AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 236
(A-24)

Introduced by: Delaware

Subject: Support of Physicians Pursuing Collective Bargaining and Unionization

Referred to: Reference Committee B

Whereas, the American Medical Association supports physicians' entitlement to engage in collective bargaining, and it is AMA policy to advocate for broadening the scope of eligibility for this right under federal law, thereby expanding the number of physicians eligible to join unions[1]; and

Whereas, the AMA highlights that bargaining units consisting solely of physicians are presumed appropriate,[1] a recommendation that aligns with the acknowledgment of physicians' unique skills, distinct expertise, and ethical and professional obligations; and

Whereas, in 1999 the AMA provided financial support for the establishment of a national labor organization, the Physicians for Responsible Negotiation (PRN), under the National Labor Relations Board (NLRB), an initiative aimed to support the development and operation of local physician negotiating units as an option for employed physicians and physicians in-training, but due to limited participation from physicians, the AMA withdrew this support in 2004[1]; and

Whereas, since 2004, the number of physicians belonging to unions in the United States has reportedly surged, with a notable 26% increase from 2014 to 2019 reaching a total of 67,673 physicians that were union members[1]; and

Whereas, the percentage of physicians in the United States now employed by hospitals, health systems, or corporate entities has seen a substantial rise, reaching 73.9% as of January 2022, compared to 47.4% in 2018, and the acquisition of physician practices by hospitals and corporate entities escalated between 2019-2022 during the pandemic[2,3]; and

Whereas, the shift from a workforce of independent professional physicians to one composed of employed physicians fundamentally alters the dynamics among hospitals, health systems, corporate entities and physicians, with a risk of adversely affecting the conditions under which care is delivered and quality of care provided,[4] consequently altering the physician-patient relationship; and

Whereas, major hospitals, health care systems, and other corporate entities that employ physicians may restrict employment options available to these professionals in a market largely influenced by their employer or where covenants not to compete may further contribute to an employer's bargaining advantage[1]; and

Whereas, the increasing corporatization of medicine, encompassing private equity involvement in health care, raises concerns about alignment of incentives, costs, impacts on physician wellness, and subsequent downstream effects on patients[5,6]; and

Whereas, in recent years, there has been a rise in physician burnout, exacerbated by the COVID-19 pandemic, primarily stemming from the excessive time dedicated to electronic health record documentation, bureaucratic administrative duties, and moral distress arising from a misalignment between physicians' values and the incentivized actions dictated by the health care system[7-11]; and

Whereas, as physicians increasingly transition to employment, there's a trend toward standardization of work schedules, time of appointments, and other aspects of work conditions. Studies indicate that burnout is directly impacted by a lack of control over work conditions and that granting more autonomy can mitigate stress and burnout, and even reduce cardiovascular risk[12]; and

Whereas, physicians encounter significant power differentials when negotiating with hospital systems as employers and may lack sufficient influence without collective bargaining to counterbalance the dynamic[1]; and

Whereas, collective bargaining serves as an effective mechanism for safeguarding patient care safety standards, enhancing work conditions, securing fair compensation and job stability, and establishing a structured process for addressing grievances; and

Whereas, unionization is linked with enhanced wages and benefits, as well as diminished disparities in compensation for minority groups[13]; and

Whereas, in 2022, the National Labor Relations Board concluded that employed physicians are not in a supervisory role simply by virtue of their position in the organization and, therefore, may be eligible to unionize[14]; and

Whereas, collective bargaining and unionization do not necessarily require resorting to strikes. For example, first responder unions often utilize binding arbitration as an alternative tactic. Other potential strategies may include work slowdowns, picketing, mass resignation, whistleblowing to regulatory and accrediting bodies, boycotting administrative tasks, and suspending billing activities, among other options; therefore be it

RESOLVED, that our American Medical Association investigate avenues for the AMA and other physician associations to aid physicians in initiating and navigating collective bargaining efforts, encompassing but not limited to unionization. (Directive to Take Action)

Fiscal Note: $43,308: Consult experts and coordinate with medical societies to identify and communicate ways to aid physicians in collective bargaining efforts.

Received: 5/3/2024

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RELEVANT AMA POLICY

D-383.977 Investigation into Residents, Fellows, and Physician Unions
Our AMA will study the risks and benefits of collective bargaining for physicians and physicians-in-training in today's health care environment. [Res. 606, A-19]

D-383.988 Collective Bargaining and the Definition of Supervisors
Our AMA will support legislative efforts by other organizations and entities that would overturn the Supreme Court's ruling in *National Labor Relations Board v. Kentucky River Community Care, Inc., et al*. [BOT Action in response to referred for decision Res. 248, A-01; Modified: BOT Rep. 22, A-11; Reaffirmed: Res. 206, A-19]
Update:
2022: In Piedmont Health Services, Inc. and Piedmont Health Services Medical Providers United, Case No. 10-RC-286648, Region 10 of the National Labor Relations Board (Region) issued a Decision and Direction of Election (DDE) in which it held that physicians are not supervisors under the National Labor Relations Act (the Act) simply by virtue of their position in the healthcare institution.

This DDE is notable, as it confirms that physicians will not automatically be considered supervisors under the Act and may seek union representation. Indeed, Piedmont's physicians and providers ultimately voted in favor of union representation. Healthcare employers should consider reviewing their physicians' job descriptions and job duties to determine whether they potentially can be considered supervisors under the Act.

H-385.946 Collective Bargaining for Physicians
The AMA will seek means to remove restrictions for physicians to form collective bargaining units in order to negotiate reasonable payments for medical services and to compete in the current managed care environment; and will include the drafting of appropriate legislation. [Res. 239, A-97; Reaffirmation I-98; Reaffirmation A-01; Reaffirmation A-05; Reaffirmation A-06; Reaffirmation A-08; Reaffirmation I-10; Reaffirmed: Res. 206, A-19]

H-383.998 Resident Physicians, Unions and Organized Labor
Our AMA strongly advocates for the separation of academic issues from terms of employment in determining negotiable items for labor organizations representing resident physicians and that those organizations should adhere to the AMA's Principles of Medical Ethics which prohibits such organizations or any of its members from engaging in any strike by the withholding of essential medical services from patients. [CME Rep. 7, A-00; Reaffirmed: CME Rep. 2, A-10; Modified: Speakers Rep. 01, A-17; Reaffirmed: BOT Rep. 13, A-19]

H-385.976 Physician Collective Bargaining
Our AMA's present view on the issue of physician collective negotiation is as follows:

(1) There is more that physicians can do within existing antitrust laws to enhance their collective bargaining ability, and medical associations can play an active role in that bargaining. Education and instruction of physicians is a critical need. The AMA supports taking a leadership role in this process through an expanded program of assistance to independent and employed physicians.

(2) Our AMA supports continued intervention in the courts and meetings with the Justice Department and FTC to enhance their understanding of the unique nature of medical practice and to seek interpretations of the antitrust laws which reflect that unique nature.

(3) Our AMA supports continued advocacy for changes in the application of federal labor laws to expand the number of physicians who can bargain collectively.

(4) Our AMA vigorously opposes any legislation that would further restrict the freedom of physicians to independently contract with Medicare patients.

(5) Our AMA supports obtaining for the profession the ability to fully negotiate with the government about important issues involving reimbursement and patient care.

[BOT Rep. P, I-88; Modified: Sunset Report, I-98; Reaffirmation A-00; Reaffirmation I-00; Reaffirmation A-01; Reaffirmation I-03; Reaffirmation A-04; Reaffirmed in lieu of Res. 105, A-04; Reaffirmation A-05; Reaffirmation A-06; Reaffirmation A-08; Reaffirmed: BOT Rep. 17, A-09; Reaffirmation I-10; Reaffirmed: Sub. Res. 222, I-10; Reaffirmed: Res. 215, A-11; Reaffirmed: BOT action in response to referred for decision Res. 201, I-12; Reaffirmed: Res. 206, A-19]

H-383.988 Physicians' Ability to Negotiate and Undergo Practice Consolidation
Our AMA will: (1) pursue the elimination of or physician exemption from anti-trust provisions that serve as a barrier to negotiating adequate physician payment; (2) work to establish tools to enable physicians to consolidate in a manner to insure a viable governance structure and equitable distribution of equity, as well as pursuing the elimination of anti-trust provisions that inhibited collective bargaining; and (3) find and improve business models for physicians to improve their ability to maintain a viable economic environment to support community access to high quality comprehensive healthcare. [Res. 229, A-12; Reaffirmed: Res. 206, A-19]

AMA Code of Medical Ethics
1.2.10 Political Action by Physicians
Like all Americans, physicians enjoy the right to advocate for change in law and policy, in the public arena, and within their institutions. Indeed, physicians have an ethical responsibility to seek change when they believe the requirements of law or policy are contrary to the best interests of patients. However, they have a responsibility to do so in ways that are not disruptive to patient care.

Physicians who participate in advocacy activities should:

(a) Ensure that the health of patients is not jeopardized and that patient care is not compromised.

(b) Avoid using disruptive means to press for reform. Strikes and other collection actions may reduce access to care, eliminate or delay needed care, and interfere with continuity of care and should not be used as a bargaining tactic. In rare circumstances, briefly limiting personal availability may be appropriate as a means of calling attention to the need for changes in patient care. Physicians should be aware that some actions may put them or their organizations at risk of violating antitrust laws or laws pertaining to medical licensure or malpractice.

(c) Avoid forming workplace alliances, such as unions, with workers who do not share physicians primary and overriding commitment to patients.

(d) Refrain from using undue influence or pressure colleagues to participate in advocacy activities and should not punish colleagues, overtly or covertly, for deciding not to participate.

AMA Principles of Medical Ethics: I,III,VI

The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.
[Issued: 2016]