

VIEWPOINT

Resident and Fellow Unions Collective Activism to Promote Well-being for Physicians in Training

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The past 3 years mark the largest wave of activism by resident physicians advocating for physician well-being since the mid-1970s. As the COVID-19 pandemic has magnified systemic factors driving persistent burnout in medicine, resident physicians and fellows are increasingly rejecting the status quo of long hours and low pay during medical training. Burnout is commonly defined as a work-related syndrome of emotional exhaustion, depersonalization, and diminished feelings of personal accomplishment.¹ Driven by a desire to counteract physician burnout, improve health care equity, and reprioritize the patient-physician relationship, house staff (ie, resident physicians and fellows) are increasingly taking action through labor unions.

Physician Advocacy and Professional Identity

Although this movement has been galvanizing for young physicians, house staff labor action has previously been denigrated as unprofessional. House staff activism in the 1970s led the Association of American Medical Colleges to influence a 1976 National Labor

responsibility. Physicians must create an environment that enables individual and societal responsibility for health. Even though this is often directed at advocating for public policy, this responsibility also requires directly addressing systemic causes of burnout that continue to undermine the physician workforce.

The Status Quo and Perpetuating Burnout

Residency training is often characterized by long hours, undercompensation, and a lack of control over working conditions, which contribute to physician burnout and consequently pose unacceptable risks to patient care. Physician burnout has been identified as a threat to patient care by the US Surgeon General, the National Academy of Medicine, and the American Medical Association. Although many proposed remedies for addressing burnout are person-centered (eg, improving individual resilience), leading experts identify a need to go deeper and directly address the underlying systemic causes of burnout.⁵ This requires critical reflection on how the culture of medicine perpetuates burnout.

For physicians in training operating within medicine's inherited hierarchy, it can be easy to feel powerless and perceive they must temporarily bear an exploitative system in the hopes of enacting change after training. Yet by not acting, these physicians consent to a culture that breeds burnout and loss of professional values, driving motivated physicians to languish and even leave the field, exacerbating the nation's physician shortage.⁶

By empowering young physicians to act with solidarity and agency, house staff unions could help cultivate the skills needed to take on this professional responsibility to speak out against systemic detriments in the health care system.

Relations Board ruling that resident physicians are students, not employees, and therefore are not protected by federal labor law.² This persisted until 1999 when the National Labor Relations Board reversed its decision and asserted that resident physicians are employees and have workers' rights to organize and bargain collectively.³ In response, the Association of American Medical Colleges suggested that by negotiating over working conditions, resident physicians could jeopardize their professional values as caregivers.⁴

The perception among some physicians that professionalism requires sociopolitical inertness represents an abdication of responsibility. Physicians exert their influence on individual health behaviors and social determinants of health through clinical care, scholarship, and translation to policy. Ongoing public health crises, such as the COVID-19 pandemic, gun violence, systemic racism, climate change, and threats to reproductive justice, underscore the magnitude of physicians' broader social re-

House Staff Unions as Agents of Change

According to 2022 data, resident physicians and fellows account for 15% of the US physician workforce,⁷ meaning that their collective voice could create substantive change. To achieve this, some house staff have opted to advocate through labor unions, which provide distinct legal protections. A union is an association of workers to promote and protect the welfare, interests, and rights of its members, primarily by collective bargaining. By unionizing, workers earn a legally protected right to contract negotiation and to adjudication of contentious working conditions. Moreover, legally mandated structures like labor management committees grant house staff leverage to negotiate for improved financial and social contracts.

House staff union activity is not new. Over the years, house staff unions have fought for public health program funding, for common sense immigration reform, and for policies to address social determinants of health

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such as paid family leave, language interpretation services, and inspections of asthma triggers in rental housing. At the peak of house staff union activism in the 1970s, 2 resident physician strikes fundamentally reshaped working conditions and physician voice. The first resident physician strike in New York City in 1975 established limits on house staff call duty to every third night, creating the first meaningful limit to duty hours in residency training.⁸ The following year, resident physicians striking in Los Angeles County, California, created a significant increase in a patient care fund that continues to be directed by resident physicians to this day.⁸ Even though strikes by resident physicians represent an extreme of collective action, their outcomes in these examples have led to lasting improvements in physician working conditions and patient care.

Since March 2021, 8 physician training centers representing nearly 4000 house staff have unionized at the University of Massachusetts, the University of California (Riverside), the University of California (San Francisco), the University of Illinois (Chicago), the Greater Lawrence Family Health Center, the University of Vermont, Stanford University, and the University of Southern California. In response to inadequate compensation for surging costs of living, a vote among Los Angeles County resident physicians and fellows overwhelmingly (>98%) authorized a work stoppage in June 2022, which would have been the first house staff strike in decades. Ultimately, this potential action led to negotiations that resulted in substantive changes in working conditions for physicians in training, including establishing a diversity fund to recruit house staff from groups underrepresented in medicine.

Addressing Skepticism and Moving Forward

Recent studies have attempted to assess the association between house staff unions and resident physician wellness. A cross-sectional study funded by the Accreditation Council for Graduate Medical Education and administered after completion of an in-training examination surveyed 5701 surgical resident physicians about burnout and failed to identify a difference in reported burnout (defined as experiencing depersonalization or emotional exhaustion at least weekly as measured by a modified version of the abbreviated Maslach Burnout Inventory) between resident physicians at unionized programs (n = 30 programs, 690 resident physicians) and resident physicians at nonunionized programs (n = 255 programs, 5011 resident physicians).⁹ The study identified improved housing stipends and vacation policies, as well as

decreased rates of sexual harassment at unionized programs. However, assessing burnout directly after a lengthy in-training examination could introduce a significant confounding factor because the stress of the setting could affect the responses of resident physicians. This highlights the inadequacy of single time point measurements and demonstrates the limitations of even validated tools to measure burnout.

Another study¹⁰ used the Delphi method to ask surgical resident physicians (n = 19), faculty (n = 5), and administrators (n = 5) at 2 general surgery residency programs to identify institutional factors they thought were implicated in surgery resident physician wellness across the 6 domains of the Maslach Areas of Worklife model (workload, control, reward, community, fairness, and values). This study, which included 1 unionized residency program and 1 non-unionized program, found the presence of a resident physician union was identified among the top 3 protective factors in the domains of control and fairness.¹⁰ Even though this study was limited by small sample size and only 2 training programs, it offers a possible framework for understanding how house staff unions could provide an approach to counteract burnout.

Against a backdrop of evolving national sentiment on labor activity, some outdated concepts of professionalism and physician autonomy have created controversy surrounding house staff union activity. Although empowering a collective house staff organization and voice is not a cure-all for burnout, it is an important step forward, and a necessary component of overall approaches to address burnout in medicine and improve the health care system. By empowering young physicians to act with solidarity and agency, house staff unions could help cultivate the skills needed to take on this professional responsibility to speak out against systemic detriments in the health care system, such as reorganization of patient care models that prioritize profit over quality of care and physician well-being or unequal access to care based on insurance coverage. Together, physicians can oppose the ongoing shift from effective, compensated, patient-centered work toward billing-focused documentation, compressed schedules, and administration-directed structures.

This is a moment for physicians to reflect on the drivers of burnout, the detractors from career satisfaction, and the opportunities to reshape a landscape that is currently failing patients and clinicians. This is an opportunity to reassemble medical training and medicine as a career that is both fulfilling and sustainable.

ARTICLE INFORMATION

Published Online: July 28, 2022.
doi:10.1001/jama.2022.12838

Conflict of Interest Disclosures: Drs Lin, Ge, and Pal reported being members of the Committee for Interns and Residents, a local chapter of the Service Employees International Union. All were involved in organizing its chapter at Stanford University without formalized positions or compensation, financial or otherwise. Dr Ge reported receiving personal fees from Melzi Surgical, a medical device company. No other disclosures were reported.

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