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SCIENCE

Medical residents nationwide are unionizing. What does that mean for the future of healthcare?

Young physicians in training are being squeezed by labor shortages, inflation and long hours.

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Eric Kalis arrived at the hospital before sunrise on a chilly March morning in San Francisco. Before the 27-year-old psychiatric resident started his day seeing patients, he headed up to a third-floor conference room, with tan walls and big windows, to vote on his future.

A representative from the National Labor Relations Board (NLRB) greeted him at the door and pointed him toward a booth surrounded by cardboard privacy flaps. Kalis filled out an orange slip of paper and dropped it into a box. Just like that, he had cast his ballot to form a union.

The process took less than two minutes, but it was a long time coming. When Kalis became a first-year resident physician at California Pacific Medical Center (CPMC) in June 2022, nearly a year earlier, he'd heard rumblings of a union drive among "house staff" — medical interns and residents. Within a few months, his co-residents announced their intent to organize, kicking off a nine-month struggle between hospital management (CPMC is part of Sutter Health) and the residents whose long hours and cheap labor make it run.

Kalis cares for some of San Francisco's most vulnerable people with mental illness, whose suffering is exacerbated by their difficulty meeting basic needs — like housing and food — in one of the most expensive cities in the United States. Yet Kalis is barely able to meet his own. More than half his paycheck is gone after paying rent, and he's drowning in more than $300,000 of medical school debt. Eighty-hour work weeks leave little time to process the trauma he sees intimately each day. At this point, Kalis feels like working conditions within the system aren't just compromising the care he can offer patients but also bristle against the ethos that called him to medicine in the first place.

"There's the assumed risk that when you go into medicine, you're going to deal with this. It would just be so much better if people had more time to decompress from things," Kalis said. "It weighs so heavily on a lot of people. … But then you just have to keep waking up and doing it over and over again, and there's never really a break."

Kalis and his co-workers are part of a wave of resident physicians across the country who are unionizing as a way to gain influence over the terms of their employment, like negotiating for adjusted wages or housing stipends that reflect the cost of living in their cities. Membership among the Committee of Interns and Residents (CIR-SEIU) — the largest house staff union in the U.S. — has grown by nearly 60 percent over the last three years. Before the pandemic, CIR-SEIU typically received a few dozen inquiries about forming a union from residents each year, according to Sunyata Altenor, communications director for CIR. The organization has fielded more than 200 inquiries since 2020.

Much of the recent growth in resident organizing has been in private hospitals, a reflection of the national political climate. The U.S. is seeing a wave of private sector organizing because residents regained this right under a ruling by the National Labor Relations Board (NLRB) in the Biden administration after losing it in the Trump era, said Kate Bronfenbrenner, a labor expert at Cornell University's School of Industrial and Labor Relations (ILR).

CIR chapters have expanded to nine states and Washington, D.C., with a strong presence in New York and California, states with high numbers of resident physicians. In the first few months of 2023, two new residency programs joined CIR.

Tangled up in this experiment is the morass of complex yet fundamental questions that plague the healthcare system — and U.S. work culture writ large — amid a growing physician shortage. How can the U.S. retain much-needed clinicians, particularly in places that are already underserved? What basic needs must a person, whether patient or provider, have in order to be safe and healthy? How is patient care affected when residents struggle to make ends meet?

“So much is already out of our control,” Kalis said. “If you want to truly take care of patients, you have to play the game. A lot of us don’t like the feeling of having to participate because it’s the only way that you can.”

Part of the issue is the structure of medical training itself. Physicians must complete residency to be board-certified as independent medical doctors in the U.S. They are matched to their employers, hospitals, through an algorithm. Programs and applicants are contractually bound to offer and accept a position if a match occurs — a commitment of at least three years with concrete terms, akin to signing up for the Army or getting drafted as a professional athlete.

“Part of … [residency] training is to put your head down, deal with the problems, don’t make waves, do what you’re told. They’ve kind of created a wave of people who are the perfect people to exploit,” said Joe Crane, national organizing director for the Doctors Council SEIU.

Kalis, the San Francisco resident, spends his days treating others as he wonders how he’ll afford his own care, an irony not lost on him as he signs doctor’s notes excusing patients from work. On a day off in January, he went to the dentist for crowns and fillings he’d postponed. After rising from the dentist’s chair, he learned from the office staff that his insurance had changed in the new year and would not cover the full procedure. After partial coverage, he’d owe nearly $1,000 out of pocket.

The bill was tough to swallow, even though CPMC increased its resident salary and stipends last summer, bringing their total benefits up to about $84,000. Kalis can empathize with patients who feel at the mercy of the healthcare system, whose psychological and emotional health still suffers as they seek psychiatric treatment, when it’s so difficult to feel stable living in San Francisco.

“It’s hard to see an explanation around the financial stressors and economic stressors that people have to live with every day, and its impact on mental health,” Kalis said. “The two are inextricably linked.”

This was top of mind when he cast his vote that March morning and as he awaited results in the evening. He paced his Lower Nob Hill apartment while doing laundry, clad in a sweater and cotton pajama pants, as we spoke by phone. He understood all that hung in the balance — not just for his colleagues, but for residents everywhere and patients they serve. But he felt confident, he told me.

I listened to his voice rise as the news came in: 85 percent of CPMC residents who voted in the election had said yes — 71-13. They'd get to negotiate a new contract with CPMC management.

"We're all part of something bigger than ourselves again," he said.

"We are such a hot deal"

A handful of factors make the medical residency system, along with the capacity to alter it, distinct from training for other fields. To start, the NLRB has bounced back and forth on a key question: Are residents students or employees?

Residents at public hospitals are subject to each state's labor laws about organizing, which vary. But the right to organize for residents at private hospitals, who are covered by the National Labor Relations Act, depends on whether they are considered students or employees — a ruling that has flip-flopped since the Clinton administration in what Bronfenbrenner calls a game of "political football."

Some have argued that hospitals are academic institutions providing hands-on training to students, while others argue that residents' responsibilities make them employees, entitling them to certain labor protections. The NLRB restored organizing rights of employees to private graduate students by withdrawing a Trump-era rule in 2021. "The pendulum has been swinging … for decades as to whether or not this classification of staff

should be considered eligible for representation," said John August, a healthcare labor expert at Cornell University's School of Industrial and Labor Relations.

Here, the line between learning and labor gets fuzzy — and where to draw it has become a lightning rod. Residents have graduated from medical school and perform duties of practicing doctors, from surgeries to emergency procedures, with supervision from an "attending" physician. Residents see patients but can ask questions and seek guidance from attendings, who are required to sign off on a resident's notes. As residency years progress, their practice becomes increasingly independent.

"Resident physicians are students who are in a training program that is a working apprenticeship. Their primary role in the program is to be trained, under direct and indirect supervision of a teaching physician, to be fully independent practicing physicians," said Jonathan Jaffery, chief healthcare officer for the Association of American Medical Colleges (AAMC).

Others see this differently. "The work hours of a resident are the worst work hours of any occupations we know, except maybe prisoners," said Bronfenbrenner. "That's a way that hospitals make profit, because they have cheap labor doing the work of doctors, and they get them to work really long hours without paying them more."

The pandemic has worsened this dynamic, as thousands of healthcare professionals died of covid and others recover from the trauma. Residents have stepped in to cover shifts and plug the holes for other staffing shortages as nurses and fully licensed physicians leave the profession at elevated rates, citing burnout, moral injury and unsafe staffing ratios.

"Each resident does approximately three practitioners' work" said Dani Golomb, a 35-year-old psychiatry resident in Kalis' program at CPMC. But they work alongside groups, like nurses and physician assistants, who are covered by different employment protections that don't apply to residents. Because residents are exempt from laws requiring overtime pay, Golomb is compensated for a 40-hour workweek regardless of time spent at the hospital.

Residents across the country typically earn somewhere between $60,000 and $85,000 a year, including benefits. That's roughly minimum wage when you account for the 80-hour weeks expected on the job. "We're in these positions of subservience, and there's not much room to advocate for yourself," Golomb said.

Unlike other professions with at-will employment, residents don't face clear options to quit due to the rigidity of the match system — unless they're willing to risk losing their medical careers or dig themselves out from mountains of debt without the promise of an eventual paycheck that can make a dent in it. People like Golomb cannot simply leave their hospital and easily find another residency spot if they're struggling personally or practicing professionally in a way that conflicts with their ethics, a phenomenon known as "moral injury."

Moral injury occurs when people perpetrate, bear witness or fail to prevent an act that violates deeply held values and beliefs, and can share similarities with post-traumatic stress disorder. Residents, who lack autonomy over which institutions they work for and report to higher-ups who make the final medical decisions, may have to treat patients in ways that contradict their values. Seeing the care that patients need — but being unable to provide it — can be another source of psychological distress.

On top of this, there are fewer residency spots available nationally than medical school graduates who need them. About 6 percent of medical doctor program graduates did not match to a residency program this year, according to the National Resident Matching Program. (This is despite a physician shortage projected to reach a shortfall of up to 124,000 doctors by 2034, according to the AAMC.) Congress sets the number of residency slots that the government helps to fund, a number that it capped in 1997 and increased modestly in 2021 for the first time since.

Much of the debate around resident wages boils down to how different people measure the "opportunity cost" of training residents against the value of the labor they provide — and where, roughly, that equation breaks even.

Some see residents' work as a steep discount for hospitals. "Residents work twice as much as I do, and yet they get paid less than half as much as I do," said Scott Goldberg, an internist at Montefiore Medical Center in the Bronx, New York. "The argument that 'Oh, we can pay them less because they're still learners?' It's profoundly exploitative," Goldberg said. Plus, people getting treated by residents are not billed any less to account for their doctors' learning curve.

When the University of New Mexico (UNM) lost accreditation for its neurosurgery residency in 2019 and temporarily closed the program, UNM had to hire 23 practitioners to cover the workload of eight departing residents. "We are such a hot deal," Golomb said. "There's not really a threat of getting fired in residency because we are the cheapest possible labor you can get."

Meanwhile, others note that hospitals significantly invest in teaching, developing and overseeing residents, and that it takes time for them to perform at the capacity of independent physicians.

"If doing all of this training and being a teaching hospital were a way to increase revenue and generate dollars, everybody would do this," said Leonard Marquez, senior director for government relations and legislative advocacy at the AAMC. But Marquez noted that only

about 1,000 hospitals out of the roughly 5,000 hospitals in the U.S. are teaching facilities that receive federal funding for graduate medical education (GME) through Medicare.

All of which highlights a key question: If resident unions negotiate new contracts and improved benefits, where will money for salary boosts or child care come from? Aren't many public and safety net hospitals already operating on thin margins, with little to spare?

When I posed these questions to Bronfenbrenner, she redirected me toward what she believes is a more fruitful inquiry — "I think you should look at: Where does the money go?"

"They scream poverty, but they're not impoverished"

Medicare has been helping to finance graduate medical education since 1965, when the Medicare and Medicaid Act passed into law. Medicare's contribution covers about 20 percent of the direct costs of training a resident, according to Marquez. Teaching hospitals supplement federal funding with sources like clinical revenue from patients with private insurance, philanthropic donations, Medicaid, and city or state funding, depending on the hospital type.

Until the late 1990s, there was no limit on how many residency positions Medicare would financially support. Teaching hospitals could seek funding for as many residents as they were accredited to train, Marquez said. However, Congress effectively capped the number of Medicare-supported residency positions per teaching hospital through the Balanced Budget Act of 1997. There are about 153,000 active residents and fellows, according to the most recent ACGME data, published last fall.

"Interestingly, you'd think that there might have been a complex formula that went into it … [to determine] where these positions should be and who gets what. But essentially, it was 'How many residents were you training at the end of 1996?'" said Marquez.

There are ways to get around this. In fact, some teaching hospitals train hundreds of residents over their caps — but they are responsible for the funding, Marquez said. If a hospital trains 125 residents with a cap of 100, the hospital receives no Medicare financing for those extra 25 positions.

There are just two ways to increase the number of Medicare-supported positions: if a new teaching hospital comes online (though Marquez caveated that this is rare) or through legislation. In 2021, Congress increased the number of Medicare-supported residency slots by 1,000 — the first bump in more than 20 years. A bill introduced in the Senate would supercharge this increase but has stalled since 2021.

On top of this, the formula for determining how much it costs to train a resident is outdated. Medicare gives hospitals two types of funding for residents: "direct" payments (known as "directs" or "DGME") and "indirects." The value of direct GME payments varies from hospital to hospital, but the base formula that the government uses to determine the

"per resident amount" unique to each hospital depends on a respective hospital's cost reports in the mid 1980s, Marquez said.

Essentially, the formula is "whatever costs that a teaching hospital was reporting back in 1984" indexed for inflation, said Marquez. However, medical costs — from the price of pharmaceutical drugs to insurance — have outpaced inflation over the last four decades.

"Directs" are supposed to offset the expenses of training residents, such as resident stipends and supervisory physician salaries. But it's murkier how hospitals use "indirect" payments.

A breakdown of direct payments is included on a hospital's required Medicare cost reports, but for indirects, "we can't disaggregate what they're doing with it," Marquez said. "You can't paint ink or dye on the money and sort of follow it through."

Mark Earnest, an internist at CU Anschutz who also holds an administrative role, echoed that how hospitals actually use Medicare money is "totally opaque."

Those dollars are meant "for offsetting the lost efficiencies of having a learner in the hospital," he said. But he pointed out that most hospital systems don't actually educate residents, with the exception of community hospitals. Hospitals typically house residents, while their affiliated colleges of medicine provide the training. In most cases, the corporate entity — a hospital — essentially writes the college of medicine a check, explained Earnest.

"That money sort of goes into a black box. We — being the School of Medicine — don't know how much money our hospital receives for the residents," said Earnest. They "always say, 'Well, we don't get enough to pay our costs on the residents.' But you never see what the dollar amounts are."

This Byzantine system brings good and bad news for Kalis and Golomb, who are anxious for change sooner rather than later. The good news: They don't have to hold their breath and wait until the Centers for Medicare and Medicaid Services (CMS) changes old policies in order to get a raise. Once bargaining begins, they will negotiate with their employer, CPMC — part of the not-for-profit system Sutter Health — that will have to conjure the funding.

"Our top priority has and will continue to be providing safe, high-quality, affordable care for our patients," said a Sutter Health spokesperson. "While we preferred to continue working directly with our Residents and Fellows, without the involvement of an outside third party, we will respect the final determination and outcome of the vote."

The bad news is that the finances of American hospitals remain murky. Reporting has suggested that some nonprofit hospitals operate much like for-profit endeavors that aim to maximize revenue and minimize labor costs.

Residents at public and safety net hospitals, in particular, may experience pushback. Executives might say there's no slack to give, that they're barely scraping by. Ultimately, it is difficult for patients and practitioners alike to determine how financially sound or under-resourced a hospital truly is. Hospital expenditures aren't usually made clear enough to fact-check such claims.

Some argue this opacity is by design and that institutions use it to their advantage. "[Montefiore] will say they're under-resourced, but their CEO made more than $7 million" in

2021, said Goldberg. “They scream poverty, but they’re not impoverished.”

Certain institutions will have an easier time moving money around than others. “I’d worry that public hospitals would be disadvantaged,” Earnest said. “There are going to be hospitals that can afford to do that without breaking a sweat. And there are going to be others … that are going to struggle.”

Beyond these constraints, pay disparities also boil down to an organization’s competing priorities and values, and ultimately their choices. Why do residents at Montefiore in New York City earn less than house staff across town at Weill Cornell and Columbia?

“Maybe they had more money, or maybe they just felt like that was an important thing to do,” said Goldberg.

What is a provider’s quality of life worth to a hospital?

Of the dozen or so people who I interviewed for this story, most could agree on one point: The problems enmeshed in the residency system are not straightforward to solve. Perhaps that’s because they reflect a broader fundamental question: How do we, or should we, value costs and productivity in a healthcare system in the first place?

“The product of the hospital is healthcare,” said Bronfenbrenner, of ILR. “Measuring these things is very difficult.”

Hospitals — and the U.S. health system writ broadly — could maximize the number of patients treated. They could aim to deliver more care for less, or focus on the sustainability of institutions in communities that desperately need them. But that doesn’t address what the effects might be on the quality of care and lives saved.

What is a provider’s quality of life worth to a hospital? It feels nearly impossible to capture the cost of physician turnover, including collateral damage to their mental and physical health. And more sobering still to collectively accept that trade-off as the way this machine must run.

If one thing is clear in this convoluted system, it’s that such questions have no universal answers in the U.S. healthcare system as it stands. Each medical institution — whether public, not-for-profit or for-profit — has their own mission, which may or may not align with that of residents assigned to work there.

Still, experts are considering small ways to tip the scales within the existing system. “Medicare should definitely be paying more for a resident,” said Goldberg. This could involve altering the “per resident amount” or funding more than 20 percent of residency costs. “Medicare should also be financing way more residency spots,” he added, particularly in specialties with shortages.

Others, like Earnest, want to elucidate financial transactions between Medicare, corporate hospital systems and affiliated colleges of medicine to shed light on the “black box” of federal funding. This could involve illuminating the value of “indirect” payments that Medicare gives hospitals in order to hold them accountable for how they spend it. He also suggests that “instead of giving the money to the hospital, give it to the School of Medicine, which is educating [the residents],” Earnest said.

Meanwhile, some are tinkering from the legislative side. A California Senate bill introduced in February would raise the minimum wage to $25 per hour for California health workers. Overtime-exempt salaried employees, like residents, would get paid twice that rate for 40 hours — bringing them up to a $104,000 salary floor. The bill is expected to face opposition, but Golomb takes heart to see people talking about it.

She understands that structural changes take time. But she also knows that residents provide essential labor and sees organizing as a path to gain leverage now. As chapters negotiate, they will continue to face stakeholders — hospital executives, program directors, administrators — with little incentive to change. Administrators may not oppose boosting benefits per se, but toe a line closer to apathy. After all, the status quo is serving them. Rejiggering scales of power could throw off this balance, not to mention take profits from their pockets.

“Whoever is employing residents is making a lot of money off of them,” said Crane, of the Doctors Council SEIU. “Be it the public system, be it a private system, be it a for-profit system — whoever is doing that is greatly financially benefited by treatment of residents.”

At the same time, some physicians say there are other fish to fry with greater urgency. Earnest points to addressing inequities among clinicians by paying procedure-based specialties lower salaries and primary care doctors higher salaries, to reduce pay disparities and incentivize new residents to enter fields with shortages most dire.

Then there are the optics of the matter. “I don’t think, when doctors complain about their incomes, that we are the most sympathetic people to whine,” Earnest said. He also considers the situation’s temporary nature: “Once people finish their residency, they’re going to get paid pretty well.”

“Residents can escape the challenges of their employment,” Earnest said. “I worry more about people who are early childhood educators, or teachers, or other folks who really will never be in positions of power relative to their economic well-being.”

Others raise concerns about how unions could affect patient care or impact the workflow of a hospital, such as transfers of care. After working in unionized and non-unionized environments both as a resident and attending, Goldberg said he hasn’t observed changes in the resident/attending dynamic, as most chapters have focused on negotiating over HR benefits rather than clinical operations.

Meanwhile, some worry about what could transpire if doctors strike, as nurses have been doing. It would be an unpleasant, dangerous surprise to show up at an emergency room with no physicians. However, even staunch union advocates frame strikes as options of last resort. Clinicians enter medicine with the goal of caring for patients, not leaving their bedsides.

There hasn’t been a resident strike in more than 30 years, though house staff at Los Angeles County-USC Medical Center came close in 2022: They voted to authorize a strike after months of stalled negotiations, before the city acquiesced in order to avert it.

Another barrier is the “old guard versus new guard” mentality pervading elite systems, including medicine. Some doctors may argue that everyone has suffered through residency and must pay their dues, even if the economic landscape has changed since their time.

The debate parallels that of student loan forgiveness, as some say, 'I cleared my student loan debt; you clear yours.'

Goldberg doesn't buy it. "It's victimizing the wrong person. We should all be saying 'Our hospitals are making lots of money. They're paying their executives handsome salaries.' Those are the people we should be aiming our critiques at," he said.

In Golomb's eyes, organizing at CPMC has helped her find some semblance of control in a demanding work environment that has, at times, pushed her to the brink and made her lose sight of her humanity. "This voice that I've been able to have throughout this process makes me feel like more of a human than I have the rest of my time in residency," she said.

"The pressure of residency is so profound, and you're given so little space to breathe and thrive and take care of yourself," she said. "We live paycheck to paycheck. … We have student loans, we have all the other things that come with just being a person existing in society."

Golomb is excited to start strategizing with her colleagues and ultimately get to the negotiating table.

"For me, my patients come first and I come second. That's something I am comfortable with, and I recognize that there's sacrifice in that," she said. "But I want to have something left over at the end of the day for myself."

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