Sawbones 526: Physicians' Unions

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[theme music plays]

Justin: Hello, everybody. Welcome to Sawbones, a marital tour of misguided medicine. Oh, me? I'm just your cohost, Justin McElroy.

Sydnee: And I'm Sydnee McElroy.

Justin: Hmm.

Sydnee: I'm excited about this one, Justin.

Justin: Oh, I just had the podcaster's nightmare. I realized that I needed to pee a little bit right when the episode started. So, uh, it's gonna be a really tight one for me, Syd, but I'm gonna find a way to focus on the show.

Sydnee: Justin, I think that is a great intro to this specific episode.

Justin: Wow, I—that's amazing. We had a thing about this in theater, you know? We would not pee before an audition. It was a well-known thing where none of the guys would pee before we had to do an audition. because there was a superstition that it would make your audition go better if you had to pee while you were doing it. Presumably 'cause the pace, you would keep the pace up and it would be high energy.

Sydnee: You'd go faster, sure. Yeah. Well, okay. I... I've never heard that. I was referencing—

Justin: So we'll do this one at rain pace, folks. Rain pace.

Sydnee: Okay. Rain pace. I was referencing that as a physician, especially during my years in training, I often worked with a full bladder, and counted the seconds until I would be able to take a break and pee. So, I thought that was good, because we're gonna talk about physician unions. And the lack of ability to pee when you need to is probably part of what led to this! [laughs quietly]

Justin: Uh, I mean, I—I think it's a little dehumanizing if you can't go use the potty whenever you need to potty.

Sydnee: Hmm. That—

Justin: I think that everybody should potty whenever they want to. That's how—I feel pretty strongly about that.

Sydnee: You know what, honey? I'm gonna tell you that not being able to pee when I needed to was one of the less dehumanizing things that I think I experienced during my medical training. [laughs quietly] If that gives you a scale. Thank you to Malena for suggesting this topic. I wasn't—so I'm familiar, of course, with the concept of doctors unionizing. But I didn't realize how... trendy this is becoming. How there are more and more physicians who are taking this route, which is really exciting. And it is a huge deal to people within the medical community in general, and I think especially physicians, obviously. The idea of physicians' unions. And it might not be immediately apparent why.

Justin: Hmm.

Sydnee: But I want to walk us through sort of the history of unions of doctors, doctor's unions, and why is it such a big deal? I mean, do you have a sense, Justin, right off the top of your head, why is it a huge deal if doctors unionize?

Justin: Yes, obviously. Because unionization, one of the big strengths of that is collective action, and it seems like to me that in—and we've seen this in some parts of the hospital system already. But when, you know, people

strike, then it creates some big gaps. And you—obviously it was huge for nurses in our region when they were striking at Cabell.

Sydnee: Mm-hmm.

Justin: And you could imagine those problems being, um, more, just because of the price of that. You know, fewer of those doctors and specialists and... even harder to replace.

Sydnee: Yeah. It's a big issue, and it wasn't always necessarily apparent why physicians would want to unionize. Now, I think—and I think you need to understand a little bit about training. We've done some episodes where we've talked about the process of training physicians in the past, in the US. I'm only talking about in the US. Systems are different country to country.

But I think it is probably relevant for me to review that a little bit, for this episode. Justin, I know you're intimately familiar with it 'cause you experienced it with me.

Justin: Yes.

Sydnee: But if you yourself have never experienced physician training in the US, or you don't have a loved one or friend or someone—if you're not familiar with it, it can be a little shocking, the way we train doctors.

Justin: Yes. It's very intense. There's not, like, a good—it doesn't really relate one-to-one to, like, grade school, or a regular job, or really any other thing. [laughs]

Sydnee: It—so, after you finish your undergraduate education, you, in this country, you go on to medical school. Or what we consider our undergraduate medical school. So it's kind of like there's undergraduate-undergraduate, and then there's undergraduate medical education, which is the four years of medical school you're going to attend, and that can be either an MD, medical degree program, or doctor of osteopathic medicine, DO program. So you're gonna attend those four years of medical school.

And those four years are challenging, but in a way that probably is a little more predictable. Like you would guess. You spend the first couple years mainly in classrooms, lecture halls, maybe an anatomy lab, learning. And then you spend your second two years out in doctor's offices, and hospitals, and in healthcare settings, doing clinical rotations where you're, like, shadowing doctors, doing work. Like, out there in the world, learning things.

And those can be arduous years, certainly especially the third year of medical school can be really challenging. I wouldn't say it is outside the realm, again, of what you would think training a doctor would look like. I think it's when you finish those four years, and now you have moved on to graduate medical education, or residency, and then perhaps even beyond to fellowship, that is when, if you're not familiar with the process, you can see how someone might want to strike... while they were going through it.

So, in the US, a medical resident—and your first year, by the way, you can be called an intern, no matter what specialty you go into. And then after that you're a resident, and it depends on what year you are, and different programs are different years. I'm not—

Justin: You—you're still a resident when you're an intern, right?

Sydnee: Yes.

Justin: It's just—I got you.

Sydnee: Yeah. You still have to finish your, um—step three of your boards that year, and then you become a resident after you finish that. So that's why it's differentiated. And there also used to be a way that you could just do an intern year, and then practice medicine, and you'd be a GP, general practitioner. Nowadays, most people don't take that route.

Justin: Right.

Sydnee: But that is also why that first year was sort of distinguished. And then after that you complete your residency in your given specialty. So for me, family medicine, three years, and I was done. Surgery is five years, and

then you can do fellowships that could be one, two, three more years on top of that. So it can be a really long time.

During that time period, you're paid... much less than you would think a physician in the US makes.

Justin: Right.

Sydnee: Because it is much less than a physician in the US makes. [laughs quietly] and you are also—

Justin: That is a correct assumption that you have made. It is quite a bit less.

Sydnee: Yes, it's quite a bit less. It is exciting, because you've only been losing money up to that point. You've just been sinking into debt, and so it's exciting to get a paycheck. But you're paid much less, and your work hours can be up to 80 hours a week. On average. I say on average, because you could, especially if you have a weekend off, the week before that you could work 100, 120 hours. Certainly many of us did.

Obviously that includes overnight shifts in the hospital. That can be as frequent as doesn't violate work hours. There's specific rules about, like, if you've been there for 24 hours awake, you have, like, six hours—I think now it's four hours—to complete your work, but you're really not supposed to engage with new work.

Like, I'm not supposed to take on a new patient if I've been awake 24 hours. I can only take care of the patients I already had. But not new ones.

So, like, there's some other rules around it. But it's extremely difficult. And historically has been a period in physician training where hospitals can really... utilize residents to the best benefit of the hospital, and not necessarily to the best benefit of the physician, or the patient.

Justin: Right. You are having—it is like a weird—oh, man. It is a weird gap in, like, the capitalist system that we understand to this point that where people are getting a lot more work, and there is no—you can't quit. Like, you

can't, like—I mean, you can. But not in—"I'll go find another place to work." Like, you are stuck there.

Sydnee: You're stuck there.

Justin: You're stuck there. You know you're not getting paid enough, and you're forced to do it, and you have no choice.

Sydnee: And you're usually in—

Justin: And it is a... almost certainly, someone in the chain is profiting off of that very low cost labor that you've been providing.

Sydnee: Oh. Well, the hospitals are.

Justin: Yes.

Sydnee: And we're also, during that time period, most of us are in six figure debt. And so the idea of quitting is so terrifying. How will I pay back this money if I don't finish my training and become a physic—you know, a full-fledged physician?

Justin: Right.

Sydnee: So anyway, despite that, despite the fact that—I mean, I spent those years—I didn't pee. I didn't eat. I didn't sleep. I didn't—I drank so much coffee that I gave myself an arrhythmia temporarily. You really—you—self-care is not a concept that existed. I think things are changing. But certainly not in my residency training. And it was worse before me. The people who came through medicine before me had it even worse than I did.

So, despite these issues, physicians historically didn't unionize for a couple of reasons. One, I think it's more of like a—the way we see ourselves. Physicians tend to see themselves as management, even though we really aren't. Fellow physicians, have you thought about it? We're not. [laughs quietly]

But they tend to see themselves that—like, "No, I wouldn't need to unionize. I'm the boss."

Justin: Yeah.

Sydnee: And you got a bo—I bet you have a boss! Most of us do these days. And I think the other thing is that the idea that medicine was supposed to sort of traumatize you is kind of baked into the culture.

Justin: Yeah.

Sydnee: I mean, it really—if you think about—even the shows that I love, M*A*S*H, or ER, or House, or even Scrubs, everyone on it is cool, and works so hard all the time, and they are... kind of miserable and kind of traumatized, but that's medicine, and that's what it is to be a doctor.

And so I think part of it is our own—the way—like, we think that this is what we're doing.

Justin: There's a mythologizing of that, like, suffering and that intensity and the hardship, for sure.

Sydnee: Mm-hmm. This is our calling. We're not supposed to be human. It's dehumanizing, 'cause I'm not a human, I'm a doctor.

Justin: Well, it's like a lot of hardship where, like, um... I mean, I think motherhood is a good example, right? Where once you go through this incredible pain, you are an owner of that pain, right?

Sydnee: Yes.

Justin: So, like, you are—you are a guardian of that pain. And there are some people who I think... that pain to them is—this—I wouldn't say this about motherhood. But, like, for those doctors, I think they feel like you need to go through that to, like, be part of the fraternity. You know what I mean?

Sydnee: Mm-hmm. Yeah, I do think there's a hazing element, if that's kind of what you're—

Justin: Yeah. Yes, that's a really—

Sydnee: Yes, I do think—

Justin: —more succinct way to put it.

Sydnee: I think that that is part of it. And for older physicians, like, "I did it. You have to do it too, to prove yourself."

There's a truth that being a physician is always going to have this element to it that feels unfair. You're gonna see really sad, heavy, hard stuff on a regular basis. Now, it's not affecting you, so I would argue it's worse for the person it's affecting. But it does affect you. You are gonna carry it home. And you do have to bear that, and then go to work the next day. And that's intractable.

But then there's a lot of it that is... tractable, and we just haven't fixed it. The other thing is that doctors were typically, historically, independent contractors. You either had your own private practice, or—you owned yourself. You were your own boss. You were not an employee, historically. We're gonna get to why this is shifting.

But the history of residents specifically trying to unionize is a little older than we we get to people who have completed their medical training. And it makes sense as why. Why would residents be the first ones to unionize?

Well, for all the reasons I just said. Because—

Justin: Right. It makes perfect sense.

Sydnee: Yes. I mean, I think the word "abuse" is a heavy word, and so I don't wanna say that we abuse resident physicians. But do we ask them to deprive themselves of basic human needs, and underpay them, and overwork them, for the privilege of being a physician? Yes, we do that.

Justin: I mean, that sounds like... I mean, if we're talking in literal terms, that certainly sounds like abuse.

Sydnee: And this is back to the 1940s. And by the way, resident physicians, the reason they're residents, they used to reside at the hospital.

Justin: Oh, yeah?

Sydnee: They lived there.

Justin: That tracks. It's still sort of—like, not—obviously they don't, but sometimes there's little bedrooms and stuff where you can sleep through the night.

Sydnee: Where you stay overnight.

Justin: Overnight, yeah.

Sydnee: Yeah, the call room. Yeah, well—

Justin: [crosstalk] set up.

Sydnee: And I will say, even though we don't reside in the hospital, at least in this area, pretty much you know where all the residents live. It's right around the hospital, because they walk to the hospital. Because they have to be there. No matter how much snow's on the ground, they gotta get there. So... we reside around the hospital. Anyway, so the first one, um, there were interns from 26 New York hospitals that organized as the Intern Council of Greater New York back in 1934.

Justin: Wow.

Sydnee: So a long time—yeah. Like, back—early days of unions at all, there were physicians who were attempting to organize. And a lot of it was for, um, salary adjustments. To give you an idea, by the way—so they were trying to get salaries of $15 a month. This was 1934. But to give you an idea, I did the math. My intern year of residency, do you know what my hourly wages were?

Justin: What?

Sydnee: A little under 12 bucks. So it's not lucrative to be a physician—to be an intern. [laughs] Now, that has shifted. Residents are paid a little more, obviously, than they were back when I went through. But you're working those hours, and you're making—I was making, like, 11.75 an hour.

Justin: Right.

Sydnee: For what I was doing. So there was this first move back in the 30s. After that, there wasn't much else until the in 50s, the Committee of Interns and Residents was formed, which is something that still exists to this day. And then a few years later in LA in 1965, there was another intern, resident association sort of formed. But all of these were pretty small.

Justin: Okay.

Sydnee: Organizing efforts. And there wasn't—it was mainly like, "We want you to pay us a little more." There wasn't a lot... like, "What are our principles? What are we—" you know?

Justin: It sounds like there's not—

Sydnee: Pretty small effort.

Justin: And also, not—like, designed to be regional, right?

Sydnee: Yes.

Justin: It sounds like these were all sort of, like, this is a big enough area that we can get enough people together to get something like this going. No aspirations of being a national thing.

Sydnee: That didn't come until the ‘70s. And in 1971, the first national effort took place in St. Louis. There were representatives from all over the US. They had a bill of rights for patients, a bill of complaints for themselves.

They approved a, like, contract, a minimum wage. You know, the kinds of stuff that unions do, right?

So it really wasn't till the ‘70s that you see this kind of national effort. And this is around the same time where in the ‘70s, you see a lot of kind of—we're hitting the height of union—like, the moment where the union busting really started. Like, the unions were pretty strong through the 50s and into the ‘60s, and as we ease into the ‘70s, you start to see unions in general across the US be undermined, and more efforts being made legislatively to try to stop unions.

So right as I think residents were trying to make themselves, you know, a force, a labor union force, was the same time that a lot of rules were being passed, specifically like Taft-Hartley, which more or less the language of Taft-Hartley prevented hospitals from striking.

Justin: Hmm.

Sydnee: Now, just like you said, Justin, this gets to I think the meat of the question. When doctors started organizing, everyone asked the same question. Well, if doctors are in a union, can doctors strike? And if doctors can strike, what happens to the patients?

Now, I will—I want you to think about that question. I think there's a lot more nuance than just that. I think it's a very simplistic view of the actions you can take. But this is why—

Justin: Sorry. I mean, you asked me what I thought it was and I just told you.

Sydnee: No! You were exactly right.

Justin: [crosstalk] simplistic.

Sydnee: But I think any time that you say "I think this is a huge force for good and something that's really important for us to do," and somebody gives you, like, a one sentence, like, "No, because then you could strike and

patients would suffer," and that's it, I think that it behooves you to stop and say, "Well, surely we could—surely we could serve both."

Justin: There's gotta be something in between there.

Sydnee: Right. But I think that argument was used on a national level and legislatively, and I can imagine there were a lot of blustery speeches given about the fear. What if your doctors all walked out?

Justin: Right.

Sydnee: You're hooked up to machines in the ICU—your loved one is—and the patient's family is all around the bed, and then you watch your doctor drop their stethoscope on the ground and march outside. Terrifying. You can imagine the kind of rhetoric that would have been—it would've been very easy to undermine a physician union effort by kind of leveraging that fear.

So, we really didn't see, like, in the ‘70s, this kind of—this attitude towards unions permeated any efforts to, you know, really start physician unions. And you didn't see the resident organizations grow much, but they continued to exist. Now, I do want to talk about the flip side of that, which is, what about the doctors who are already done with their training? 'Cause this has been really focused on the concerns of residents, which a lot of 'em—not all of 'em, depending on your specialty—but a lot of 'em do go away. When you finish your training, you make a grown up salary. [laughs quietly] You get to pee when you want to. You have a little more control.

Justin: And anywhere you want to.

Sydnee: [laughs quietly] Not—well, no, you still gotta go to the bathroom. But, you know, you get to pee. You get to eat. You get to—you get a little more freedom. You get a little more autonomy. Depending on where you work, that's still limited. But you get a little more of a personhood back.

Justin: Right.

Sydnee: So why did attending physicians, why did physicians done with their training strike? So I want—or why did they unionize? So I want to talk about that. But first, we gotta go to the billing department.

Justin: Let's go!

[theme music plays]

[ad break]

Justin: Well, Syd, why do those—why are the old dogs—why are they so upset? Aren't they happy with their fat paychecks?

Sydnee: So, they... they aren't. [laughs quietly]

Justin: Aww, no!

Sydnee: The first strike that included all doctors, not just doctors in training, was in 1966 in New York, and it was to protest low wages. [laughs quietly] Um, but—from the Doctors Council. But the, uh—but in the ‘70s, the SCIU announced that there was gonna be a physicians' union formed in Nevada. So, it's a big deal to get the SCIU to recognize, like, this is an entity that's organizing. So that's very exciting.

Um, and the Union of American Physicians and Dentists were founded, which is also—bridging that divide between physicians and dentists is so exciting, too. Any time we can do that. 'Cause again, I don't know about teeth, and dentists, I need you. [laughs quietly] 'Cause I don't know. They won't teach us. They refuse to tell us anything.

Justin: Okay. I think you should leave teeth to them. I think that they're territorial, and I understand it. They don't want you meddling in there, in those weird bones.

Sydnee: They—no. They don't want—they don't want us doing it 'cause they know we don't know what we're doing. [laughs quietly]

Justin: No, you'll make them explode!

Sydnee: They explode on their own, we've established this.

Justin: That's true.

Sydnee: Yeah. So—

Justin: Unless it was something the doctors did. It might be something doctors did. You don't know.

Sydnee: Um, so the problem is that basically, when they established this in the ‘70s, the AMA... was a little concerned. Because the idea of—so the American Medical Association is its own lobbying organization. It's not a union, right? Like, they're not... it's not a union of physicians.

Justin: Right.

Sydnee: They're a political lobbying group. They're—you know. They will advocate on mainly national levels for policies that benefit physicians. But it's not the same as a union. But they felt like—like, "We're here. I mean, we exist. Why don't we just have sort of a department of negotiations? And then you can just—like, if you're part of the AMA, we can help with that too."

Justin: Okay.

Sydnee: And so I would say at that moment, a lot of doctors who may have been sort of thinking about unionizing and, like, "Well, we could form one of these too. The SCIU is recognizing this. There's a chance that we could have a little more control over our destinies as physicians."

I think a lot of 'em probably turned to the AMA instead. And said, "Well, the AMA will be that for me." And that really, honestly, until the ‘90s, you don't really see much else movement. There are a couple of resident unions here and there throughout the country. Mainly once they're done with training, physicians don't join unions. If you talked about resident unions, I mean, even when I went through, just talking about the idea of unionizing, everybody was just ready to scream. Like, "Don't even say it." Like, this is not even—which is relatively recently.

But what started to shift in the ‘90s were HMOs. So as these huge healthcare management organizations started buying up smaller systems—so you've got hospitals, you know, joining forces. You've got... big systems buying private practices, and smaller healthcare groups.

Justin: Conglomeration, things being rolled up into one another, yeah.

Sydnee: Yes. Exactly. And this was—it started in the ‘90s, and then actually in response to the Affordable Care Act, which was wonderful and transformed, especially in this area, healthcare in such a positive way, in so many ways, so this is not me slamming the Affordable Care Act.

But there was even more after that—it was profitable for these systems to buy up these smaller little offices. Primary care got gobbled up in there as well. All the sudden, hospitals weren't just for hospital medicine. A hospital system has multiple different specialties, outpatient practices, primary care and sub-specialties and all that within it. Right?

Justin: Right.

Sydnee: Like, that didn't—if you think about it, that's not what hospitals used to be.

Justin: They used to be hospitals.

Sydnee: They used to be hospitals. [laughs quietly] And what came with that is a lot of monopolizing. Right? In a lot of areas.

Justin: Trying to lock down the entire medical market.

Sydnee: Yes. Your healthcare system is essentially a monopoly. Think about the healthcare system in your area, and... it probably is. A lot of them are.

So, anyway, what you saw is that back in 2012, about 29% of US doctors were either directly or indirectly employed by a hospital. By 2022, 10 years later, 74% of doctors were employees of hospitals.

So—or some sort of corporate entity. And the problem with that is that all the sudden, as a doctor, I was kind of educated to believe that I was the boss. I literally write things that we call orders to give to people. And what comes with that is a lot of responsibility. That's always the—that's the double-edged sword they always teach you in medical school. You are the one in charge. You make the decisions. But also, you get the blame. So if things go wrong, you get all the fault. So be really careful with your decisions.

Justin: My uncle told me something about this. He said "With great power, buddy, sometimes there's gonna be a little bit of responsibility with that, pal, and you just gotta deal with it. I'm sorry, but that's the way it is."

Sydnee: Is that what he said?

Justin: He did. Used to say it to me all the time.

Sydnee: What was he—what was he doing when he said that? Was he—

Justin: Trying to keep me from wrestling.

Sydnee: —laying on a sidewalk and—

Justin: Trying to keep me from wrestling, actually.

Sydnee: [laughs]

Justin: I told him I had a future as a wrestler. And he said I wasn't ready for Bonesaw, so he told me I wasn't ready for wrestling.

Sydnee: But it's true—it's really weird when I think about the fact that it... it was impressed upon me that I was the boss. And then I began working in a healthcare system where I was not in any way the boss!

Justin: And when you have a systemized, like—when you have a system, what you're talking about is the power of the individual hospital is now subsumed by, like, an even bigger entity., right? So you matter even less in the, uh—you think about shows like—it's funny, we were just talking about

Scrubs. And it's like, the joke of that show is how small they were in comparison to the hospital. And now it's not even that. It's how small you are to the, like, corporation that owns the hospital, and the six other hospitals in the state.

Sydnee: And I think it is that that has driven this shift. Because I can tell you that, you know, in residency, the bargain they're always trying to convince you of is that you won't have a life for this period of time. You are owned by the hospital, and you will give everything to the hospital. But you'll get a life when it's all over. And I think the problem is that when the hospital continues to be your boss forever, when the system, these giant healthcare systems—it's not just hospitals.

But these giant... you know, high—like, big money making healthcare systems are your boss, you don't really ever get control. Your hours, the number of patients you have to see, the amount of time you get to see your patients, everything is so micromanaged. There is so much paperwork and administrative stuff laid on us now as physicians. I spend so—I mean, I don't, because of the kind of medicine I practice.

Justin: Right.

Sydnee: But prior to where I am now, you spend so many more hours doing the administrative tasks around medicine to satisfy insurance companies and pharmaceutical companies, and your hospital administration. So much more than you actually spend taking care of people, which is what you wanted to do. And eventually you get to the point where you realize, other than that I get paid more money than I did in residency, is my life really any better? Am I still just... you know.

Justin: Yeah. A cog.

Sydnee: Yes, a cog! And I think that that—that sort of internal conflict, like "I've lost my autonomy. I no longer work at a private practice. I no longer am able to make these decisions on my own." I think that's really why we started to see in recent years, unions have started rise among the medical community. So if you look from 2014 to 2019, the number of physicians who belong to unions grew by 26%.

Um, it's still only a tiny percentage of doctors that are in unions. It's, like, 7% as of the last count. It is still growing, I will tell you. And that was why—actually, that was the impetus for doing this topic right now is that there have been a lot of news articles that have come out just in the last couple months about physician groups in Rhode Island, and Massachusetts, and New York, and Pennsylvania. A lot of northeast, you know, school-based, university-based programs, and then outside of those that are unionizing, and being recognized as a national union.

There are so many more resident physicians, and now more and more attending physicians, doctors who have finished all their training, who theoretically should have control over their own practice, and don't, who are joining these unions. And I think what's really fascinating about that, and exciting—well, I don't want to say it's exciting. Because the flip side is that other types of unions have been steadily declining since the ‘70s, since that peak, since we saw that union busting in the ‘70s. You see that union membership has declined to nearly 10% today, from a peak of 35%.

Justin: Wow.

Sydnee: So at the same time where I think the US government has done a lot to suppress unions, um, and entities have—the US government has allowed entities to suppress unions, at the same time, doctors all the sudden are flocking to unions.

Justin: Mm-hmm.

Sydnee: The AMA, by the way, does—they've had to issue briefs and papers, and there's a round table and a webinar you can watch on, uh, collective bargaining, pros and cons, should you do it?

Justin: Yeah.

Sydnee: Which I think is interesting that it's presented that way. But what they're saying is, "We don't—we support your right to unionize. If you want to unionize, you can."

They're not really gonna weigh in... positive or negative.

Justin: We're not gonna tell you how to do it.

Sydnee: They are gonna tell you that they can do a lot of what unions do... but if you wanna unionize, you can. Why would it be good?

Justin: Well...

Sydnee: Why would it be good for physicians to unionize?

Justin: Uh, I mean, I think the big one is when you talk about workload, if physicians are happy, and they're not being put under, like, really huge, intense workloads and intense, uh, stuff they gotta deal with so often at work, we know that, like, the physician suicide rate is dismal. And I think that aside from that, if you have physicians that are happier, then you have better care for everybody, and I think that you don't want a doctor who is fried and exhausted, and at their wit's end, and distracted by paying their bills, etc. But that would be my argument, probably.

Sydnee: I think—

Justin: For everybody, [crosstalk] I think.

Sydnee: Yeah. Well, I was gonna say, that's an excellent argument for unions in general, right?

Justin: Right.

Sydnee: I mean, you are absolutely, 100% right. Um, unions mainly do three things. They advocate for you politically, they provide mutual aid and welfare, and they collectively bargain. Um, physicians for a long time, I think our welfare has been at stake. We talk a lot about in the medical world, there was burnout. Physicians were experiencing burnout. And then we decided that wasn't a good word for it, so we started saying compassion fatigue, which I think might be worse, in some ways. And then we started talking about moral injury.

And what that means is I'm working in a system that doesn't allow me to...

Justin: Feel or process—

Sydnee: To act in accordance with my own morality and values.

Justin: Oh, okay. Gotcha.

Sydnee: The system is making me do things that contradict my values. And that's the healthcare system. I want you to have this medicine. Your insurance won't approve it. I can't give it to you, so I'm gonna give you something else that I don't think is as good a choice.

Justin: The system is making that happen.

Sydnee: The system made it happen. I feel bad about it. You're upset. No one's happy. I go home with that every day. The system is doing that, and unions would give us an opportunity to fight that system, to make that better, to relieve that moral injury that we're experiencing, by giving us some sort of, you know, power over the system in general.

Obviously collective bargaining so that we work together. The strike thing is always going to be... the thing people throw in your face. "We don't want doctors striking."

There are a lot of creative ways to hold healthcare administrators accountable without walking out of patient rooms.

Justin: I would strike, but not bill. That's what I would do. I would work but not bill.

Sydnee: That is—that was done I believe in the UK. There was a—was that where it was? There was a group of one residents at one hospital who did that for one day. They took care of all the patients, they just didn't submit any billing. And it took one day for the administration to meet all of their demands.

So yeah, I mean, I think there are creative ways to take care of patients while still fighting for the things we know are right. And it's important, because... what our welfare, what we are able to be and do as doctors, obviously directly impacts the patients we're taking care of. We can be better and do better, and our healthcare system can improve. And we can get more primary care doctors, and make sure that if you can't get in with your doctor because they're being expected to carry a patient load that's unreasonable...

Justin: Yeah. You also attract better people, more people, better people to the profession. It's a more desirable field.

Sydnee: Yeah. The other thing people will tell you as a reason why—'cause I was reading through all the pros and cons. What did the AMA tell me were the pros and cons?

The other con they'll tell you is that if we collectively bargain for a certain wage, and then your hospital wanted to do, like, performance-based incentives, they couldn't do that. I think that's just a capitalism argument. That's what they're always trying to tell you, right? Like, "But what if you could earn more?"

Justin: Right? "What if they wanna get even more money?"

Sydnee: They're just dangling a carrot, but there's always a stick.

Justin: Sure.

Sydnee: So I think that's important to remember. And I will say the final thing about this. I think this trend is happening exactly when it needs to, for all these reasons we've talked about. Because being a physician shouldn't mean that you go through training where you can't pee when you need to. That's ridiculous. That shouldn't be part of it. You should be able to be a whole human and be a doctor. I think that the—generationally we're shifting from this view of "Being a doctor is all I am, and I'll sacrifice everything for it," to "Being a doctor is my job, and I love it and I'll do it really well, but I also have other things."

I think that's happening across all disciplines. And then right now, you know, we talk about how our ability to practice medicine is limited by, like, prior authorizations we have to do, you know, length of stay, throughput time, all the stuff the insurance companies and hospitals put on us. But what about the legislative overreach? Is the AMA lobbying effectively enough to stop government entities from preventing us from practicing ethically appropriate medicine, from living up to our oaths?

'Cause I would say that in our state, the governor has issued—the brand new, newly elected, carpetbagger governor has issued a religious exemption for vaccine mandates. As an executive order. He wants it done. Undoing one of the things West Virginia can be proudest of, which is that we have excellent vaccination laws, and mandates, and rates, and we protect kids in this state. He undid it with one swift executive action.

Imagine if West Virginia had a nationally recognized physician union that could fight that. We could stop that in a day with our collective voices. That is the power, if doctors work together. We can protect abortion rights, we can protect transgender healthcare, we can protect vaccine mandates. With unions, we could have that kind of power and leverage. So at the end of the day, I think right now, if there was a union here I could join, I'd be very excited to do it.

Justin: Thank you so much for listening to our podcast. We hope you've enjoyed yourself, and learned something. A new wrinkle in your—your noggin, there. Thanks to The Taxpayers for the use of their song, Medicines, as the intro and outro of our program. And thanks to you for listening and coming along for the ride. We sure appreciate you. That's gonna do it for us for this week. Until next time, my name is Justin McElroy.

Sydnee: I'm Sydnee McElroy.

Justin: And as always, don't drill a hole in your head.

[theme music plays]

[chord]

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