The Rise and Potential of Physician Unions

The consolidation of hospital systems and physician practices under a single corporate umbrella has resulted in major structural changes to the practice of medicine. In 2012, 60% of practices in the US were physician-owned, 23.4% of practices had some hospital ownership, and only 5.6% of physicians were direct hospital employees. After a surge in acquisitions of physician practices over the decade, and in response to the COVID-19 pandemic, the fraction of physicians employed by hospitals or health systems reached 52.1% and 21.8% by other corporate entities in 2022, for a total of an estimated 74% of practicing physicians. Many physicians now are employed by consolidated corporate health care systems that span many different communities and increasingly are spread across multiple states.

This rapid transformation has largely followed an aggressive strategy, put forward by hospital and corporate leadership, that seeks scale and exploits market power. However, it is also a strategy that is increasingly at odds with the interests of the physicians working in these organizations. The strategic differences are revealed in a variety of important policy differences, spanning from payer contracting strategies, compensation incentive structures, and service line prioritization. These differences suggest the potential for growing challenges for US medicine.

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Strategic conflicts between hospitals and physicians are not new, but physicians have traditionally negotiated with hospital interests and managed conflict by striving to maintain their independence. The large health care systems currently gaining traction lack avenues for physician advocacy and meaningful participation in organizational governance. As a result, a new trend is likely to emerge: the pursuit of physician unions. Although physician unions have been in existence since the late 1970s, the number of physician unions remains very low compared with other professions and industries. Data for 2021 suggest that 5.9% of practicing physicians and surgeons are union members, while union contracts cover 8.1% of practicing physicians. However, union-organizing attempts are on the rise in the health care industry, with recent successful resident-organizing drives at Stanford, the University of Southern California, and the University of Vermont. Since January 2022, the National Labor Relations Board has received 153 petitions for representation to initiate the unionization process in the health care industry overall, but only 3 include attending physicians. Given the changing nature of medical practice driven by corporate takeovers, these trends suggest there is a missed opportunity for physicians to join together to improve their status, and this opportunity could be helped by a better understanding of labor law.

Labor Law and Unionization

Current labor laws were born out of decades of conflict between labor and management. As part of the New Deal, Congress passed the National Labor Relations Act of 1935 (NLRA), later amended in 1947 through the Taft-Hartley Law. The NLRA allows the formation of unions and the right for those unions to bargain collectively over terms and conditions of employment in private sector businesses. To enforce the NLRA, Congress created the National Labor Relations Board (NLRB), an independent agency with 5 members appointed by the president. The NLRA is a product of legislative trade-offs and compromises, including the critical question of which workers are covered (and thus are eligible to form a union). The NLRA covers almost all private sector employees, including professionals, but because the NLRA is intended to protect laborers, it does not cover independent contractors, supervisors, or managers. Because the NLRA offers little definition of the various worker groups, determining who is a laborer, manager, or supervisor requires a fact-intensive inquiry by the NLRB.

After decades of disputes over unionization in the health care industry, the applicability of the NLRA to several groups seem generally settled. Medical residents, barring unusual circumstances, may form unions. Nurses may generally organize, but “charge” nurses are excluded from unions as supervisors. Part-time physicians working as independent contractors are not covered by the NLRA, nor are physicians in private practice. Full-time salaried physicians at a medical institution are permitted to unionize if they do not exercise meaningful supervision of other employees, but according to a 1980 decision by the Supreme Court, tenured and tenure-track faculty were considered to be managers and are excluded.

The unionization process starts with the filing of petition with the NLRB with proof that 30% of a given group of workers want representation by a specific union. The NLRB administers a vote, usually through a secret ballot of workers, to determine whether a majority choose to unionize. The NLRB then requires the employer to bargain in good faith with the union over terms and conditions of employment, including compensation, benefits, work rules, scheduling, and a grievance procedure for settling disputes. There is no requirement that an agreement must be reached, only that bargaining is conducted in good faith.

Union Considerations

For physicians working in multihospital systems, several elements of this framework must be addressed. First,
physicians need to determine whether collective bargaining is in their interest, in contrast to each physician contracting individually for their services. If collective bargaining is seen as advantageous, physicians need to determine who the union represents: all physicians within a system or only those at a specific hospital? All physicians across specialties or only specific departments? This latter concern reflects the potential challenge when different clinicians have different compensation and governance interests within a single organization.

Second, and related, physicians must consider the benefits of collective bargaining for salary. For example, primary care physicians and specialist physicians may decide to join the same union and participate in joint negotiation with the hospital in a fee-for-service payment model, but they might prefer different unions when the financial interests of primary care physicians and specialist physicians diverge under a capped payment model (this diversity of interest is reflected when nurses and other clinical staff join different unions or different bargaining units under the same union). Importantly, opting for collective bargaining does not require joint negotiations for salary. Sports and entertainment unions, for example, involve contracts that allow star performers to negotiate their own financial deal while the union contract covers other terms such as workplace conditions and benefits.

Third, and most critically, physicians should consider the benefits of collective mobilization to shape hospital policies. Collective bargaining can help address strategic issues that are of great interest to employees, such as in 2022 when nurses at Sutter Health went on strike over staffing shortages and access to adequate personal protective equipment. Policies related to the practice of medicine may benefit from explicit consideration through collective bargaining. Physicians and hospital managers might disagree over patient discharge policies, documentation standards, quality improvement programs, and requirements for after-visit services. For example, hospitals may be incentivized to collect exhaustive coding detail to support their marketing activities, such as for US News & World Report rankings, whereas physicians are pressured to support these activities without direct benefit or compensation. Similarly, physicians in one community might identify local clinical needs and want their hospital to expand services that are not prioritized at a corporate level. Physicians can use labor law to address these kinds of disagreements with hospital leadership.

Unions are not a panacea. They are a tool available to certain physician employees and can be sought as a response to growing tensions within large hospital systems. However, they may not provide as much leverage for input into strategy as physician-led organizational structures such as physician-owned practices or other professional corporation models. For example, Kaiser Permanente Medical Groups are independent regional entities that negotiate with Kaiser health plans and hospitals. Further, unions are likely to expose differences in perspectives and incentives between rank and file physicians and their leaders (such as department chairs). This divergence of interests might further complicate the advocacy of physician interests into governance. In addition, unions will be necessarily reactive to the strategy that underlies large hospital systems, but they can curtail certain abuses such as aggressive relative value unit-based compensation schemes, limit contract provisions such as noncompete clauses, or redress policies that are particularly insensitive to physician needs.

While there are some concerns that unionization might harm patient care by interfering with the patient-physician relationship, it is important to recognize that many business strategies of consolidated health care systems are also potentially harmful to patients, and that unionization might be a lever that physicians can use to push back against those potential harms. Physician unions will be unable to convert the capital-intensive nature of health care systems into a meaningfully different economic enterprise. Those who question the sustainability and wisdom of these US health care giants are unlikely to find that unions can be used to curtail the deleterious effects of health care consolidation.

Conclusions
Over the last decade, there has been a substantial transformation in the organizational structure of physicians practice from independent medical groups to employment by large health care systems, transforming the control of medical care and altering the role of physicians within organizations. Conflicts between physicians and hospital leaders over governance, compensation, work rules, and strategy will likely lead to an increased likelihood of discussions of physician unions as a response. While unions offer benefits compared with individually negotiated employment agreements, they may be limited in their ability to address the higher governance concerns of the profession.