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"Physician Unionization—Penn Residents, Fellows Bring Debate to Philadelphia," The Legal Intelligencer, authors Christopher Tellner, Greg Hyman, Alexandra Lynch, Gregory Brown, 3-28-2023

As the strain on health care workers imposed by COVID-19 passes, it is an open question whether Penn will be the exception or the rule for hospitals in Pennsylvania. By Gregory F. Brown, Alexandra E. Lynch, Christopher J. Tellner and Gregory S. Hyman

Last February, a supermajority of over 1,400 residents and fellow physicians employed by the University of Pennsylvania Health System (Penn) agreed to be represented by the Committee of Interns and Residents (CIR). CIR is a branch of the Service Employees International Union (SEIU). CIR-SEIU represents more than 24,000 residents and fellows nationwide. If Penn recognizes the union, it would be the first group of doctors in Pennsylvania to organize with CIR. The union would join eight other groups of resident physicians in the nation who elected to be represented by CIR in the last year. As Pennsylvania is part of a national trend, a look at costs and questionable benefits of physician unionization is warranted.

Unionization is not available to every physician. The National Labor Relations Act (NLRA) governs the right of employees to unionize and engage in collective bargaining. NLRA section 2(3), codified at 29 U.S.C.A. Section 152, specifically excludes supervisors and independent contractors from collective bargaining. The majority of physicians in the United States fit the definition of supervisors or independent contractors under the NLRA and are consequently barred from union membership. Physicians organized into a group large enough to exert bargaining power may also encounter obstacles under antitrust laws. Consequently, the trend in resident unionization does not presage a wave of unionization among doctors in general.

In contrast, resident physicians who are non-supervisory employees of a hospital fall into the broad definition of “employee” of NLRA Section 2(3), which is “any employee,” subject to limited exclusions. See 29 U.S.C. Section 152(3). Until 1999, the National Labor Relations Board (NLRB) did not recognize residents and fellow physicians as “employees” under the NLRA because it considered them “primarily students.” See Cedars-Sinai Medical Center, 223 NLRB 251 (1976); St. Clare’s Hospital & Health Center, 229 NLRB 1000 (1977). In St. Clare’s Hospital, the NLRB observed that residents and fellows (collectively house staff) render services that are “directly related to- and indeed constitute an integral part of—their educational program.” The NLRB in St. Claire’s Hospital further observed that the educational experience is “an intensely personal one,” whereas collective bargaining, as its name implies, “represents the very antithesis of personal individualized education.” The NLRB also observed that the teacher-student relationship is different than the employer-employee relationship because there is a mutuality of interest in the teacher-student relationship to foster the student’s education, which is absent in a classic employment relationship.

In 1999, the NLRB reversed its position on house staff status in NLRB v. Boston Medical Center, 330 NLRB 152 (1999). There, the NLRB determined that house staff are “employees” under the NLRA and can form a union. The NLRB observed that while house staff are medical students learning their chosen craft, they are also “employees” within the meaning of NLRA Section 2(3). According to the NLRB, 80% of the house staff activity at issue involved direct patient care. It also noted that house staff do not pay tuition, are paid a salary, receive fringe benefits, are subject to workers’ compensation insurance, and are provided malpractice insurance by their employer. It analogized residents with fledgling attorneys working at law firms, who learn the profession while being considered traditional employees.

Although more than two decades passed since Boston Medical Center recognized the right of house staff to unionize, such unions remain rare. The COVID-19 pandemic precipitated the Penn residents and fellows’ unionization effort, during which they did not receive a cost-of-living increase or raise. They were also required to work extra shifts without additional pay. The residents and fellows claim that unionization will secure better working conditions, compensation, and protections, and therefore alleviate stress and burnout.

Unionization may not achieve the residents’ goals of avoiding stress and burnout. In 2021, JAMA Network Open conducted a cross-sectional survey of 5701 surgical residents. The study was conducted between Dec. 5, 2020, to March 16, 2021, during the heart of the COVID-19 pandemic. It included 690 residents from 30 unionized residency programs. It found that unionized programs were more likely, but not always, to offer housing stipends and four weeks (instead of two-three weeks) of vacation time to residents. However, these limited “benefits” did not alter the unionized employees’ work experience. The study “did not detect any difference in burnout,

suicidality, job satisfaction, duty hour violations, mistreatment, salary, or the educational environment between residents at unionized and nonunionized programs." The study concluded that "these findings suggest that resident labor unions do not appear to improve resident well-being."

JAMA Network Open's findings correspond to the unique characteristics of resident employment, which in many ways render stress unavoidable. As St. Clare's Hospital observed nearly 50 years ago, a residency is not a pure employment relationship, but rather is an integral part of a physician's training. Compensation is low when compared to the income of similarly educated individuals, and 80-hour work weeks are the norm. The intensity of the experience is intended to produce seasoned practitioners with nearly instinctive judgment.

Further, a residency is inherently different from a normal employment process, more closely resembling an educational institution. Residents are placed in programs through a national "match" process that relies in part on an algorithm. The process is competitive, and certain residencies are coveted by applicants. Once a resident is employed in a program, changing to a different one is cumbersome. The incoming resident typically cannot negotiate for a higher salary once accepted. Additionally, unlike more traditionally unionized fields, a medical resident will not remain a hospital employee for an indefinite period, and any benefits of union membership will be, at best, temporary. In that setting, there are limits to what collective bargaining can achieve without undermining a residency's educational benefit.

The possibility of a resident physician strike is another concern. While there has not been a resident strike since the NLRB's Boston Medical Center decision, one was narrowly avoided in Los Angeles County hospitals in mid-2022. The strike threat reportedly resulted in a salary increase for the residents. However a resident strike's effect on public safety and patient care raises ethical considerations unique to the medical field. The hypocritic oath provides that "I will follow that system of regimen which, according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous." A resident strike, which could cripple a hospital's ability to serve its patient population is arguably inconsistent with the oath.

As the strain on health care workers imposed by COVID-19 passes, it is an open question whether Penn will be the exception or the rule for hospitals in Pennsylvania. However, it appears likely that utility of resident physician unionization will remain open for debate for years to come. The ultimate question, which may never be answered, is who benefits: those residents and fellows who join a union, or the union itself. Certainly, patients will unlikely appreciate any benefit.

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