along with many of you and saw the feelings that were presented, the movement to ask for repeal. I heard Dr. Peterson speak at that time and saw the tremendous concern that was expressed by the physicians as the implications of PSRO became known.

In the Federal Register of December 20th the proposed PSRO areas were announced. In that announcement 182 areas were listed. There was a six-week period for comment. After the comments came in, the final areas were designated at a press conference on March 15th, and the number of areas had been increased from 182 to 203. There were two states, Washington and Georgia, who combined areas into a single state PSRO. Some of the areas in other states were increased, California, went from 25 to 28, Michigan from eight to ten, Maryland from five to seven. So that the final area designations were made at that time.

Of course, the next step then is the development of a PSRO. And that is what is being done now.

It has been recognized that in the development of a fully functioning PSRO there would be at least two steps, and these are mentioned in the legislation. There is the conditional PSRO, which will operate as a conditional for up to two years, and then a final operational PSRO. It is also recognized that there must be a stage prior to the conditional, and this has been designated as a planning-stage PSRO. (Planning PSRO's are not mentioned in the legislation.) So we have planning, conditional and operational PSRO's. Operational PSRO's are nonexistent at this time, and really we have no guidelines to go by to see how they will specifically develop. But on the 25th of March contracts became available to apply for funds for planning and conditional PSRO's.

I want to talk a little bit about government funding. Government funding is in three areas. There are grants, contracts and agreements. Grants are the usual funding mechanism for universities.

PSRO's are funded under contracts. These contracts have very specific mechanisms. A contract with the government is to do a specific task in a specific period of time. And the tasks that you are to do are outlined very specifically in the requests for proposals. This is not like the grants, say, for cancer research or something like that.

At the end of the contract period you produce a product. The contracts are on a cost-reimbursable basis. You bill the government for your specific costs within your budget, and then they will pay these costs. So PSRO's are under a cost-reimbursable contract.

The planning contracts provide funds to organizations to design a formal plan for assuming the duties and functions of a conditional PSRO. The contract plan is to include how they would be organized, how they would

obtain members, what medical organizations they represent, how they will carry out peer review and how they conform to these guidelines that I have shown you here.

Chapter 7, which is about 35 or 40 pages, outlines the type of review that will be done.

The requirements for an organization to obtain planning contracts are minimal. We talked about some of these earlier this morning when we were talking about Los Angeles. They have to be professional physician organizations whose membership is open to all doctors of medicine and osteopathy licensed to practice in the area. They have to be incorporated as nonprofit organizations--not at the time that they apply, but at the time they obtain the funds. So that an organization can apply at this time, but it has to write into its contract that it will be organized as a nonprofit corporation before the award on June 30th. Such organizations have to have membership that represents the physicians in the area and they must, as I mentioned this morning, have the potential to obtain twenty-five percent of the physicians in the area. And it is very possible, like may occur in Los Angeles, that more than one organization in an area may apply for a planning contract.

So this is fairly simple and straightforward, except that the contracts are set up to do a specific task.

The estimate at this time is that between 50 and 75 planning contracts will be received.

A second level of funding is for the conditional PSRO. These contracts require a considerable degree of sophistication and experience in the field of peer review. They have to have peer review functions. They have to describe admission certification, continuing state review, medical care evaluation studies, the method that they will be using in their review process. They have to have a detailed plan of how they would assume this responsibility, the individuals who are going to be involved, a detailed protocol of the mechanism and a timetable of how they will phase in the hospitals in their area.

In this country at this time I would estimate that there are not over ten or possibly 12 functioning organizations that are qualified for conditional PSRO status.

So we have planning and conditional PSRO's. During the year there was a new development. This had been suggested for some time, but official notification first came on the 20th of December 1973 in the Federal Register. And this is the PSRO support center. The purpose of a support center is to stimulate and support the development of an operational PSRO. Support centers could provide professional and administrative technical support to assist the PSRO in carrying out its organizational and review responsibilities. Support centers are to encourage physicians and local PSRO's to organize and apply for designation as planning or conditional PSRO's. They

are to help the local PSRO provide information to the physicians to help them meet the organizational requirements. The support centers also have a role in assisting the conditional as well as the operational PSRO's. They can develop review procedures, develop criteria, assist in the analysis and use of the data and provide common professional and technical services. Support centers may also enter into contracts with state councils to assist them in their functions, the dissemination of information and the coordination of data.

Remember that support centers are not mentioned in the legislation. The support center concept has gradually emerged as the need for technical assistance has become evident. Many of these support center functions previously have been carried by the state medical societies, but now the development of support centers is being encouraged in states in which there are five or more PSRO's. The support center function looks very much like the organization which the larger state medical societies were talking about when there was controversy over single versus multiple areas.

There are 14 states that have five or more PSRO's. It is possible for a state to have more than one support center. A state like California might want a support center in the northern part and in the southern part. New York, with a large number of PSRO's, also might want more than one support center. In the midwest a support center might develop from a single state, such as Colorado or Utah, in which they support the other single state PSRO's in the area.

The response to support centers has been mixed. Pennsylvania has already received a contract for \$246,000 for a support center. There are a number of other states that I know of that will be coming in for support centers. Ohio very likely will come in. New Jersey will request a support center, Virginia may, Maryland probably will.

And then, if we go to the other extreme, I would think that Texas and Florida, who have a suit against HEW on the area designation, would probably not apply for a support center.

But I see this as a very interesting problem, and I would like you to put yourself in the position of HEW. Would you fund an organization whose primary function is to educate physicians and to develop PSRO's? And the language is very interesting. At one time it just said: "an educational program." But when it finally came out in the RFP it came out as "an affirmative educational program." So that if an organization was on record as being totally opposed to the PSRO concept, to the program, they had voted for repeal, if such an organization applied to HEW to become a support center--they wanted the money, they met the organizational requirements for a support center--would you fund such an organization?

I think we will know that answer probably towards the end of June. I think it's possible that some of the states like Illinois and Indiana may

well come in for a support center. The same is true with some of the planning contracts. There are certainly organizations who have gone on record as being opposed to PSRO and yet have applied for planning contracts. Again, in the planning contract there is a specific task. It says that, "At the end of six months we will have developed a plan to become a conditional PSRO." A conditional PSRO is a functioning organization. It takes a tremendous amount of work even in areas where there was support for the peer review concept as in Colorado, Utah, and New Mexico. It took 18 months to two years to develop some of these plans. And yet the planning contract states that they are to develop plans for a conditional PSRO within six months.

So the planning contracts--all of the contracts, in fact--are due in two days. That is April 30th. And funds are going to be made available on the 1st of July.

The planning contract, the planning PSRO, is not mentioned in the legislation, so it is not subject to a vote of the physicians in the area. But as the planning contract progresses toward becoming conditional, it is estimated that probably at the end of four months--which would be in this round of funding along in October--then there will be notification to the physicians in the area that HEW plans to sign a contract for a conditional PSRO with this specific organization. I don't know exactly how the physicians will be notified. We were discussing this a little earlier this evening. If an organization such as the one that was mentioned in Los Angeles County, which involves the interns and residents, does indeed go in for planning money, how all of the physicians would be notified. But in October they will be notified. And I anticipate that this notification will say: "This organization has been in the planning stage and plans to be a conditional PSRO." And then if ten percent of the physicians in the area by petition state that they don't feel this organization represents them, then they are required to hold an election. And I don't think it would be very difficult in most areas to get ten percent of the members to say that they want an election. Not that they necessarily aren't for the organization; but oppose the whole concept of PSRO.

Another interesting point is that this mechanism is not available for the support centers. They are not mentioned in the legislation. Therefore, they are not subject to disapproval by election. So if the areas in the state vote that they don't want a PSRO and they have a support center, I wonder if the functions of the peer review process might then be taken over by the support center.

As you know, there is the 1st of January 1976 deadline that has been talked about so often when, if the physicians don't do it, somebody else is going to do it. The organizations that are appointed by the Secretary do not have, as near as I can tell, a polling mechanism; physicians do not have to be polled to see if they agree with the HEW designate.

So this is where we stand right now. There seem to be many areas in the country that are going to come in with some type of organization for planning, conditional PSRO's and support centers.

We talked a little bit about repeal. I don't think that this legislation can be repealed. There are others in this room who may be in a better position than I am to discuss this. But I do not think that you can significantly alter the legislation at this time.

Now, there has been talk of adding technical amendments. I think there is a technical amendment to go in that says that in states that have less than three PSRO's you can have a state council. I think that is very conceivable. I think it's possible that organizationally the PSRO program may be shifted--and I am not saying that it will be, but it could be organizationally shifted from one area of HEW, from the health segment, over to the Social Security Administration. But that is an administrative task. As for the PSRO law, I don't think you can repeal something that is designed to increase quality in medicine and reduce the cost. And that is what the government contends this will do.

Let me talk a little bit about cost. I feel that the eventual cost of this program has been underestimated.

[Laughter and applause.]

DR. BAUER: The Director of the Bureau of Quality Assurance at the meeting on the 1st of April of this year stated that at maturity he estimated the annual budget for PSRO would be \$100 million. If you divide this out by 200 PSRO's, this comes to \$500,000 per year for each PSRO area.

I don't know how these figures were obtained. I have to take my estimate from what is going on at the present time.

Certainly in the foundations which are so-called "prototype" PSRO organizations, in reviewing claims, there is a range of charges. I think Colorado is \$10.46; Maryland is fourteen-something and I think some of the others are upwards of \$18. But if you take---

DR. BRENNAN: Is that per hour?

DR. BAUER: That is per claim.

DR. BRENNAN: How much per hour?

DR. BAUER: Are they paid?

DR. BRENNAN: Yes. How long does it take them to review a claim? Two days?

DR. BAUER: I don't know how long it takes them.

DR. BRENNAN: Well, that is important.

DR. BAUER: But this is the figure. They are paid on claims review. So many claims, and the foundations get so much money.

DR. BRENNAN: Yes. But you need an hourly rate. You can't just say so much per claim.

DR. BAUER: I can't give you the hourly rate.

DR. BRENNAN: Well, it is important.

DR. BAUER: But even if you take the present figures -- if you take a mid-figure of \$15, if you review 11,000,000 Medicare and Medicaid discharges of last year, then you come to \$165 million without doing any other functions. And this is just a part of the range of requirements that a PSRO will have to do. This doesn't take into account such things as physician profiles, hospital profiles, patient profiles. It has no cost built in for state council activities, there is nothing in there for the National Professional Standards Review Council. And it does not include medical care evaluation studies.

So I do not see how the figure was arrived at of \$100 million for the entire program.

UNIDENTIFIED VOICE: (A spectator from Stockton.)

We just went through this, and our PSRO Committee submitted a claim to the State for what they thought was an exorbitant price of \$40 an hour. And the State said: "Fine. No problem." And I can see why, because for \$18 a claim, depending on how many claims you have -- you know. And they thought this was a great deal.

DR. BAUER: Well, there have been various fees paid in a number of areas. I think Nevada is paying \$50 an hour. I think that some are paying \$25, and some are paying \$35.

UNIDENTIFIED VOICE: You have to have an hourly rate instead of a claim rate, we thought, anyway.

DR. BAUER: Well, there are problems with a claim rate. Because, again, in Colorado, which I was familiar with, the number of claims being reviewed gradually went down and they were being billed on a per-claim rate. So they were set to do, say, 1,000 claims, and their claims went down to 500. So they will probably now be on a flat, fixed fee kind of review system.

But I see a large number of administrative problems coming with this. Many of them are not outlined. There has never been a functioning PSRO. The various segments of the PSRO legislation were brought together, from Sacramento, some from Colorado; parts of this were developed in Utah. So I think that there will be a multitude of operational problems, and maybe this will sink the program. Certainly I see problems in criteria development and how they are going to be adopted. I see problems in the whole field of data collection.

Dr. Schwartz mentioned that the real winner is going to be IBM.

At the National Council meeting on Monday of this week Roy Crystal, who is the data man in PSRO, got up and explained a number of these problems.

And Don Harrington said: "Yes. We know the problems. What we want is the solutions."

UNIDENTIFIED VOICE: I expect Don Harrington doesn't know the problems, nor does he know the solutions. Because Don Harrington is in our area.

DR. BRENNAN: He is an artist, not appreciated in his own home.

DR. BAUER: All right. I'm just about through with my talk anyway, and I will be glad to field some questions. I think I have outlined some of the problems, but I still think PSRO has the potential to be a workable program.

DR. SHEA: The question I'd like to ask is: You are going to spend an awful lot of money, you are going to save a lot of money. Are you going to spend more money than you save at \$18 a claim?

I think I will quit practicing medicine and just review claims!

DR. BRENNAN: That is what several people have said in our community.

DR. BAUER: Are you asking me if at the end of this program I think that this will be a money-saving program?

DR. SHEA: Yes.

DR. BAUER: I think it is unlikely.

DR. SHEA: Why do it, then?

DR. BAUER: The legislation is here. I mean, you have one of two choices.

DR. SHEA: Alice is in Wonderland, too!

DR. BAUER: But you can say, "We will repeal it" or you can ignore it and you can take the chance. I have heard people here say that they would rather have nonphysicians doing the review process. And I think this is a viable alternative. But I also think it is a risk, and you have to realize that this may occur.

It is surprising that this legislation was passed without more places for consumer input, because there really isn't much in the legislation.

PSRO's are physicians organizations. There is a place for an advisory group and there is a place for some consumers on the state councils. But there really is not much place for the nonphysician in the organization.

DR. MARCUS: Dr. Bauer, as we struggle to clamber out through the looking glass, why would you imagine such an intricate, totally cumbersome, totally inefficient and, by your own estimate, uneconomical program be devised when, if cost control is a factor and physician resistance to this program is anticipated; why does not the government simplify its approach as the government of Portugal did by combining the ministries of health and defense and simply drafting all the doctors? There is no need for an intricate bureaucracy under those circumstances. And why is all of this euphemistic claptrap made about improving the quality of health care? Why is this precedent set in American judicial procedure where the punishment precedes the crime?

[Laughter and applause.]

DR. MARCUS:when the real objective is how to cut down on spiraling health care costs. As I stated in my remarks earlier, if health care costs are a problem, let the government set a figure, a percentage of the gross national product, if you will, that it is willing to allocate to health care. Then let those people who wish a share of that kitty have some bargaining input and debate, if you will, the merits of the modalities of that health care as part of that bargaining procedure, after which some sort of accommodation can be reached which will not give everything to one party or the other. But to ask physicians to be Judas sheep and lead their fellows into this sort of involuntary servitude strikes me as being devious in the utmost.

I acknowledge with you and with the government the need to control health care costs. But I resent the glib Senate Committee report of unnecessary surgery being rampant in the land. There was no due process, there was no trial, there was no accusation, there was no opportunity to defend. This is a conclusion that has been reached by a curbstone opinion and, accordingly, it has no validity.

Now, your statement that PSRO is a fait accompli, a law of the land, and it may be bad legislation, raises a question. This afternoon I was face-tious in speaking about civil disobedience; but, after hearing you, perhaps I may be more impelled to think more in that direction. We are faced with a situation in which certain prerogatives are going to be taken from us. Rather than having us as individuals fit our own necks into the yoke, try them on for size, adjust the tension to suit our capacity to absorb it, why is it not better to accept us honestly as adversaries and have this out in a fair and open judicial procedure?

[Applause.]

[Laughter.]

DR. HENDERSON: (From Auburn, California). Placer County is part of the five-county Sacramento Medical Foundation area. I believe the Sacramento Medical Foundation has a good bit of input in the PSRO legislation. We have had a PSRO program at our hospital for approximately a year. Prior to that time we had utilization committees which were effective, tissue committees, credentials committees and so forth. We had a tightly-operated hospital with, I think, good doctors. Our standard stay in the hospital -- I have forgotten the exact figure -- was something like 4.7 days, which is the lowest in the five-county area.

Now, about a year ago -- and I'm not sure of the exact month -- we started a PSRO program patterned after the concept called "CHAP," Certified Hospital Admissions Program.

Since then we have a registered nurse in the hospital hired by the Foundation who reviews all Medicaid and Medicare patients. She certifies that they need to be in the hospital in the first place and sees that they don't stay one day too long. And she operates on the theory that if she can save one day per hospital stay she would have made her salary up. She covers two hospitals. Last week she told me that in the year she has been there, she has not found a single patient that shouldn't have been in the hospital, and she didn't shorten the stay by any days. In fact, in most of the stays, if they are certified for eight days, the patient goes home in five. If they are certified for ten days, they go home in six.

So I asked her: What was her salary worth for the past year?

And she said that she didn't know, but she sure kept busy and she enjoyed the job and meeting all the fellows!

[Laughter.]

DR. HENDERSON: Now, the other girl in Grass Valley and Nevada City has had about the same experience in the adjacent counties. We do have one questionable hospital in the foothills, and she has had some problems there in which she forced people out. But that hospital did not have a utilization review committee or a credentials committee or an adequate staff composed of practicing physicians. But in a year of a so-called "PSRO program" we have done nothing but pay her salary.

DR. BAUER: Let's say that the routine in your hospital was effective and let's say it has done just what has been accomplished, either with or without the program, in that the stays were reduced and there were no significant areas where the length of time could be further reduced. Then what would you think? And I am asking this as a question. If this program is effective, this stage will be reached sometime. And perhaps that is the time the program should be either reduced or terminated or something else.

I think it is unlikely that this would take place. But I think that

it sounds as if you have developed, either because of or in spite of this program, a very efficient utilization review mechanism.

DR. HENDERSON: We had it before she came.

DR. BAUER: Yes.

DR. BRENNAN: Dr. Bauer, first of all I'd like to say that we are not trying to pick on you. But you are a likely target. There are many things I would like to bring up as points of fact or information. One is that Dr. Don Harrington, who you know -- he was one of the founders of our foundation -- told us, in setting up this PSRO, that really there was nothing different in what was going to be done because we had been doing it for years and years. However, we were going to comply with the law and serve as an example again and that for our reward we now were going to have a nurse coordinator sit in judgment of our hospital admissions.

I just bring this up as a point of fact or information.

Now, I want to ask a question. I realize you are not an attorney. But isn't this a violation of the patient's, the Medicaid and Medicare patient's relationship with his physician? The principle of confidentiality. Isn't there an invasion of privacy when you have only one actual agency that is dispensing care and these people are unable to purchase care from the private sector and they have to deal with a government agency and this government agency through the PSRO can have various clerks, paramedics, whatever, nurses, review the charts and the patient's history, isn't this an invasion of their privacy? This I would like to see answered.

DR. BAUER: I see a hand in the back.

MR. LILLEY: Max Lilley. When you sign up for the Medicaid or Medicare program, the patient waives the privilege as far as the government is concerned.

DR. BRENNAN: He waives his rights as a civilian. Is that right?

This is unconstitutional, isn't it?

MR. LILLEY: I am going to give you an answer. I am not going to argue with you.

DR. BRENNAN: OK.

MR. LILLEY: And this is the answer.

There are some confidentiality problems that will arise with the PSRO. And the government assured us in the meeting that I was at with the Health Lawyers Association that they would have a complicated system of preserving

confidentiality.

They discussed how the Army and Navy use computers and still preserve their secrets by numbers and such. Now, they have already thought about this in Washington. And Sidney Edelman, if you really want to write somebody and get an explanation, could perhaps give you a better one than I could give you. But the answer to your question is that if you are a Medicare or Medicaid patient, you waive that privilege in the first step, and then the government has to make other arrangements to preserve that confidentiality.

Now, I am giving you the answer of the federal government. It is not my answer. I'm on your side.

UNIDENTIFIED VOICE: Is that Medicare as well as Medicaid?

MR. LILLEY: Yes.

DR. BAUER: Sidney Edelman is the chief counsel for HEW.

DR. BRENNAN: Basically, I think this is where PSRO has its weakness and where we should attack it. It is very vulnerable.

DR. MEYER: Donald Meyer. I would just like to make a comment before I ask a question.

In listening to this tonight, I am, very frankly, happy to hear you express your honest views.

Dr. Bauer, it occurred to me -- and it goes back to Dr. Peterson asking me who was going to say grace tonight. And I said: "I don't want to antagonize any agnostics or even Christian Scientists or anybody else who might not like the way I said it. But somehow it came to me that Moses came down from the mountain with two tablets that set the precedents and the law of an entire civilization. Had he had to also accept the doctrine of PSRO in stone, he would never have made it down that mountain!"

[Laughter.]

DR. MEYER: The question, though, that I have for you is: We are all concerned about money. But somehow when we get back the \$100 million figure, it really doesn't register to most of us. In the Congress of the United States \$100 million, \$165 million, \$200 million, \$2 billion are figures that are thrown around very loosely. But, perhaps more to the point, has anyone given any consideration as to how many physician hours are going to be spent per annum in PSRO and how if the skilled services of those highly-trained health care providers are used, patients could still obtain medical care?

DR. BAUER: I don't know that this problem has been addressed specifically.

There have been general statements made, which may or may not be valid,

that the present UR functions that have been talked about here will be carried out in a somewhat different form, but that it should take no more time than a good functioning UR committee does now.

DR. ASIMUS: (from the Los Angeles County Interns and Residents Association.) I feel like I'm in the CMA, where PSRO is discussed ninety percent of the time and they ended up deciding to repeal it. It was no good, "Do away with it," and so forth. And the interns and residents that were there were sort of dissatisfied with medical politicians.

Now, you are deciding something that is going to involve the rest of your careers and it is going to involve all of my career. What I am dissatisfied with is your feeling of being abused and somehow having your best meetings whenever you are abused and somehow not having very good attendance when it comes to being creative. I think someone mentioned that word before.

What I say is that American medicine needs to be reviewed, just like our residencies need to be reviewed. People within our residencies today say: "No one should review us. We are through medical school, we are into this program and you know we will do our job and we will get our board certifications and send us out." And I defend them on that idea, except that I don't believe it. I think that they need to be reviewed. I think that all the physicians here need to not only have cost review but also have peer review. And I don't think we have done a very good job of doing it, myself. At least, when I moonlight I am not impressed. And I'm saying that after a few drinks and in the tenor of this meeting. I hope you invite me back, anyway!

DR. BRENNAN: A rebel!

DR. ASIMUS: I don't think anyone likes to be reviewed, but I think it's going to be necessary. We are going to be involved in a system with the government that, as Dr. Schwartz pointed up earlier today, is going to cost the people a hell of a lot of money. And I think that we have to justify good quality of care. And I haven't seen American medicine able to do that themselves up to this point, which led the politicians and others to do it for us. And I would like to see a more creative, positive approach to this problem instead of simply saying "do away with it. We are not going to play a part in it." Try to amend it, work with it and realize that it is here. And if you don't do it for yourselves, at least protect the interns and residents who are coming up the ranks now.

[Applause.]

CHAIRMAN PETERSON: These are supposed to be questions. Pretty nearly everyone has had a chance to make a speech tonight. Why don't you all talk about that after the meeting?

Do you have a question?

DR. SWITZER: Really, just a comment.

CHAIRMAN PETERSON: All right. Let's keep our comments down to comment size and get on with it.

DR. SWITZER: Dr. Switzer, Tucson, Arizona. There are so many areas, of course, where you can attack PSRO. I will just pick a couple of them that have been discussed tonight. One is the little girls who review these things. We have them in our hospital. We don't have PSRO yet; but of course, we have review committees.

Goodness gracious! If I can't fool those little girls who review, then there are a couple of very prestigious institutions of higher learning that completely missed doing their jobs, or I'm just not trying. I mean, if I want to justify a stay and I am not able to do that in the progress notes and what I write and everything for these girls to review, unless somebody who is a urologist comes in and goes over the charts and maybe sees the patient, examines the patient or whatever is necessary to do to make the decision that he shouldn't be there and take a lot of time, if I can't fool those girls I'm an idiot or I'm not trying or these people wasted their time.

The second thing is: There has been a tremendous emphasis on getting people out of the hospital. And it seeps into your mind, and it seeped into my mind. And I said: "Gee! I've got these people in for prostatectomies. They are in four days. This is too long. I've got to get these people out in three days. I'm wasting hospital beds." And so recently I have been getting some people out in three days, and I have been getting some people out that maybe before I would have had in for six days and I've gotten them out in four or five days. Some of these people have had trouble. They should have been in the hospital longer. But this has seeped into my judgment, and I didn't realize it until I had a couple of them just a couple of weeks ago. And I said: "What is the problem?" I'm a better physician than that. And then I figured out what the problem was. This had crawled into my judgment mechanism. And it scared me.

I was lucky. They were problems that sort of took care of themselves, and I was able to take care of them on the outside. But I don't like to practice lucky medicine. I think I'm too good a doctor to practice lucky medicine, and I'm not going to do it any more. I'm not going to do it. I'm going to keep those patients in until I think they should go home. I don't care what the Utilization Review Committee thinks.

[Applause.]

DR. SHEA: This will be short and sweet.

As of December 1973 the average stay in a VA hospital in this country was 8.9 days. In California it is 6.1 days. And at the hospital in the area where I practice it is five days.

You are even better than we are at 4.7.

Are the PSRO's going to affect government hospital utilization?

DR. BAUER: At the present time, because of the committee structure, the VA hospitals come under a different committee.

[Laughter.]

DR. BAUER: Wait a minute. And therefore, they are not subject to this legislation. There are things going on to include the VA hospitals.

The first resolution that was passed by the National Professional Standards Review Council was that if this is good enough for the private hospitals, it should be done in all federal hospitals. Now, whether this will be put in practice, I don't know.

DR. SHEA: I think that if the government wants me to practice, then they had better practice too. I don't want to listen to any more idle preachments from a government I have almost no confidence in.

[Applause.]

CHAIRMAN PETERSON: Well, Dr. Bauer, there ought to be at least two advantages in light of the time that we have spent on this tonight. One, we have been educated.

The second thing is that you have afforded us an opportunity to ventilate. And I think that is good for all of us.

[Laughter.]

Now I will tell you that, as we heard today, muscle is the name of the game. This day we have talked about problems, we have talked about the law, we have talked about the desirability of becoming employees or even the undesirability of becoming employees. We have talked about protecting our patients and we have talked about protecting ourselves.

I agree with Dr. Marcus that we are an honorable profession, and we have to keep it that way. We cannot settle for less than the best of medical care. The reason we are forming a union is to produce a unified and well-disciplined group which will be able to deal with the confrontation which is coming. Hopefully, this confrontation will be only at the bargaining table. But we must be ready to handle our responsibilities when they arrive.

You may say: "What confrontation?"

The confrontation that our little red-headed friend by the name of Stewart Altman talks about down in Health, Education and Welfare. If you

haven't read it, it is in the last Prism. It is coming. And this is why we are here. We can talk about the niceties of all the rest of it, but we are not forming a debating society. We are forming a union to deal with the problems which are coming. You will probably be called upon to make some sacrifices of consequence if you really are serious about what we have been talking about tonight.

So good night. Dream of victory in our cause and sleep comfortably, if you can.

[Applause.]

[Whereupon, at the hour of 9:48 o'clock p.m. the above dinner meeting was concluded.]

SUMMARY OF THE WORKSHOP ON
PROBLEMS OF SALARIED PROFESSIONALS

In the workshop on the Problems of Salaried Professionals it was pointed out that the first problem for the professional to know is what collective bargaining statute he is covered by and what that statute contains.

The major groupings are these. (In addition, there are occasional situations where the Railway Labor Act would apply.)

1. Federal Government -- such as the Veterans Administration or the Public Health Service. Labor Relations are governed by Executive Order 11491 and amendments. These give professionals the right to engage in concerted activities, to join and participate in a union, and for the union to engage in collective bargaining.

2. Professionals employed by State governments -- would be covered by whatever law applies in that particular state. In California the law gives professionals the right to join a union and to participate in union activities. The organization has the right to meet and consult with management for the purpose of acquainting management with the organization's viewpoints. There is no provision for a signed collective bargaining agreement, but management is supposed to reflect the results of the "meeting and consultation" in their personnel policies. In some states state employees have full collective bargaining rights and in some states there are no provisions for collective bargaining.

3. Employees of local government agencies -- such as counties, cities or special governmental districts. In these situations state laws would apply and these laws vary from state to state. In California the Meyers-Milius-Brown Act covers local government agencies. The professional has the right to join and participate in union activities and his organization has the right to "meet and confer in good faith" with management. The results of the meetings are to be contained in a memorandum of agreement which becomes a union contract.

4. Employees of a private University or College -- such as Stanford Medical School. The National Labor Relations Board has now asserted jurisdiction over private Universities and colleges so that their employees have all the rights enjoyed by persons employed in private industry or business. These include the right to form and join unions, to engage in concerted activities, to urge others to take similar actions and to be free from coercion or discrimination in the exercise of these rights. If the organization obtains exclusive bargaining rights, management is required by law to negotiate a signed collective bargaining agreement.

5. Professionals employed by a private non-profit medical institution -- are not covered by statutes as the National Labor Relations Act exempts non-profit hospitals from coverage. This situation will probably change shortly. A bill to remove the exemption has passed both houses of Congress and is now in conference committee to resolve differences between the Senate and House versions.

A question which came up immediately in the workshop was the difference between a union and a professional association. Many professionals tend to have serious reservations about joining unions. The panelists felt that it was an artificial distinction and not really relevant. The objectives of a professional organization center around improving patient care. A program built around collective bargaining would naturally flow into the area of patient care. Wherever a House Staff association has engaged in collective bargaining there has been a significant improvement in patient care. The participants from New York where collective bargaining has been going on for over ten years stated that they have never pursued an item which would hurt patient care.

Another discussion area centered around what procedures to follow when the employed professionals are in different situations. Some were full-time salaried professionals, others worked on a part-time basis or served as consultants while interns and residents were also present. A participant stated that in San Francisco the collective bargaining ordinance exempted part-time employees and management refused to include them for the purpose of a representation election.

The panelists felt that professional organizations should fight hard to get collective bargaining rights for professionals employed on a part-time basis. The reason for this is that the vast majority of professionals are in that situation. They combine a private practice with part-time employment for a medical institution and it is in the part-time situation that they need representation.

On the question of bargaining jointly for residents and interns and other doctors and dentists the panelists reported that both situations existed. No one was prepared to say that joint bargaining was necessarily a better procedure or a worse one. The key consideration was for the participants to seek the method which created the most power. In New York the professionals were in separate groups but often bargained jointly. They had also created a Council which encompassed all the groups.

There was unity among the panel participants on the need for professional organizations to seek professional help from persons with negotiating experience and from competent labor attorneys. Although the attorneys often served as the spokesman in collective bargaining it was felt that this was not the best procedure. House staff associations have a particular problem in developing experienced and competent negotiators because of their transient situation of their members. One answer for them was to employ an executive secretary who would be able to insure continuity of operations.

The point was made again by all the panelists with collective bargaining experience, that its use had made dramatic and major improvements not only in wages and working conditions for salaried professionals, but also in the quality of patient care.

**SUMMARY OF THE WORKSHOP ON GRIEVANCE PROCEDURES
AND PROCESSING FOR THE PROFESSIONAL**

The Workshop on Grievance Procedures within Medical Unions met under the chairmanship of Dr. Clinton V. Ervin, Jr. There was an open discussion aimed at delineating areas where union grievance committees could be of benefit to members in their dealings with third parties.

The panel comprised a knowledgeable group of individuals. Dr. Clinton Ervin, a director of the Union of American Physicians, is a clinical surgeon in full-time private practice, with a long background of committee work in hospital staff and county medical society affairs. Dr. Ervin has served as chief of staff of the Mills Memorial Hospital in San Mateo, California. Currently, he is serving as chairman of the Grievance Committee of the Union of American Physicians, which is based in California. In addition, Mr. Joseph G. Glass and Mr. William E. Glass, father and son attorneys representing the Doctors' Association of the City of New York for many years, contributed their own expertise. Ms. Judith Skiber, a member of the administrative staff of the UAP with familiarity in the day-to-day handling of grievance procedures and Mr. Thomas Bond, labor expert for the UAP, were the additional participants.

The workshop was conducted without structure. Members of the panel were introduced and questions were directed to them by participants in the seminar. The audience was composed of physicians in private practice.

It became apparent that there existed a common denominator of complaints voiced by employed physicians and those in private practice. Messrs Glass, whose experience has been primarily with employed physicians, spoke to this point. "Wages, hours and working conditions" bear considerable similarity to "remuneration and conditions of employment."

Broadly speaking, the issues a union grievance committee is likely to encounter fall into two categories. The first consists of individual grievances in which a physician member feels he has been treated unfairly. This may relate to a specific fee or authorization for treatment by a third party. The second category would include a larger question which would relate to many physicians. Examples would be overall fee structures and the scope of medical treatment permitted under programs such as Medicaid, Workmen's Compensation and the Crippled Children's Program. The individual grievances are properly handled by the union grievance committee. The broader questions require solution at a higher level.

Considerable expertise is needed in the handling of individual grievances. Ms. Judith Skiber's long background in the processing of medical claims -- industrial, private insurance, and all the governmental programs -- together with her previous extensive clinical work as a registered nurse

was felt to be a key ingredient in the success of the UAP's grievance program.

The basic process used in the solution of grievances is the same for employed physicians or those in private practice: work your way up through the echelons of the bureaucracy to someone with authority to act and deal with the problem. Most problems are resolved informally in telephone or face-to-face conversations. Rarely is it necessary to say, "I demand a hearing on this matter." Or, "If you don't talk to me, I'll see you in court." Formal proceedings are cumbersome and time-consuming and are rarely necessary if one sticks strictly to the issues and stays away from personalities.

Bureaucracies are required to obey the law like anyone else, but like anyone else they are commonly ignorant of the law or slant it to suit their own purposes. Impartial hearings are therefore proper when there are differences which cannot be reconciled informally.

The most common question addressed to the panel was, "How do I get my claim paid?" This included processing without unreasonable delay and adequate levels of reimbursement. Repeatedly, the panel emphasized the necessity for good staff work within the complaining physician's office. Frequently, problems are generated by inaccurate or incomplete claim forms. Much of Ms. Skiber's time is used in educating physicians to correct deficiencies in their office procedures. This alone is a valuable service.

The UAP Grievance Committee is selective in the pursuit of claims. The union cannot and should not attempt to collect an unreasonable claim, and certainly not a fraudulent one. There are, however, many legitimate claims which get stalled in their party processing. Here the union can be most effective.

Stalled claims can be dislodged by invoking provisions of the applicable laws and regulations which have been written for the protection of the public. In essence, the position is taken that physicians are also members of the public and so are entitled to due process. Third parties are asked to cite the provisions of their regulations under which payment is being withheld or refused. Rarely is an explanation given, since most such claims are rapidly settled. This approach is often technical and beyond the experience of the individual union member who may well have previously written off a legitimate fee in frustration.

The panel was also asked how to organize a grievance committee. It was acknowledged that the work is time consuming and that it is necessary to find people who are willing to work. Within the UAP Dr. Ervin is backed up by grievance committee members with clinical experience similar to his own. A broad base of experience encompassing familiarity with various areas of medical care is essential. Committee members must be dedicated to principle rather than detail. This may involve spending considerable

time on issues involving only a few dollars when an important principle is at stake. Belligerent individuals are to be avoided since the aim of the grievance committee is not to fight but to win.

SUMMARY OF WORKSHOP ON ORGANIZING, THE PROFESSIONAL SOCIETY
AND THE UNION

The Workshop was called to order by Dr. Sanford A. Marcus, President and founder of the San Francisco based Union of American Physicians, and Vice President and Secretary of American Federation of Physicians and Dentists (AFPD). Dr. Marcus first called on Dr. Gerald J. Lustig, President of the New York State Federation of Physicians and Dentists, and a founding Vice President of the AFPD. Dr. Lustig, a thoracic surgeon in private practice, began by emphasizing the difference between a professional society (he, it was noted is President-elect of the Richmond County Medical Society) and the union, that the professional society-association is mainly concerned with the scientific and educational concerns of the profession, while the union addresses itself to the day-to-day socio-economic problems of its physician or dentist member. Dr. Lustig recounted his experience during the early 1950's as one of the founders and organizers of the Committee of Interns and Residents of New York City, which is recognized as the pioneer organization in physicians' collective bargaining.

Next, Dr. Marcus recognized Dr. William W. Anderson, the Union of American Physicians (UAP) Director of Organization/Membership. Dr. Anderson, a neurologist in private practice, recounted the many trial and error experiences of the UAP in reaching its relatively high level of membership, as the largest physicians' union in the United States; that persistence is one attribute of successful membership recruitment. Dr. Anderson further emphasized to the workshop participants many of whom would leave this conference to form local organizations; that it was absolutely necessary that they hire as their first staff person a labor union trained organizer-business agent person. Further, that simultaneously with the recruitment of private practitioners, that the UAP is involved in the representation of our colleagues who are employed by the counties, municipalities, state and other governmental agencies. That the UAP had just won its first collective bargaining unit after filing three representation petitions in behalf of the physicians employed by the County of San Mateo, who had been included in a "wall-to-wall" unit along with kitchen helpers, para medical and ancillary employees. Now, with exclusive representation of the physicians by the UAP, the doctors could negotiate a collective bargaining agreement not only concerned with increased salaries, but would have a direct input in matters relating to the delivery of quality patient care. Again, and in conclusion Dr. Anderson emphasized the absolute necessity of hiring staff conversant in labor union custom, procedures and labor laws.

Dr. Marcus then recognized Mr. Thomas Bond, UAP Coordinator and senior staff labor relations specialist; first complimenting Tom Bond as the UAP staff person most responsible (along with Mr. Norman Amundson, Coordinator of Labor Education Programs, University of California at Berkeley) for putting this conference together and for it being an event of national significance. Mr. Bond then described in some detail certain programs which are essential to the successful operation of a labor union, in contrast to the professional society-association: that essentially a labor union does two things 1) organize the unorganized thereby providing the strength of numbers

and resources with which to confront the adversary; 2) services, represents its members and in an adversary posture. Included in the above is a dues administration program which accommodates new members into the system continuously (in contrast to a professional society whose emphasis is on annual recruitment, or annual renewals.) In conclusion, Mr. Bond stated that based upon his 14-years of experience that most union organizing success is based upon hard, non-glamorous work; that there are no short cuts such as PR gimmicks, no short cuts -- only hard work. Dr. Marcus again thanked all the participants, and the meeting was adjourned.

SEMINAR SUMMARY, CONCLUSIONS AND FUTURE DIRECTIONS

by

Philip R. Alper, M.D.

Conference Reporter and Editor of Proceedings

Portions of the following report appeared in Medical Economics Magazine on June 24, 1974 and are included with the magazine's permission. (P.R.A. - Ed.)

In the preceding pages, we see that the Nation's physician-unions donned caps and gowns to further legitimatize their aims and aspirations. This historic first seminar on "Doctors' Unions and Collective Bargaining" was co-sponsored by the University of California at Berkeley and the American Federation of Physicians and Dentists. More than 100 paying participants attended the seminar in Berkeley's magnificent old Claremont Hotel, coming from as far as Miami, Florida and British Columbia, Canada.

The green light to physician unionization was given by Harry Schwartz, Ph.D., author of "The Case for American Medicine", and now visiting professor of Medical Economics at Columbia University. "Unionization among the Nation's 360,000 doctors is inevitable," said Doctor Schwartz. He pointed to the movement toward the "collectivization of American medicine" that has been taking place in recent years. Thus, Doctor Schwartz viewed collective bargaining as a legitimate reaction to the progressive domination of the medical scene by the government and other powerful third parties. Doctor Schwartz verbalized his conviction that physicians' unions share an identity of purpose with patient welfare, a contention that was later repeatedly made by other speakers. "The Case for American Medicine" was distributed as a source material for the seminar.

"I read all the horror stories about what's wrong with American medicine and watched the same thing on television, and I just knew this couldn't be the way things really were. That's why I decided to do some research and write the book," Doctor Schwartz said. "Sure there are imperfections in American medicine," he continued. There isn't a physician shortage, but there is a maldistribution of physicians both geographically and in medical specialties. But when the New York Times recently ran a survey of twenty important problems bothering the man in the street, health care came out fourth from the bottom in importance. "Most Americans are happy with their medical care," declared Doctor Schwartz. "In fact," he continued, "I think the country is going down the wrong road. Most people can take care of themselves with the help of insurance and the attention of government should be focused on the poor and on catastrophic illness.

The "politics of envy" and the "politics of demagoguery" have been

responsible for designing systems by which auditors and computers in Washington are increasingly controlling medicine. "The government will be a monopsonist, i.e., a monopsonist is a sole consumer to whom a provider must sell his services if he is to survive. It is a monopoly in reverse). As government increasingly interferes in the practice of medicine and relies evermore heavily on computerized auditing, there can be only one winner. "It will be IBM".

Eye-opening statistics were then cited by Doctor Schwartz to buttress his case. There has been a one-third decline in infant mortality since 1965. There has been an increase of 50,000 physicians in the United States since 1965. This represents a 16 per cent increase during the time that the population increased only by 4 per cent. However, there are other trends within medicine itself that also have significance for the future. The number of salaried physicians has gone up by 22 per cent, rising from 77,000 to 94,000 during this five-year period. The increase in the number of physicians working for fee-for-service (office based) rose only 9 percent, indicating that an increasing number of physicians are becoming salaried employees. The most drastic change was a fall in M.D. researchers from 15,400 to 8,300, a drop of 45 per cent, and a phenomenon that Doctor Schwartz believes does not bode well for the future of the Nation's health. This drop he attributed to the effect of non-organization in changing times.

"With the government the dominant buyer of health services we are seeing a 'partial oligopsony' affecting health care delivery. But though only a dominant buyer, the government is acting as if it were already the sole purchaser of health care services. Having promised more than it is willing to pay for, a number of techniques are now being employed by Washington to cut costs in health care. These are:

1. Discriminatory price control treatment.
2. The artificial assertion of a shortage of doctors.
3. The promotion of physician replacements with the allegation that such substitutes are just as good.
4. The subsidization of medical collectives -- the HMO.
5. A bid for complete control and an actual rationing of medical care in both quantity and kind via the PSRO.

Physicians' assistants will eventually become competitors and may ultimately find themselves in an adversary position with physicians. Collective bargaining for the preservation of individual physician rights is an obvious response to this trend. "Doctors should bargain for their rights -- just like everybody else does," said Doctor Schwartz. "I'm a card-carrying member of two unions myself."

Next the legal issues facing physicians' unions were considered by Walter Kintz, supervising attorney for the National Labor Relations Board, Region 20. He gave an erudite discussion of the legal differences between employees, supervisors and independent contractors, and went into the fact

that physicians may, even though in private practice, function in any or all of these roles even in a single given day. After elaborately detailing the nature of these differences and the evolution in definitions, Mr. Kintz got to the meat of his remarks. "Muscle" is what unions are all about. The extent to which unions have the wholehearted support of their members and have economic power determines their effectiveness. Unions work most effectively outside court rooms, lawyers' offices and the National Labor Relations Board," he said.

A physicians' union will qualify as a labor organization even if it represents only one clearly employed individual and negotiates on his behalf. Any one collective bargaining agreement negotiated for that individual will certify the group as a labor organization. (Note that the employed physicians of San Mateo County Hospital have designated the Union of American Physicians as their bargaining agent even though the majority of the members of the Union are in private practice). Mr. Kintz went on to point out that such hybrid organizations are not at all unknown in labor today. For example, barbers' unions have both employer and employee barbers. The Teamsters' Union negotiates on behalf of supervisors, even though supervisors are normally on their own when it comes to protection of the Labor Relations Act. Furthermore, a strong organization of employed individuals may have a significant impact on independents and self-employed individuals in the same field. Thus, the Teamsters have been able to set floors under the charges of independent truckers to prevent competition that would possibly cost jobs to their own employed drivers.

What became clear was that the examples cited, although not directly pertinent to physicians, did indicate a considerable flux in the way labor operates today. Definitions are changing, new combinations form, and to a degree the law follows established facts. Doctor Sanford Marcus later noted that two years ago Mr. Kintz could barely conceive of physicians' unions. Today, he can envision a role for them. Mr. Kintz said that unions work in three ways -- legally, illegally and extralegally. Speaking personally, and not as a representative of the NLRB, he implied that physicians interested in unionizing would seek these extralegal avenues -- the area in which the most creative union activity occurs.

The implications of Mr. Kintz' remarks were that doctors' unions need not tie themselves in knots attempting to conform to Federal Law designed for other types of work. There is no reason to call local representatives shop stewards, nor any need to establish elaborate language making it look like doctors are boilermakers. They aren't.

Murray Gordon, the very knowledgeable labor attorney who for years has counselled the Council of Interns and Residents of the City of New York, expanded on these remarks, "Physicians' unions are unique and cannot profitably adapt the job actions of trade unions. The physician's allegiance to his patient has no parallel in trades where the quality of a product is not normally a concern of workers in their role as unionists." Mr. Gordon pointed,

however, to a unique advantage of physicians' unions. In dealing with hospitals and government, the adversary is not making a profit from physician labor, and where physician union activity properly identifies with patient interest, the adversary will be placed in an untenable position -- one in which there isn't even an economic advantage to himself to defend. So Mr. Gordon believes that it is not necessary for doctors' unions to seek the protection of the labor laws. The most effective weapons are insistence, exposure and publicity and the application of muscle on particular issues.

Why can't the AMA do this? Because, according to Mr. Gordon, they don't wish to retreat from their lofty position and do the dirty work that this takes. Though Mr. Gordon's experience was derived from representing clearly employed house staff, he found no difficulty in extrapolating what he has learned to the situation of the self-employed physician. He pointed out that even in situations where collective bargaining was not mandated as a matter of law (as in Minnesota), effective collective action could still occur. He illustrated this with the success of the house staff at the Mayo Clinic in organizing, negotiating, wage increases for themselves, establishing a grievance procedure and guaranteeing an input in major policy committees. There is also no reason to seek employee status in order to establish effective bargaining rights. Because, at best, the self-employed doctor can only hope to establish himself as a Federal employee vis a vis the PSRO or other Federal agencies. Federal employees have only limited collective bargaining rights and it is not worth seeking them out. Harry Schwartz pointed out that the greatest potential for M.D. unions lies in their ability to act as consumer advocates fighting for quality medical care, rather than in the purely self interested terms of employees seeking only benefits for themselves.

"Nobody is going to run a strike benefit party for physicians who are striking for higher wages," said Professor George Strauss, Acting Director of the Institute of Industrial Relations at the University of California in his opening remarks to the Conference. This author concluded personally that responsible physician unionism could be the only realistic form of union activity for doctors.

I heard all this with a feeling of sadness because I myself in becoming a physician never dreamed of the necessity for or utility of collective action. Harry Schwartz' remarks touched me because of his understanding of the difficulties facing medicine and the unfairness of much of what is happening. When intemperate politicians promise much but then don't want to pay the bills, chaos results. My reaction was that collective action and the securing of bargaining rights might serve a purpose in halting two very disturbing trends in government. The first is to seek total solutions backed by huge sums of money in a crisis atmosphere. We have seen Federal programs come and go with unbelievable rapidity in recent years, leaving resentment and deception in their wake and a transient profit for opportunists

who jump on the bandwagon. The second is a new trend toward administrative law. Bills such as the PSRO legislation are passed without hearings, without the knowledge of Congressmen, and then become reality in the hands of a small group of people in back offices in Washington when their edicts are published in the Federal Register.

Doctor William Bauer spoke on PSRO's. This, too, was a sad experience. Doctor Bauer, formerly head of PSRO for the Department of HEW, is now a private consultant assisting people setting up PSRO's. He is also a Clinical Assistant Professor of Medicine at Georgetown University in Washington where he continues to live after leaving Colorado. Doctor Bauer pointed to the fact that at the recent AAFMC Meeting in Washington, 500 people attended. There was no mention of repeal or dissatisfaction with PSRO legislation among these representatives of the foundation movement. The meeting was an implementation meeting. The foundations are becoming the units for the implementation of PSRO. Doctor Bauer disputed the fact that there is no place for compassion in PSRO. "Socio-economic indications for care would be taken into account," he said. "However, there would be pressure to seek less expensive alternatives." One had the impression that Doctor Bauer was in a difficult position. He felt that compliance was necessary because the legislation exists and that it is unlikely that something designed to improve quality and contain costs would be repealed. However, he also felt that it was unlikely that the PSRO would save money. He is certain that original government estimates of costs are grossly understated. As an observer, one could only sympathize with the moral dilemma that this created for Doctor Bauer -- and for many American physicians.

What then are the weapons available to physicians' unions? The leaders of the unions in New York (Donald Meyer -- Chairman of the Conference and originator of the idea for the symposium), Sanford Marcus (UAP President in California) and Stan Peterson (AFPD President) all echoed the words of the attorneys in stating, "We will not withhold services from patients." With this breadth of representation, this can be considered to be union policy on a national level.

What weapons are available? Those mentioned by Mr. Gordon. Also a variety of procedures in the broad category of civil disobedience. "Creative sabotage" was a term mentioned by Harry Schwartz. "Imagine the chaos that would result if every doctor followed all regulations to which they were subjected to the letter." (This was a favorite way for noncoms in the Army to get even with officers they didn't like.) Noncompletion of forms and failure to perform other bureaucratically required jobs that did not affect patients directly would be other weapons.

It isn't easy for physicians' unions to secure negotiations, however. Currently Doctor Marcus is working with the American Arbitration Association to attempt to resolve a California dispute over Workmen's Compensation fees. (The AAA, incidentally, was also represented at the seminar.) But the willingness to negotiate does not guarantee that government hospitals or the insurance

industry will readily enter into negotiations. Doctor Amstadter, President of the Southern California Council of the UAP, pointed out that although 90 per cent of doctors in one hospital were unionized, so far hospital administration would not bargain with them with regard to payment for utilization review time spent by physicians.

An intriguing thought was presented by Doctor Anthony Bottone, young head of the Council of Interns and Residents of New York. "Collective bargaining can prevent strikes," he said. He pointed to the fact that negotiations can result in progress and relieve pressure before intolerable events and misunderstandings occur. Doctor Bottone indicated the need for responsible action and cited the recent strike at San Francisco General Hospital in which an amalgam of vague goals combined with an inability of leadership to commit its membership, and resulted in much confusion and little accomplishment. (I think there is a good lesson here for hotheads who are ready to take on the entire world). Doctor Bottone was well received by the group which included primarily practicing physicians. Doctor Sanford Marcus later pointed out that the accomplishments of house staff -- learning from our juniors as he put it -- originally led him to the idea of forming the UAP.

Collective bargaining rather than law suits are the most effective way to get action, according to Doctor Bottone. There is an unwillingness to stand out that prohibits even interns from lodging grievances and seeking redress. Doctor Bottone felt this may have relevance to practicing M.D.'s.

Hearing Doctor Bottone's story about a resident who sustained a crush injury of the hand, while pushing an OB patient to the delivery room because a messenger wasn't readily available, gave me some pause for thought. I found myself thinking back to my own intern days and concluded that I probably would have done just what that resident did -- nothing. The heroic posture came naturally. Here again, there were mixed feelings on hearing the success stories of current house staff in righting many of the inequities which we all knew existed. Is it necessary for young doctors to suffer in order to become capable and dedicated? Only the future will tell. Present thinking is that it is not.

The mutual understanding that characterized the young physicians and older colleagues who attended the seminar was striking. This extended to other participants at the meeting. Sylvia Urlich, Executive Director of the Westchester General Hospital in Miami, Florida, Legislative Chairman of the Federation of American Hospitals and President of the Florida League of Hospitals said, "Physicians have every right to join together in an association -- a movement -- a 'union of purpose' -- to protect and preserve that which merits preservation in the practice of medicine." She added that many of the oppressive regulations that hospitals now work under have been imposed on them, and have not been sought. She hoped that hospitals and doctors could work together to jointly solve their problems. Ms. Urlich is currently working on a Ph.D. thesis on physicians' unions. Serious interest in doctors'

unions was also encountered in the presence of Gloria V. Engle, Ph.D., of the USC School of Medicine, who has written extensively on the subject.

New unions are springing up around the country. Tuscon urologist Doctor Switzer told us that he was triggered into union activity when he found himself discharging patients too soon after prostatectomy "because cost consciousness has so thoroughly seeped into my thinking that I found myself going against my better judgment." After a couple of complications that fortunately were not significant, he has gone back to his usual practice but simultaneously has become active in the union movement.

Similar sentiments were voiced by Doctor John MacCarthy, an internist from Merced, California, who addressed the group to show how inequitable payments by Medi-Cal worked a hardship not only on the physicians in his area, but appeared to be accentuating a physician maldistribution in the State. Doctor MacCarthy pointed out that his area, the lowest in fees, was not the lowest in income nor did it have the highest welfare rate in the State. He explained that computer-flukes creating inequities years ago, have now been perpetuated for seven years without redress. "The Union of American Physicians was the only organized group of doctors to publicly make a representation on our behalf," he said.

Doctor Peterson acknowledged that the California UAP, now divided into Northern and Southern Councils was the most effective State organization. Doctor Marcus said the "strength of a union is at the local level." Doctor Peterson added that "the locals are going fine, but affiliation with the American Federation is necessary to help in the solution of national problems." Total union membership was estimated at 55,000 nationally.

There was much education, exchange of practical information and a minimum of rhetoric at the seminar. Most of the unions represented contain only physicians. Some include dentists, most notably the Doctors' Association of the City of New York headed by dentist Donald Meyer.

Instructional workshops were held to show how to organize and obtain membership, and then provide services to retain membership. Thomas Bond, organizer of the Northern California UAP, introduced this discussion. His views were reinforced by Doctor William Anderson who spoke of the work it takes to get members and the need for adequate staff working under physician direction, but knowledgeable in labor practices, to do the day-to-day work. A sample Union Constitution was distributed. The special problems of employed physicians were reviewed separately. The handling of local grievances was discussed by Doctor Clinton Ervin. He pointed out that much of the frustration doctors encounter is due to the fact that third parties with whom they deal do not stick to their own rules. The Grievance Committee of the Union Local sees to it that they do. When doctors -- or patients -- are given short shrift, the union goes to bat for them. Almost \$500,000.00 in claims have been won for doctor and patient alike by Doctor Ervin's UAP Grievance Committee.* Carriers or intermediaries are asked to cite the

*As of October, 1974, this sum is close to one million dollars.

section of their regulations or policies under which payment is refused. Usually payment is forthcoming in very short order. However, it should not be assumed that the union will automatically go to bat for any cause. The doctor engaging in questionable practices is no more welcome in the union than elsewhere. (I was reminded of an old labor adage, "Nobody likes to negotiate on behalf of a bad worker").

The soberness and seriousness of purpose of the seminar were impressive. This made me reflect back to the comments of an executive of a County Medical Society some months ago who said, "I'm not worried about the doctors' unions -- there are too many good people in them." The tone of the meeting, to me, seemed to confirm his impression. A representative of organized medicine attending the Conference also appeared impressed by the professional quality and seriousness of the meeting. Though he was still concerned by what he called "duplication of effort and fragmentatation," it was clear that he was taking the union movement seriously.

What about organized medicine? (Currently) "the AMA is a paper tiger -- a weak organization rent by internal feuds -- and not a very good union," said Harry Schwartz. The unions have the advantage of youth and a fresh image. They are not hampered by long histories of past policies, nor are they tarred with the onus of previous defeats. It was felt that organized medicine has never fully recovered from losing the Medicare War.

What about connections with organized labor? Local unions are not being encouraged to affiliate with organized labor as occurred when the Las Vegas, Nevada group joined with the Service Employees International Union. Doctor Marcus mentioned an exchange of correspondence with George Meany, inquiring about the possibility of affiliation. Mr Meany answered, "Talk to me in ten years when you are all on salary." Dr. Marcus added that George Meany is not a man given to humor. Professor Strauss also said that organized labor will probably not object to the organization of physicians, but is much more likely to see them as adversaries than allies. Thus, the physicians' union movement appears headed in a purely professional direction and away from trade unionism.

Let me now add a few more of my own thoughts before concluding this summation. The newest fact of union life is the increasing number of professional people becoming unionized. So far most of these have been employed persons, and have entered established unions. Historically, with the amalgamation of the AFL and CIO, distinctions between crafts and trades virtually disappeared. Yet now I wonder whether the physicians' union movement may not be a forerunner of a trend back toward separate professional (if not craft) unionism. Dr. Schwartz' statistic of the almost 50 per cent drop in the number of research doctors illustrated how in violently fluctuating times professionals have more reason to stick together than to fight with one another. I can easily envisage a reduction in the town-gown rift as professors find it to their advantage to join with private physicians in a common union. It shouldn't be forgotten that professors' salaries and opportunities have always been to some extent a reflection of what is needed to keep them from

turning to private practice for their livelihood. More community of interest exists than might appear on the surface.

One of the nicest surprises of the meeting was the markedly friendly reception given by the local press. "M.D. Unions Win Favorable Prognosis", appeared as a headline on Page One of the Sunday San Francisco Examiner. Similar sentiments were voiced in the Oakland Tribune. In conclusion, the Berkeley Seminar shows that physicians' unions have forged further ahead in their bid to move from vigorous infancy to active, functional maturity.

PARTICIPATING ORGANIZATIONS

AMERICAN FEDERATION OF PHYSICIANS AND DENTISTS

President: Stanley S. Peterson, M.D.
President
Missouri Physicians and Dentists Guild
1736 East Sunshine, Suite 302
Springfield, Missouri 65804
(417) 881-8934

First Vice President: Donald C. Meyer, D.D.S.
President
Doctors Association of the City of New York
233 Broadway, Room 4001
New York, New York 10007
(212) 422-3666

Recording Secretary: Sanford A. Marcus, M.D.
President
Union of American Physicians and Dentists
Northern Council
World Trade Center, Suite 337
San Francisco, California 94111
(415) 391-9341

Corresponding Secretary: Gerald J. Lustig, M.D.
President
New York State Federation of Physicians
and Dentists
50 Broadway, 26th Floor
New York, New York 10004
(212) 422-7999

Treasurer: Robert E. Kelleher, M.D.
President
Massachusetts Federation of Physicians
and Dentists
1160 Rockdale Avenue
New Bedford, Massachusetts 02740
(617) 993-1070

Vice President: Robert L. Amstadter, M.D.
President
Union of American Physicians and Dentists
Southern Council
502 West Alosta Avenue, Suite 26
Glendora, California 91740
(213) 963-7551

Vice President: R. W. Switzer, M.D.
President
Professional Guild of Arizona
310 North Wilmot Road, Suite 201
Tucson, Arizona 85711
(602) 296-7169

AMERICAN FEDERATION OF PHYSICIANS AND DENTISTS

Alabama Physicians and Dentists Guild
Patrick B. Jones, M.D.--Secretary-Treasurer
1914 Fairview Avenue
Dothan, Alabama 36301

United Physicians and Dentists of Florida
Robert Elkin, M.D., Chairman
9106 S. W. 87th Avenue
Miami, Florida 33156

Michigan Federation of Physicians and Dentists
Frederick C. Swartz, M.D.--President
720 Seymour Avenue
Lansing, Michigan 48906

New Jersey Federation of Physicians and Dentists
Anthony J. DiCroce, M.D.--President
201 Arnold Avenue
Point Pleasant Beach, New Jersey 08742

Ohio Physicians and Dentists Guild
Ernst Rose, D.D.S.--Secretary
30 West Liberty Street
Hubbard, Ohio 44425

Oregon Federation of Physicians and Dentists
William A. Bartlett, M.D.--President
2860 Daggett Street
Klamath Falls, Oregon 97601

North Carolina Federation of Physicians and Dentists
John J. White, Jr., M.D.--President
3001 Maplewood Avenue
Winston-Salem, North Carolina 27103

GROUPS PRESENTLY ORGANIZING

Jerome Wolensky, M.D.
8790 West Colfax
Lakewood, Colorado 80215

Marvin H. Meisner, M.D.
501 Howard Avenue
Altoona, Pennsylvania 16601

J. Paul Reimer, M.D.
1930 Ferris
Lawton, Oklahoma 73501

Joe L. Troska, M.D.
306 East 12th
Ada, Oklahoma 74820

Richard A. Gillespie, M.D.
501 20th Street
Suite 606
Knoxville, Tennessee 37916

Travis R. Cavens, M.D.
784 14th Avenue
Longview, Washington 98632

Robert Rosenthal, M.D.
President
Northeastern New York Physicians Guild
602 New Loudon Road
Latham, New York 12110