American College of Emergency Physicians®

ADVANCING EMERGENCY CARE

Unionization

An Information Paper

This information paper was created by members of the ACEP Medical-Legal Committee
June 2024

Unionization is a pressing topic, directly relevant to ACEP's mission and values, and increasingly important to the membership. The ACEP Board of Directors tasked the Medical Legal Committee with authoring this paper to explore key issues for the benefit of the Board and College members. The Committee humbly submits the following information paper in answer, with gratitude for contributions from Leon Adelman, MD, MBA, FACEP; the Ethics Committee; the Emergency Medicine Practice Committee; Jonathan Fisher, MD, MPH, FACEP, Senior Director of Workforce and EM Practice; and Mollie Pillman, MS, MBA, CAE, Senior Vice President of Member Engagement.

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EXECUTIVE SUMMARY

Question: What is the viability of attending EM physician unionization?

The emergency medicine work environment is facing unprecedented challenges: escalating boarding issues, lack of resources, ever-dwindling reimbursement, sub-optimal staffing, due process infringements, loss of physician autonomy, and employment instability. Unionization is increasingly being discussed as a potential solution to some of these problems. While resident physicians have an established history of unionizing, attending physicians outside of publicly funded "county" hospitals and the Veterans Health Administration do not. ACEP member surveys show that interest is currently high; of the 4804 ACEP members who responded to a January/February internal survey, 2872 (59.8%) are very interested or interested in joining a union and an additional 1031 (21.5%) are not sure, but interested in learning more. Importantly, there is also member opposition to unionization. **The question before us is to examine the viability of attending physician unionization in emergency medicine (EM)**.

Answer: The Medical Legal Committee (MLC) was asked to discuss the history of unions in the US, examples of EM unionization to date, options for EM unionizing, potential ramifications for ACEP, and other questions posed by the Board of Directors and membership.

First, for context, a brief history of unions in the US and examples of EM Unionization to date. Second, a pro/con analysis was conducted. Potential benefits of unionization explored include increased bargaining leverage, due process protections, and improvements in morale, workplace conditions, and patient safety. Potential disadvantages include disparate eligibility, individual interests being subjugated to the good of the whole, potential conflicts with Right-To-Work laws, antitrust law, EMTALA, and overarching moral/ethical concerns, particularly as it pertains to striking. **This paper takes neither a pro- or anti-union position and is intended to aid the ACEP Board of Directors in its analysis of how EM unionization may or may not support the vision and mission of the College and serve as a resource to College membership.**

What are the options for pursuing unionization in EM? Unionization options include EM-only, physician-only, multi-specialty physician-only, and single- or multi-specialty unions that also include non-physicians. At the time of this writing, both the AMA and ACEP have policy language advocating against unions that include non-physicians, however existing unions in which ACEP members have taken lead roles include non-physicians, so ACEP's position on this issue must be addressed as we move forward. Per the National Labor Relations Act (NLRA), non-unionization options that still leverage the benefits of collective bargaining also exist and merit exploration.

What are potential ramifications for ACEP? ACEP is attuned its members' needs and must be mindful of legal constraints. Members face unprecedented challenges in a work environment that affords less physician input than ever before. Workplace conditions, physician morale, marketplace stability, and patient safety are increasingly prominent concerns. As ACEP continues to urgently explore solutions to these issues, it must also consider the significant potential deleterious impact of an anti-trust action on the College. **Thus, these authors recommend an appropriate and timely formal legal analysis prior to official College-sponsored or affiliated unionization action.**

Value and Next Steps

The Board of Directors will have complex decisions to make as it determines how best to proceed to meet our members' needs. The MLC strives to provide information to assist with those critical decisions.

The Medical Legal Committee prioritized the development of this information paper. Work-in-progress was submitted to the Board to facilitate discussion and input at the March 5, 2024 meeting and feedback incorporated in the final work-product to be completed in advance of ACEP's Leadership and Advocacy Conference in Washington, DC, in April, 2024. The Medical Legal Committee remains ready to aid the Board of Directors and ACEP membership.

PHYSICIAN UNIONIZATION

A Brief History of Unions in the United States

The organization of laborers to increase bargaining power is not a new concept. The first labor strike (which, interestingly, was pre-union) was in 1768 when New York tailors organized to protest a wage reduction. The first union formed in Philadelphia in 1794, when shoemakers unionized. The trend caught on and the National Labor Union (NLU) formed in 1866 to canonize the eight-hour work day. The NLU folded in 1873, not having achieved its aim; the 50-year fight for the eight-hour workday, first won in 1916, was upheld by the Supreme Court of the United States in *Wilson v New* in 1917. Union popularity and power continued to rise through the 1970s and then started to fade with the Reagan administration, with union membership falling by five million between 1975 and 1985.

Physicians were not early to unionize. Historically, the attending physician work model was one of physician-owned, independent practice, thus excluding attending physicians from protection by the National Labor Act (NLRA). Employed interns and residents were the first to turn to unions, collectively bargaining—and at times striking—for principles such as work-hour restrictions, work-load limits, and pay increases. The largest housestaff union, The Committee of Interns and Residents (CIR), is part of the Service Employees International Union (SEIU) with a membership of over 30,000 residents and fellows and a number of negotiating victories under its belt. CIR has grown significantly over the past three years, with membership increasing to 30,000 physicians, approximately one-fifth of all US resident physicians, across 56 residencies. Notable programs that unionized between 2021 and 2023 include Mass General Brigham, the University of Pennsylvania, Stanford Healthcare, and George Washington University.[i] Given the shift in the attending practice model (over half of Emergency Medicine physicians are employed as of 2020 according to the American Medical Association (AMA)) an increasing number of emergency physicians (EPs) have become eligible for union membership. When combined with the increasing challenges of deteriorating working conditions and market instability, today's attending physicians are exploring unionization in a new light.

Examples of Emergency Physician (EP) Unionization

On April 26, 2023, the Providence Medford Medical Center attending emergency physicians, PAs, and nurse practitioners unanimously voted to form the first emergency medicine union in the United States. The union of hospital-employed clinicians is named Southern Oregon Providers Association (SOPA). SOPA is organized within the Oregon Nurses Association and the American Federation of Teachers.

A second emergency medicine union was created soon thereafter. In another unanimous vote, the Ascension St. John Hospital emergency physicians, PAs, and nurse practitioners formed the Greater Detroit Association of Emergency Physicians (GDAEP). GDAEP is an independent organization. TeamHealth employs the GDAEP clinicians. On April 8, 2024, GDAEP filed notice of intent to strike on April 18, 2024. The Michigan College of Emergency Physicians and the American College of Emergency Physicians responded with a letter urging the parties to immediately proceed to good-faith negotiations.

The number of physician unions in the US is increasing, though it still represents a significant minority of practicing physicians. An article in JAMA estimated that 5.9% of US physicians were union members in

2021. The largest attending physician unions in the United States are the Union of American Physicians and Dentists (UAPD) and the Doctors Council, a branch of the Service Employees International Union (SEIU).

Founded in 1972, the UAPD represents 5,000 healthcare workers, including physicians, dentists, podiatrists, PAs, nurse practitioners, and pharmacists. In 1976, the UAPD organized the first US attending physician strike in order to combat significant increases in malpractice insurance rates. In the 1990s, the union advocated for a national "Patients' Bill of Rights" to address the increasing corporatization of healthcare. The UAPD also led reforms of California's prison healthcare system and negotiated for improved working conditions for University of California physicians. More recently, the UAPD has led contract negotiations with Washington's Multicare Health System and with Los Angeles County.

The Doctors Council was created in 1973 in New York City to represent the physicians employed by the city and its Health and Hospitals Corporation. In 1999, the Doctors Council joined the SEIU, which represents over 2.1 million members.

In October 2023, Allina Health primary care physicians, PAs, and nurse practitioners formed the largest private-sector clinician union in the US. The union, with over 400 members, was formed within the Doctors Council. Allina Health objected that the physicians were ineligible for union membership by being "supervisors or managerial employees," but the health system was overruled by the National Labor Relations Board (NLRB) in January 2024.

The newest attending physician union as of this writing is the Salem Physicians Union, formed in March 2024, by the hospital-based physicians at Salem Hospital (within the Mass General Brigham Health System). The union is part of the American Federation of State, County and Municipal Employees (AFSCME) Council 93. The authors expect to see additional physician unions recognized by the NLRB in the near future.

Benefits of Unionization

The physicians in the Salem Physician's Union cite the following benefits of unionization: collective bargaining, job security, professional support, and solidarity. Per the union's formation announcement, in today's healthcare environment, physicians have become increasingly marginalized despite the fact that they are the experts in patient care. Physician unions may provide a collective voice to effect positive change. The National Labor Relations Act (NLRA) forbids employers from interfering with employee organization in order to bargain collectively or work together to improve terms and conditions of employment, thus offering a more secure position for negotiating.

Collective Bargaining and Contract Negotiations

The AMA's 2023 Advocacy Issue Brief on physician unionization points out that the organization of an NLRB-certified formal union is not a prerequisite to collective bargaining and contract negotiations. The NLRA protects eligible physicians from retaliation for attempting to negotiate workplace issues, though there may be significant challenges in effectively invoking those protections if not a member of a union. Perhaps surprisingly, only two eligible physicians are needed; more than two, of course, means greater leverage. The same AMA document cited a 1997 NLRB decision (*New York Univ. Med. Ctr.*, 324 NLRB 887) that found that the association of staff psychiatrists at Bellevue Psychiatric Hospital was a protected labor organization, in part because it found that the association was essentially functioning for that purpose. In general, when viewing union negotiation successes through the historical lens, aims that were previously

unattainable without a union (such as wage increases, work-hour limits, non-salaried benefits, and jobsite protections) were achieved with the collective bargaining model.

Work Conditions, Quality, and Safety

In a MedPage Today op-ed, ACEP member Bryce Pulliam, MD, of the Southern Oregon Providers Association Union (SOPA) explained that the reason for creating the EM union in Oregon was to "show other physicians how we can use our union power to advocate effectively for patient care and safety." He cited boarding and patient safety concerns, as well as EPs being continually asked to "do more with less." Lastly, he described loss of physician autonomy and the rapid replacement of long-standing physician groups by large contract management groups as impetus for unionization.

In Detroit, Michigan, ACEP member Michelle Wiener, MD, explained that she was motivated to lead a unionization effort when the employer responded to concerns about long wait times, crowded departments, and limited resources by decreasing physician staffing. This sentiment continues in Minnesota where, per an article in Healthcare Dive, Allina clinicians cited chronic understaffing, burnout, and compromised patient safety due to the corporatization of care as their motivation to unionize.

In all of these examples, patient safety issues stemming from boarding, crowding, staffing, and resource availability are at the forefront. In theory, the collective voice and bargaining power that unionization provides could be the critical mass needed to leverage change on these key issues to improve the work environment and patient care.

Historically, unions have focused on workforce issues such as hours, salary, and worker safety (as opposed to product quality) so there is no apples-to-apples precedent to estimate how physician unionization might be most effective. Additionally, given that attending physician involvement is a relatively new concept, it will take some time to see how effectively physician unionization achieves the desired aims.

Grievances and Due Process

As previously noted, the NLRA protects eligible physicians from retaliation for attempting to negotiate workplace issues, but it may be difficult to invoke those protections if not a union member. There are a number of examples of EPs speaking out during the height of the COVID pandemic who were met with immediate termination. Additionally, contractual stipulations (at-will status, contractual waiver of due process, good-will/reputation clauses, etc.) often create additional disadvantages for physicians. However, unionized employees are afforded additional protections, also known as Weingarten Rights (*NLRB v J Weingarten, Inc*., 420 U.S. 251 (1975). These protections require that an employee be informed that they are entitled to union representation in a number of circumstances, including disciplinary interview or other events that could trigger termination. These rights are not readily available to at-will employees.

Disadvantages of Unionization

Varied Interests

Physicians must thoroughly assess their own perspectives and grievances prior to participation in a union. Anyone considering forming or joining a union must evaluate whether or not the proposed union's mission and objective are concordant with their own.

Among physicians, there is a wide spectrum of practice experiences and employment status. A recent poll of 1,600 providers revealed that there was a wide range of interest in joining a union between specialties, with 73% of primary care physicians interested and 61% of surgical respondents potentially interested.

Experiences in a democratic physician group in rural America will vastly differ from those of a salaried hospital employed physician in an urban academic center. Thus, there is no one-size-fits-all solution, union or otherwise.

Union membership is often heterogeneous and may include physicians across various specialties or even non-physician members. Emergency physicians will likely have different perspectives on some issues than hospitalists or radiologists, creating conflict when decisions serve the majority of, but not all, members. Additional considerations include whether the union is local or national because priorities and agendas of a large, national union may not represent the local politics and practice environments. Furthermore, personal situations may conflict with other members' or the union's primary mission. The union's activities as a whole will impact unionized physicians regardless of their personal opinions and may affect relationships with other healthcare workers or patients.

One ACEP member provided anecdotal evidence based on experience working as an EP in another country: Physicians unionized and many specialties significantly benefited from the union achieving its bargaining goals. EPs, however, were disadvantaged by the outcome. This is a scenario that could certainly result from unions that cross specialty lines and/or involve non-physician members.

Public Perception

Some specific concerns that physicians have voiced about joining a union include: politics, hassle, cost, "tarnished" professional reputation, and harm to the doctor-patient relationship. The Hippocratic oath includes: "I will remember that I remain a member of society with special obligations to all of my fellow human beings." Becoming a physician requires a significant investment of time, energy, money, and sacrifice. Though public perception has waxed and waned over the years, physicians still enjoy a particular status in the hospital and the community at large; maintaining the trust and respect of patients, legislators, each other, and ourselves is paramount to upholding our oath. Though these potential effects are speculative and may not in fact be borne out, their potential bears consideration.

Moral and Ethical Concerns

In a recent systematic literature review, Essex et al identified three major themes associated with healthcare worker strikes, including:

1. the impact on the relationship between healthcare workers patients and society;
2. the consequences or harms of a strike; and
3. the conduct of the strike action.

Though there is no direct evidence that strikes increase mortality, the very concept of a strike is a moral concern for many physicians. The counter-argument, however, is that if strikes lead to improved staffing and a safer healthcare environment, more patients would benefit that would potentially be harmed. Regardless, it is likely that there would be little sympathy for physicians standing on a picket line if patient harm occurred as a result. Additionally, though the National Labor Relations Act requires that physician unions provide a 10-day notice of any "concerted refusal to work," some argue that such short notice, even in an NLRA-compliant strike, could put scheduled physicians in a precarious position between union loyalty and the moral and ethical aspects of patient care.

Decreased Motivation, aka the "Race to the Bottom"

One of the arguments offered against collective bargaining is the assertion that performance will be disincentivized, risking a "race to the bottom," an unacceptable outcome for healthcare professionals.

Examples can be offered on both sides of this argument, with anecdotes of unsafe staffing ratios and call-in policies on one side and the performance outputs of unionized National Football League players on the other. A collectively bargained contract by nature will rely on a generally uniform set of standards. Still, performance-based and other incentives such as holiday or night shift differentials, production metrics, etc. may help mitigate this concern and would remain accessible in a union contract so long as all employees have equal access to these provisions.

Other Consequences

Additional considerations include impacts of unionization on non-members, whether by choice or due to eligibility restrictions.

Options for Pursuing

The Board of Directors has several options to consider in deciding whether to pursue any action in response to increasing interest in physician unionization. These options may not be mutually exclusive, and include:

1. Staying neutral on unionization, while continuing to provide resources such as OpenBook to help EPs to be informed as they make decisions about their careers;
2. Supporting the concept of unionization and curating resources and referrals for those who are interested;
3. Investing in greater collective bargaining efforts without formal unionization;
4. Partnering with one or more existing national unions to form local branches; and
5. Supporting the creation of a new union solely to protect the interests of emergency physicians.

ACEP must consider the legal, financial, reputational, and member value aspects of each of these options. It should be noted that successful, widespread unionization without ACEP's involvement could have significant implications for the College if members are incentivized to rely on an organization other than ACEP to meet their needs for professional representation and unity.

Potential Limitations

Partnership Status

EPs who are formal partners or owners cannot unionize. The NLRA protects employees; partners and owners are not considered employees under the NLRA.

Independent Contractor and Supervisor Status

Independent contractors—as defined by the NLRB—cannot unionize. Whether or not a physician is actually an independent contractor for this purpose rests on much more than the title of the contractual relationship between the parties. As outlined in *Atlanta Opera*, the Labor Department's new rule (effective March 2024) reverses the 2019 *SuperShuttle* decision. *SuperShuttle* implemented business friendly rules based on "entrepreneurial opportunity." *Atlanta Opera* reverts to the *FedEx II* "totality of the circumstances" standard and sets a higher bar for business owners to successfully classify EPs as independent contractors. While the rule focused on minimum wage protections, it will influence the availability of other benefits, including the right to unionize. More specifically, more recent interpretations suggest that emergency physicians with long-term contracts would be eligible for union formation by the NLRB because they meet all six of the Department of Labor criteria for employee status.

Supervisors cannot unionize. The definition of a supervisor for this purpose has also been subject to legal scrutiny. Prior rulings have held that physicians were not supervisors of staff (such as clerical personnel, medical assistants, and non-physician healthcare providers) and thus not blocked from participating in unions on that basis. Still, not all potential supervisory roles have been definitively addressed. The conundrum for employers who want to categorize physicians as supervisors is that they then accept the supervisor's right to control others in the workplace, which then renders that individual who is subject to control an employee rather than an independent contractor. Prior legal decisions have clarified that ED Medical Directors are considered supervisors.

One can look at the trends in labor law and reasonably conclude that employers will increasingly be forced to accept that EP's are not independent contractors or supervisors for the purpose of determining eligibility to unionize.

State Restrictions: Right-to-Work Laws

Approximately half of US states have Right-To-Work (RTW) laws, which make it illegal to condition employment on joining and paying dues to a union. In March of 2023, Michigan repealed its Right-To-Work Law; this is uncommon in RTW history and is an example of how state law can affect unionization. For those states with RTW laws, (AL, AZ, AK, FL, GA, ID, IN, IA, KS, KY, LA, MS, NE, NV, NC, ND, OK, SC, DS, TN, TX, UT, VA, WI, WV, WY and Guam) a non-member cannot be charged for representation. So, in RTW states, non-members can benefit from the added leverage of the collective bargaining process (the benefits of which apply to all affected employees) without paying dues. In non-RTW states, non-members can be charged a fee (a so-called "shop fee") to offset union costs. Whether or not the state has enacted RTW laws, unions are legal and the same NLA regulations and NLRB precedents apply.

Federal Restrictions: Antitrust Law

ACEP's current tax status as a professional association merits caution as options for collective bargaining are considered. According to the summary of the 2005 DC Legal Symposium of the American Society of Association Executives[1], professional societies are considered a "suspect class" and can and have run afoul of antitrust laws, regardless of intent:

Associations as "Walking Conspiracies"?

1. The antitrust laws are implicated when two or more otherwise independent entities engage in concerted action to restrain trade. Because professional associations are traditionally considered to be combinations of competitors, the conduct of a single association is often subject to antitrust scrutiny.[2]

2. More specifically, because associations consist of individuals or entities who compete with one another in their businesses or professions, trade associations and professional societies can be used to benefit the economic interests of members at the expense of non-members. Alternatively, they can facilitate concerted action by members against suppliers or distributors to the injury of competition and consumers.

3. But, associations are not walking conspiracies.[3] Thus, an association would generally not be considered to be a combination of competitors in conducting the day-to-day business affairs of the organization--*e.g.*, entering into contracts with vendors, landlords, utilities, etc. As noted above, in the absence of direct evidence of

conspiracy, the plaintiff must provide evidence that "tends to exclude the possibility of independent action."[4]

Collective Negotiation/Refusal to Deal

1. The antitrust laws frown upon agreements among competitors that limit their independent decisions about the terms as to which they will bargain with their customers or suppliers.[5]

2. The courts have been particularly wary of attempts by professional societies to require or facilitate collective action by their members on the economic terms under which they will do business with each other or with other parties, including third party payors in the healthcare industry.

    a. In *Professional Engineers*, the Court struck down the society's ethical cannon barring its members from engaging in competitive bidding, finding the association's attempt to substitute its judgment for the ordinary give and take of the marketplace offensive to the central premise of the antitrust laws.[6]

    b. Likewise, in *Indiana Federation of Dentists*, the Court held that an organization of dentists violated the antitrust laws by collectively refusing to submit x-rays with reimbursement claims, as requested by the insurers.

    c. In *Pennsylvania Dental Ass'n v. Medical Service Ass'n of Pennsylvania*,[7] a dental association was found liable for antitrust violation for encouraging dentists to disassociate themselves from Pennsylvania Blue Shield in order to force Blue Shield to increase the upper limit on charges by participating dentists.

    d. *In the Matter of Colegio de Cirujanos Dentistas de Puerto Rico, a professional association*, FTC All Documents. No. 9710038 (March 21, 2000), the FTC accepted, subject to final approval, a proposed consent order settling charges that the Colegio de Cirujanos Dentistas de Puerto Rico ("Colegio"), an association of dentists in Puerto Rico organized boycotts and refusals to deal, and engaged in other anticompetitive conduct, designed to raise prices for dental services.[8]

3. It is important to evaluate whether the association’s actions have exclusive or actual binding authority or control in a market or practice area. Courts generally disfavor plaintiffs who assert that an association was a co-conspirator to exclude the plaintiff from a practice or market without proof that the association exerts actual or provable control.[9]

Antitrust law is a complex issue. A definitive analysis of its implications in the question before the Medical Legal Committee is far beyond the scope of this paper and the qualifications of its authors. It is, however, important to note that ACEP is no stranger to antitrust concerns, and an awareness of the potential ramifications of these laws is paramount. Prior to any direct ACEP involvement in unionization of EPs, a comprehensive legal analysis by attorneys well-versed in labor law is recommended.

Federal Restrictions: EMTALA

Colloquially referred to as the "anti-dumping law," EMTALA (Emergency Medical Treatment and Labor Act) was part of the 1985 Consolidated Omnibus Budget Reconciliation Act, 42 U.S.C. §1395dd, (COBRA) enacted in 1986. Stemming from hospital practices that involved care termination/refusal and ambulance diversion based largely on the patient's ability to pay, EMTALA requires a medical screening examination and necessary stabilizing medical treatment prior to an appropriate transfer.

Is there a conflict between EMTALA and Unionization?

During discussion of physician unionization, concern is often raised about the potential conflict between an emergency physicians' union's power to strike and EMTALA. This question rests on the following syllogism:

1. There is little benefit to unionization without the power to strike;
2. EPs can't strike because EMTALA forbids it; and
3. Therefore, EPs cannot (or should not) unionize.

The National Labor Relations Act (NLRA) states that "[e]mployees shall have the right. . . to engage in other concerted activities for the purpose of collective bargaining or other mutual aid or protection." The act specifically delineates that strikes by healthcare workers required 10-days' written notice to both the healthcare institution and the federal government.

This discussion will focus solely on premise two: Does EMTALA prevent EPs from lawful striking? We contend that it does not. Why? EMTALA binds the hospital, the EP on duty, and physicians who are on call for the emergency department. It does not bind EPs who are not on duty. A lawful healthcare workers' strike provides notice to the hospital to allow the opportunity to secure adequate staff to meet EMTALA obligations. Thus, an EP who engages in a lawful union strike is not violating EMTALA. To the authors' knowledge, there are no formal legal or regulatory decisions to the contrary.

In general, striking is considered a last resort, for use only when stakes are high and all reasonable efforts at negotiation fail. EPs are bound by the tenets of EMTALA when on duty and, if unionized, bound to adhere to the National Labor Relations Act, including giving 10-days' written notice prior to striking. An EP cannot (legally) simply walk out the door and join a picket line in the middle of the shift; however, there are currently no EMTALA-based contraindications to NLRA-compliant EP striking known to these authors.

Striking: Successes and Reservations

The most public show of CIR's power was in representing the resident physicians at NYC Health + Hospitals/Elmhurst during their 3-day strike in May 2023. Elmhurst had been an epicenter of the early COVID pandemic. However, the Icahn School of Medicine at Mount Sinai, which employs Elmhurst's residents, was paying them less (reportedly approximately $7,000 for first-year residents) than they paid their residents in more affluent hospitals. CIR's description of the strike's resolution included wage increases of 18% over three years, a $2000 ratification bonus, an enforceable agreement to negotiate on hazard pay, a meal allowance, holiday pay, and ACGME leave.

However, as noted in preceding sections, there are significant concerns regarding the potential consequences of attending physician strikes. When residents strike, even though there is certainly a definitive and profound impact on patient care delivery, there are still attending physicians on duty to deliver care. Attending physician strikes carry significant additional ramifications.

One author notes that though they are lawful, physician strikes "appear to create an ethical conflict with the Hippocratic tradition and obligation to place patients' best interests as the primary moral consideration in medical practice." If the Hippocratic Oath requires that physicians let nothing interfere with the best and most appropriate care available to each patient, is there a point at which staffing and working conditions rise to a level of interference that must be addressed, even by striking, if other methods fail? Is striking in and of itself so contrary to the tenets of our duty to provide care that there is no justification for it, under any condition? And if, as according to the AMA, physicians should refrain from striking, are the other potential benefits of unionization still effective without that ultimate form of leverage? If physicians belong to a union that negotiates outcomes that benefit many patients, but not *their* patients, have they violated their Hippocratic oath? And what of the autonomy concerns? If physicians join a multi-specialty union, could they find themselves at cross-purposes with their fellow members, particularly those without direct EMTALA obligations? What of multi-site groups that span regions with different priorities? Unions that represent both physicians and non-physician providers? The changing landscape of healthcare can seem to pose as many questions as it answers, all of which merit consideration as we determine the path forward.

ACEP is currently reviewing its policy on Collective Bargaining, Work Stoppages and Slowdowns (revised 2020).

The Path Forward

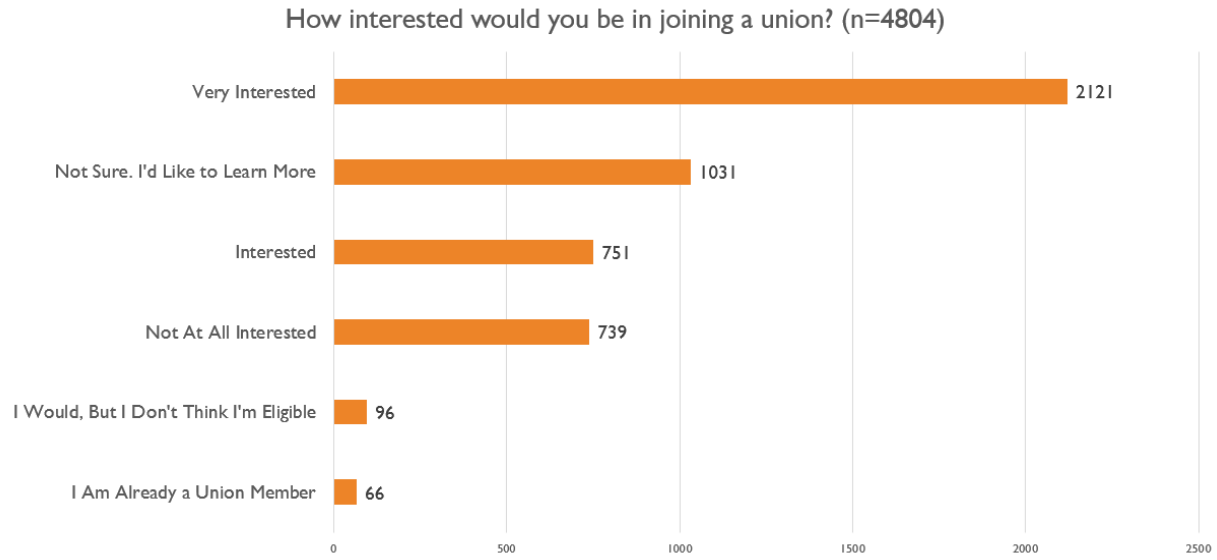
The time is upon us. Several EM unions have formed and it is likely that more will follow. History is being made as we contemplate the first EM attending physician strike in the US. ACEP's membership is diverse and practices in a wide variety of environments. Our adaptability and resourcefulness are integral to our strength and identity as a specialty. As the preeminent experts in emergency medicine, we stand united in the mission of providing quality emergency care in the best possible circumstances and supporting each other every step of the way.

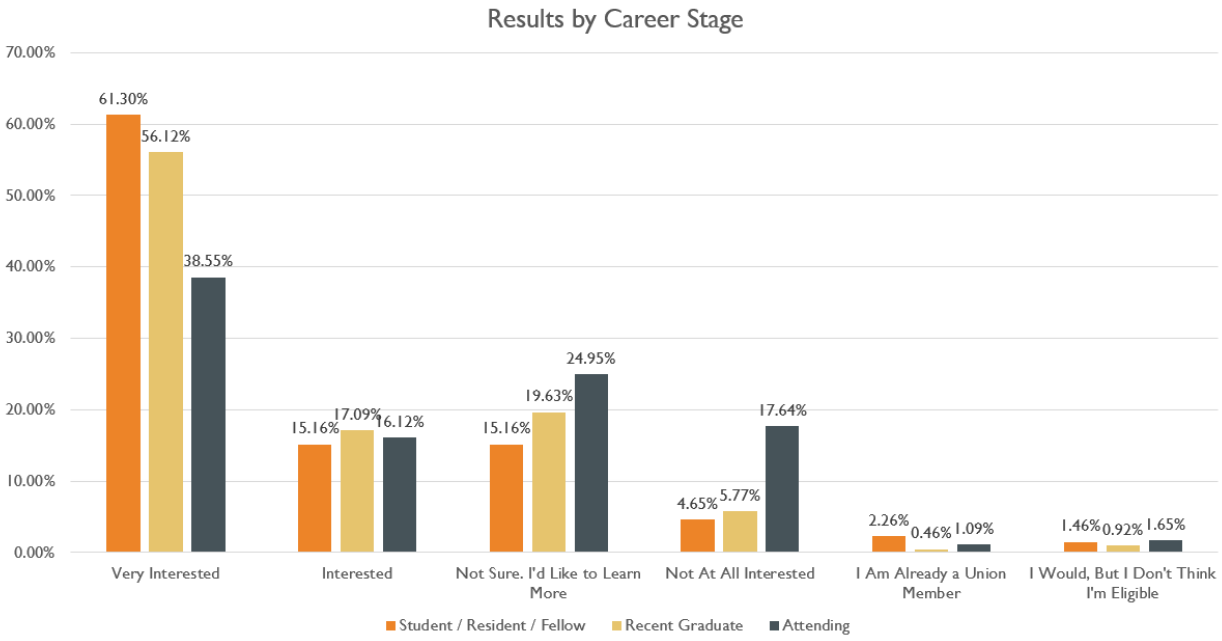
The following appendix includes data collected from ACEP membership that includes member sentiment about unionization, recurrent themes and concerns, and how ACEP can best represent that interest of members. It also includes additional resources and references.

Appendix

ACEP Unionization Poll

In January and February 2024, ACEP sent a poll to 50,590 emergency physicians with the question, "How interested would you be in joining a union?". 4,804 (9.5%) responses were received:





1489 free text survey responses were summarized by ChatGPT for those who were interested or wanted to learn more. Overall, the responses reflect a strong interest in exploring unionization as a means to address various challenges faced by emergency physicians, including workplace conditions, the role and scope of practice, job security, and the influence of corporate medicine on the healthcare system. There is a call for ACEP to play a more active role in addressing these concerns and supporting emergency physicians in their efforts to potentially unionize.

Several key themes and concerns emerged:

1. Scope of Practice and APPs: There is significant concern about the increasing role of Advanced Practice Providers (APPs) and how they affect the job roles and responsibilities of trained emergency physicians. Questions are raised about ACEP's actions to preserve the role of physicians in clinical decision-making and to address unsupervised practice of APPs.
2. Working Conditions and Boarding: Physicians are asking about solutions to issues like ED boarding, prolonged patient stays in the ER, and the impact of these practices on hospital reimbursements and patient safety. There is a call for better strategies to mitigate these problems.
3. Trends and Job Satisfaction: There is a notable trend of emergency physicians seeking to exit the field or diversify their careers due to dissatisfaction, which raises questions about the factors driving this trend and whether there have been major surveys or focus groups addressing it.
4. Benefits and Protections: Respondents inquire about sick time, time off, retirement match, and other benefits, expressing a desire for improved protections and provisions within their roles.
5. Unionization Logistics: Questions abound on the specifics of forming a union, the potential for retaliation, the benefits of unionization, and the impact on various aspects of the profession, including tort reform and the ability to negotiate better working conditions.
6. National Unionization Efforts: There is a query about the absence of a national emergency physicians' union and what is preventing such a movement from taking place.
7. Hospital Administration and Corporate Medicine: A common theme is the impact of hospital administration and corporate medicine on the practice of emergency medicine. Questions are directed toward ACEP's role in advocating for ED physicians and the challenges posed by corporate medicine, including the role of contract management groups (CMGs).
8. Protection from Exploitation: There's a clear concern about exploitation by hospitals, corporations, and private financial entities, with physicians seeking ways to protect themselves through collective bargaining and other union-related activities.
9. Impact on Patient Care: Many respondents are concerned about how unionization could potentially impact patient care, with some asking how it could be used to advocate for better patient safety measures.
10. Legal and Ethical Considerations: There are inquiries about the legality and ethics of unionization, and how union activities could align with physicians' professional obligations.
11. Influence and Advocacy: Respondents are interested in how a union might empower them to better advocate for their interests and those of their patients and whether ACEP will support such efforts.
12. Residency and Training Concerns: Questions about the impact of unionization on residency training and the administration of board exams are also present.

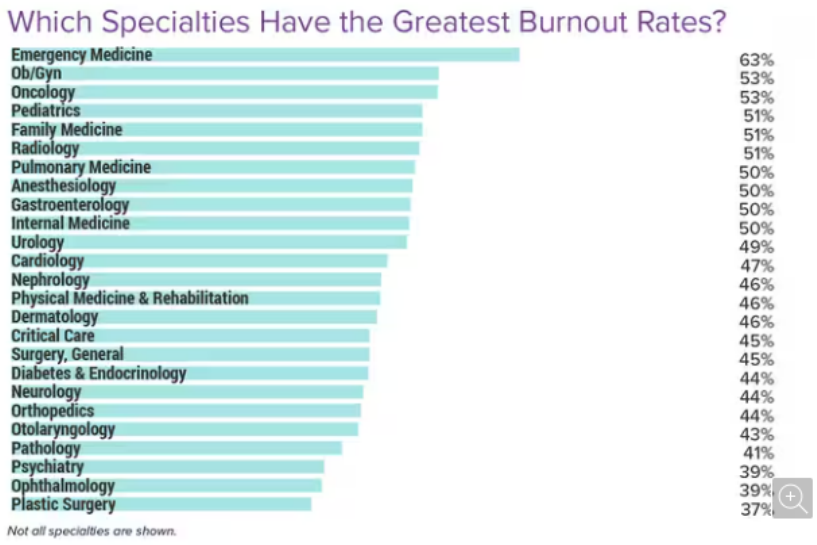
An additional 448 responses were summarized from those who were not interested in unionization. Their responses indicated a preference for self-organization, professional advocacy, and maintaining autonomy over joining a union.

Key themes included:

1. Concerns about high dues and questionable representation.
2. Belief that unionization may not improve patient care and could harm relationships with hospital administration, potentially leading to job losses or replacement by non-physician providers.
3. Frustration with previous experiences with unions, citing lack of teamwork and confrontation.
4. The view that unionization might undermine professional autonomy and decision-making rights.
5. Suggestions that physicians can and should advocate for themselves and their profession without union involvement.

6. A preference for addressing challenges through professional organizations and advocating for physician ownership of practices.
7. Fear that unions might devolve into politically driven organizations that don't truly serve their members' needs.
8. A desire to maintain professionalism and independence, avoiding what some see as a negative impact on the physician-patient relationship.

ACEP members rely on the association to represent their interests, and many have expressed a belief that ACEP has not done enough to improve their daily working conditions and ability to provide the best patient care. The 2024 Medscape Physician Burnout & Depression Report, released in January, again showcases the poor morale of ACEP members and their colleagues and a feeling of having lost the ability to create necessary change in their own environment.



The potential consequences of continued burnout and attrition in emergency medicine include poor patient outcomes, less influence as a specialty, and revenue impact to ACEP.

Suggested Next Steps

The Medical Legal Committee suggests that this is a highly complex issue and that the Board must continue to explore all perspectives and options prior to taking action. Next steps may include:

1. Identifying options/areas for further research;
2. Reviewing current policy and revising as needed;
3. Conducting thorough legal analysis before concerted action is taken; and
4. Providing resources to members who wish to learn more.

Other Resources

AMA Advocacy Center Issue Brief: Collective Bargaining for Physicians and Physicians-in-Training (2023) https://www.ama-assn.org/system/files/advocacy-issue-brief-physician-unions.pdf

Examples of EP Unionization

Stanford's collective bargaining contract brought significant wins for residents. Per CIR, "this agreement, secured after thirteen months of contentious negotiations, includes one of the most substantial compensation

increases for a first contract achieved nationally by the union. Along with a 21% compensation increase over the three years of the contract, the Bay Area physicians secured many of their core priorities. These include a $50,000 annual stipend for a resident wellness committee, a $20,000 fertility benefit package, a retirement plan with a 2% contribution and 2% match, retention of essential departmental benefits, and crucially, a new fatigue mitigation policy providing all housestaff access to free rideshare services home after working a long shift. Significantly, under the terms of the new contract, the 2025 cohort of first-year resident physicians at Stanford will become the first interns in the country to earn six-figures."

References

[1] Source: Portman, Robert M, Jenner & Block, LLC, "Association Antitrust," American Society of Association Executives, DC Legal Symposium, Washington, DC, September 23, 2005.

[2] *See Indiana Federation of Dentists*, *supra* n. 13; *Maricopa County*, *supra* n. 1; *Professional Engineers*, *supra* n. 1; *See also Allied Tube & Conduit Corp. v. Indian Head, Inc.*, 486 U.S. 492, 500 (1988) ("private standard-setting associations have traditionally been objects of antitrust scrutiny"); *American Society of Mechanical Engineers v. Hydrolevel Corp.*, 456 U.S. 556, 571 (1982) ("[A] standard-setting organization . . .can be rife with opportunities for anticompetitive activity. . . . When the great influence of [the organization's] reputation is placed at their disposal, the less altruistic of [its] agents have an opportunity to harm their employers' competitors through manipulation of [the standard-setting organization's] codes.").

[3] *Consolidated Metal Products v. American Petroleum Institute*, 846 F.2d 284, 293-94 (5th Cir.1988); *Moore v. Boating Industry Associations*, 819 F.2d 693, 712 (7th Cir.), *cert. denied.* 484 U.S. 854 (1987) ("a trade association is not always and at all times 'involved in concerted action'"). *See also Jack Russell Terrier Network of Northern California v. American Kennel Club, Inc.*, 407 F.3d 1027 (9th Cir. 2005) (national dog breed club and regional affiliates not capable of conspiring as separate entities under antitrust laws); *Viazis v. American Association of Orthodontists*, 314 F.3d. 758, 764-65 (5th Cir. 2002) (professional society's enforcement of its ethics rules against a member physician does not constitute an unlawful conspiracy in the absence of evidence that the proceedings were a sham or that the standards were pretextual); *American Council of Certified Podiatric Physicians and Surgeons v. American Board of Podiatric Surgery*, 185 F.3d. 606, 620-21 (6th Cir. 1999) (certification body cannot conspire with its diplomate physicians because under the "intracorporate enterprise doctrine," no conspiracy is possible within a single enterprise—although member physicians could conspire among themselves); Jung v. Ass'n of Am. Med. Colleges, 300 F. Supp. 2d 119, 165 (D.D.C. 2004) (in challenge to National Medical Residential Program, court dismissed complaints against American Board of Medical Specialties and Council of Medical Specialty Societies because "it will not impute the activities of either organization's members to the organization itself absent allegations that the entity participated in the conspiracy"). The Jung case is also useful for its discussion of jurisdictional issues in association antitrust cases.

[4] *Monsanto v. Spray-Rite*, *supra* n. 5; *American Chiropractic Association vs. Trigon Health Care, Inc.*, 367 F.3d 212, 227 (4th Cir. 2004) (no evidence that health insurer and medical societies that that placed their members on committee formed by insurer to offer input on clinical issues conspired to publish allegedly misleading guidelines on lower back treatment and to implement coverage policies aimed at limiting usage and reimbursement of chiropractic services); *Viazis*, *supra* n. 22, 314 F.3d. at 764, (no conspiracy shown between professional society and manufacturer to exclude orthodontic bracket designed by plaintiff because plaintiff failed to provide evidence of an explicit agreement shown or any circumstantial evidence tending to exclude possibility that manufacturer was acting independently in refusing to market the device). *See also DM Research Inc. v. College of American Pathologists*, 170 F. 3d 53 (1st Cir. 1999) (no conspiracy demonstrated between CAP, which accredits clinical labs, and National Committee for Clinical Laboratory

Standards (NCCLS), which sets standards for labs, simply because CAP incorporated certain NCCLS standards into its accreditation program); *Super Sulky, Inc. v. United States Trotting Ass'n*, 174 F.3d 733 (6th Cir.) (no conspiracy can be inferred in case in which manufacturer of sulky used in harness racing brought federal antitrust conspiracy and state tortious interference claims against harness racing association that had established standardized rule for sulkies, which resulted in the banning of manufacturer's product), *cert. den.*, 528 U.S. 871 (1999); *Hall v. United Air Lines, Inc*., 296 F. Supp. 2d 652, 672 (D.N.C. 2003) ("mere memberships and associations in [trade associations], without more, do not create a plus factor or even an inference of conspiracy").

[5] *Kartell v. Blue Shield of Massachusetts, Inc.*, 749 F.2d 922, 930 (1st Cir. 1984), *cert. denied*, 411 U.S. 1029 (1985). *See also Alston*, *supra* n. 24, 974 F.2d at 1214 ("In a market consisting of individual service providers and individual consumers, concerted action by the suppliers even on matters not directly related to price is viewed with great suspicion").

[6] *See also FTC v. Superior Court Trial Lawyers*, 493 U.S. 411 (1990) (bar association engaged in *per se* violation of antitrust laws when members collectively decided to stop serving as court-appointed attorneys for indigents until District of Columbia raised their compensation).

[7] 815 F.2d 270 (3d Cir.), *cert. denied,* 484 U.S. 851 (1987).

[8] According to the proposed complaint, the Colegio promulgated a Code of Ethics that bars dentists from contracting with any health insurance plan that was not endorsed by the Colegio. The Colegio refused to approve plans unless they: reimbursed dentists on a fee-for-service basis rather than capitation; were open to participation by all dentists; and were "responsive" to raising fees at the Colegio's request. Plans sought the Colegio's endorsement or approval in order to secure a sufficient number of participating dentists. The complaint also alleges that the Colegio acted as the collective bargaining agent for its members and set the prices and other terms under which its member dentists would deal with plans operating under Puerto Rico's Health Insurance Act of 1993, a program to provide health care services to the indigent.

[9] *The Podiatrist Association, Inc. v. La Cruz Azul de Puerto Rico, Inc.*, 332 F.3d 6 (1st Cir. 2003) (no evidence that medical doctors exerted enough control on the boards of health-care plans to exclude podiatrists).