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Not the Last Word

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Not the Last Word: Why do Residents Want to Join Unions?

Joseph Bernstein MD[1]

In the United States, more than 10% of residency programs are now unionized, and many others are on the path to unionization [8].

I find this trend worthy of comment, but maybe not for the reasons you surmise. Yes, I am 30 years older than some of my residents. As such, I might be expected to invoke a grumpy "ungrateful kids these days" sentiment against unionization: "You have an 80-hour work*week*? Why, when I was in training, we had 80-hour work*days*!"

But that's not the comment that comes to mind. For one thing, an 80-hour workweek rule might enhance residents' well-being, but only if the rule is followed. Beyond that, residency is just different these days. In some ways, it's much harder. For example, in 1996, the year I finished training, there were about 250,000 total knee replacements in the United States. These days, we are creeping up on almost 1 million annually. That is, the hours may be capped, but the workload certainly is not.

Other examples abound. Back in residency, I was (grudgingly) granted a few minutes to answer a page, if only because I needed the time to find a pay phone. My attendance at conferences was monitored by a sign-in sheet with 40 remarkably similar-looking signatures, not a GPS-enhanced location-tracking smartphone app. And if the statute of limitations has expired, I might be willing to admit here that my surgical case lists were composed by memory at the year's end, not logged in real time by the electronic medical record.

In short, I reject the idea that residents seeking unionization are misguided or ungrateful. Even with all the liberalizing changes, residency is characterized by hard work and unrelenting demands—things that are not undone by wellness officers or resilience training workshops.

Rather, I was initially intrigued by the trend toward unionization because it appears to be so short-sighted. Even in the most grueling specialties, residency is a time-bound and finite phase. One might assume that residents would quietly persevere and endure the challenges until the term of their training is complete.

It is reasonable to anticipate that residents would be more tolerant of temporary discomforts, given that physicians, as a group, exhibit a remarkable capacity for delayed gratification. Pursuing a career as an orthopaedic surgeon requires postponing one's adult life for approximately a dozen years after college, before obtaining one's first "real job." Individuals willing to do that, you might think, would also stoically trek through the desert on the way to the promised land.

The fact that residents are unwilling to suffer in silence—despite their mastery of deferred gratification and their undoubted capacity to identify their self-interest—is both revealing and enlightening. What do residents know that their learned elders do not?

My best explanation is that residents have discovered a deep truth: There is no proverbial promised land, no pot of gold at the end of the rainbow. They recognize that the conditions they currently experience are strikingly similar to what is awaiting them once their training is complete (Table 1). They see that some attending

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Table 1. Differences between job stressors: resident physician vs. attending surgeon

	Resident	Attending surgeon
Education and testing	Must take tests to attain board certification	Must take tests to retain board certification
Regulatory requirements	Subject to rules of Centers for Medicare & Medicaid Services (CMS), Health Insurance Portability and Accountability Act (HIPAA), and the Drug Enforcement Administration (DEA). Must follow institutional policies and procedures	Subject to rules of Centers for Medicare & Medicaid Services (CMS), Health Insurance Portability and Accountability Act (HIPAA), and the Drug Enforcement Administration (DEA). Must follow institutional policies and procedures
Risk for burnout	Long working hours, juggling multiple responsibilities, frequently encountering emotionally challenging situations in a high-stakes environment all the while trying to balance personal and professional lives in the face of inadequate institutional support and financial pressures	Long working hours, juggling multiple responsibilities, frequently encountering emotionally challenging situations in a high-stakes environment all the while trying to balance personal and professional lives in the face of inadequate institutional support and financial pressures
Performance evaluations	Regular performance evaluations to ensure maintenance of high standards of care. May be held responsible for things out of one's personal control, inducing a sense of learned helplessness.	Regular performance evaluations to ensure maintenance of high standards of care. May be held responsible for things out of one's personal control, inducing a sense of learned helplessness.
Duty hours	Limited to 80 hours per week	Unlimited

surgeons are treated by management like cogs in a machine—just like residents, albeit with higher pay and rank.

Thus, the motivation for joining a residents' union goes beyond protesting reduced meal allowances, the loss of free parking, or any other pretext one might invoke. These reasons are to resident unionization what the assassination of Archduke Franz Ferdinand was to World War I—a catalyst, perhaps, but not the cause.

The true cause driving resident unionization is the existence of fundamentally divergent interests, priorities, and goals among healthcare systems and physicians at all levels. Yet unlike attending physicians, who have options like special contracts for exceptional performers or the freedom to relocate, residents lack these and other avenues to address conflicts. Consequently, residents will default to their one available option: unionization.

Moreover, once unions notch a victory or two, successfully wresting important concessions from management, collective bargaining will look more and more appealing. Even those residents currently disdainful of a "physician-workers of the world unite!" mindset might change their attitudes. As such, the primary importance of resident unionization lies not in its immediate influence on healthcare delivery, but in what it may foreshadow: namely, an impending surge in attending-physician union membership in years to come.

Robust union membership will make clear that the healthcare delivery systems of today are not what they were when I started my career. Robust union membership will accelerate further change. I'm nostalgic and optimistic at the same time.

Paul J. Dougherty MD

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The fact that some residents have unionized, and the motivations behind this choice, both deserve our attention. While Dr. Bernstein seems to feel this is caused by a dehumanized, capitalist, medical industrial complex, he forgets that unionization has been around a long time overseas. In the United Kingdom, both registrars and consultants (the equivalent of our residents and faculty) have been unionized since

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about the time of the inception of the National Health Services (1948). It is unclear whether healthcare or physician wellness is better overseas: Patient volumes are very large at some UK institutions, physician burnout is also a problem there, and insufficient resources causing treatment delays in that system have made the news.

Back in the United States, unionization has occurred recently at Miami, Stanford University, University of Vermont, and University of California San Francisco (UCSF), among others. Editorials in *JAMA* [12] and the *Wall Street Journal* [15] espousing resident/fellow unions have appeared without any critical discussion. These editorials were written by union representatives who are in training as fellows. They advocate unions to promote better patient care and improve physician wellness, with one editorial claiming that unions will reorganize both education and medicine at large. Rather than this altruism, it appears that leverage for housing support was a major reason for some of the recent unionization. Stanford, Miami, and UCSF are all located in high rent areas. Because resident salaries are largely funded through the federal government, salaries are similar across the country regardless of the city in which the training takes place. Therefore, the cost of living does make a difference for residents. While resident salaries are above the average income for a family of four in the United States, living in some of these major cities may still be financially difficult.

Collective bargaining for residents also has a history in the United States, being present since the 1970s. A National Labor Relations Board decision in 1999 [4] held that residents are both employees and students, agreeing that collective bargaining or unions are allowed.

I was part of the collective bargaining negotiations as program director at another institution before I came to Jacksonville. I've now been a program director at medical centers both with and without collective bargaining, and from that experience, I can firmly state that residents gain no advantage through unionizing. In my experience, despite spending months in collective bargaining, the salary and benefits negotiated were not perceptibly different from other nonunion residency programs in the area. Why? When the educational process is in question, residents have other avenues to voice their concerns: within the program, within the institution, and through the ACGME. But concerns about pay and benefits, which can be handled by the collective bargaining process, are largely fixed by the economics of how resident education is paid for. In other words, there is no reservoir of resources for resident pay and benefits that has not been tapped out already. Residents are, by definition, not independent practitioners, and therefore services are not directly billable. Residents do work to obtain experience, allowing them to embark on what I feel is still a very fulfilling and rewarding career. Because salaries in residency programs in the United States are substantially federally supported, until or unless that level of support increases, large changes in resident compensation are unlikely to occur.

Regardless of how one feels about collective bargaining or unionization, transparency in the process is needed on both sides. As I mentioned earlier, recent editorials [12, 15] have posited benefits for residents to unionizing that have not been documented and may be misleading. Likewise, though the potential for strikes to occur at inopportune moments is real (such as with the NHS recently), they are rare.

As I discussed in my previous column on this topic [8], the recent increase of unionization among residents in the United States may have more to do with a perception of residents not feeling like they have a sufficient voice within an institution, and not because they are being exploited. This perception, in my opinion, can be more than offset by good educators and mentors within a program or an institution. Second, a strong resident's council within an institution can provide a solid voice for concerns or change. Third, the major cause of physician burnout cited by several reviews is the amount of documentation that physicians must enter into the electronic medical records (EMRs) we use. By not promoting the first two items, whether as part of a unionized program or otherwise, we will see the continued erosion of our educational milieu. Major efforts to replace the current EMRs should be a future focus of all professional medical organizations. Finally, Dr. Bernstein agrees with Lypson et al. [13] in that the ACGME addresses many of the concerns cited by those promoting unionization and has made substantial improvements in resident conditions. It might be time to revisit the NLRB ruling [4].

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Residency lays the critical foundation for our development as physicians. What we learn in residency shapes our practice patterns [14, 18], but more importantly, our personal and professional identities as independent physicians are developed during our years as housestaff. When we apply to residency, we craft personal statements that describe the physicians we aspire to be. These essays capture our motivations to deliver compassionate and humanistic care while advocating for our patients' health and a healthcare system that is ever more effective and equitable. But as residents, we experience firsthand how our healthcare systems often implement profit-promoting measures that hamper our ability to connect with patients and deliver quality care. This contradiction between our aspirations for clinical excellence and the reality of our experiences is a core driver in the increasing rates of burnout throughout training—all during a critical period in the development of our identities as physicians.

As Dr. Bernstein notes, this is the key motivator for the residents seeking to organize and effect change. While the difficult working conditions of residency undeniably are a focus of housestaff unions, the motivations that underpin our efforts are rooted in the loss of physician autonomy and consequential deterioration of the patient-physician relationship over the past decades. As housestaff, we have limited influence in the healthcare systems that we work in, and we observe that our attendings are similarly hampered in their ability to advocate for positive change. This is reflected in the rapid transformation of our healthcare systems over the past few decades [5]. In just 3 years (2019-2021), the percentage of physicians employed by hospitals or corporate entities increased from 62% to 74%, and the percentage of medical practices owned by hospitals or corporate entities increased from 39% to 54% [2]. Back in 2012, 60% of physician practices were wholly owned by physicians [11]. As the physician-patient relationship takes a back seat to profit-motivated healthcare, we see profound impacts on our communities. For example, the closure of Hahnemann University Hospital in Philadelphia in 2019 led to a loss of a critical safety net hospital and the abandonment of 550 residents and fellows [16].

Without solidarity among specialties and the legal right to collective bargaining as a union, residents and our educational leaders often are excluded from conversations about how healthcare is delivered. A common concern is that housestaff unions will negatively impact the resident-faculty relationship, but in our experience, the opposite is true. Our educational leaders are our fiercest advocates because we share the same experiences and goals of delivering excellent patient care while developing physician leaders. We are organizing to ensure these goals are prioritized; without the power of collective action to do otherwise, we see our healthcare systems continuing to prioritize profits over the patient-physician relationship and physician well-being.

There is a growing trend of residents voting to form unions in overwhelming majorities. In 2022, there were eight new unionization campaigns [19], including ours at Stanford, and 2023 has included prominent campaigns at the University of Pennsylvania and Mass General Brigham. Housestaff have overwhelmingly voted in favor of unionizing with victory margins greater than 80% at Stanford, University of Pennsylvania, George Washington University, and the Montefiore Health System, to name a few. This wave of housestaff unionization is an actualization of the professional identity we write about in our personal statements: that of the physician whose mission is to improve health. We hope that Dr. Bernstein is correct when he argues that this trend may reflect the beginning of a larger movement among our attending physician counterparts, and we look forward to improving the delivery of health services, together.

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Unionization of medical training programs was a relatively new concept to me, but after doing a little bit of research, I learned that housestaff have been organizing as early as the 1930s [10]. There is a rich and fascinating history of activism and lobbying in medical training. The story began in New York City during the Depression when second-year interns became unhappy with the lack of pay, absence of teaching rounds, and dangerous working conditions. In 1935, the Interne Council of Greater New York was organized (later named the Interne Council of America). Early accomplishments of this group included securing salaries of USD 15 per month to New York City hospital interns, successful lobbying for the inclusion of interns under the New York State Workmen's Compensation Law, and upgrades of multiple hospital-based medical libraries.

The Committee of Interns and Residents (CIR) was established in 1958 and still exists today. Currently, approximately 15% of US residency programs, representing over 22,000 housestaff, are unionized under the CIR. Residents unionize to improve patient safety, ensure that residents have a voice to maintain their

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wellbeing, increase compensation, enhance diversity initiatives to recruit residents, augment child-care benefits, expand parental leave options, and increase education subsidies. Other forums for advocacy in residency outside of collective bargaining agreements include institutional House Staff Associations. However, unlike unions, House Staff Associations cannot go on strike or withhold their labor for provisions regarding wages, vacation, family leave, or working hours.

As we have learned much about safety from the airline industry, I thought it would be interesting to evaluate what aviation has done with regard to unionization. Similar to medicine, the Air Line Pilots Association, International (ALPA), now the largest pilot union, originated in 1931 during the Depression when management was pushing pilots to fly longer hours for less pay and in high-risk situations [1]. Currently, numerous unions support workers in aviation, including those for air traffic controllers, pilots, and transport workers, most of whom are affiliated with the American Federation of Labor and Congress of Industrial Organizations (AFL-CIO). Some of the aviation union successes include obtaining exit lighting in aircrafts, requiring standardized signage on runways and reinforced doors to separate pilots from passengers, requiring cockpit voice and flight data recorders, and eliminating strict flight attendant regulations (like forced retirement at 32, remaining single, and adhering to strict weight, height, and appearance requirements).

The Economic Policy Institute published a special edition in 2007 [9] that found that 44% of all workers (not just within healthcare) favored union representation and 90% of workers desired greater collective say at the workplace than they had. In 2020, Blanchflower and Bryson [3] found union membership to be positively associated with a range of well-being metrics, including life satisfaction, happiness, and trust, as well as with satisfaction with democracy, education, and the overall economy. A national cross-sectional survey administered in January 2019 after the American Board of Surgery In-Training Examination [6] found that unionized residency programs offered improved vacation and housing stipend benefits, but resident unions were not associated with improved burnout, suicidality, job satisfaction, duty hour violations, mistreatment, educational environment, or salary.

There are some potential downsides to unionization, including required yearly dues, the potential for workplace tension, concern that funds may be improperly utilized (as in the form of high salaries for union leaders), restrictive union rules that lead to lack of flexibility, loss of individual voices, driving up costs for organizations, and protection of possibly unqualified or idle employees. In healthcare, one concern would be a union strike of resident physicians that could disable a hospital system. The last time a CIR union went on strike was in 1981 [15], but recently, 93% of voting resident physicians and fellows working at Jamaica and Flushing Hospitals in Queens have voted in favor of authorizing a strike if their demands are not met in a contract dispute [17].

Negatives aside, on the whole, collective bargaining for improved working conditions for trainees and safer patient care seems like a potentially promising prospect. Like Dr. Bernstein, I remain optimistic about the future.

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