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Controlled But Not Employed: The Clash of Labor Law and the Corporate Practice of Medicine

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Abstract

What is the message? As the corporatization of the medical profession continues, physicians are increasingly turning to labor law to collectively bargain over the terms and conditions of their employment. However, due to state bans on the corporate practice of medicine (CPOM), physicians working for private-equity-backed companies, hospitals, and other corporations are often not directly employed by these corporate entities. Such complex and indirect employment arrangements heighten the salience of labor law doctrines that, at times, allow unionized workers to compel multiple corporate entities to collectively bargain, including those that do not directly employ the workers. As physicians unionize, legal disputes over the application of these doctrines are beginning to surface and may shape the contours of physician unionization and CPOM bans.

What is the evidence? A review and analysis of recent labor law, legislative initiatives, court rulings, legal doctrine, and market developments.

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Introduction

Physicians are beginning to unionize in response to increasing corporate employment. However, these employment relationships are often indirect and complex, involving numerous corporate entities that jointly exercise control over physicians. In fact, due largely to state bans on the corporate practice of medicine (CPOM), many hospitals and corporate-owned medical practices do not actually employ physicians. Such arrangements raise the salience of two related law labor law doctrines: the "single employer doctrine" and the "joint employer doctrine." Both doctrines can enable employees to unionize against non-employer entities that nonetheless control their working conditions. As discussed below, the application of these doctrines, which is now beginning to occur, may shape the contours of physician unionization and CPOM enforcement.

The Corporate Practice of Medicine

The current corporate structures of physician employment formed in response to state bans on the corporate practice of medicine (CPOM). Historically, these bans prohibited corporate entities from owning, controlling, or employing physicians.[1] Rising to prominence in the mid-1900s, these laws often originated in state courts through judge-made or "common" law. State legislators followed suit, codifying CPOM bans by prohibiting lay entities from clinical decision-making and requiring for-profit medical practices to be physician-owned.

While states have relaxed CPOM enforcement since the 1970s, the basic structure of these laws is largely still in place: medical practices must be exclusively or majority owned by licensed clinicians, typically physicians. And as corporatization of the medical sector continues, numerous states are now looking to strengthen these laws.[2] Due to this legal ownership landscape, corporations interested in controlling the medical practice have devised a workaround, known as the "PC-MSO," or "Friendly PC" model ("PC" stands for "professional corporation," which is a common corporate form of physician-owned medical practices). In these arrangements, a corporate entity, such as a private-equity-backed company, will use the vehicle of a management services organization (MSO) to exercise functional control over a medical practice

or a physician staffing company.

While MSOs traditionally assist medical practices with back-office administrative tasks, lay-owned corporations – through contracting – can transform the MSO into the controlling entity. For example, the MSO often takes control of all business and administrative elements of the practice, allowing it to require that physicians see more patients, dictate coding and billing procedures, make personnel and scheduling decisions, and control many of their functions of the practice that influence the nature and quality of care delivered. MSOs may also require that physicians sign restrictive contracts such as noncompete agreements, gag clauses, and stock transfer restriction agreements (STRAs), which in effect place the MSO in control of the equity of the physicians.

In the most extreme version, the Friendly PC model, the MSO will install a “friendly” or “captive” physician leader. This physician will be licensed in the state to practice medicine and can therefore satisfy the formal requirements of physician ownership, but in substance, the physician serves as a direct extension of the MSO. This physician, who may not actually practice at the clinic, is often financially compensated by the MSO and even serves on its executive board. The physician may have a direct role in MSO management or receive a minority equity stake in the MSO.

Another scenario of corporate non-employer control implicates hospitals. Many hospital-based physicians work for a corporate staffing company that contracts on behalf of physicians with the hospital. This practice, too, has historical roots in CPOM laws, which barred hospitals from employing physicians. That prohibition continues in some states today, such as Texas and California. The use of physician staffing companies is pervasive even in states that permit direct employment by hospitals. In these arrangements, the hospital, as a party to the contract with the staffing company, exercises varying degrees of control over the employed physicians. Like MSOs in the PC-MSO context, however, the hospital entity is not the formal employer of the physician (nor might be the staffing company using the PC-MSO model).

The upshot of these arrangements is that the corporate entity exercising control of physicians is not actually the legal employer. As physicians are increasingly attempting to unionize under these structures, the fact that the corporation is not the physicians’ employer complicates the application of federal labor law, which is largely predicated upon a direct employer-employee

relationship.

The Single Employer and Joint Employer Doctrines

Under the National Labor Relations Act (NLRA), which governs private-sector unions, only "employees" can organize a union, and independent contractors are expressly excluded. The NLRA defines neither employees nor independent contractors, so issues regarding employee eligibility have been the subject of litigation for decades. The NLRA also only references "employers," which typically involves a single employer. But as corporate ownership structures have become more complex, the National Labor Relations Board (NLRB) has developed two related doctrines that, at times, can broaden the NLRA's scope to include corporate entities that are not technically employers but functionally operate as such.

The first of these doctrines is the "single employer" doctrine. It applies in situations where there appears to be multiple entities controlling the employees, yet they functionally operate as one enterprise so that "for all purposes, there is in fact only a single employer."[3] If the entities are deemed a single employer, the NLRA's protections for collective bargaining apply to it as if it were one employer, rather than multiple separate entities. To determine whether these multiple entities constitute a single employer, the NLRB looks at whether there is interrelation of operations, centralized control of labor relations, common management, and common ownership or financial control.[4] Centralized control over labor relations tends to be the most critical element, and common ownership, while typically necessary, is not dispositive. The single employer doctrine tends to be used in the context of a business subcontracting integral parts of its operations.

A related but distinct principle of labor law is the joint employer doctrine, which has been subject to significant legal disputes in recent years. Historically, courts and the NLRB found joint employment where one or more entities exert "direct and immediate" control over the employment terms of employees seeking unionization. Under this fact-specific inquiry, if a group of employees can show that an entity effectively controls the working conditions of unionizing employees, it will be found to be a joint employer with the direct employer and compelled to comply with the requirements of labor law, such as good-faith collective bargaining.

In 2015, the NLRB relaxed the "direct and immediate" standard for the joint employer doctrine

in *Browning-Ferris Industries*, which held that the putative joint employer need only "share or codetermine" the terms and conditions of employment.[5] The ruling implicated businesses that make heavy use of contractors, staffing companies, and franchisors, and drew vigorous opposition from the Chamber of Commerce and employers such as McDonald's.[6] The Trump Administration's pro-business NLRB then issued regulations in 2020 returning the standard to the pre-*Browning* "direct and immediate" control requirement. Later in 2023, the Biden NLRB issued yet another set of rules discarding the 2020 rules and reimplementing the *Browning-Ferris* standard, but a U.S. District Court promptly stayed the new rules' enforcement, a ruling that is now pending appeal.[7] Going forward, the standard will remain subject to much dispute, and it may influence the outcome of joint-employer questions in the context of physician unionization.

Implications for Physicians

Whether physicians can successfully invoke the single and joint employer doctrines will influence the effectiveness of unionization. For example, if physicians unionize against a staffing company but are unable to compel a hospital to collectively bargain, the physicians will be unable to negotiate working conditions dictated by the hospitals. The same is true for physicians employed under a PC-MSO structure: the MSO, if it can avoid the status of employer, would not be compelled to bargain over the working conditions it controls. On the other hand, if physicians can invoke these doctrines, they will not only be able to bargain over all the conditions of their employment; they'll also be protected from retaliation for unionizing or striking, as labor law would prohibit the hospital, for example, from terminating a contract with a physician staffing company in response to unionization.

These labor law questions could also implicate the enforcement of CPOM bans. In states where CPOM bans prohibit corporate employment of physicians, findings from the NLRB and courts that MSOs or hospitals are essentially functioning as employers could encourage tighter regulation of the PC-MSO model. The specter of such findings could serve to benefit unionizing physicians. As corporate entities using the PC-MSO and Friendly PC models seek to avoid adverse determinations as single or joint employers, physician unions may be able to gain concessions in bargaining in exchange for withholding a challenge on single or joint employment.

With physician unionization and corporate employment accelerating in recent years, these

questions are no longer theoretical. For instance, a recent NLRB case considered a physician union challenge to the Friendly PC structure in California. There, the unionized physicians are directly employed by two professional corporations, Family Medicine and Healthcare Partners Medical Group. Those professional corporations are each solely owned by Dr. Derek Chao. Dr. Chao is the "friendly physician" installed by the professional corporation's MSO, Optum, which is a subsidiary of the insurance conglomerate, UnitedHealth Group. Dr. Chao, in fact, works for Optum as the president of Optum West.

In the dispute before an NLRB regional director, the unionized physicians unsuccessfully argued that Optum should be considered a single employer.[8] The fact record demonstrated that Optum controls management and administration functions, employment of nonclinical staff, training, marketing, employment policies for physicians, and many other forms of control. However, the NLRB regional director found under a single-employer analysis that the entities did not comprise an "integrated enterprise." The director here appeared to focus on the absence of a common owner of the distinct entities, finding that "the record is devoid of references to the specific entity known as Optum, Inc." In a footnote, the director concluded that the union would also fail under a joint employer analysis, "based on the dearth of record evidence concerning that entity."

The case has limited value given the undeveloped fact record and the sparse analysis of the joint employer question. But it is nonetheless relevant that the NLRB regional director found for Optum despite uncontroverted evidence of the Friendly PC model. That is, the fact that the sole owner of the formal employer (the medical practice) is a physician employed and paid by Optum was insufficient to conclude that Optum was a single employer. Future challenges, with more developed fact records, will help clarify how the NLRB interprets PC-MSO arrangements.

Joint employment questions are also bound to arise where physicians treating patients in a hospital setting are employed by corporate staffing companies. Today, one-third of emergency room physicians are employed by private-equity-backed staffing companies, such as Envision and TeamHealth. Hospitalists and other hospital-based physicians, such as anesthesiologists, are also increasingly employees of staffing companies. In California, a pending federal lawsuit is alleging that Envision's use of the Friendly PC model violates the state's CPOM ban. In Michigan, physicians at a hospital staffed by TeamHealth have unionized, and they recently went on strike. In all of these arrangements, the degree of control exercised by both the lay MSO and the non-

employer hospital may supply grounds for single or joint employment status.

In a recent case of first impression, an NLRB regional director in Seattle found joint employer status to exist between a hospital system, PeaceHealth, and a staffing company, Sound Physicians.[9] The dispute involved a unit of thirty physicians, physician assistants, and nurse practitioners unionizing against Sound. The clinicians argued that while they were formally employed by Sound, the hospitals had direct influence on their terms of employment and were therefore joint employers. Sound argued that any control over terms and conditions of employment by the hospitals was indirect and merely a result of the contract between Sound and PeaceHealth for staffing support. The director, while expressly rejecting the 2023 heightened joint-employer standard, found Sound's arguments to be unpersuasive. The director concluded that the hospitals exercised sufficient control over wages, benefits, hiring, discharge, and other employment-related issues to be a joint employer. Sound and PeaceHealth have appealed the decision.

Together, these recent cases suggest that more disputes over single and joint employment are forthcoming in the context of physician unionization. The regional decisions by the NLRB are not binding on other regions, though early decisions might have a persuasive effect. How physicians and employers strategically navigate these doctrines will be a development worth watching.

Conclusion

As corporatization of the medical profession continues, physicians are increasingly turning to labor law to collectively bargain over the terms and conditions of their employment. At the same time, state lawmakers and courts may be looking to strengthen CPOM bans that limit or prohibit direct employment of physicians, leading to the PC-MSO and other models of contractually complex employment relationships that will continue to evolve. Together, these factors raise the salience of the single and joint employer doctrines for physician unionization efforts, potentially allowing unionizing physicians to compel multiple corporate entities to comply with labor law rules set forth for employers. How courts and labor boards view these questions will influence the relative power of physicians in the context of unionization–and may influence rejuvenated efforts to enforce CPOM bans.

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[4] *See Radio Union Local 1264 v. Broadcast Service*, 380 U.S. 255, 256 (1965).

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[7] *U.S. Chamber of Commerce et al. v. NLRB et al.,* No. 6:23-cv-00553 (Mar. 8, 2024).

[8] *Centers for Family Medicine, GP, and Healthcare Partners Medical Group, PC*, Case 23-RC-311869 (2023).

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