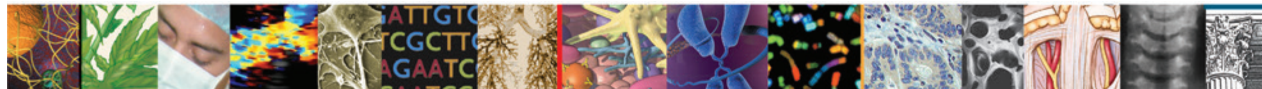

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Perspective
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Hospital Consolidation and Physician Unionization

Kevin Schulman, M.D., and Barak Richman, J.D., Ph.D.

The U.S. health care delivery system is undergoing a massive restructuring. Two developments have characterized this transformation. First, since the 1990s, hospitals have been consolidating to form health systems that now exert monopolistic leverage in many health care markets in the United States. Second, after the passage of the Affordable Care Act in 2010, these systems — along with large insurers and other corporate entities — began aggressively acquiring physician practices.

The result has been a sea change in physician-practice structures. In 2012, only 5.6% of U.S. physicians were directly employed by a hospital,[1] and another 23% were in a practice that was at least partially owned by a hospital, according to a survey from the American Medical Association. By January 2022, the proportion of hospital-employed physicians had risen to 52%, with another 22% of physicians being employed by other corporate entities.[2] Most physicians now face the possibly new experience of being employees of increasingly large organizations — a challenging scenario for a profession that has jealously guarded its independence and autonomy.

Not coincidentally, another workforce-related change has been slowly occurring in the United States: the formation of physician unions. Between 2014 and 2019, the proportion of physicians who were unionized grew by 26% (albeit from a low level), and this trend has accelerated over the past few years.[3] In 2023, newspapers throughout the country reported on a successful union drive by 400 primary care physicians at Allina Health, based in Minneapolis. In the northwestern United States, about 200 hospitalists at six Legacy Health hospitals formed a union. In early 2024, physicians at Salem Hospital in Massachusetts, affiliated with Mass General Brigham, and anesthesiologists at Cedars–Sinai Medical Center in Los Angeles formed unions. This activity was in addition to a parallel wave of labor organizing among house staff in major health systems, including at Stanford Health Care (where we have appointments) and Penn Medicine; the Committee of Interns and Residents, a union under the Service Employees International Union, reports representing more than 30,000 U.S. members, which is nearly the total number of people who matched into residency programs in 2023.

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Unionization is neither a rash reaction to professional frustrations nor an upstart, leftist political movement; it is a natural consequence of hospital consolidation and the corporatization of health care delivery. Depending on the way in which a health system chooses to allocate overhead costs among various clinical services, physicians can find that management seems to view their service as a financial drain on the organization. Executives may also consider physicians to be largely interchangeable, despite such matters as clinical focus or tenure in a community or at a facility. Amid shifts in practice structures, physicians may experience a deterioration in their working conditions, job satisfaction, and — most important — involvement in the governance of health care delivery, which has prompted some critics to warn that physicians are becoming "cogs of capitalism."[4]

Unions are structures that permit collective bargaining between labor and management. Under the National Labor Relations Act, passed in 1935, employers are obligated to negotiate with unions on matters concerning "wages, hours, and other terms and conditions of employment."[1]

With U.S. physicians increasingly becoming employees, they have also become exposed to a world in which the terms and conditions of their employment, compensation, and clinical practice are enshrined in legal contracts. Although these agreements are often described by health systems as "standard," they are subject to negotiation. Individual physicians typically have little expertise in conducting negotiations, however, and little bargaining leverage.

Collective bargaining by means of unions offers a potential remedy to this power imbalance. As physicians explore whether collective bargaining can address their new concerns about the health care system and the future of medicine, they are likely to find that unions offer two opportunities that otherwise wouldn't be available in today's health sector.

The first is the opportunity to negotiate over wages with monopolists. By definition, a monopolist employer (or, more precisely, a single purchaser, or monopsonist, of labor) will set wages at subcompetitive levels. Employers with a unionized workforce, however, are under a legal obligation to negotiate in good faith with union representatives. This obligation explains why workers in industries dominated by a single employer, such as sports leagues, often choose to form unions. Without the National Football League (NFL) Players Association, for example, the NFL could set below-market wages, and the world's best football players would have little bargaining recourse. The National Basketball Players Association has negotiated over "collective revenue," and the new National Basketball Association (NBA) collective bargaining agreement ensures that the players collectively will receive 51% of the league's basketball-related income. Contrary to popular belief, collective bargaining is intended to bring order — not chaotic threats of work stoppages — to management–labor relationships, which helps explain why previous physician strikes have had no discernable effect on health care outcomes.[1]

The second opportunity offered by unions involves the ability to voice concerns about and influence organizational governance. Unions often express workers' concerns about non–wage-related matters, including issues affecting job satisfaction, professional meaning, and workplace conditions. Only a fraction of the NBA's collective bargaining agreement's 676 pages concern compensation. The NFL Players Association regularly holds teams accountable for player safety, training-room resources, and other nonmonetary concerns. The Air Line Pilots Association advocates for aviation safety at an industry level and addresses operational performance issues affecting individual airlines. Governance matters are a primary concern for many U.S. physicians who are grappling with new challenges regarding staffing, clinical care workflows, functionality of electronic health record systems, and patient care resources, but who find that their ability to address any of these issues is limited.

It should therefore come as no surprise that recent unionization efforts by physicians have been driven largely by nonwage issues. Physicians supporting these drives have emphasized concerns about staffing, burnout, and the quality of patient care as motivations for unionization. Collective bargaining has been a direct response to the most negative consequences of hospital consolidation for physicians' roles in organizational governance and for clinical practice.[5]

Any decision to pursue unionization, however, will require phy-

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sicians to make strategic decisions about how they organize. One focal issue involves the identification of a bargaining unit. Labor law grants employees wide latitude in deciding whom a union represents. Some physician unions include only highly supervised physicians, such as residents, and others cover only a single medical specialty. The new union at Allina Health includes primary care physicians, nurse practitioners, and physician assistants. One limitation to collective bargaining is that a single representative negotiates for the entire bargaining unit, but a broad unit that might pursue substantial governance and pay reforms will necessarily represent physicians with diverse clinical interests. It can be difficult, for example, for the NFL Players Association to simultaneously advance the interests of quarterbacks and linemen, who tend to improve over time and have long careers, and those of running backs, whose performance often peaks shortly after they enter the league. If physicians cannot reconcile their interests within a single bargaining unit, various physician unions could present conflicting agendas when negotiating with management at a particular institution.

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An audio interview with Kevin Schulman is available at NEJM.org

It's still too early to assess whether this new wave of physician unionization can counteract the monopolistic and corporate tendencies of hospital employers and whether unions can help satisfy physicians' interest in governance and restore some of their professional autonomy. Regardless of how union-organizing efforts pan out, understanding the motivations underlying this trend is critical. For most physicians who have been accustomed to making decisions about resources, service provision, and staffing, the new prevailing employment model remains something of a shock. But hospital-consolidation trends that have implications for both professional satisfaction and clinical autonomy most likely aren't going away. If the collective response is hopelessness and dissatisfaction, the medical field may be at risk for large numbers of physicians exiting practice at a time when demand for services is increasing owing to the aging of the U.S. population. We believe that both the physician community and policymakers should monitor growth in unionization efforts to assess whether unions have exhibited the ability to achieve their stated goals and continue to explore parallel strategies for redressing potential harms associated with hospital consolidation. It's clear that the medical field in the United States is in a period of adjustment, and it remains an open question how important physician unions will be during this restructuring.

Disclosure forms provided by the authors are available at NEJM.org.

From the Clinical Excellence Research Center, School of Medicine (K.S., B.R.), and the Graduate School of Business (K.S.), Stanford University, Stanford, CA; and the George Washington University School of Law, Washington, DC (B.R.).

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