Navigating House Staff Unionization

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Disclaimers

- President, National Association of DIOs (NADIO)
- I am not a labor lawyer
- Labor law varies from state to state and is different in public vs. private settings
- Some hospitals/health systems are more unionized than others which influences attitudes towards housestaff unionization

Think of This Scenario

- You are employed at a hospital that may not have been high on your list of top choices in a city you may have never been to before. It costs a lot more to live there than when you were in medical school and you now need a car to get to work
- You are working 80 hours some weeks with night and weekend work responsibilities and little control over your schedule
- Student loans are coming due
- APPs working 3-4 days per week make twice what you do
- Hospital leadership makes changes without engaging housestaff that negatively impacts your well-being
- The hospital does not provide mental health resources to employees outside the hours of 9 am to 4 pm M-F

“We went into medicine because we want to take care of people, but at the heart of it, we just don’t think that great patient care should have to come at the expense of our well-being,” said Dr. XX. “In fact, we believe our health and our patients’ health are actually intertwined. Creating a system where physicians can be our best for patients and be our best for ourselves is what we’re hoping to achieve as a union.”

A Bit of History

- Intern Council of Greater New York established in 1934 as first resident union to address working conditions, compensation, education
- National Labor Relations Act (1935) thought to exclude most hospital workers
  - Several court cases with rulings that house staff were students
- Committee on Interns and Residents (CIR) founded in NYC's public hospitals in 1957
- University of Washington Housestaff Association formed in 1964 but not legally recognized until 2014. Now Resident and Fellow Physician Union-Northwest (CIR)
- 1969: Residents at Boston City Hospital (a public hospital) unionize and negotiate first collective bargaining agreement
  - Merged with Boston Medical Center, a private hospital in 1996, which voluntarily (at the last minute) recognized the union

A Bit of History

- 1970s: University of Michigan House Staff Association and San Francisco Interns and Residents Association recognized as collective bargaining agents
  - 1980 SFIRA 4-day strike

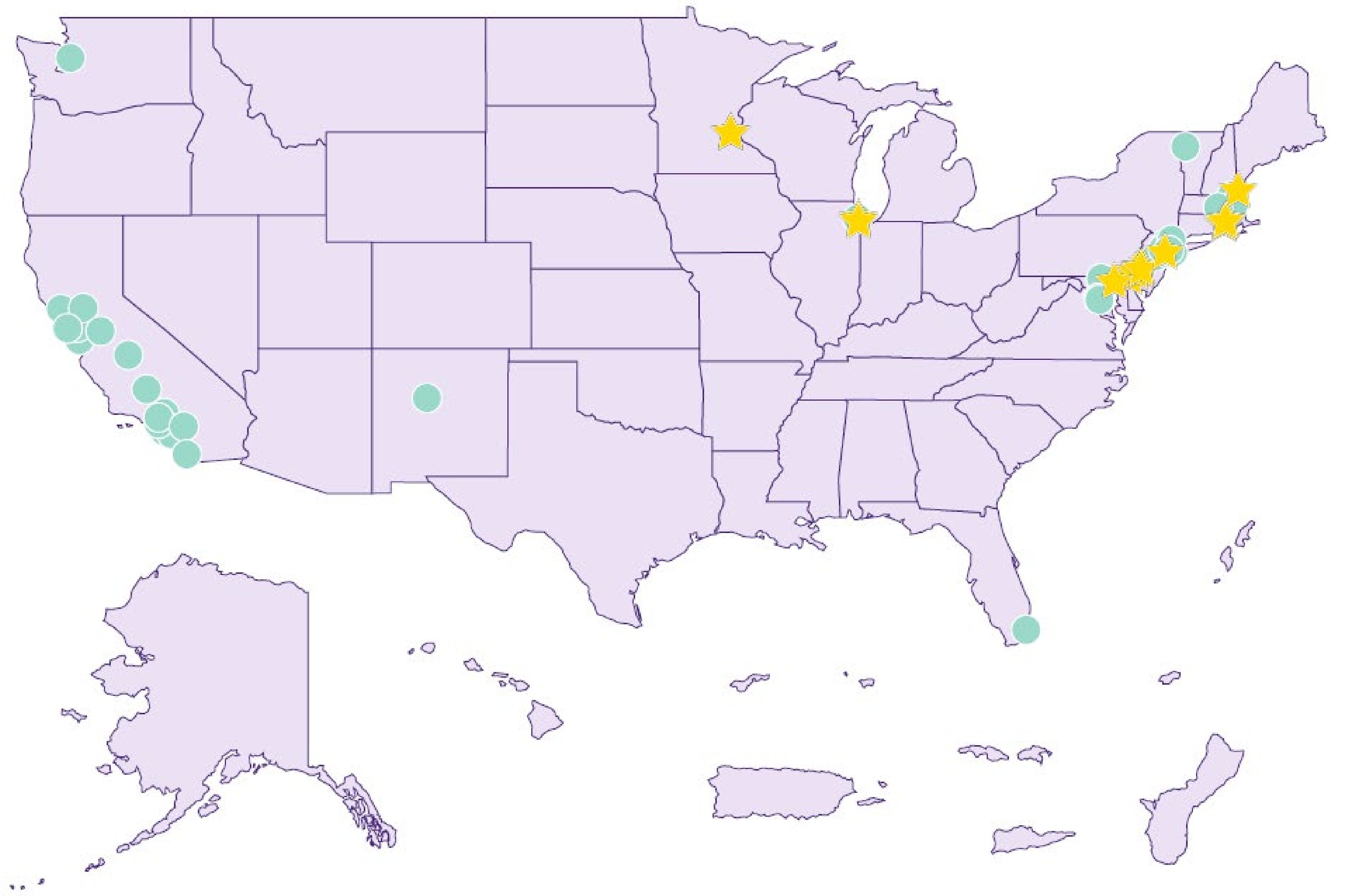
- 1976: National Labor Relations Board (NRLB) ruled residents and fellows are students, not employees, and are barred from organizing for purposes of collective bargaining under the NLRA

- 1997: CIR affiliated with Service Employees International Union (SEIU)

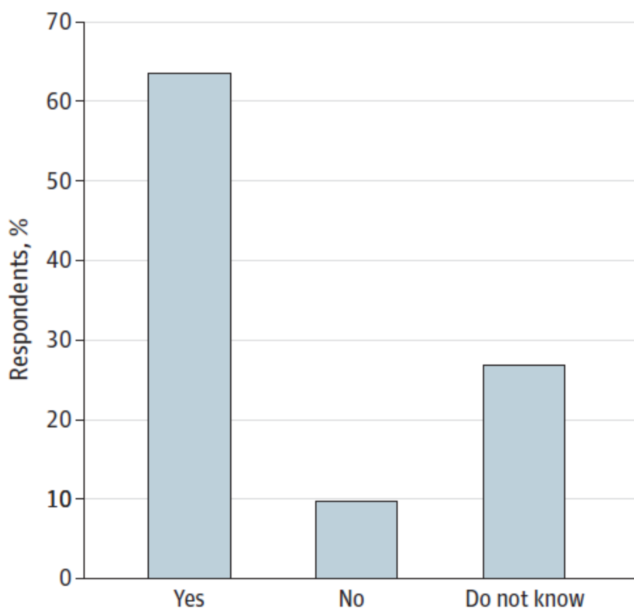
- 1999: NRLB ruled residents and fellows are employees with right to organize for purposes of collective bargaining under the NLRA at both public and private hospitals

- 2023-2024: Strikes at Mt. Sinai (NY), University of Buffalo

- 2025: CIR/SEIU claims to have 40,000 members (~20% of total)



Other unions: AFT/AFL-CIO, Union of American Physicians and Dentists, independent/local unions



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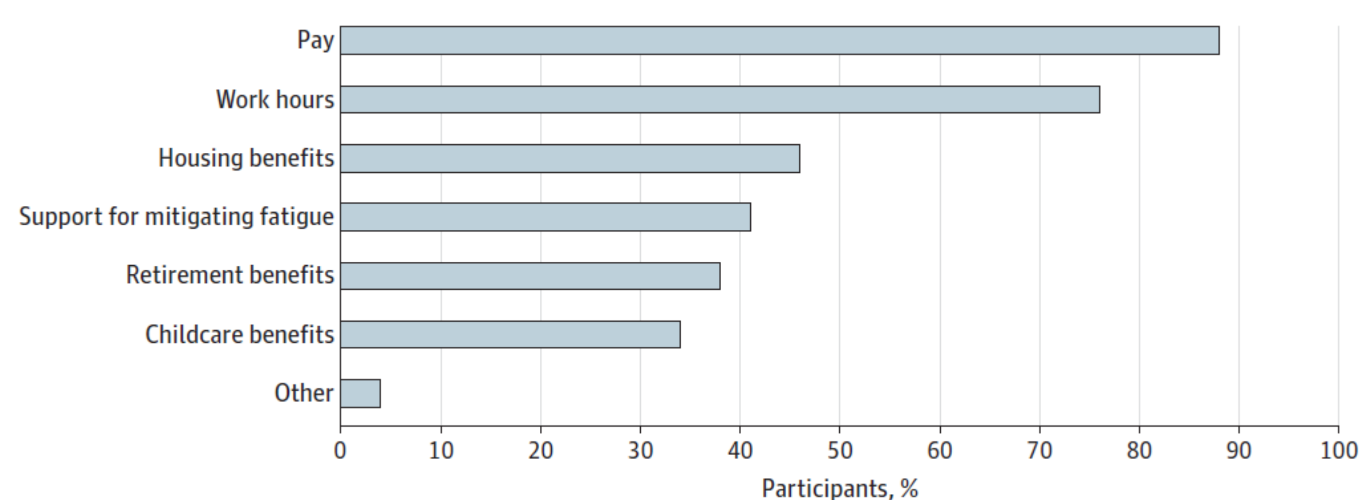


The Process

- Residents/fellows contact a union about unionizing
- Organizing committee is formed to work with the union locally
- Residents/fellows sign union authorization cards (electronically)
- Once majority (usually at least 2/3) of residents/fellows sign cards, union requests voluntary recognition (30% is minimum required by law)
  - If management agrees or if law requires, the union is recognized as sole collective bargaining agent
  - If management refuses and not required by law, a petition is filed by the union with the NLRB for an election
- A hearing is held with the NLRB, union, and management

If Not Voluntarily Recognized

- Both parties present their positions about:
  - Who should be included and not included in the potential bargaining unit
  - When the election should be held
  - How the election should be held (in-person or mail ballot)

- The NLRB will issue a Decision & Direction of Election that details who is eligible to vote and when/how the election will be held.

Before the Election

- **Union campaigns to vote yes**
  - Enlists support of elected officials, other local unions
- **Employer campaigns to vote no**
  - Concern about unionization of other groups

What Led to Penn Housestaff Unionizing?

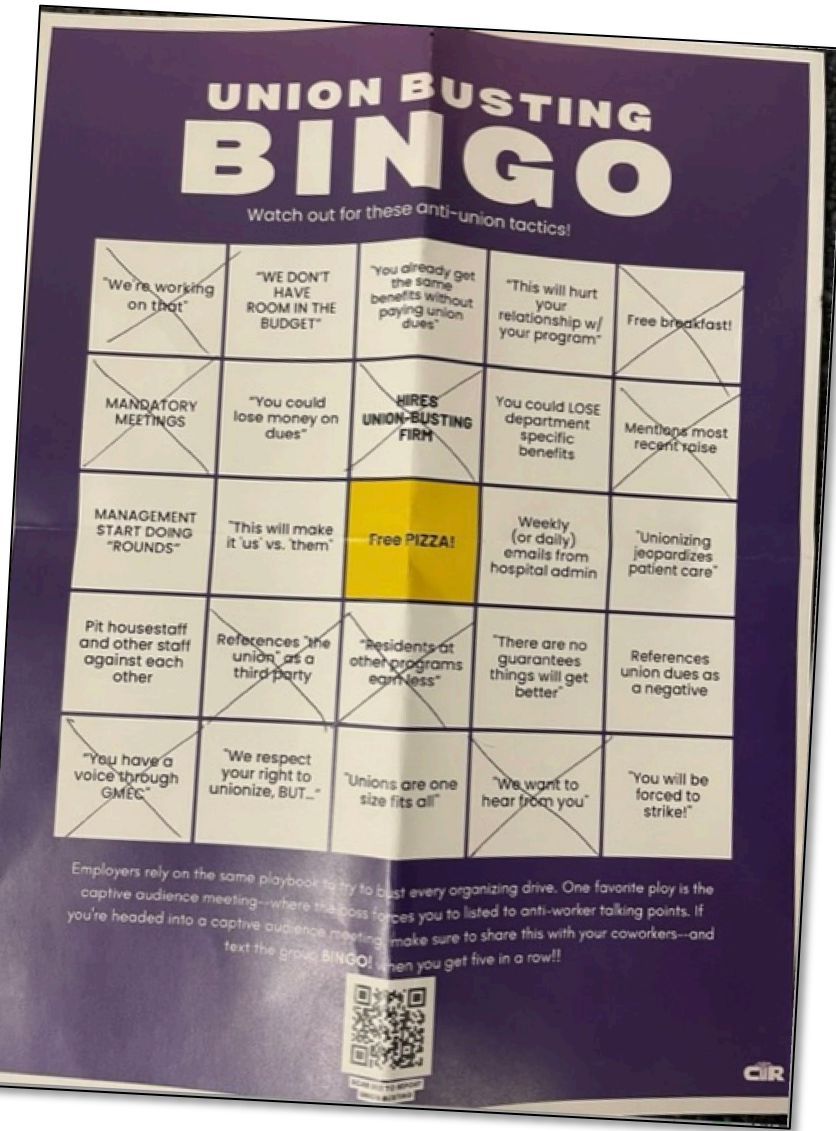
- **During the pandemic:**
  - Initially extra duties without extra pay while nurses/APPs received additional pay
  - Hazard pay refused
  - Stress, burnout, feeling lack of control over lives
  - Health care heroes dissipated, moral injury, loss of meaning from work
  - Loss of educational experiences
- **As the pandemic subsided**
  - Unionization elsewhere with large salary increases, stipends
  - Penn was making a lot of money
  - Subsidized parking was taken away
  - Rumors that housestaff did not have equal access to childcare
  - High inflation, rent increases
  - “Penn gets all this money from Medicare for GME…we should get more of it”
  - Higher salaries at CHOP
  - Wanted a “seat at the table”

How Penn Responded

- Forced election
- Hired consultants (who knew nothing about GME) and outside legal counsel
- Hired a union-experienced HRO (who know almost nothing about GME)
- Tried to limit who was in the bargaining unit
- Attempted to enlist chairs, PDs, faculty
- Launched a multi-pronged "educational" campaign
- Launched house staff website

  facts4pennmedhousestaff.org

CIR/SEIU Materials On Campus



The Election

- Overseen by representatives of NLRB, union, and management
- Outcome is determined by simple majority vote of those who vote in secret ballot by means determined by NLRB
- If no vote, union can try again in one year
- If yes vote, all house staff in the bargaining unit are represented by the union as their exclusive representative for collective bargaining
  - May be challenges to some votes or post-election determination about some voting groups
- Almost all have been overwhelmingly in support of unionization

What Happens Once Union is Recognized?

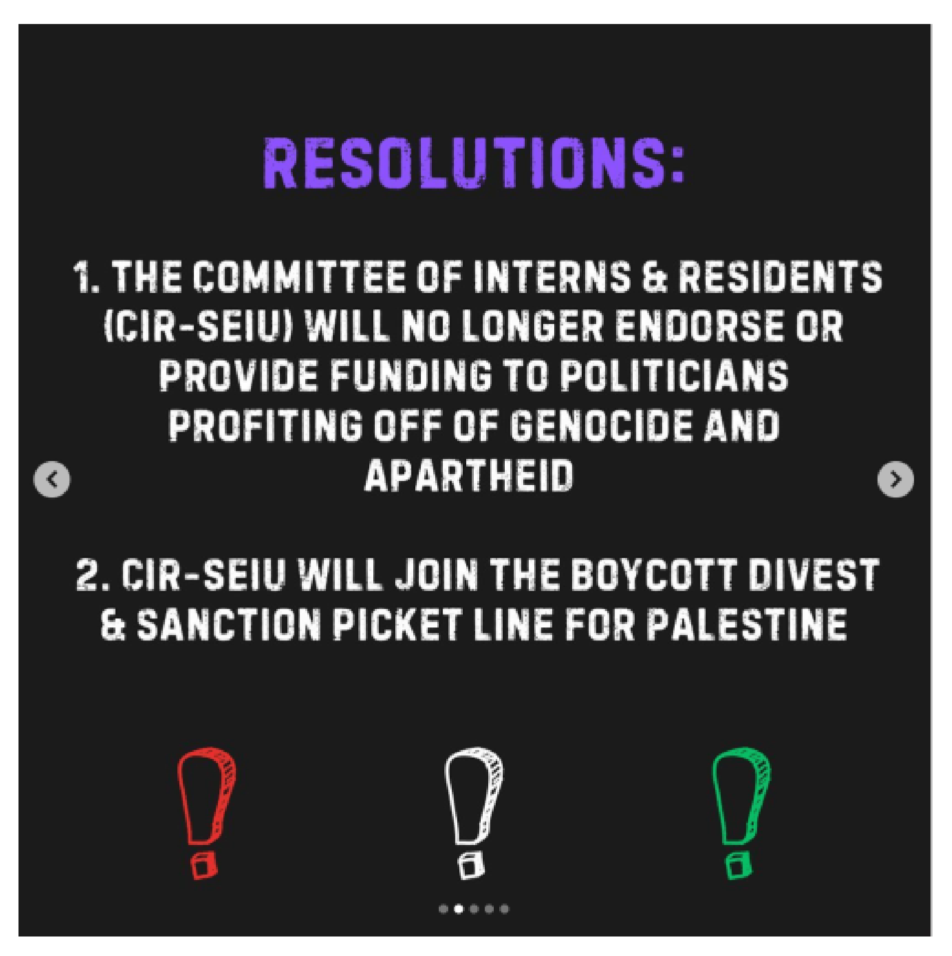
- Negotiations over the collective bargaining process begins
- The status quo prevails with no "direct dealing" until a CBA is agreed upon and ratified
- Typically takes 12-18 months for first CBA
- Once ratified, house staff become subject to union bylaws and rules of membership and management is bound by the terms of the CBA
- Represented house staff pay union dues (currently 1.6% of base pay) as a condition of employment
  - Requirement varies by state
  - Post-tax, not deductible
  - Typically collected by employer on behalf of the union

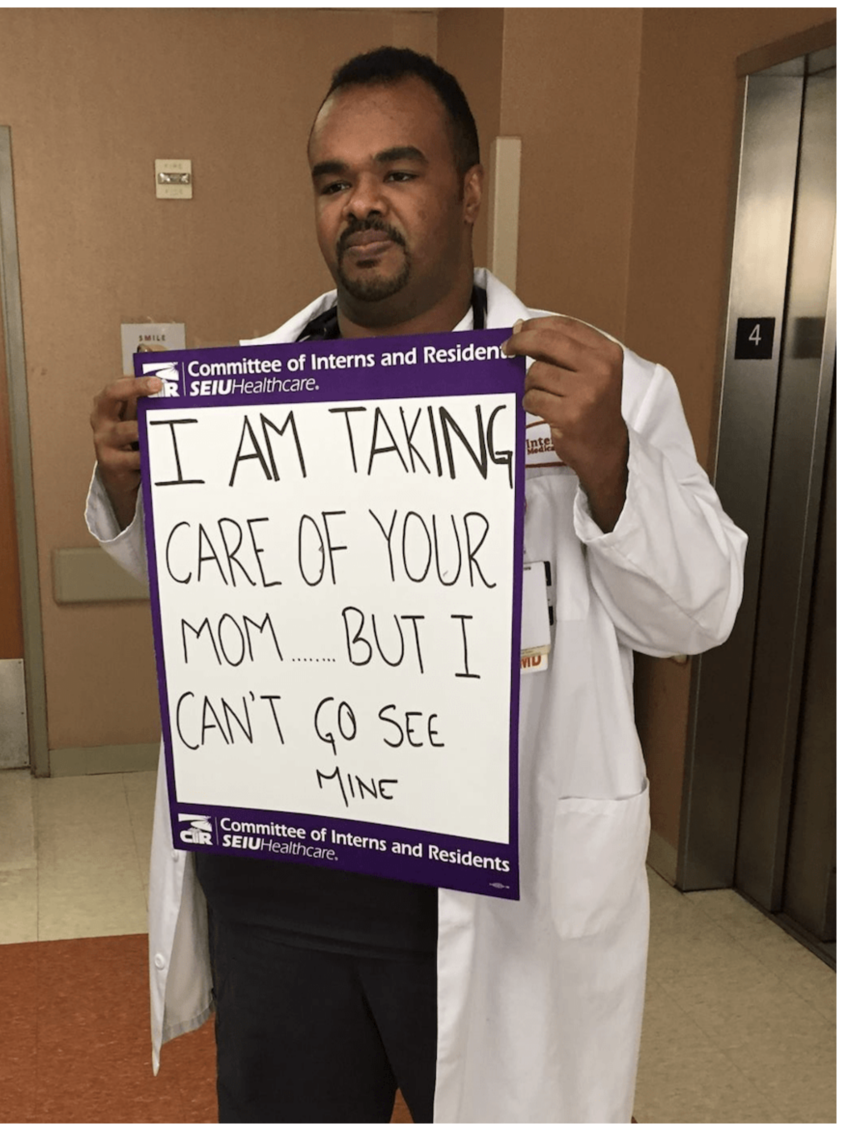
Collective Bargaining

- Law requires good faith bargaining, not agreement
- Only required to bargain on pay, wages, hours and other conditions of employment
- Neither party may insist on bargaining over non-mandatory (permissive) subjects such as work rules and procedures, equipment and supplies, number of employees to hire

- The union can only get what employer is willing and able to give
- No time limit on negotiations.
- If parties cannot agree→potential of a strike
- Other types of job actions generally not permitted

No Obligation to Bargain Over Social Issues





Collective Bargaining at Penn

- Penn labor attorney
- CHRO
- COO to the CEO

- CIR/SEIU staff
- Housestaff

- Mix of virtual and in-person/hybrid

- I was a “consultant” to Penn
- I arranged for bargaining team to review proposals with PDs

How a Union Changes GME

- Complicates the relationship with house staff
- Slows decision making.
- Union leaders may insert themselves into areas of quality of care and academics
- Obstacles in day-to-day operations with rules about everything from holiday and sick leave to classifying research time.

- Union relationship is dependent on the leaders of the union, who may have different agendas than those they represent.

- Has not generally been seen as a negative for recruitment and may be a positive

How a Union Changes GME

- Loss of program-specific time-off policies and benefits.
- Loss of program-specific flexibility to allow for away/global rotations
- GMEC policies defers to CBA
- GME Office and GMEC no longer the advocate for house staff with administration.
- Program directors become employment managers.
  - Lose the autonomy and flexibility to create the unique environments within each program.

- GMEC grievance and appeal process unchanged
- Grievances may go to arbitration

What Got In (28 pages)

- Work duties, caps, call, jeopardy, supervision
- Non-discrimination, DEI, religious accommodations
- Health, safety, security, EAP
- Labor Management Committee
- Lactation
- Call rooms
- Health benefits, holidays, vacation
- Malpractice insurance
- Retirement
- Salary increases of 3% per year
- $100 minimum moonlighting pay
- Leave, 2 additional paid weeks for new parents
- A minimum of $1000/yr for conferences
- $500 annual meal allowance
- Health care appointments < 4 hours don’t count towards PTO
- $11,000 annual stipend

Mostly not changed

What Didn't Get In

- 14%, 10%, 7% salary increases over the 3 years of the CBA
- $1,000 per resident per year into a Wellness Committee fund
- $600/mo meal allowance
- $800/mo housing allowance
- Childcare allowance
- Free Penn gym membership
- $2000 moving reimbursement
- Free parking, fully reimbursed public transportation, mileage paid if travel > 10 miles to any work location
- Paid Uber/Lyft/cab if residents don't want to use public transportation for early or late shifts
- Eight standard holidays + four "floating holidays" + holiday pay
- 10 sick/personal days
- Pay for boards, unrestricted medical license
- Payout for unused vacation/leave
- 100% paid health/dental/vision/life/disability insurance
- Change in PGY level determination

Management Rights and Grievance Procedure

- **Management rights**
- **Assessment of the bargaining unit**
- **Effects bargaining**

- **Grievance procedure**
  - Applies to interpretation and application of the CBA
  - Does not apply to actions related to academic performance (GMEC appeal policy applies)
  - Step 1—PD
  - Step 2—GMEC Chair
  - Step 3—Hospital CHRO
  - Arbitration (AAA)

Unions and Strikes at Hospitals

- Can generally strike only if failure to reach 1st or subsequent CBAs
- Unity breaks, rallies are permissible

- CBAs typically have a no-strike clause during the term of the agreement
- No other job actions permissible prior to CBA

- NLRB requires minimum of 10-day notice
- Strike notice may be sufficient to gain benefit

- Most strikes are less than one week which means usually no loss of pay

- It is illegal for a healthcare institution to fire or discipline workers, including residents, for participating in a protected strike, as long as proper notice is given and strikers do not engage in serious misconduct.

What Happened at Penn

- GME and program policies needed to be updated to reflect CBA (or at least refer to it)
- Needed to sort out who owns what, who pays for what, what falls to GME Office vs. program vs. corporate HR
- Need someone in HR who knows GME (or even better someone in GME who knows HR)
- PDs like to be able to say “this is what the GME Office says”
- VA does not cover stipends unless considered part of pay
- Union did not do a good job educating housestaff about the terms of the CBA
- Some housestaff seem not to have read or understood the CBA

- Part of orientation
- Union has tried to engage over GMEC actions…unsuccessfully so far
- Union has set up tables in public areas and had to be escorted out by security

What Happened at Penn

- Disputes about PGY level
- Grievances about schedule changes, jeopardy call, interpretation of CBA
  - Some residents are very literal, concrete, and don't seem to care much how their behavior affects their colleagues
- Residents have lost ability to use intermittent parental leave, department paid educational opportunities unless from a grant
- Cap placed on allowances for reimbursement for meetings
  - Residents view CBA as floor, HR as a cap/limit
- Maximizing use of days off, vacation, FMLA leave
  - Much more complicated, regimented and inflexible with HR management
  - Treated like all other employees
- "Abuse" of provision that health appointments < 4 hours don't count toward PTO
  - Not considering may extend training, though

Does Unionization Help?

Table 3. Residency Program Outcomes for Unionized and Nonunionized Programs[a]

Outcome	Program, No./total No. (%)		Linear regression, OR or mean difference (95% CI)[b,c]	IV analysis, difference in probability (95% CI)[d,e]
	Unionized	Nonunionized		
PGY-1 salary, mean (SD), $	61 932 (4557)	57 798 (4652)	Mean difference, 552 (−1115 to 2220)	7180 (−2182 to 16 542)
Vacation length, wk				
<4	2/29 (6.9)	118/170 (69.4)	OR, 19.18 (3.92 to 93.81)[f]	0.77 (0.09 to 1.45)
4	27/29 (93.1)	52/170 (30.6)		
Subsidized childcare	0/29	16/170 (9.4)	NE	−0.07 (−0.50 to 0.37)
Housing stipend	10/26 (38.5)	9/56 (16.1)	OR, 2.15 (0.58 to 7.95)	0.62 (0.04 to 1.20)
Relocation stipend	2/29 (6.9)	20/170 (11.8)	OR, 1.13 (0.16 to 8.18)	0.24 (−0.26 to 0.74)
Technology stipend	13/29 (44.8)	76/170 (44.7)	OR, 0.85 (0.34 to 2.12)	−0.60 (−1.46 to 0.26)

Does Unionization Help?

Table 2. Association Between Program Unionization Status and Resident Outcomes[a]

Outcome	Resident group, No./total No. (%)		Logistic regression, OR (95% CI)[b]	IV analysis, difference in probability (95% CI)[c]
	Unionized	Nonunionized		
Burnout	297/690 (43.0)	2175/5011 (43.4)	0.92 (0.75 to 1.13)	0.15 (−0.11 to 0.42)
Suicidal ideation	26/690 (3.8)	234/5011 (4.7)	0.69 (0.44 to 1.08)	−0.08 (−0.17 to 0.01)
Job satisfaction				
Thoughts of attrition	89/689 (12.9)	578/4996 (11.6)	1.00 (0.76 to 1.31)	0.08 (−0.09 to 0.24)
Dissatisfied with decision to become a surgeon	37/685 (5.4)	253/5004 (5.1)	1.02 (0.66 to 1.56)	0.11 (0.00 to 0.23)
Dissatisfied with time for rest	152/688 (22.1)	897/5004 (17.9)	1.01 (0.74 to 1.38)	−0.07 (−0.28 to 0.13)
Duty hour violations	299/672 (44.5)	2079/4911 (42.3)	0.88 (0.65 to 1.18)	−0.30 (−0.65 to 0.05)
Mistreatment				
Any discrimination[d]	344/630 (54.6)	2490/4657 (53.5)	0.88 (0.70 to 1.09)	−0.05 (−0.23 to 0.13)
Bullying	441/668 (66.0)	3294/4906 (67.1)	0.85 (0.70 to 1.05)	0.05 (−0.23 to 0.33)
Sexual harassment	170/668 (25.5)	1525/4868 (31.3)	0.70 (0.56 to 0.87)[e]	−0.07 (−0.27 to 0.12)
Educational environment				
Dissatisfied with educational quality	105/688 (15.3)	456/5003 (9.1)	1.49 (1.03 to 2.17)	0.05 (−0.14 to 0.24)
Inadequate time for patient care	99/686 (14.4)	458/4982 (9.2)	1.38 (1.01 to 1.90)	−0.02 (−0.17 to 0.12)
Lack of protected educational time	124/678 (18.3)	610/4959 (12.3)	1.47 (0.95 to 2.29)	0.00 (−0.23 to 0.23)
Inadequate time in operating room	93/681 (13.7)	363/4957 (7.3)	1.55 (0.97 to 2.49)	0.00 (−0.15 to 0.16)
Inadequate autonomy in operating room	83/682 (12.2)	427/4955 (8.6)	1.14 (0.72 to 1.82)	0.00 (−0.20 to 0.20)
Inadequate autonomy in clinical decisions	37/682 (5.4)	207/4972 (4.2)	1.22 (0.68 to 2.21)	−0.03 (−0.14 to 0.09)
Lack of effective support staff	183/683 (26.8)	786/4984 (15.8)	1.70 (1.13 to 2.57)	−0.01 (−0.22 to 0.21)
Program not responsive to resident concerns	68/685 (9.9)	360/4965 (7.3)	1.21 (0.78 to 1.87)	0.03 (−0.11 to 0.16)
Program did not take wellness seriously	82/686 (12.0)	378/4978 (7.6)	1.53 (1.02 to 2.28)	0.01 (−0.13 to 0.15)

Does Unionization Help?

Table I. Salary and benefits compared across unionized and independent dermatology residency programs

	Unionized programs Average ± SD (min-max)	Independent programs Average ± SD (min-max)	*P* value
Number of dermatology residents (PGY2-4)	14.0 ± 7.0 (3-26)	10.8 ± 5.3 (2-26)	.077
PGY2 salaries (2022-23)	$66,477 ± $14,318.43 ($58,461-$80,565)	$62,608 ± $6551.00 ($42,000-$83,783)	<**.001**
Educational allowance ($/y)	$1259 ± $648.81 ($500-$2000)	$1364 ± $1429.11 ($255-$7500)	.154
Paid parental leave (d)	23.5 ± 16.1 (0-60)	31.1 ± 26.4 (0-180)	.757
Sick leave (d)	12.7 ± 6.2 (4-24)	20.0 ± 32.0 (0-180)	.052
Vacation time (d)	19.9 ± 3.6 (10-28)	17.6 ± 3.6 (5-30)	.930
Independent parental leave (# of programs, percentage)	12 (41.4%)	68 (62.4%)	.546
On call meals (# of programs, percentage)	19 (65.5%)	66 (60.6%)	.861
Additional stipends (on call meals, moving, cell-phone, state license charge)	5 (17.2%)	16 (14.7%)	<**.001**
Technology stipend (# of programs, percentage)	19 (65.5%)	40 (36.7%)	.125
Dental benefit w/no additional fee (# of programs, percentage)	9 (31.0%)	40 (36.7%)	.188
On-site child care (# of programs, percentage)	6 (20.6%)	25 (22.9%)	.131
Subsidized child care (# of programs, percentage)	6 (20.6%)	7 (6.4%)	**.011**
Urban (vs rural)	27 (93.1%)	93 (85.3%)	.942
Cost-of-living index covariate	121.7 ± 20.5 (92.9-173.5)	100.5 ± 12.3 (83.5-140.6)	**.006**

J Am Acad Dermatol 2024

Does Unionization Help?

Table 3. PGY-1 salary and total compensation offered by unionized and non-unionized internal medicine residency programs in the United States.

	Program Type				
Outcome	**Unionized**	**Non-Unionized**	**β**	**95% Confidence Interval**	**p-value [a]**
PGY-1 Salary, mean (SD), $	69648 (6145)	62214 (6069)	2108.6	670.7, 3563.7	0.002
Total Compensation, mean (SD), $	73477 (9117)	63251 (6596)	4600.2	3576.16, 5728.2	<0.001
	Following Adjustment for Cost-of-Living				
PGY-1 Salary, COL Adjusted, mean (SD), $	62515 (5669)	62475 (5149)	-9.1	-1317.5, 1299.7	0.99
Total Compensation, COL Adjusted, mean (SD), $	65887 (7752)	63515 (5701)	2076.7	607.6, 3551.5	0.03

Final Thoughts

- With rare exceptions, unionization is probably going to happen eventually at many larger hospitals and medical centers if legal in the state
- Upping the ante in an attempt to avoid unionization largely fails and just raises the “floor”
- Mostly driven by a relatively few activists; others support or choose not to oppose
  - Interest among residents > fellows and varies among programs
- It’s all about the money and time off
- DIO should stay out of it. Chairs, PD, and faculty should probably as well

- Patient care and education goes on
- It just costs more and is a bit more of a hassle for the GME Office and DIO

DISCUSSION