Behind the sharp rise in US resident physicians organizing into unions

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There is a growing movement among resident physicians in the United States to fight against inadequate pay, under conditions of financial stresses caused by massive debts, as well as impossible, long hours of demanding work in under-resourced health care systems.

While this takes initial expression in unionization efforts across numerous hospitals, resident physicians are quickly finding themselves confronting the reality of union bureaucracies beholden to the demands of a health care industry itself under the chokehold of the financial markets. A similar experience with the pro capitalist, burueacratized unions faces every other sector of the working class.

The tensions among physicians in training, who typically work 80 hours a week and earn as little as $15 or less per hour, have only been aggravated by the impact the COVID-19 pandemic on health care and the overall state of the global economy more generally, that has seen crushing levels of inflation.

The recent strike by 165 resident physicians at New York City's Elmhurst Hospital Center in May was the city's first strike by doctors since 1990, according to the Committee of Interns and Residents (CIR) local of the Service Employees International Union, their bargaining agent. The doctors in training who perform the brunt of the difficult work in evaluating and treating patients in every aspect of their care are employed by the Icahn School of Medicine at Mount Sinai Hospital in Manhattan.

After only three days, their union abruptly ended the strike, announcing that a tentative agreement had been reached. This came on the heels of scheduled strikes being called off at two hospitals in Jamaica and Flushing in Queens. The deliberate intervention on the part of CIR to separate these disputes is part and parcel of the union bureaucracy's modus operandi—divide and conquer.

The striking Elmhurst physicians, who were forced to return to their grueling work schedule, had no realistic chance to review the agreement before ratification. Clearly, the decision by the union to abruptly call off the strike was not dictated by the interests of the residents, but the needs of hospital management, which is totally reliant on residents to keep the hospital functioning

The strike demonstrated the role of CIR as a pro-management labor police force. The terms of the agreement fail to close the financial gap between residents' pay and the high cost of living in New York City. In fact, none of the fundamental issues raised by residents were addressed. Meanwhile, the CIR isolated residents at Elmhurst from other disputes by resident physicians and even from other health care workers at the same facility.

Meanwhile, on June 7, the CIR announced that just 30 miles away, across the Hudson River, 1,100 Rutgers resident physicians, who have been bargaining for a year, were to hold an informational picket at the University Hospital in Newark. As Dr. Elena Wickstrom, a Rutgers resident, noted, "We are passionate about doing whatever it takes to deliver great care to our patients—that's why we became doctors. But no one should have to sacrifice this much—our well-being, delaying life goals—just to finish their medical training."

And then on June 8, in Massachusetts, medical residents and fellows (physicians in training for subspecialties, which extends their training period from between three to seven years beyond the typical four-year residency) at multiple Massachusetts General Brigham (MGB) hospitals voted 1,215 to 412 to join CIR. Formal recognition is pending the certification of the results by the National Labor Relations Board (NLRB) next week.

Once certified, with more than 2,500 eligible members, the union created at MGB would become one of the largest of the kind in the country. Since 2021, amid the ongoing pandemic, membership in CIR-SEIU has nearly increased two-fold from 17,000 to 30,000. This figure includes members from such health systems as Stanford Health Care, the University of California systems, San Francisco Medical Center, Montefiore Medical Center in New York and Children's National Medical Center in Washington D.C.

In response to the drive to unionize, there has been intense pushback from hospital leadership. In a statement issued to the press by Dr. Paul Anderson, interim chief academic officer at MGB, he wrote, "As an organization dedicated to training the next generation of caregivers, we are proud of the education that we provide to our residents and fellows, and we recognize the vital importance of the unique partnership between faculty and trainees in our institution. While we are disappointed with the outcome, this election is part of a continuing national trend among medical trainees seeking collective bargaining through union representation."

Indeed, residents play a critical part in health delivery, a fact not overlooked by the health systems who are utterly reliant on them to provide the brunt of hospital-based health care to patients. In an important report last year, titled, "How much are resident physicians worth?," the author highlighted the withdrawal of accreditation of the University of New Mexico's (UNM)

neurosurgery program in August 2019.

As a result of the loss of accreditation, eight neurosurgery residents at the facility had to leave and seek other accredited training programs. To fill in for the residents, UNM had to hire 23 advanced practice providers to replace them, a ratio of one resident for three advanced practitioners. Given these new staff were paid $115,000 per year, twice the salary of the residents, it meant the cost to the hospital to treat patients rose six-fold. And this doesn't take into account that neurosurgery specialists now have to perform more of the tasks usually assigned to residents, taking away from their attending to patients in the operating room, where they can be more productive in terms of the overall functioning of the health system.

As the report notes, "Having residents doesn't just increase attending billing —it also increases the hospital's ability to bill for its services. A financially happy hospital is one where the ICUs are full, there's rapid bed turnover in the ED and on the wards, and the lab and radiology departments are abuzz with the latest diagnostics. Residents are invaluable in keeping up that pace. Moreover, having residents allows a hospital to care for higher-acuity patients. It's difficult to provide, say, high-level oncology or cardiovascular care *without* having residents and fellows to share the intense clinical workload."

Besides the massive workload burden they carry, resident physicians face significant financial debts that further contribute to the high levels of burn-out that have been registered by numerous surveys.

According to the Association of American Medical Colleges (AAMC), a graduating medical student in 2021 faces a median debt of $200,000, which does not include what they might owe from their undergraduate degrees. The average in-state tuition for medical school at a public institution is nearly $39,000 per year. This only includes tuition, fees and health insurance. For those attending private institutions, this increases to over $61,000. In both these figures rent, food, transportation and cost of living are not included.

In a survey by the AAMC, 14 percent said their debt was over $300,000. When they attend residency, earning minimum wage, these debts are deferred. Although graduating physicians can expect a considerable wage increase when they begin practicing, they face crushing debt, and they will also most likely join a health system as an employee because of the astronomical costs of forming a private practice and hiring staff and property to build a clinic.

Since the pandemic, there has been an acceleration nationwide of health system acquisition of physician practices. According to a study conducted by the physicians Advocacy Institute, since 2019, 108,700 additional physicians became employees of hospitals or other corporate entities, of which 83,000 occurred after the onset of the pandemic. This accounts for a near 20 percent increase over a three-year period.

Meanwhile, hospital and corporate entities acquired 36,200 additional physician practices, resulting in a 38 percent increase in the same period. In all, 74 percent of all physicians (484,100) are now employed by a health system or corporate entity, representing a 13 to 24 percent increase. The implication here is that with the ownership of the productive capacity of physicians by giant health conglomerates, the exploitation of medical school graduates will increase and extend beyond their residency years.

The proletarianization of physicians employed by health systems as wage laborers is bringing this previously relatively privileged social layer into the class struggle. With the soaring costs of health care and declining rate of profits, the need by Wall Street to extract ever greater amounts of surplus value impacts every aspect of the class struggle. This includes social layers that in the past may not have considered themselves part of the working class.

For the ruling elites, the additional profits squeezed from residents are just new subheadings in their account ledgers. For training physicians, workers at health systems and patients that access them, these are a matter of life and death.

Physicians have far more in common with every other worker in the health care sector and other sections of industry compared with the financial parasites that exploit them. Like other sections of workers, physicians face conditions of intensified exploitation policed by union bureaucrats beholden to the demands of finance capital.

In a rationally functioning society workers would not be classified in a socially stratified ranking that pits each against the other. Under capitalism health care is provided or withheld based on the profit motive, and not determined by societal needs or as a social right. The disastrous short-term and longer-term social impact of the COVID-19 pandemic was not inevitable, but took place because of the subordination of public health, like every other aspect of economic and social life, to the profit interests of big business.

The entry of sections of physicians into the class struggle is a significant development, given medicine's critical role in society. This is in fact an international phenomenon bound up with the breakdown of public health systems under the impact of an intense crisis of the capitalist system as a whole. Workers should assimilate this development, which poses even more sharply the necessity for a political struggle against a social and economic system that prioritizes the private accumulation of wealth over basic human needs.