

ARTICLE

Physician movement toward organized labor indicative of serious root causes

What's trending: Physicians and residents look to unions, collective bargaining

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Organizing, unionizing, and collective bargaining are on the rise in healthcare. The 27 healthcare labor strikes in 2023 alone are evidence of that. While nurses and other hospital workers have unionized for many years, a new group has joined them: physicians and residents.

Residents and fellows have unionized at several major healthcare institutions across the country in the past few years, including academic medical centers and regional health systems.

Forces at play include persistently challenging working conditions, increasing percentages of employed physicians, and high levels of burnout. Healthcare workers are concerned about both their own well-being and the associated impact on patient care.

Why it matters

This increased trend toward unionization is a symptom of challenging workforce dynamics. Assessments by the Chartis Center for Burnout Solutions shine light on some of the most prominent issues that are spurring physicians to action. These issues include:

1. **Patient safety.** Physicians' concerns about patient safety have intensified in recent years. For example, one academic health science center in 2019 started comparing scores on the assessment question, "To what degree is burnout impacting safety?" The assessment looked at 12,000 reported safety events, which included everything from near misses to serious errors. It then armed quality staff responsible for reducing errors with case-based insights. As quality has improved, so has the score of related physician burnout at the institution.

2. **Feeling unappreciated.** This is a critical driver of physician turnover and burnout. But a serious schism exists between what healthcare leaders often consider appreciation and what front-line physicians do. Both leaders and physicians recognize the power of compensation. Beyond that, leaders often think of public expressions of mass appreciation. Yet data indicates that addressing day-to-day work impediments, consulting workers about what they need to improve their workflows, and privately expressing affirmative appreciation are far more effective.
3. **Marginalization of physicians in decision-making.** Physician input into their daily practice has steadily eroded. Scheduling can be a particularly challenging issue. As health systems have consolidated, metrics such as fill rates can result in unintended consequences if scheduling templates and centralized scheduling don't allow for the tailoring certain specialties or settings need. Common sources of physician frustration include insufficient time with certain patients and appointments with patients who still need prerequisite visits or testing. For example, an orthopedic patient may present without having scans the surgeon needs to make care decisions. On the surgical side, operating room (OR) staffing done en masse means that many surgeons who perform highly technical or stressful procedures may be operating with entirely new teams every time they go into an OR.
4. **Sheer number of hours for residents and fellows.** Despite duty call rules, hours are an obvious stressor for residents and fellows. A common concern is having time for family obligations, their own medical appointments, and other needs. Informal conversations with medical students at multiple institutions revealed that many are strategically ranking unionized residencies higher in their match choices. They believe salary and time off will be more favorable at these institutions. They noted that residents who were part of unions spoke openly about well-being instead of feeling like it was a forbidden topic that would only reveal an applicant's weakness or lack of commitment.

What's next

To address these root issues, leaders should consider these tactics and strategies:

1. **Formally assess what matters to physicians.** Leaders sometimes jump from crisis to crisis, responding to the most pressing problems or most vocal physicians. But taking the pulse of the entire physician community can be much more effective. Leaders can harvest the wisdom of front-line physicians through focused listening groups and well-being surveys aimed toward soliciting recommendations. They can then use these insights to prioritize actions and diminish collective physician frustrations.

For instance, one academic health system applied such insights, addressing portal screening and reducing interactions with insurance companies. As a result, it reduced the average work week by 5 hours for physicians across specialties. This, in turn, dramatically improved burnout rates.

2. **Develop a shared governance model.** Instead of focusing on collective bargaining, in which participants work toward agreements under threat of labor action, organizations can proactively include physicians in governance. Physicians who are selected, elected, or a combination of both can collaborate with organizational leaders on decisions that matter for their practice environment.

For example, a chief executive officer discovered through a survey and focus groups that physicians wanted more assistance with discharge planning, interpreting, and social work. He used a shared governance model to identify potential hires to address this need within the confines of a dedicated budget.

Similarly, patient safety is at the forefront of healthcare professionals' concerns. Organizations that embrace high reliability care alter their culture to empower the workforce with data, processes, and support that ensure high-quality care. A high-reliability culture also fosters a learning environment in which employees can openly discuss quality issues and recommend improvements. In a culture of high reliability care, physicians are involved in input, decision-making, and enactment, much like owner-operators.

3. **Reinforce accountability for change.** Once an organization establishes the desired improvements and shared-governance model, it needs to ensure shared accountability for achieving goals. Leaders need to have a system in place that includes measurement, monitoring progress against targets, and communicating the change back to physicians.

Physicians often feel that the administration simply talks a good game, but they want to see actual changes, backed up with data and examples. For instance, if a goal is reducing serious medical errors by 20%, then leaders should regularly review progress. They also need to share month-over-month results and the steps for ongoing improvement.

4. **Celebrate and spotlight true physician engagement.** Leaders should build opportunities to raise physician voices in governance and decision-making processes. But these efforts will not dramatically increase credibility with physicians unless leaders also execute a coordinated communications and engagement campaign that recognizes those successes.

For example, one recent effective campaign included giving front-line physician leaders the tools and training they needed to lead and drive communications. Under their leadership, the campaign focused on meaningful communications and engagement opportunities that spotlighted physician-led initiatives, celebrated that work, and fostered a sense of a community that truly values its physicians.

Whether or not a hospital or health system has seen movement toward organized labor, implementing strategies to address the root issues underlying the trend will ultimately build a stronger workforce. Doing so will also foster better outcomes for their patients and their organization.

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