Resident physician labor unions have existed in a limited capacity in the US for decades, but this landscape has been rapidly changing for the past 5 years. Resident labor unions first appeared in 1934 in New York to advocate for compensation (there was none), ultimately forming the Committee of Interns and Residents (CIR) in 1957.1,2 Amid a more intense period of activism in the 1970s, the National Labor Relations Board (NLRB) ruled in 1976 that resident physicians are students, not employees, and therefore are not protected by federal law.3 This ruling stifled any substantial change until 1999, when the NLRB reversed this decision and declared resident physicians as employees entitled to the right to organize and collectively bargain.4 As of May 2024, the CIR represents 32,000 trainees, about 20% of the resident workforce.5 Although not the majority, this number was only 16,000 (10%) in 2019.6 In fact, since late 2021, trainees from at least 14 institutions have voted to unionize, reflecting an accelerating pace of change.7,8 It has been suggested that changing work attitudes shaped by the COVID-19 pandemic catalyzed this movement, but little research has explored trainee perceptions.

Foote et al9 present a thought-provoking qualitative analysis assessing general surgery residents and program faculty and leadership perspectives on trainee unionization. Amid 15 site visits that occurred in 2019 to 2020 to study resident well-being, they identified and reviewed 22 interviews from 2 programs (one with a union in place for over 20 years and one program that has recently unionized), including 13 resident-focused interviews (with representation from each year of training), in which unionization was discussed. Three major themes emerged from this work: (1) surgical residents unionize for voice and agency, (2) union-negotiated benefits have varying levels of efficacy and relevance to surgical residents, and (3) unionization affects the educational environment. It is important to remember that the data analyzed were not derived from a study that focused on unionization but rather from further analysis of the unionization theme in the context of a more extensive study. This design serves as a strength by eliminating any bias influenced by the targeted questions about unionization. Still, it may have also thwarted other themes from being uncovered and limited the generalizability of the findings (as compared with those from a study that intentionally included trainees from more specialties and leadership teams from more institutions).

With that being said, the themes generated from the exploratory analysis by Foote et al9 take a crucial step forward by helping the graduate medical education community begin to close the substantial gaps in knowledge of unionization's effects on various learning environments.

With surgical residents giving the majority of the interviews (13 of 22) in the study by Foote et al,9 themes 1 and 2, which reflect surgical resident perspectives, are sound given that the number of interviews is in a range to achieve saturation. Surgical residents unionizing for voice and agency (theme 1), which provides a more straightforward path to enact change, is entirely consistent with why groups of laborers have unionized throughout history. In fact, the CIR itself advertises, “Through our union, we have a powerful voice in the fight to improve our healthcare system … and solve problems we see in our hospital every day.”2 The corporatization of medicine, which inevitably creates systems focused on throughput and the bottom line, places trainees in systems that can overemphasize work and deemphasize education. This environment in the broader context of stark generational differences and changing societal attitudes toward work likely explains the impetus behind this theme.6 Further data are needed to confirm that it extends beyond surgical trainees, but it is not difficult to imagine that it does.
Union-negotiated benefits have varying levels of efficacy and relevance to surgical residents (theme 2), and most gains were felt to be primarily financial, from direct salary increases to other nonsalary benefits (meals, educational stipends, parking, etc). Other union-negotiated benefits were less consistently appreciated or accessible. For instance, time-off benefits had several reported barriers, including potentially extending training time, inadequate coverage of required patient care duties, and possibly perceived judgment from colleagues. Depending on specialty-specific cultural and educational norms, these barriers will be present in varying degrees in different training programs. Furthermore, negotiated contracts must preserve the educational requirements dictated by regulatory bodies (eg, eligibility for board examinations), which vary widely between specialties. Thus, more data are needed to determine the variation of efficacy and relevance of certain benefits across specialties.

Additionally, the uniformity of benefits and regulations across programs within an institution due to the union was felt within the 2 programs surveyed by Foote et al,\(^9\) resulting in a loss of certain preunion benefits and a loss of flexibility to meet individual residents' needs. This observation has been anecdotally reported in at least 1 other large internal medicine residency program regarding the loss of certain “perks.”\(^10\) Of course, this will be highly institution and contract dependent, as the reverse could also be true, with programs with fewer benefits being brought to the same level as other programs within the same institution offering additional benefits. Furthermore, it may be that the size (as a surrogate of funding) of the program matters, with smaller programs (with less funding) receiving increased benefits and larger programs (with more funding) feeling more restricted from the required equalization of benefits, but again more data from a broader sample size are needed to confirm this.

The third theme, that unionization affects the educational environment, is more exploratory and hypothesis generating than the other 2 themes. The program leadership perspective seems to drive this theme, which is much more limited in this study, with only 1 program director, 2 designated institutional officials (DIOs), and 1 department chair from 2 institutions being represented, each of whom will have a slightly different perspective (eg, DIOs are typically involved in contract negotiations, whereas program directors are not). Undoubtedly, similar to what is described in the commentary for this theme, residency program leaders find themselves in an uncomfortable middle space when navigating the adversarial dynamics that frequently accompany labor relations in the US, especially amid contract negotiations. However, to what extent this dynamic persists following the contract negotiation is unknown (although the study by Foote et al\(^9\) suggests it does), and much more supportive data gathered from various institutions, contracts, and specialties is needed. Furthermore, not all of the effects are negative, as suggested by the program director’s comment in this study about gradual improvements in hospital-wide support, which will ultimately benefit not just the work and educational environments but also patient care itself.

In closing, as highlighted by the conflicting rulings of the NLRB in 1976 and 1999, a resident physician lives in a very gray area between a student learner and an employee. As the trend toward trainee unionization progresses rapidly, best practices on leveraging a union to enhance the work environment without inhibiting the learning environment are promptly needed. Foote et al\(^9\) have taken a crucial step forward by attempting to characterize the effects of unionization on a smaller scale. However, the themes generated from this study also clearly highlight the need for a much broader dataset to ensure the generalizability of themes across all graduate medical education in order to create initiatives to preserve the educational alliance.
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REFERENCES


