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Author: Sara M. Krzyzaniak, MD, Stefanie S. Sebok-Syer, PhD, Saadia Akhtar, MD, and Fiona Gallahue, MD

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Exploring How House Staff Unions Impact the Program Director-Resident Educational Alliance

Sara M. Krzyzaniak, MD, Stefanie S. Sebok-Syer, PhD, Saadia Akhtar, MD, and Fiona Gallahue, MD

S.M. Krzyzaniak is associate professor, residency program director, and associate vice chair, Department of Emergency Medicine, Stanford University, Palo Alto, California; ORCID: https://orcid.org/0000-0002-8173-2750.

S.S. Sebok-Syer is assistant professor, Department of Emergency Medicine, Stanford University, Palo Alto, California; ORCID: https://orcid.org/0000-0002-3572-5971.

S. Akhtar is professor, Department of Emergency Medicine and Department of Medical Education, and associate dean for graduate medical education well-being and resilience, and associate dean for graduate medical education, Icahn School of Medicine at Mount Sinai, New York, New York; ORCID: https://orcid.org/0000-0003-4835-8725.

F. Gallahue is professor and residency program director emeritus, Department of Emergency Medicine, University of Washington, Seattle, Washington; ORCID: https://orcid.org/0000-0002-

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2690-3270.

Correspondence should be directed to Sara M. Krzyzaniak, Department of Emergency Medicine, Stanford University, 900 Welch Rd., Suite 350, Palo Alto, CA 94304; email: skrzyz@stanford.edu; X (formerly Twitter): @smkrzyz.

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Abstract

In 1999, the National Labor Relations Board determined that residents function as employees, thereby allowing them to freely unionize. From 2020 to 2023, house staff (i.e., resident physicians and fellows) unions have significantly increased, and 8 physician training centers, representing nearly 4,000 house staff, have unionized since March 2021. While unions provide residents with an important tool in effecting change in their workplace, their introduction into the educational milieu has the potential to alter the program director (PD)-resident relationship. In this article, the authors use the educational alliance framework to detail 3 factors required to support a quality educational relationship between a resident and their PD. They also elaborate on how the introduction of unions may impact the PD-resident relationship and explore the potential unintended consequences of unionization as it pertains to this relationship. The authors then use 2 social psychology theories, naïve realism and motivated reasoning, to describe common framing dynamics that lead to conflict during collective bargaining processes. They conclude by offering strategies that PDs may use to mitigate tensions that arise in contract negotiations, even without a direct seat at the table. Ultimately, PDs should anticipate continued growth of resident unions and prepare themselves and their programs for the tensions that may arise from this action. The PD role as a neutral third party ought to be preserved, which is possible if all parties set reasonable expectations for the changes in the PD's role and responsibilities under a union. PDs should understand the 3 core aspects of the educational alliance and the importance of establishing credibility with their residents early on to build a strong foundation.

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House staff (i.e., resident physicians and fellows) unions have significantly increased from 2020 to 2023, which is important given that house staff currently account for approximately 15% of the U.S. physician workforce.[1] This shift in collective bargaining and advocacy by unions presents an opportunity to reflect on the current state of medical education training programs, improve house staff salaries and benefits, shape hospital policy, advocate for patients' needs, and support well-being and diversity, equity, and inclusion initiatives. On the one hand, unions enable house staff to take a more active role in being change agents within their institutions. On the other hand, the introduction of a union into the program director (PD)-resident relationship changes the roles and responsibilities of both the PD and resident. One of the changes that has been underexplored is the way in which the introduction of unions may fundamentally impact the educational alliance, a framework that describes the relationship between residents and their educational leadership.

Residency is a transformative experience as residents transition out of a learner role as a medical student and into the role of a physician and an employee with the ultimate goal of achieving competency and entering independent practice. This transition and training time is essential to early-career physicians' development of core professional skills and to their professional identity formation. The PD-resident dyad is altered when a third entity (i.e., a union) enters the relationship. In most instances, this requires an adjustment in expectations and experiences on the part of both residency leadership and the residents themselves. In addition, the inclusion of unions in the PD-resident relationship has the potential to transform the educational alliance, which is critical to operating an effective training program and ensuring that residents have what they need to develop into competent physicians. Throughout this article, we represent the

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experience and perspective of residency PDs and focus specifically on the PD-resident relationship, as PDs often have few opportunities for direct mitigation of the tensions experienced by institutional leaders during collective bargaining (i.e., institutions rarely come to PDs to ask for opinions, vent about the collective bargaining process, or seek advice on how to approach a tough issue, while residents who are frustrated with the process often do seek guidance and support from PDs).

The History of House Staff Unionization

The National Labor Relations Act of 1935[2] was the first U.S. law permitting employees to unionize and subsequently led to the creation of the National Labor Relations Board (NLRB). However, residents' ability to unionize has been subject to legal controversy over the years. Despite the fact that the largest union in medical education—the Committee of Interns and Residents/Service Employees International Union—was founded by residents in New York City's public hospitals, the ability of other house staff to legally unionize has been limited by state collective bargaining laws.[3] In 1976, the NLRB determined that house staff at Cedars-Sinai, a private hospital, were not allowed to unionize because their status was that of "student[s]," not "employee[s]." This ruling effectively limited resident unionization efforts.

In 1999, this was reversed for all programs when the NLRB determined that residents function as, and are thereby considered, "employees." Since this ruling, residents have had the opportunity to freely unionize.[4] Recently, residents working in hospitals from California to Vermont voted to unionize in an effort to advocate for better working and living conditions.[1,5,6] Although the exact number of residencies that are currently unionized is not centrally available,

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the Committee of Interns and Residents/Service Employees International Union reports having over 22,000 members, and since March 2021, 8 physician training centers, representing nearly 4,000 house staff, have unionized.[1]

What Is the Educational Alliance?

Adapted from the therapeutic alliance that exists between a therapist and patient, the educational alliance is a framework that describes the educator-learner relationship as it pertains to communication and feedback.[7] This framework details 3 factors required to support a quality educational relationship between a resident and their supervisor (e.g., PD). First, there must be a mutual understanding by both parties regarding the purpose and goals of the relationship. Second, the resident must believe there is an agreement on how to work toward the goals. Third, the resident must respect, trust, and value their PD and believe this feeling to be mutual.[8] The value a resident places on the PD is subject to a credibility judgment and is grounded in the belief that the PD is capable of helping them achieve their desired goals. Telio and colleagues showed that these credibility judgements rely on a combination of factors and are continually reassessed throughout the duration of an educational relationship.[8]

The quality of the PD-resident educational alliance warrants careful consideration because it predicts how effective the PD will be in guiding and mentoring a resident through their training.[8] The first 2 components of the educational alliance (i.e., mutual understanding of the purpose and goals of the relationship and the resident's belief that there is an agreement on how to work toward the goals) are often established before a resident joins a program through the application and onboarding processes.[9–11] The final component (i.e., the resident respecting, trusting, and

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valuing their PD) and subsequent credibility judgements are often determined based on direct observation of PD activities and efforts made by both parties to nurture a relationship that is aligned with the shared goals of residency.

In most training programs without a union, residents rely on their PD to advocate on their behalf to departmental (i.e., chairs and vice chairs), graduate medical education (GME), and institutional (i.e., hospital directors) leadership to enact changes to resident benefits and working conditions. Examples of this advocacy include supporting residents in crisis or stepping in to find creative solutions for resident-specific issues, such as modifying an individual resident's work hours or providing them with financial support to access supplemental mental health resources. Many PDs report that advocating for residents is a highly fulfilling aspect of their PD role.[12] These advocacy activities represent a foundational element of trust in the PD-resident relationship and support credibility judgements, which in turn are critical to fostering the educational alliance.

One tool used by PDs to advocate for improved resident working conditions is the Accreditation Council for Graduate Medical Education's (ACGME's) Common Program Requirements.[13] The ACGME established these program requirements to enhance the learning environment, working conditions, and overall experience of residents. These efforts led some to question whether the ACGME (and by proxy, PDs) serves as a pseudo union to support a robust working environment for residents.[14] While revisions to the ACGME program requirements continue to support resident well-being, the tools to reinforce recommendations are blunt (i.e., citations or withdrawal of accreditation) and have the potential to negatively affect resident education despite

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their good intentions. Additionally, revisions to ACGME program requirements in response to evolving programmatic and learner needs are not immediate and thus can be slow in effecting meaningful change, may not be adequately comprehensive, and are often imprecise with recommendations (e.g., they indicate food must be available to residents, but precise articulation of food allowances or the hours that food should be available are not specified).[14] Thus, using the ACGME program requirements alone may limit the power of PDs to enact timely, rapid, and wide-ranging change to support residents and may explain why some residents feel the need to unionize.

The Introduction of Unions Into the PD-Resident Relationship

House staff unions have the potential to rapidly articulate the precise needs of a broad resident body to fill gaps within the ACGME program requirements and address well-being issues, such as specific food allowances and vacation time.[1,15,16] This strength may be leveraged by residents and PDs alike, allowing broad benefit changes to be managed by a third party (i.e., the union) and allowing the PD to focus more on the program's specific needs. However, a collective contractual agreement could also limit a PD's flexibility and ability to tailor the residency experience for an individual or a single program. This can be problematic as the various GME specialties often have different needs and priorities including, for example, meal and education stipends, performance bonuses, and transportation. This potential loss of flexibility and advocacy power of the PD could undermine the PD-resident relationship that forms the foundation of the educational alliance. The ensuing role of the PD could shift to a primarily administrative one: directing education, maintaining program accreditation, and supporting residents on a smaller scale within the parameters of the union agreement.

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Union certification and subsequent collective bargaining processes are traditionally contentious and often bring to light tensions between a union and the employer as both sides pursue their goals and aim to maximize their own gains.[15,17–21] During negotiations, both sides may leverage the media to bolster their cause or use other tactics in hopes of ensuring successful outcomes, and the union may even threaten or authorize a strike. These strategies have the potential to influence public perception and impact the recruitment of incoming residents to a program. These actions can also contribute to misalignment between institutional and residency program needs and the needs of residents. As noted by Jordan Cohen, former president of the Association of American Medical Colleges, "the adversarial dynamics that frequently characterize labor–management relations in the American workplace are fundamentally antithetical to the atmosphere necessary for education."[22]

Ultimately, PDs may find themselves in an uncomfortable third space in the relationship between unionized residents and the institution. Our experience is that PDs, frequently employed by the institution, feel the weight of institutional concerns and are often unable to remain completely siloed from institutional priorities. These priorities are both financial and service-related, as PDs are expected to ensure adequate clinical coverage by residents. This latter responsibility carries additional weight with the possibility of resident work-stoppages or modified strikes.[23] This is further complicated by the fact that PDs must maintain constructive relationships with their institutions for future program gains. Furthermore, residents may perceive a lack of PD support during collective bargaining due to the legal statutes that limit direct involvement of the PD in this process. Thus, it is imperative to highlight the shifting dynamics brought forth by the

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introduction of this third entity into the educational alliance and manage expectations of the PD role during the collective bargaining process.

One of the core tenets of establishing a sound educational alliance is that residents respect, trust, and value their supervisor. The loss of opportunities for direct PD advocacy within a unionized program, combined with the required distance of the PD during the sometimes tense collective bargaining process, can lead residents to interpret a lack of commitment to residents' priorities on the part of a PD. The position of the PD, situated between the unionized residents and the institution that employs them, presents a challenge to tangibly demonstrating a commitment to shared goals (e.g., around well-being during residency training). For these reasons, the concern that some PDs may have about resident unions is understandable.

Using Social Psychology to Understand Unionization Tensions

The topic of unions is inherently charged, and the decision to unionize and subsequent collective bargaining processes often highlight disparate views not only among resident groups, but also between residents and institutional leadership. Both sides may see the same set of facts and have vastly different interpretations of them, influenced by their individual goals, emotions, and personal identities. The result is often bewilderment and frustration when confronted with divergent opinions about the same set of circumstances. This discordance is described by 2 theories from social psychology: naïve realism and motivated reasoning.

The first theory, *naïve realism*, describes the tendency for individuals to believe that their perception of the world is objective and impartial and that people with divergent views from

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their own are therefore either uninformed or biased. However, one's perception of the world is influenced by their past experiences, cultural identity, and emotions. This is summarized by the writer Herb Cohen who reflected, "You and I do not see things as they are. We see things as we are."[24] The result of naïve realism is that it can be difficult for one to understand incongruent perspectives on reality, leading to arguments and polarization. This tendency to overemphasize one's own perspective is an example of an egocentric bias.[25] A common controversy often seen around union discussions is the degree to which residents have agency in decisions impacting their working and learning environment. Although institutions may point to numerous clinical, administrative, and educational committees with resident representation, residents who believe their voice is not heard may dismiss this as a false narrative from a biased institution and point to unpopular top-down decisions.

The second theory is *motivated reasoning*. This describes the notion that individuals are inclined to believe whatever facts best support their opinion. A familiar medical corollary is confirmation bias, which can lead a physician to focus on data (e.g., diagnostic results) that support their favored diagnosis, while dismissing contradictory evidence. In distinction to this unconscious cognitive bias, motivated reasoning is directed by personal emotions that are influenced by social contexts and groupthink. This tendency may lead someone to trust a narrative that is not fully truthful and lead to a false social consensus. An example within the context of unions is the notion of value. Residents advocating for union representation have described feeling undervalued by their institutions and being treated as cheap labor, commonly citing long work hours and low pay. Residents may dismiss contradictory evidence that would demonstrate value, such as comprehensive free or low-cost health insurance coverage, paid vacation time, and

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stipends, all of which are benefits that are not often afforded to physicians after training is complete.

Strategies to Manage Conflict and Support the Educational Alliance

Although PDs do not have a direct role in contract negotiations, they serve an important role in supporting residents, who may feel frustrated and devalued. Less commonly, PDs may also serve as a formal or informal advisor to the institutional negotiating team. For these reasons, PDs have an opportunity to help mitigate the tensions that arise in contract negotiations, even without a direct seat at the table. There are several strategies to counteract the forces of motivated reasoning and naïve realism. The first is to encourage individuals to use a strategy called self-distancing. In this approach, both the resident and institution are asked to separately consider a topic from the perspective of a neutral third party who wants the best for all involved. Second, evidence suggests that naïve realism may be overcome through simply raising awareness of the naïve realism bias along with training about its consequences in real life conflicts.[26] For example, one study showed that reading an article about naïve realism led students to be more open-minded when reading a dissenting opinion piece.[27] Examples of real life conflicts that may resonate with residents could be drawn from current political issues, such as how immigration is viewed through differing political lenses, the policies that have ensued from those perspectives, and the impact of these policies on patients who are immigrants. Finally, PDs should acknowledge the strong emotions that accompany the dialogue around unionization. It is impossible to divorce emotions from many of the discussions, as residents may see objective facts as direct value judgements against who they are as individuals and clinicians. Motivated reasoning is often fueled by "hot" cognition, which describes the influence of emotions on one's

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thinking.[26] It can lead to more rigid thinking, psychological resistance, and reactivity. This contrasts with "cold" cognition in which information is processed independent of emotions.[26] Strategies that PDs can use to mitigate hot cognition include role modeling emotional self-control, examining one's own assumptions, and moderating controlled and thoughtful discussions around controversial topics. An understanding of the role of naïve realism and motivated reasoning in the approach to contentious topics as well as a dedicated curriculum to educate residents on these potential sources of bias will help PDs foster productive and supportive discussions with their residents and institutional leaders alike.

To maintain a productive PD-resident educational alliance, it is critical to preserve alignment between residents and PDs within a unionized program. There are several strategies PDs can employ, similar to those used by business leaders in navigating politically charged topics in the workplace.[28] The first is to start fostering the educational alliance *early*, ideally before a crisis emerges. PDs should create opportunities during intern orientation to establish a shared understanding of the PD-resident relationship. This sets the stage for the first requirement of the educational alliance: a mutual understanding of the purpose and goals of the relationship. The PD can further achieve the second tenet of the educational alliance by ensuring an understanding of how to work toward the goals (i.e., developing into a competent physician, achieving professional fulfillment, and obtaining a job or fellowship of one's choice). The second strategy is to encourage institutions to allow PDs to demonstrate support for residents, particularly around times of contract negotiation, while also maintaining their legally required distance from the negotiation table. If this is successful, unionization may enhance the PD-resident relationship by improving transparency around how decisions are made and who has the ultimate decision-

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making power. Residents may assume that PDs have more influence than they do, while in practice, PDs are often the messenger for hospital- and department-level decisions, especially around staffing and benefits. As a result, in some scenarios, unionization may promote the perception of a PD as a supportive advocate, while contentious issues are negotiated between hospital and union representatives. The third strategy to support alignment is to encourage residents and institutions to approach sensitive topics with curiosity and an appreciation for the other side, a strategy that is also a core principle of achieving psychological safety in the workplace. PDs should consider using the approach-avoidance model of persuasion.[29] This model contends that a successful strategy to promote change is by minimizing or avoiding resistance, and indirect methods that avoid conflict may be more effective than a direct confrontational approach. This approach aims to invoke openness to change by reducing intense defensive reactions.

Conclusions

PDs across the country should anticipate continued growth of resident unions and prepare themselves and their programs for the tensions that may arise from this action. Although the process may be adversarial at times, the PD role as a neutral third party ought to be preserved, which is possible if all parties set reasonable expectations for the changes in the PD's role and responsibilities under a union. The PD should understand the 3 core aspects of the educational alliance and the importance of establishing credibility with their residents early on to build a strong foundation.

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