The defining characteristics of a learned profession include autonomy (self-direction, self-discipline, and self-employment), authority (abstract body of knowledge and prolonged formal training), and legitimacy (strong code of ethics and an obligation to place client interests above personal gain) (1). In the mythic past, the physician alone decided what was best for the patient—indeed, had a duty to do so. The advent of managed care and health plan consolidation has greatly eroded physicians’ traditional autonomy by interposing health plans’ decisions about what services warrant payment and who should provide them (2).

The position paper in this issue proposes to reassert physicians’ autonomy through joint negotiation with insurers about quality, access, and payment (3). However, the paper renounces the traditional mechanisms for compelling negotiation—job action (“work to rule”), price fixing (“usual, customary, and reasonable”), and mandatory membership (“closed shop”)—and would also prohibit joint negotiation by housestaff. Although the goal of reasserting professional autonomy may be laudable, several of the paper’s assertions warrant continued discussion. Does the proposed solution (joint negotiation) solve the problem (loss of autonomy)? What are the unintended consequences?

EMPLOYEES OR PROPRIETORS?

Antitrust law applies to firms (for example, corporations, partnerships, and sole proprietors) (4). Labor law applies to employees. Extensive judicial precedent explores the distinguishing characteristics of employees versus independent contractors. Antitrust law prohibits “restraint of trade” (5). Labor law governs the relations between employers and unions. Antitrust law does not apply to labor unions (6), and labor law does not apply to cartels of nonemployees. Antitrust and labor law therefore intersect only under limited circumstances, such as unions conspiring to restrain trade or labor racketeering by organized crime.

Over one third of U.S. physicians are now full-time employees. Some are employed by staff-model health maintenance organizations, universities, or the government or military. Some are housestaff. Some work in private practices owned by third parties, while others are hospital-based specialists (7). As employees, these physicians already have the right to bargain collectively over compensation, terms of service, working conditions, and even “non–lunch bucket” issues (some blue-collar unions have an honorable history of advocacy on behalf of the downtrodden and powerless). Thus, with minimal changes in paperwork, the Permanente Medical Group or a housestaff association could reinvent itself as a union, perhaps with collective bargaining that encompasses their employer’s customers (the plans and payers).

In contrast, independent physicians, because they are individual firms and not employees, fall under the antitrust laws’ prohibition against restraint of trade. Reasonable minds may disagree on whether particular joint negotiations, cartel arrangements, trade association activities, “conscious parallelism,” or other relationships between independent physicians actually restrain competition (for example, cross-coverage for night call). Legalizing joint negotiation would affect only these independent physicians, not physicians who are employees.

Independent physicians’ loss of professional authority appears to derive mainly from the limited number of plans with which they can negotiate (“oligopsony” of buyers) (8). Legalizing joint negotiation could transform independent physicians from rivals (many sellers) to a limited number of practitioner cartels (“oligopoly” of sellers). However, an oligopoly plus an oligopsony do not make up a free market with perfect competition. Their negotiations would not necessarily increase seller autonomy. For the individual physician, such an arrangement would substitute the controls of a joint negotiation (physician cartel to members: “For diagnosis A, perform service X”) for competition among members of an oligopsony (physician to plan A: “I recommend service X for my patient, and it’s not on your formulary. It is on plan B’s formulary. Perhaps my patient should switch insurers.”). To date, practitioner-operated plans have not demonstrated greater success at defending physician autonomy than those run by professional managers (9, 10).

The textbook solution to an oligopsony is antitrust action (11). Theoretically, creating more health plans through such action would increase competition, permitting independent physicians to retain more auton-
omy by refusing unacceptable contracts. Admittedly, regulatory barriers to new entrants, low profitability, ongoing consolidation of existing plans, and other factors militate against developing sufficient market competition to confer professional autonomy on independent physicians. It is also uncertain whether more competition among buyers of health services would have the same effect as in other markets, given medicine’s unique services, self-induced demand, and third-party payment.

**Self-Interest or Public Interest?**

Professionalism inherently conflicts with unionization and cartelization. By definition, a profession must serve the public interest (12). By law, a union must serve its members’ interests (13). A profession has its own disciplinary board that enforces its code of ethics and requires members to place their clients’ interests ahead of their own (14). Thus, overly aggressive incentives from health plans should cause state medical boards to raise questions about conflict of interest. Conversely, a union that serves the public interest to the detriment of its members’ interests breaches its “duty of fair representation” and risks being removed from control for cause. Indeed, unions that represent both workers and retirees, or an unduly broad range of job categories, have occasionally succumbed to conflicts between internal factions.

One solution envisions separate professional societies and unions working in parallel. The American College of Physicians–American Society of Internal Medicine, American Medical Association, Federation of State Medical Boards, and other organizations would promote physician professionalism, including autonomy. The International Brotherhood of Teamsters; the International Union, United Automobile, Aerospace, & Agricultural Implement Workers of America (UAW); or the United Association of Journeymen & Apprentices of the Plumbing, Pipefitting, Sprinklerfitting Industry of the United States & Canada (UA) would bargain for physician wages, benefits, hours, and other terms of service. Individual physicians would decide their relative commitment to professionalism versus unionism. The market would determine whether both paradigms can coexist.

A nonjudgmental discussion of the role of decreasing physician incomes could also enhance understanding of the conflict between public interest and self-interest. When employees feel underpaid, money often becomes the focus of unrelated grievances (for example, respect, supervisor conflicts, and discrimination complaints) (15, 16). Medicine originated as a learned profession by branching off from the medieval priesthood, whose members were sworn to poverty and service (17). Until the mid-20th century, most physicians enjoyed high prestige but only modest incomes. Conceivably, the high incomes of successive generations of new physicians have obscured their understanding of medicine’s public service ideals. Law and accounting have already moved toward practice models that are more profit-oriented than professional. The potentially corrosive effect of changing physician incomes on medical professionalism may thus warrant further serious scrutiny.

**Students or Employees?**

Finally, a separate position paper should address collective bargaining by housestaff. The position paper in this issue (3) seeks to reassert the professional autonomy of independent physicians in an oligopsonistic market. Housestaff are not independent physicians and do not care as much about autonomy. Housestaff interests traditionally pertain to pay, hours, discipline, and promotions, all of which are classic union issues. Whether collective bargaining interferes with housestaff education has no direct bearing on professional autonomy or on the business relationships among practitioners, plans, and payers.

In any event, the 1999 decision of the Boston Medical Center versus House Officers’ Association, Committee of Interns and Residents, makes these considerations moot (18). Housestaff can unionize regardless of their employers’ or program directors’ wishes. Enlightened firms have long known that an employer that treats its workers so badly that they organize deserves having to deal with a union.

Overall, the position paper in this issue deserves the utmost commendation for raising one of medicine’s most important current issues: Are physicians independent professionals, or agents for plans? Each role presents different opportunities and different obligations; either role is legitimate, but embracing one necessarily detracts from the other. Each carries unavoidable personal costs and policy side effects, truths reflected in the
old saying: “‘Take what you want,’ said the Lord, ‘and pay.’”

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Disclaimer: The views presented in this paper do not represent the policy of any U.S. government agency.

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