THE FUTURE OF PHYSICIAN UNIONIZATION

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BACKGROUND

The National Labor Relations Act (NLRA) administered by the National Labor Relations Board (NLRB) was amended in 1974 to include private nonprofit hospitals. Under the provisions of this law and NLRB rules, all hospital employees were given the right to engage in protective concerted activity for the purpose of union organizing and to engage in collective bargaining on all matters involving their hours, wages, benefits, and working conditions. At that time few physicians were employed by hospitals, as the vast majority were in private practice. Since the NLRA was amended there have been over 2,000 NLRB conducted union representation elections. As of 1985, roughly 35% of private nonprofit hospitals have union representation in one or more of the following NLRB designated bargaining units: Physicians, Registered Nurses, Other Professionals, Licensed Technical, Office Clerical, Service Maintenance, Security.

TODAY

There are 5,121 community hospitals and 58% or 2,970 are non-governmental, private, nonprofit hospitals and multi-hospital systems covered under the NLRA. There are currently 1,030,000 licensed physicians, with approximately 866,000 primarily engaged in direct patient care. Of these, approximately 450,000 are employed in non-governmental, private, nonprofit community hospitals and work under individual employment agreements. An informed estimate is that approximately 8-12% of the 450,000 NLRB-eligible physicians are currently represented by a union. This low number is due to several factors, including:

- continued emergence and adaptation to the hospital-employed physician model;
- physician lack of knowledge regarding the NLRA, NLRB, and protective organizing rights;
- lack of a proven collective bargaining model that resolves issues while protecting existing employment contracts;
- lack of union knowledge and expertise in physician-specific employment issues that can be negotiated through collective bargaining;
- physician perception that unions are detrimental to patient care.

In addition to the above, it would be difficult to negotiate a collective bargaining agreement that could replace existing physician employment agreements while adequately addressing the specific needs and nuances of individual specialty physicians.

SHIFT IN PHYSICIAN EMPLOYMENT

By best estimates, there are approximately 450,000 physicians now working in 2,970 non-governmental, private, nonprofit hospitals; of these, approximately 2,100 are part of a multi-hospital system. This dramatic shift from private practice to physician employment was initiated by hospitals and health systems that actively acquired physician practices and established physician employment models to expand their market presence and gain negotiating leverage with insurance providers. For physicians, it eliminated the risk and burden of

private practice while providing employment contracts that could:

- assure a secure income;
- provide competitive employee benefits;
- offer less time doing administrative work;
- provide access to larger referral networks;
- shift the risk and costs associated with insurance company negotiations, EMR systems, compliance matters, and the recruitment and hiring of support staff, etc., to the hospital.

COMPETITION FOR PHYSICIAN TALENT

Of the current 866,000 physicians actively engaged in clinical practice, it is estimated that 46% are over age 55 and 20% are already age 65. If everyone had equal access to physician care, it is estimated that we would currently be short approximately 220,000 physicians. Hospitals will need to actively recruit physicians to just stay abreast of current demand. Competition among hospitals for physician talent will increase over the next few years.

Competition for physician talent will be more acute in pediatric hospitals. There are 200 children's hospitals across the United States. This includes 50 freestanding acute care children's hospitals and numerous pediatric hospitals embedded within larger health systems. Currently there are 78,000 board-certified pediatricians, 62,000 of which are practicing general pediatricians. It is estimated that by 2037, there will be a shortage of 13,000 pediatric physicians, with several key specialties already facing substantial shortages and access problems.

EMERGING PHYSICIAN DISSATISFACTION

With the shift in hospital-based physician employment now a reality, physician dissatisfaction with the current employment model is beginning to emerge. This dissatisfaction is multifaceted; the issues, intensity, and levels will vary by hospital, but here are the basic themes:

- underlying distrust between hospital senior leadership and physicians;
- unresponsive leadership in addressing legitimate physician concerns;
- poor communication and lack of transparency in compensation decisions;
- lack of input into matters affecting work, medicine, and patient care;
- job stress due to staffing, long hours, call schedules, patient load, etc.;
- job insecurity due to perceived arbitrary decisions and lack of job protection.

NEW PHYSICIAN EMPLOYMENT MODEL

The new physician employment model consists of two separate employment agreements: the current individual employment agreement, which typically contains boilerplate language intended to protect the hospital, and a Physician Master Collective Bargaining Agreement containing negotiated language intended to protect physicians and address collective concerns.

It can be argued that with this new employment model, physicians have the best of both worlds. In fact, this employment model already exists under the NLRA and NLRB rules in the NFL, NBA, and MLB. Professional athletes employed by their respective teams have both an individual employment agreement and a Master Collective Bargaining Agreement. In the case of these major league sports teams, rather than each team negotiating a separate master agreement, they elected to have their league negotiate one master collective bargaining agreement that covers all teams. In the case of hospital-based physicians, it would be one Physician Master Collective Bargaining Agreement for their respective hospitals or health system.

If hospital-based physicians were to follow the lead of professional sports and file for an NLRB-supervised election by securing a 30% showing of interest among all non-management physicians, and if 50% + 1 of voting physicians voted for representation, the hospital would be required to bargain in good faith for a Physician Master Collective Bargaining Agreement that would establish terms, conditions, and safeguards for all physicians beyond those included in their respective individual employment agreements.

PROJECTED PHYSICIAN UNION ORGANIZING

We believe the level of physician union organizing will increase over the next few years as examples of the new physician employment model begin to emerge and circulate among hospital-based employed physicians through professional journals, physician networks, social media, and third-party union media campaigns. It should be noted that physicians do not need a third-party union to create their own "in-house" professional association to negotiate a Physician Master Collective Bargaining Agreement, as their organizing activity is protected under Section 7 of the NLRA, and the NLRB will respond to any unfair labor practice filed by physicians for any violation of their protected concerted rights to organize. We anticipate an "in-house" physician self-organizing template will emerge from physician advocacy groups, and this "in-house" model will start to materialize.

VULNERABILITY TO PHYSICIAN ORGANIZING

It is important for hospitals to understand that unions do not organize physicians; physicians organize themselves. Any organizing activity will come from within, based on current levels of dissatisfaction. That is why "in-house" organizing is just as viable a threat as a third-party union. Often, there are "flash points" that trigger union interest. There are two types of "flash points": a perceived aggrieved act that triggers an emotional reaction and a sustained failure to resolve a serious problem. Here are some examples:

Compensation

Failure to resolve compensation related issues can be a "slow boil" that eventually triggers union interest.

Physician compensation is complex, as it is governed by a combination of federal fraud-and-abuse laws, tax law, Medicare regulations, state law, and employment law. The federal Stark Law (42 U.S.C. §1395nn) is the single most important legal constraint on hospital-employed physician compensation. It requires the following: compensation must be for legitimate identifiable services; be at fair market value; not be determined based on the volume or value of referrals to the hospital; and be "commercially reasonable" even if the physician made no referrals. In addition, certain Medicare regulations affect physician compensation arrangements, particularly when physician services are included in provider cost reports or specific reimbursement programs. Historically, Medicare has also imposed limits on some reimbursable physician compensation costs.

Hospitals rely on independent compensation consultants and validated external benchmark compensation survey data to document reasonableness and fair market value (FMV). Because of these requirements, hospitals are basically restricted to paying physicians a salary based on a FMV salary range, signing bonuses, quality incentives, work RVU productivity bonuses, call coverage pay, and medical director stipends.

While physician collective bargaining cannot circumvent the laws governing physician

compensation, it can address disputes regarding such thorny issues as FMV, commercial reasonableness, salary range placement, annual market factor wage adjustments, wRVU calculations, and other related matters. These "slow burn" irritations are often more of a concern than statutory pay limits.

Typically, a hospital will have an established salary range based on FMV for each physician specialty and pay within that range somewhere between the 10th and 90th percentile. Determination of what percentile to pay within that range is negotiable, as is the "Control Factor" (dollar per wRVU rate), which is set by the hospital as part of the physician compensation plan. A physician's productivity compensation is often calculated as Compensation = wRVUs x Control Factor per wRVU. In addition, some hospital systems use an "internal" control factor when building compensation models. These may be referred to as budget adjustment factors, specialty normalization factors, quality-performance multipliers, market adjustment factors, or compensation pool factors. In this example: Compensation = wRVUs x $70 x 0.95.

When it comes to physician compensation, the devil is in the details, with timeliness, transparency, and communication being essential.

Job Security

In 49 states plus Washington, D.C., employment is governed by what is called "at will" employment; this means absent any contractual agreement otherwise, both employer and employee may terminate their employment "at will" without recourse. Montana is the sole state that departs from this at-will doctrine, as employees are protected by the state's Wrongful Discharge from Employment Act, and employers generally need "good cause" to terminate.

Hospital-based employed physicians' job security is controlled by the provisions of their employment agreement. If physician employment is "at will" with, say, 90 days' notice and there are no offsetting contractual termination provisions, a physician's job security is never longer than 90 days. If a physician's termination is perceived as arbitrary or capricious, it undermines trust in leadership and creates job insecurity. How a hospital treats one physician signals to all other physicians how they may be treated. In a Physician Master Collective Bargaining Agreement, the following provisions are intended to protect the physician.

Termination for Just Cause. No physician shall be terminated without just cause, defined as loss of medical license, exclusion from Medicare/Medicaid, criminal conviction, serious misconduct, or failure to maintain privileges. The employer shall provide written notice and a 90-day opportunity to cure any alleged performance deficiency. Actions based upon quality-of-care concerns shall require completion of medical staff peer review procedures and due process rights.

Termination Without Cause. The employer may terminate without cause upon six months' written notice. Compensation, benefits, and incentive opportunities shall continue unchanged throughout the notice period. The employer shall pay for all required medical malpractice tail insurance coverage.

Staffing

Adequate staffing to assure quality care and reduce burnout is an emotional issue. Examples include:

- unfilled vacant physician positions as well as vacant unfilled NP or PA positions, that increase workload or reduce the time necessary to adequately treat patients;

- unbudgeted but needed specialists to handle increased volume of patient referrals;
- an insufficient number of specialists and/or surgeons needed to handle call coverage, resulting in burnout and lack of crucial personal time away from work.

"Staffing" clauses are one of the most important—and most heavily negotiated—subjects in healthcare collective bargaining agreements. Hospitals typically resist language that limits management's ability to assign work, while physicians seek enforceable standards that protect patient care, physician workload, and physician retention. The following is an example of contract language that can be included in a Physician Master Collective Bargaining Agreement.

Staffing. The hospital recognizes the importance of maintaining adequate staffing levels to support safe, timely, and effective patient care. Physicians shall not be required to accept patient assignments that, in their professional judgment, would compromise patient safety or violate applicable standards of medical care. The hospital shall make every effort to ensure:

- new patient appointments are within 30 days for routine referrals;
- urgent referrals are within 72 hours;
- specialty consultations within medically appropriate timeframes;
- sufficient staffing to limit mandatory call coverage to no more than one (1) weekday in seven (7) and one (1) weekend in six (6), except during temporary vacancies or declared emergencies;
- physician shall not be routinely assigned patient volumes that materially exceed nationally recognized specialty benchmarks absent mutual agreement or declared emergency conditions;
- physician recruitment efforts shall be initiated within thirty (30) days of a vacancy.

Failure to meet these standards for two consecutive quarters shall trigger a formal staffing review and corrective action discussions.

Lack of Input

Most hospital-based physicians want to feel they have input and control over matters that affect their professional life and their practice of medicine. Ideally, this need is adequately met through effective responsive physician leadership and transparent communications with senior hospital leaders. However, when this unresolved need is not met, the following provision can be included in a Physician Master Collective Bargaining Agreement.

Joint Physician–Management Council. The hospital and union/physician association shall establish a Joint Physician–Management Council ("Council") to promote collaboration regarding patient care, physician practice conditions, quality improvement, staffing, physician well-being, operational efficiency, and strategic initiatives affecting physicians. The Council shall consist of an equal number of physician representatives selected by the physicians and management representatives appointed by the hospital. Physician members shall constitute no fewer than fifty percent (50%) of the Council's voting membership. The hospital's Chief Medical Officer or designee shall serve as a management representative. The Council may invite subject matter experts to participate as non-voting advisors. The Council shall meet at least monthly, with additional meetings scheduled upon request of either party when urgent matters affecting patient care, physician staffing, physician safety, or physician workload arise. Physician representatives shall be compensated at their regular rate for all Council activities occurring outside scheduled

clinical time. No physician shall be disciplined, evaluated adversely, denied advancement opportunities, or otherwise retaliated against for raising concerns, presenting recommendations, or participating in Council activities. The Council shall be authorized to review and discuss:

- physician staffing levels and vacancies;
- recruitment and retention initiatives;
- patient access and appointment wait times;
- clinical workload and productivity expectations;
- call schedules and coverage arrangements;
- electronic health record functionality;
- quality and patient safety metrics;
- physician wellness and burnout indicators;
- new clinical programs and service lines;
- facility expansions, consolidations, or closures affecting physicians;
- policies materially affecting physician practice.

The hospital shall provide the Council with relevant non-confidential information reasonably necessary to evaluate issues within the Council's jurisdiction, including:

- physician vacancy data;
- recruitment metrics;
- turnover statistics;
- patient access measures;
- quality metrics;
- physician engagement survey results;
- workload and call coverage reports.

Prior to implementing any material change affecting physician staffing, workload expectations, compensation structure, call coverage, clinical scheduling, clinical operations, or physician practice conditions, the hospital shall provide notice to the Council and an opportunity for consultation.

Physician Master Collective Bargaining Agreement Provisions

The following is a limited thumbnail list of potential negotiated provisions in a Physician Master Collective Bargaining Agreement.

1. Recognition
2. Purpose
3. Management Rights
4. Physician Rights and Professional Autonomy
5. Compensation
6. Workload and Panel Management
7. Staffing
8. Call Coverage
9. Hours of Work
10. Professional Development
11. Malpractice Coverage
12. Benefits
13. Peer Review and Due Process
14. Discipline
15. Termination For Just Cause
16. Termination Without Just Cause
17. Reduction in Force
18. Physician Management Council
19. Union Rights
20. Grievance Procedure
21. Binding Arbitration
22. Patient Safety Protections
23. Wellness and Burnout Prevention
24. No Strike / No Lock Out
25. Duration

THE NEW PHYSICIAN EMPLOYMENT MODEL IS COMPELLING

Just like professional athletes, the potential for physicians to have the best of both worlds in their employment setting is compelling as it gives them the value of their individual employment agreement and the added benefit and security of a Physician Master Collective Bargaining Agreement.

ON THE HORIZON

Unlike non-physician employees, physicians are the only ones licensed to practice medicine, they are ultimately accountable for patient medical management, and they alone lead the hospitals allied health teams. They are "the mission." Physician union organizing is collegial, begins from within, and is led from within. It is fruitless to attempt to fight a physician union organizing attempt with traditional counter union defense methods, as "they are the union." To attack their union, whether it be a third-party union or an in-house association, is to literally attack your own physicians, thereby magnifying the conflict and reinforcing the need for a Physician Master Collective Bargaining Agreement.

In the future, hospitals can expect a new and energized effort, either from within or by third-party unions, to secure the required 30% showing of interest necessary to file for an NLRB supervised physician representation election. If an election is filed, the likelihood of a physician union winning is estimated at over 80%, based on prior election results. Emerging unions such as the Union of American Physicians and Dentists (UAPD) are well financed, actively organizing, and monetarily incentivized as their union dues are 0.9% of a physician's annual salary. Nationwide current average physician annual earnings are $374,000. Therefore, this union would receive on average $3,366 annual dues per physician. Despite the cost of union representation, on September 2, 2026, physicians and PAs at Banner Health in Phoenix, AZ, voted for representation in an NLRB election.

Banner Health physicians, providers in Arizona vote to form union

In the future, we believe physicians will seriously consider forming their own "in-house" union.

PRAEVENIRE MELIUS EST QUAM CURARE

"Prevention is better than cure"

Today, enlightened hospital governance is faced with four options when confronted with the reality of physician efforts to create the new employment model and negotiate a Physician Master Collective Bargaining Agreement.

1. **Ignore it** with the belief physicians are satisfied with the status quo and have no real interest in change.
2. **Fight it** in which case you may create a public relations nightmare, especially if being organized by a union adept at corporate campaign tactics.
3. **Embrace it** if you believe it will provide a manageable structure to address physician concerns and be used as both a recruitment and retention tool.
4. **Prevent it** if you have the physician leadership and are willing to proactively adopt unique physician employment policies and practices designed to eliminate the need.