Commentary: **Experience With Resident Unions at One Institution and Implications for the Future of Practicing Physicians**

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Abstract

This commentary discusses the forces behind the formation of a resident union at the University of New Mexico School of Medicine and the union's evolution over its first three years. Because unions exist primarily to provide an avenue for advocacy to their members, they could have a negative impact on resident professionalism and on the faculty–resident mentor relationship. Resident unionization could also adversely impact the perceived balance between education and clinical service, to the detriment of the professional identity development of resident physicians. Despite this concern, the authors express their initial, cautious optimism that the union is instead currently promoting resident professionalism. The resident union has provided a forum for a unified resident voice, the engagement of the residents in safety and quality improvement activities, and advocacy for, and direction of, additional patient care funds, all of which has encouraged resident professionalism. Residents who have been active in the union also seem to have maintained altruistic professional attitudes as well as engagement in their educational activities. However, as the environment changes from one of increasing resources to one of stagnant or decreasing institutional resources, inevitable conflicts will arise between advocacy for resident salaries and benefits and patient care needs, and the manner in which the resident union will balance these conflicting needs and what impact it will have on the residents' professional identity development is unclear.

Three years ago, our residents at the University of New Mexico School of Medicine voted to unionize. As program directors and assistant and associate deans, our initial reactions were ones of confusion. We asked ourselves, "Why?" "Why now?" and "What will this do to the education of residents?" We wondered what impact unionization would have on the residents' development of a professional identity, a topic recently identified by Cooke et al[1] as a major priority in medical education, and what impact unionization would have on the overall culture of our institution. Now, three years into this experiment, we have some tentative responses to these questions and thoughts about the implications of resident unionization for other institutions and for medical practice more broadly in the coming years.

First, to understand why this may have happened, we must look at the institution. Each institution has its own unique environment, which includes working conditions, the presence of other unionized workers, and the presence of key individuals among the residents who might lead the effort for unionization. At our institution, low salaries, threats of increased premiums for resident health insurance benefits, and the presence of a few key resident leaders likely led to the unionization. Certainly, similar conditions exist at other institutions across the country and have not led to unionization, perhaps because there are substantial disincentives for residents to unionize. Residents, by their very nature as temporary inhabitants of a position for three to five years, are different from long-term workers, such as truck drivers, police, teachers, and auto workers, who fill a position in an industry for an extended period at a relatively stable salary level. For residents, their future earnings are connected to their success in their training program and their ability to graduate with demonstrated competence in their chosen field, instead of connected to any salary increases obtained during residency. Negotiated higher earnings obtained through unionization primarily benefit future residents rather than those doing the negotiating. Work hours and health insurance, which are already requirements under the Accreditation Council for Graduate Medical Education (ACGME) standards, would not be expected to change significantly due to the presence of a union. Thus, residents might not have much to gain from unionization. They would have to sacrifice the time needed to complete contract negotiations and to attend regular union meetings, as well as the portion of their salaries (1.5%) that they would pay as union dues. Other potential costs could include the disapproval of their program directors and institutional leaders, which might adversely affect their job prospects and future fellowship opportunities. And so, with all of these costs in mind, one must again ask, "Why?" and "Why now?"

The answer may be found in the generational ethos of the current residents. Unlike their predecessors, who sacrificed family, personal wellness, and present gratification for altruistic purposes and the opportunity for future prosperity and independence, current

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residents face the likely prospect of large loan repayment burdens and often desire the security of a long-term employee relationship with a hospital or physician group. Also, the increasing proportion of women in the resident workforce may create different work–life balance needs than those that impacted the largely male workforce of previous generations. None of these many changes should imply that current residents are less professional than previous generations. Rather, they face very different personal life pressures, financial considerations, and an ever-changing medical system, all of which have led to a need for greater advocacy for improved, current working conditions. Unionization provides a group identity in the advocacy for these working conditions, unlike the uncertainty in working conditions inherent in a more classical apprentice relationship. This strategy may be particularly compelling when residents perceive their mentors (e.g., faculty, attending, and program directors) as having little voice in the structure of the current bureaucratic training institution, as is often the case in the complex environment of faculty practice, hospital, and university governance structures.

Jordan Cohen,[2] former president of the Association of American Medical Colleges, in his 2000 article, in reaction to the National Labor Relations Board decision to classify residents as employees, not students, for the purposes of forming a union, raised the following concern:

> The adversarial dynamics that frequently characterize labor–management relations in the American workplace are fundamentally antithetical to the atmosphere necessary for education. Educational objectives cannot be achieved without a firm foundation of trust between teacher and learner. The foundation for collective bargaining is, by contrast, naturally adversarial.

Current litigation concerning payment of Social Security for residents has raised the question again about whether residents function more as employees, who pay Social Security, or more as students, who are exempt.[3]

As we have attempted to understand the impact of unionization on the important trusting relationship between learner and teacher, Dr. Cohen's words echo our own concerns.

The annual negotiations with our resident union occur every spring for two to three hours each week for six to twelve weeks; additional meetings of our negotiations group consume two to three more hours weekly. This is all time away from educational activity by the residents and faculty who participate. The negotiations concerning benefits and salaries have been, at times, awkward, with residents emphasizing their efforts in providing clinical service, a distinction that is at odds with what we try to emphasize in creating a positive balance between education and service in residency training. Negotiations concerning raises for residents occur within a context of limited resources that must also support nurses, faculty, staff, and unfunded patient care needs. Unlike union negotiations with private industry, which impact management profits, negotiations with public hospitals to increase salary may decrease public services, risking public support for the union. To counteract such perceptions, our residents sought to allocate money to a patient care fund, which they control, for unmet patient care needs. This fund has been used for medical equipment, for discharge medications for patients who cannot afford them, and for transportation assistance. The assumption behind this fund is that residents have a unique perspective about the priority of patient care needs that is not represented within the current budgetary system. Before the unionization, residents and other physicians could participate in the hospital budget committee that assesses and prioritizes all requests for funding. Because of the scheduling of the meeting and the long, complex budget review process, physicians often felt that their requests did not fare well in the final budgetary decisions. Faculty physicians and residents perceived the physicians' voices to be weak compared with those of the nurses or the administrators. With the presence of the union, the influence of the residents' voices regarding a portion of the budget was greatly enhanced. Because the patient care fund improved the quality of patient care, this aspect of unionization did not seem to erode professionalism as Cohen had feared but may have actually enhanced it.

Similarly, resident engagement is needed in hospital quality improvement activities, including participation in the implementation of the electronic medical record system, in duty hours compliance, in attendance at quality review meetings, and with advocacy for public funding of the hospital. The union has become an identifiable and responsible partner with the ability to mobilize residents; additionally, it has organized and focused the previously decentralized, departmentally based residents and has helped to create a sense of common purpose and identity that can lead to effective action.

Less than 60% of our residents have chosen to belong to the union, and other resident organizations, led by an elected resident council, continue to exist outside of the union structure. Although we have tried to maintain a clear separation between the organizations, many of the same residents who find voice in the union also participate in nonunion resident organizations, creating substantial overlap between the key resident leadership roles. The union has contributed to organizational culture change, resulting in the empowerment of the organized residents, who have supplemented the efforts of individual residents and faculty attempting to influence institutional policy by themselves. Our residents have reached out to the residents at other institutions to assist in union development efforts elsewhere and also have found areas of common interest with the residents at institutions that already have unionized. They have become active nationally in the discussion of duty hours, to the consternation of the ACGME, encouraging the Occupational Safety and Health Administration to provide oversight of resident work hours in lieu of the ACGME. A deeper appreciation for other unionized workers at the hospital, a breaking down of class and racial barriers, and an understanding and appreciation of the contributions that all health care workers make to hospital function have developed.

A recent article by Lucey and Souba[4] concerning professionalism suggested that the creation of environments conducive to professional behaviors may be, at times, a more important element of professional behavior than the personal attributes of individual physicians. If resident unions can contribute positively to the clinical environment and the environment of wellness for all health care workers, then they can help to enhance professionalism. If, on the other

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hand, they emphasize salaries and benefits for residents heedless of the impact on the institution and patients, then they may harm professionalism and endanger the survival of the institution. Recognition of the subtle line between these outcomes requires a maturity and trust that, if present, might have obviated the need for the union in the first place.

On the basis of our experience in the first three years of negotiating with a resident union, we are cautiously optimistic about the impact of resident unionization. Although we are disappointed that concerns about such issues as health benefits and salary led to unionization, we also recognize the current reality that in a large bureaucracy where residents and faculty funnel their needs through chairs, who communicate with the dean, who then negotiates with the hospital, the residents' voices may get lost in the din. We also wonder if faculty ultimately will take a similar route after observing the relative successes of the resident unions. As physicians increasingly find themselves underrepresented in important decisions made by those with organized voices, they may perceive unionization as a mechanism to regain the voice that they once had in a less complex hospital environment.

Unions, by their nature as advocates for the needs of their members, risk encouraging resident union members to put their needs above those of their patients, which is an inversion of the most basic principle of medical professionalism. However, if the union can help to create a more equitable, effective institution through the engagement of residents in process improvements and enhanced clinical quality, then it may ultimately create a more professional environment and thereby enhance professionalism. As resident unions evolve, how they resolve the inherent conflicts between individual advocacy and public advocacy, when both objectives involve the same limited funds, will impact public perceptions of the union and the professionalism of resident members. The behaviors of resident unions may be the leading edge in what will ultimately become a broader physician organizational process, and the precedents and leadership of resident unions may indicate the directions that such a process will follow.

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