REPORT 2 OF THE COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT (A-24)
Scenarios on Collective Action and Physician Unions

EXECUTIVE SUMMARY

The AMA estimated in 1998 that between 14,000 and 20,000 physicians were union members. By 2014, that number grew to 46,689 (5.7 percent) of 820,152 actively practicing physicians in the United States; in 2019, there were 67,673 physician union members, 7.2 percent of the 938,156 physicians actively practicing in the United States and an approximate 26 percent increase from 2014 in the percentage of physicians belonging to unions. Additionally, in April 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 (NLRA) simply by virtue of their position in the health care institution and thus are eligible for union representation.

As more physicians and physicians in training enter large systems, employment and unions, their needs from professional organizations and trusted voices will change. For the AMA to continue most effectively in its role as the largest advocate for physicians in the United States, it will be essential to adapt to the changing practice environment and consider how to provide its constituents with timely and useful education and support.

To that end, the Council on Long Range Planning and Development (CLRPD) conducted a scenario-building exercise to consider how changes in the macro environment in which health care is delivered may impact the capabilities and goals of physician collective bargaining. The focal question considered by the Council was: How can our AMA support the empowerment of physicians and physicians in training through collective bargaining to provide the best possible care for patients?

This informational report presents the findings of that exercise, which focused on four critical uncertainties in the macro environment that were likely to impact physician needs: the overall strength of the U.S. economy, patient perception of quality of care, consequences/ethics of work stoppages, and working conditions.

The goals of this exercise were multifaceted. It allowed the Council to consider an extremely complex issue through the lenses of specific factors rather than generalities. It allowed the Council to consider how the capabilities and goals of collective bargaining would be likely to change based on overarching factors affecting the United States and health care environments. Finally, it allowed for dynamic consideration of how the needs of physicians and physicians in training, as well as the role of the AMA would necessarily change based on the shifting environments in which physicians will practice medicine.

REPORT OF THE COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT

CLRPD Report 2-A-24

Subject: Scenarios on Collective Action and Physician Unions

Presented by: Gary Thal, MD, Chair

BACKGROUND

The AMA estimated in 1998 that between 14,000 and 20,000 physicians were union members. By 2014, that number grew to 46,689 (5.7 percent) of 820,152 actively practicing physicians in the United States; in 2019, there were 67,673 physician union members, 7.2 percent of the 938,156 physicians actively practicing in the United States and an approximate 26 percent increase from 2014 in the percentage of physicians belonging to unions.[1] Over the same time period (1998-2019), the percentage of all U.S. workers in unions fell from 13.9 percent to 10.3 percent;[2] the proportion of physicians, residents and fellows in unions is increasing against the national trend of all workers.

Additionally, in April 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 (NLRA) simply by virtue of their position in the health care institution and thus are eligible for union representation.[3]

In its reasoning, the Region focused on the fact that the physician's primary role is to provide health care to patients, not participate in the administrative and personnel functions reserved for other lead medical providers (who were excluded from the petitioned-for unit). The Region found that the physicians are not held responsible for the performance of other employees and provide only sporadic supervision. The Region specifically disputed the fact that some of the petitioned-for physicians were found to be the "supervising physician" of another credentialed provider, as required by North Carolina's professional licensing law. The Region based this finding on a prior NLRB decision, which held that a governmental requirement that a health care provider be supervised by a physician does not necessarily establish the physician as a supervisor under the NLRA. This DDE confirmed that physicians will not automatically be considered supervisors under the NLRA and may seek union representation. Piedmont's physicians and providers subsequently voted in favor of union representation. Prior to this decision, unionization among physicians had largely been confined to medical residents and public-sector physicians.[4]

Since that decision, frequent occurrences of unionizing among physicians, residents, and fellows have been observed:

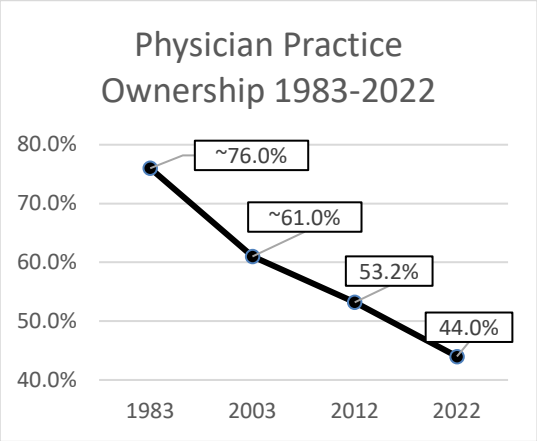
- Roughly 400 primary and urgent-care providers across more than 50 clinics operated by the Allina Health System in Minnesota and Wisconsin voted to unionize in October 2023, appearing at the time to be the largest group of unionized private-sector physicians in the United States. More than 150 nurse practitioners and physician assistants at the clinics were also eligible to vote and became members of the union.[5] Further appeals by Allina were unsuccessful.[6]

- Physicians at six Legacy Health hospitals in Oregon and Washington voted to unionize; the vote was certified by the National Labor Relations Board November 17, 2023. The hospitalists' decision to unionize had the stated goals of improving local health care and giving frontline physicians a voice in the decisions that impact their patients' care, communities' health and hospital working conditions. Approximately 200 hospitalists employed by Legacy Health joined the approximately 700 Oregon Nurses Association nurses and mental and behavioral health professionals already employed by the system, making it one of the largest hospitalist union groups in the country.[7]

- In January 2024, residents and fellows at Northwestern University's McGaw Medical Center voted to unionize, citing concerns with a lack of information around pay increases and benefits from the health system. More than 1,300 residents and fellows were set to join the Committee of Interns and Residents/Service Employees International Union after nearly 800 voted in favor of the move. The Committee of Interns and Residents (CIR) is the largest housestaff union in the United States, representing over 32,000 resident physicians and fellows as of March 2024.[8,9]

The most recently available list of hospital residency programs that have joined CIR has been included as an appendix. This list does not represent all unionized residency programs, and the number of unionized residency programs has continued to grow.

Among the most significant drivers of increased unionization among physicians and physicians in training are undoubtedly the dramatic decrease in physician practice ownership, the related increase in the number of employed physicians, and the shift away from small practices. While current estimates on the number of employed physicians vary, with one recent study finding 73.9 percent of physicians to be employed by hospitals, health systems, or corporate entities,[10] an AMA Policy Research Perspective published in July 2023 found that, in 2022, 49.7 percent of physicians were employees, 44.0 percent were owners, and 6.4 percent were independent contractors. This represented a significant contrast to 2012 when 53.2 percent of physicians were owners, to the early and mid-2000s, when around approximately 61 percent of physicians were owners (Wassenaar and Thran 2003; Kane 2009), and the early 1980s when the ownership share was around 76 percent (Kletke, Emmons, and Gillis 1996). Practice size continued a redistribution of physicians from small practices to large ones. The percentage of physicians in practices with 10 or fewer physicians fell from 61.4 percent in 2012 to 51.8 percent in 2022. In comparison, the percentage in practices with 50 or more physicians grew from 12.2 percent to 18.3 percent.[11]



Source: Kane C. Recent Changes in Physician Practice Arrangements: Shifts Away from Private Practice and Towards Larger Practice Size Continue Through 2022. American Medical Association.

The analysis also found that in 2012, 44.3 percent of physicians under the age of 45 were owners. By 2022, only 31.7 percent of physicians under the age of 45 were owners. This suggests that a smaller percentage of each successive class of physicians has started their post-residency career in an ownership position. Furthermore, the employment status of young physicians is different than that of older physicians. In 2022, 51.3 percent of physicians aged 55 and over compared to 31.7 percent of physicians under age 45 were owners. This indicates that when physicians retire, owners are not replaced in the workforce on a one-to-one basis; they are more likely to be replaced by physicians who are employees.[12]

The moves away from practice ownership and into employment, and away from small practices and into large ones, seem likely to continue, if not accelerate, in the foreseeable future. As such, so too will the prevalence of physicians, residents and fellows who may consider unionization.

SCENARIO DEVELOPMENT

As more physicians and physicians in training enter large systems, employment and unions, their needs from professional organizations and trusted voices will change. For the AMA to continue most effectively in its role as the largest advocate for physicians in the United States, it will be essential to adapt to the changing practice environment and consider how to provide its constituents with timely and useful education and support.

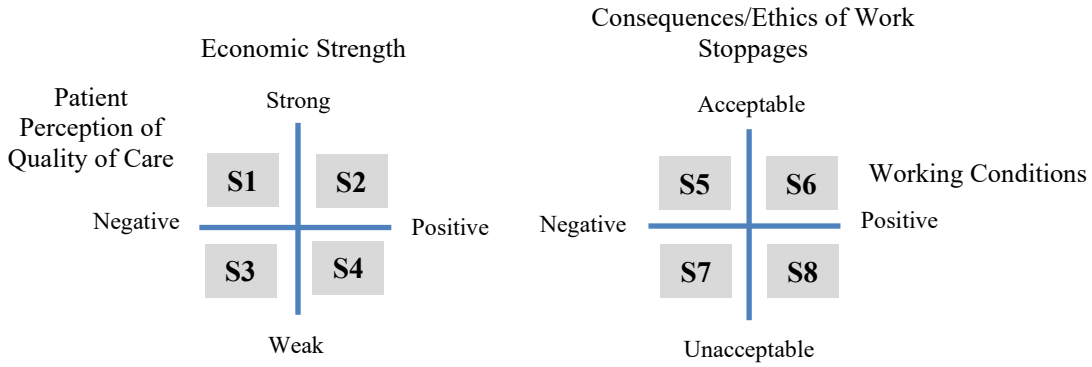
To that end, CLRPD conducted a scenario-building exercise to extrapolate on how changes in the macro environment in which health care is delivered may impact the capabilities of physician collective bargaining. The Council identified the following focal question for this exercise:

> *How can our AMA support the empowerment of physicians and physicians in training through collective bargaining to provide the best possible care for patients?*

Based on this question, the Council identified a list of driving forces and factors in the overall environment that would influence the needs of physicians in different environmental scenarios. From this list, members were asked to rank each driver based on two metrics: (1) how important each one was to the focal question and (2) how uncertain the outcome of each driver was. The goal of this step was to identify both the most important and most uncertain driving forces ("critical uncertainties"). The Council identified the following critical uncertainties:

- Overall strength of the U.S. economy
- Patient perception of quality of care
- Consequences/ethics of work stoppages
- Working conditions

These driving forces were subsequently combined into two matrices, from which were created eight distinct scenario spaces (S1-S8):



The Council considered what the implications of each scenario space would be for physicians and patient care, and, subsequently, what role the AMA could play in supporting physicians in each scenario. The goals of this exercise were multifaceted. It allowed the Council to consider an extremely complex issue through the lenses of specific factors rather than generalities. It allowed the Council to consider how the capabilities and goals of collective bargaining would be likely to change based on overarching factors affecting the United States and health care environments. Finally, it allowed for dynamic consideration of how the needs of physicians and physicians in training, as well as the role of the AMA would necessarily change based on the shifting environments in which physicians will practice medicine.

In the following section, the Council contemplated the world of each scenario space including the connections between the two driving forces; how the interplay between those forces would affect patients, physicians, and the health care environment; what the needs of physicians might be to support the delivery of the best possible patient care; and how the AMA might be best positioned to support those needs.

SCENARIO SPACES

Scenario 1 – Strong Economy & Negative Patient Perception of Quality of Care

In a scenario in which the economy is strong, but patients have a negative perception of quality of care, the Council identified several challenges and opportunities. In terms of opportunities, the Council noted that in times of economic prosperity, the position of unions, and the overall position from which physicians could collectively bargain would be enhanced. Most obviously, employers in such a scenario would have opportunities to make payment concessions. This could be of particular benefit to residents and fellows, to whom payment and quality of life relative to working hours is an ongoing concern. More directly related to the negative perception of quality of care, physicians in such a scenario would likely be able to advocate and negotiate toward changes in health systems and care delivery that would enhance patient satisfaction. For instance, physicians negotiations could work toward allowing physicians to spend more time with individual patients, which can lead to increased patient satisfaction.[13] Furthermore, improvements in how a clinic is run, e.g., adequate staffing, setting and managing expectations, facilitating streamlined and personalized communication between physicians, staff and patients might all be negotiated for in a strong economic environment, which could have the twofold benefit of improving patient satisfaction and improving working conditions in the future. CLRPD identified study, communication, and messaging as primary roles of the AMA in such a scenario. It would be essential to understand the drivers of the poor perception of quality of care and communicate those to physician groups as bases for negotiations. Additionally, identifying and sharing practices that lead to improved patient satisfaction could help unions and other physicians engaged in

negotiations to self-assess and pinpoint potential points of action that have been proven to improve the patient experience. On a high level, the AMA's most valuable roles in such an environment would be to help physicians understand the patient experience, identify solutions that have been shown to improve those experiences, and communicate those solutions to aid in collective bargaining during a time when physicians would be expected to be in a stronger position to make appreciable gains through negotiation.

Scenario 2 – Strong Economy & Positive Patient Perception of Quality of Care

The Council noted that when organizations hit weak economic times, physicians are often overseen and restricted in greater ways. Health systems with strong finances, however, tend to allow physicians greater autonomy. Autonomy, raises, and improved working conditions were identified as the primary objectives in Scenario 2. If a health system is in a strong financial situation, and patients are satisfied with the quality of care they receive, physicians will be in the strongest position possible to demonstrate their successes and leverage those successes into personal gains and health system improvements that acknowledge and reward their expertise and achievements. In such a scenario, physicians in negotiation would likely work to demonstrate the positive outcomes of their work and use those data points to leverage their employers to make decisions that increase patient and physician satisfaction. The AMA-RAND study, "Factors Affecting Physician Professional Satisfaction and Their Implications for Patient Care, Health Systems, and Health Policy," noted that drivers of physician satisfaction include providing high-quality care or working at practices that facilitate the delivery of such care; income stability; payment arrangements that were perceived as fair, transparent, and aligned with good patient care; and reducing the cumulative burden of rules and regulations.[14] The AMA's work on physician satisfaction and practice sustainability could prove a major asset in such a scenario by providing data points to both physicians and health systems to demonstrate how satisfied physicians improve patient care and perception of care, the hidden costs of physician burnout, and the value of system and working condition improvements. It was also noted that in recent times, physicians often see pay reductions and pay increases are much more infrequent. In a scenario when measurables demonstrate high patient satisfaction, and the overall economy is strong, physicians would be in a strong position to collectively bargain for pay increases.

Scenario 3 – Weak Economy & Negative Perception of Patient Care

The converse of Scenario 2, this scenario imagined an environment in which the economy is weak, and patients have a poor perception of the quality of care they receive. In such a scenario, it was noted that everyone would be struggling, i.e., patients, physicians, and employers. This could be described as a "stop the bleeding" scenario in which negotiations would focus on preventing the weakening of the position of physicians. Among the focal points the Council identified as particularly significant in such a scenario were scope of practice and burnout. Health systems in weak financial situations will look for opportunities to reduce costs, which may include increasing the use of non-physician providers. It would be essential in such a scenario for physician unions and physician negotiators to push back against scope creep through collective bargaining. In health systems where patient care was already being delivered by mid-level providers, poorly perceived quality of care could act as an argument against scope creep. Conversely, health systems in which patient care was predominantly being delivered by physicians may attempt to leverage patient dissatisfaction to push for increased utilization of mid-level providers. Physicians would need data demonstrating the true effects of scope creep as it relates to both cost and quality. Other tendencies in such an environment would likely be to push physicians, residents and fellows into working longer hours, shorter and higher quantities of patient visits, and cost cutting measures, all factors likely to lead to even further reduced quality of care, poorer quality of life and worse educational environments for physicians in training, and increased burnout. The AMA's work on burnout could

be of value in this environment, providing support to struggling physicians and demonstrating to employers the mechanisms to and the value of reducing burnout.

Scenario 4 – Weak Economy & Positive Patient Perception of Quality of Care

The Council noted that in this scenario, most of the issues related to a poor economy would still be relevant, as employers in a weak economy would still likely attempt to cut costs and get more for less. In theory, physicians in this scenario should be better positioned to negotiate against cost-cutting measures such as scope creep, as high patient perception of quality of care should be a focus of collective bargaining and a strong argument against such measures. However, several complicating scenarios were noted, including the possibility that in such an environment, employers may be more willing to take risks in care delivery, viewing the positive patient perception of quality as a backstop against possible declines. Additionally, the Council noted the distinction between patient perception of quality and quality care itself, and that some patients receiving direct care from mid-level providers may have a higher perception of the quality of care they receive (for instance, if mid-level providers spend more time with their patients than physicians can). It was also noted that by replacing one physician with two mid-level providers, health systems could charge more, thereby increasing revenue at the expense of both physicians and quality of care. Still, in an environment in which patient perception of quality is positive, the AMA could examine the causes of that positive perception, identify best practices to reduce costs while preserving quality of care, and communicate those best practices to health systems and physicians.

Scenario 5 – Negative Working Conditions & An Acceptable View of Work Stoppages

A complicating scenario related to physician unionization is the idea of work stoppages and the potential impacts of work stoppages on the health of patients. Section 1.2.10 in the Code of Medical Ethics states that physicians who participate in advocacy should "[a]void 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."[15] As unionization becomes more prevalent among physicians, unions will explore all possible tactics to increase leverage during collective bargaining. In January 2024, thousands of junior physicians in the United Kingdom (UK) engaged in a six-day strike over low wages leading to the postponement of more than 110,000 appointments.[16] Senior doctors and other medical professionals were available to cover emergency services, critical care, and maternity services. This represented the longest strike in the history of the UK's National Health Service (NHS).[17] The NHS national medical director said it would take hospitals "weeks and months" to recover from the stoppage.[18] Despite the obvious impacts physician work stoppages have on health care delivery, it is impossible to ignore the possibility that they may become a reality in the United States in an environment with a more highly unionized physician workforce. There are obvious parallels to be drawn between junior physicians in the United Kingdom and residents and fellows in the United States, who earn significantly less than their more senior colleagues, while working potentially more hours per week.

Scenario 5 imagines a situation in which physician working conditions are poor and the consequences of work stoppages are viewed as an acceptable tactic in collective bargaining. While what is "acceptable" will always vary between groups, individuals, organizations, etc., this scenario is one where the opportunity for work stoppage or the threat of work stoppage and other forms of collective action is most realistic. The Council noted that in such a scenario, it would be essential for the AMA to provide a backstop of support demonstrating the moral and ethical duty of physicians to act in the best interest of patient care and communicate that work stoppages are not and should not be about money, but about physicians doing what they can to fulfill their duty to

their oath and to their patients. Members also noted that work stoppages can take a variety of forms, such as—like in the case of the NHS strike—predetermined and preannounced periods of unavailability by physicians in an effort to highlight system inadequacies (rather than, for instance, a strike of indeterminable duration) and that this types of collective action could more easily be viewed as action toward improving patient care and not harming it. On a high level, this scenario made apparent the likelihood of a future in which physician work stoppages of some form, and the downstream consequences of those stoppages, would become a reality, and the AMA's most effective means of supporting physicians in such an environment will need to be considered, particularly as it relates to potential conflict with AMA policy and the Code of Medical Ethics. In response to policy adopted at the 2023 Annual Meeting of the House of Delegates (H-405.946, "Supporting Efforts to Strengthen Medical Staffs Through Collective Actions and/or Unionization) the Council on Ethical and Judicial Affairs (CEJA) is developing a report for the 2024 Interim Meeting "to review the advisory restricting collective action in section 1.2.10 of its Code of Medical Ethics to allow for more flexibility on the part of physicians who have exhausted other non-disruptive methods for reform." Current AMA policy on unions and collective bargaining has been appended to this memo.

Scenario 6 – Positive Working Conditions & An Acceptable View of Work Stoppages
The Council viewed Scenario 6 as an ideal time for the AMA to engage in organizing, preparation and analysis. While work stoppages in such a scenario would be less likely to be necessary, laying the groundwork to preserve desirable working conditions and keeping them heading in the right direction can occur during this time, as well as can the preparation for a future in which work stoppages may become a necessary/useful tool. Such a scenario would present the AMA with an opportunity to analyze progress that has been made and by what mechanisms and communicate those successes to other physician groups attempting to improve their own conditions. This scenario could also present an opportunity to analyze the overall status of unionization and collective bargaining and successful organizational structures and negotiation tactics with the hope of working toward scenarios where improvements continue without the need for work stoppages or the threats of work stoppages. As one member put it, this scenario is "time to get to work."

Scenario 7 – Negative Working Conditions & An Unacceptable View of Work Stoppages
In Scenario 7 it becomes essential to identify solutions and collective bargaining strategies to push toward improved conditions without the threat of work stoppage. If the public and/or physicians themselves determine that any level of disruption to care delivery cannot occur, unions will necessarily find themselves in a weakened position for negotiation. The AMA could aid physicians in such a scenario by identifying, or proliferating already identified, successes that have occurred without the need for work stoppages. The Council also noted that in a scenario in which working conditions are deteriorating, but work stoppages are not an option, physicians may simply choose to quit, leading to a worsening physician shortage and poorer access to quality care. The Council noted that this scenario space is not unlike what physicians encountered during the worst of the COVID-19 pandemic, during which working conditions were as bad as they could have been, but no physician group would have been willing to threaten a strike even if they were already in a union or looking to join one. That situation led to early retirements and physicians considering alternative career paths, along with rises in physician mental health issues and suicides. Non-compete clauses also present a significant challenge in such an environment, as physicians dealing with declining working conditions who have signed such clauses cannot simply change systems but must either relocate or remain and suffer. Providing support and resources to physicians in challenging situations represents another area where the AMA could make a significant impact.

Scenario 8 – Positive Working Conditions & An Unacceptable View of Work Stoppages
Not unlike Scenario 6, unions in Scenario 8 would likely be focused on attempting to "lock in" the progress being made. Such a scenario may present opportunities to establish metrics to better quantify improvements in working conditions. The Council observed that more opportunities may exist for medical associations including the AMA to engage in benchmarking and best practice research and sharing. In this scenario, techniques other than the threat of work stoppages have clearly been effective, evidenced by improving working conditions. However, it was noted that it is unlikely that conditions would be improving among all physicians and across all employers, so this would be a time to work through unions and organizations to identify and implement best practices as widely as possible and to include experienced physicians, residents, and fellows. It was also noted that both the overall quality of working conditions, as well as the trend in working conditions (i.e., improving or declining) are relevant; good working conditions can decline just as poor working conditions can improve, making the establishment of benchmarks even more useful in allowing physicians and systems to assess the overall state of conditions as well as making changes easier to assess.

DISCUSSION

As part of its deliberations, the Council considered not only how the needs of physicians and physicians in training will change in an increasingly employed and unionized workforce, but how those changes in workforce trends would impact the AMA, its membership and its mission, i.e., what does unionization mean for the AMA and other medical associations? The goals and capabilities of these organizations remain consistent—regardless of how physicians work and organize—and include advocating for physicians and trainees, communicating on their behalf, convening groups to facilitate collaboration, providing timely educational resources, and identifying and sharing best practices to help physicians achieve their practice and career goals. Organized medicine provides value to all physicians, whether or not they join a specific association or a union. As has been observed with the move away from private practice and towards employment, the challenges physicians and trainees face as practice models evolve do not become apparent immediately, but often do so suddenly and urgently; organizations working on their behalf must remain nimble and responsive to their evolving needs to provide effective support and membership value. On the rapidly developing issue of physician collective bargaining and unionization, it will be essential to monitor changes in the space, maintain awareness of difficulties and successes as they occur, and identify the most effective roles of the AMA in the context of the changing workforce and macro environment.

The Council believes that an open forum at an upcoming HOD meeting through which physicians, residents and fellows who have encountered unionization directly could share their experiences would be extremely useful in expanding the Association's understanding of the impacts such efforts have on grassroots members and facilitate discussion and idea sharing among those currently involved in these initiatives. It will also be essential for stakeholders throughout AMA membership and staff who are either involved in or likely to be impacted by the growing trend of unionization to find opportunities for collaboration to maximize understanding and impact.

This analysis assumes a future in which a greater proportion of physicians and physicians in training choose employed practice models and join unions. While the exercise focused on specific factors in the overall environment to assess how the needs of physicians and physicians in training would be impacted, and how the AMA could aid negotiating physicians in such environments, the needs and wishes of physicians are relatively consistent regardless of work setting and include providing high-quality care; working environments that facilitate high-quality care; stable, fair, and transparent pay arrangements; and reduced regulatory burdens. However, the mechanisms available

to work toward these goals will change along with environmental factors and changing models of care delivery and organizational structures. The Council will continue to monitor this evolving area.

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Appendix 1 – Committee of Interns and Residents Unionized Hospitals

CALIFORNIA		
Alameda Health System / Highland Hospital	Oakland	CA
California Hospital Medical Center	Los Angeles	CA
Harbor-UCLA Medical Center	Torrance	CA
Kern Medical Center	Bakersfield	CA
LAC+USC Medical Center	Los Angeles	CA
Santa Clara Valley Medical Center	San Jose	CA
St. Mary Medical Center – Long Beach	Long Beach	CA
St. Mary's Medical Center – San Francisco	San Francisco	CA
Sutter Santa Rosa Regional Hospital	Santa Rosa	CA
UC-Irvine Medical Center	Orange	CA
UCSF Medical Center	San Francisco	CA
UCSF Benioff Children's Hospital	Oakland	CA
Valley Consortium for Medical Education	Modesto	CA
Zuckerburg San Francisco General (formerly SFGH)	San Francisco	CA
FLORIDA		
Jackson Memorial Hospital	Miami	FL
Illinois		
University of Illinois-Chicago	Chicago	IL
MASSACHUSETTS		
Boston Medical Center	Boston	MA
Cambridge Health Alliance	Cambridge	MA
NEW JERSEY		
Bergen Regional Medical Center	Paramus	NJ
Christ Hospital	Jersey City	NJ
Hoboken University Medical Center	Hoboken	NJ
Jersey City Medical Center	Jersey City	NJ
Rowan University SOM (Kennedy/Lourdes)	Stratford	NJ
Rutgers University – NJMS	Newark	NJ
Rutgers University – RWJMS	New Brunswick	NJ
St. Michael's Medical Center	Newark	NJ
NEW MEXICO		
University of New Mexico	Albuquerque	NM
NEW YORK		
Bellevue Hospital Center	New York	NY
Bronx Lebanon Hospital Center	Bronx	NY

Brookdale Medical Center	Brooklyn	NY
Brooklyn Hospital Center	Brooklyn	NY
Coney Island Hospital	Brooklyn	NY
Elmhurst Hospital Center	Queens	NY
Flushing Hospital Medical Center	Queens	NY
Harlem Hospital Center	Manhattan	NY
Institute for Family Health	Manhattan	NY
Interfaith Medical Center	Brooklyn	NY
Jacobi Medical Center	Bronx	NY
Jamaica Hospital Medical Center	Queens	NY
Kings County Hospital Center	Brooklyn	NY
Kingsbrook Jewish Medical Center	Brooklyn	NY
Lincoln Medical & Mental Health Center	Bronx	NY
Maimonides Medical Center	Brooklyn	NY
Metropolitan Hospital Center	Manhattan	NY
Montefiore Medical Center North	Bronx	NY
New York Methodist Hospital	Brooklyn	NY
St. Barnabas Hospital	Bronx	NY
St. John's Episcopal Hospital	Queens	NY
St. Luke's-Roosevelt Hospital	Manhattan	NY
Westchester County Health Care	Valhalla	NY
Woodhull Hospital Center	Brooklyn	NY
Wyckoff Heights Medical Center	Brooklyn	NY
Vermont		
University of Vermont	Burlington	VT
WASHINGTON, DC		
Children's National Medical Center	Washington	DC
Howard University Hospital	Washington	DC
St. Elizabeths Hospital	Washington	DC

Appendix 2 – AMA Policies Related to Unionization and Collective Bargaining

Code of Medical Ethics Opinion 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.

Investigation into Residents, Fellows and Physician Unions D-383.977

Our AMA will study the risks and benefits of collective bargaining for physicians and physicians-in-training in today's health care environment.

Implementation

Our AMA continues to study the risks and benefits of collective bargaining for physicians and physicians-in-training and works closely with state and national medical specialty societies interested in the issues raised in this Resolution.

Our AMA developed an advocacy issue brief that studies the risks and benefits of collective bargaining for physicians and physicians-in-training and shared this document with all state and national medical specialty societies. Our AMA will continue to work closely with state and national medical specialty societies interested in the issues raised in this Resolution.

Employee Associations and Collective Bargaining for Physicians D-383.981

Our AMA will study and report back on physician unionization in the United States.

Collective Bargaining: Antitrust Immunity D-383.983

Our AMA will: (1) continue to pursue an antitrust advocacy strategy, in collaboration with the medical specialty stakeholders in the Antitrust Steering Committee, to urge the Department of Justice and Federal Trade Commission to amend the "Statements of Antitrust Enforcement Policy in Health Care" (or tacitly approve expansion of the Statements) and adopt new policy statements

regarding market concentration that are consistent with AMA policy; and (2) execute a federal legislative strategy.

Collective Bargaining and the Definition of Supervisors D-383.988

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.

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.

Antitrust Relief as a Priority of the AMA H-380.987

Our AMA will continue its aggressive efforts to achieve appropriate negotiations rights and opportunities and necessary antitrust relief for physicians, by whatever means. Achieving this important goal will remain a top priority for the Association.

Physicians' Ability to Negotiate and Undergo Practice Consolidation H-383.988

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.

Antitrust Relief for Physicians Through Federal Legislation H-383.990

Our AMA:

(1) encourages state medical associations and national medical specialty societies to support federal antitrust reform bills, such as H.R. 1409, as originally introduced in the 112th Congress, and consider sending in letters of support for such antitrust reform legislation to their respective Congressional delegations and select Congressional leaders;

(2) supports the intent of antitrust reform bills, such as H.R. 1409, as originally introduced in the 112th Congress, that put access to quality patient medical care and patient rights ahead of health insurer profits;

(3) continues to advocate for the principles that support that any health care professional, including a physician or a physician group, which is engaged in negotiations with a health plan regarding the terms of any contract under which the professional provides health care items or services for which benefits are provided shall, in connections with such negotiations, be exempt from federal antitrust laws;

(4) continues to advocate for the concepts and limitations incorporated in H.R. 1409, as originally introduced in the 112th Congress, including: no new rights for collective cessation of service to patients, no amendments to the National Labor Relations Act; and no application of H.R. 1409, as originally introduced in the 112th Congress, to the Medicare program under Title XVIII, the Medicaid program under Title IX, the SCHIP program under Title XXI of the Social Security Act; or programs related to medical services for members of the uniformed service, veterans, federal employees health benefit program or Indian Health Services;

(5) will send a letter of support to Congress of the principles contained in H.R. 1409 as originally introduced in the 112th Congress; and

(6) will work with members of Congress to promote antitrust reform in light of Accountable Care Organization (ACO) development.

Antitrust Relief H-383.992

Our AMA will: (1) redouble efforts to make physician antitrust relief a top legislative priority, providing the necessary foundation for fair contract negotiations designed to preserve clinical autonomy and patient interest and to redirect medical decision making to patients and physicians; and (2) affirm its commitment to undertake all appropriate efforts to seek legislative and regulatory reform of state and federal law, including federal antitrust law, to enable physicians to negotiate effectively with health insurers.

Resident Physicians, Unions and Organized Labor H-383.998

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.

Collective Bargaining for Physicians H-385.946

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.

Physician Collective Bargaining H-385.976

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.

Supporting Efforts to Strengthen Medical Staffs Through Collective Actions and/or Unionization H-405.946

1. Our American Medical Association will: (1) reevaluate the various efforts to achieve collective actions and/or unionization for physicians nationally; and (2) request CEJA to review the advisory restricting collective action in section 1.2.10 of its Code of Medical Ethics to allow for more flexibility on the part of physicians who have exhausted other non-disruptive methods for reform.