Since the beginning of Ronald Reagan’s presidency, the proportion of workers in the United States who belong to a union has declined by approximately 50%, while income inequality has increased by approximately 20%.1 Today, just 10% of all US workers are employed in unionized positions.1 But following the recession that started in 2007 and 2008 and then the temporary resurgence of a social democracy during a pandemic that exposed neoliberal policy as a public health disaster, labor organizing against exploitation and public abandonment has been increasing. Amid growing concern about workforce attrition associated with the demoralization of nurses and physicians in a flailing medical industry shaped by profit rather than ethics,2,3 health care workers have become increasingly involved in this revival of labor politics.

A wave of nurses’ strikes and house staff unionization has put this ideological shift front and center in contemporary health care politics. There are now approximately 70,000 physician union members in the US, representing 7% of physicians—a nearly 30% increase relative to a decade ago. Much of this interest in labor movements is likely due to house staff exploitation via high medical-education costs, undercompensation, excessive work hours, and an infantilizing hierarchical culture characterized by intensive personality policing under the veneer of racist, misogynistic, and classist professionalism norms and their self-defensive moralisms.

It is into this context that the analysis of housing affordability and housing-related benefits for house staff by Brewster et al interjects.4 Using data from the 2022 to 2023 academic year, Brewster et al4 found that compensation levels at 60% of 855 institutions administering residency programs imposed rent-burdened status on their resident physicians (ie, they required residents to devote >30% of monthly income to rent). Brewster et al4 also found that while inflation-adjusted rental prices increased by 18% between 2000 and 2022, inflation-adjusted first-year resident salaries decreased by 0.2% during that same period. Concluding with a call for more equitable compensation, Brewster et al4 note that resident labor unions have been associated with improved access to housing stipends.

This adds to what should be already clear rationale for physicians, nurses, and other health care workers to unionize to protect their own interests and to protect patient safety by improving working conditions.5 But there is another intertwined and more fundamental issue at stake: the political education of the most influential workers in what may be the most powerful industry in the US. Worst-among-peer-nations life expectancy, alongside globally unparalleled health care spending and rapidly declining trust in medicine, public health, and government, make undeniable that the US is in need of a basic reorganization of its health systems. After allowing health care over the last half century to be dominated by private entities motivated by profit and enabled by depoliticized concepts of charity as substitutes for rights guaranteed by public systems, to achieve meaningful change will require a repoliticization of care. This must be linked with mass movements to demand public investment in universal health care and, even more importantly for public health, infrastructures for everyday nonmedical care that are essential for preventing disease and shrinking the currently elephantine footprint of reactive US medicine.6,7

As underlined by the tradition of social medicine left to us by physicians like Rudolf Virchow, Frantz Fanon, and Paul Farmer, the practice of medicine—let alone public health—is intrinsically political.8 To deny this is itself a political act in service of the status quo of US health capitalism that is inflicting at least tens of thousands of preventable deaths each year. And yet the most significant
resistance to the explicit politicization of medical care so that we might organize for redress of policy-manufactured health inequalities comes from inside our own house.

Many US physicians, who—once out of training—are rewarded for their loyalty to the existing industry with mean salaries more than twice those paid to physicians in the next-highest-compensating nation, have been professionalized into a convenient political nihilism. As historians of the profession, like Paul Starr, Charles Rosenberg, and Rosemary Stevens, have shown, we have for more than a century been indoctrinated into what Max Weber described as the protestant ethic and the spirit of capitalism.9

At the center of US medical ideology are twinned ahistorical notions of meritocracy and individualism by which public responsibility for protecting health is replaced by personal responsibility, irrespective of the history and policies determining one's circumstances. These ideas operate both on interpersonal and structural planes, shaping physicians’ perceptions, standards of care, and institutional practices. This, in turn, prepares us to absorb the self-affirming narrative that we supremely value patient autonomy while also believing that we have no ethical duty to counter the heteronomy imposed by viciously “free” markets that serve the rich by perpetually extracting maximum wealth and labor from the poor.

Standard US medical education is designed to defend and reproduce these professional norms, including through the so-called informal curriculum, through which many of the most formative political lessons and class affiliations are imbibed. The fact is that physicians have been receiving a political education for generations—it has just been largely off the books. And it has been overwhelmingly conservative, profoundly uncritical, and reflexively protective of an ethically bankrupt field that has spent a century building up a capitalist health care industry.

The exploitative conditions faced by medical trainees have been a key component of our political apprenticeship. These conditions also function to recruit those who are more likely to be receptive to it. By making training so financially burdensome that it is often inaccessible to all but people from wealthy families, who bring with them their class backgrounds, medical schools enforce a selection pressure that aids in perpetuating existing professional norms by suppressing their potential disruption by individuals who belong to communities most harmed by them.

Poor working conditions for residents and fellows, which are endured with the certainty of future financial security and high status, also function to normalize exploitation. This likely spills over into how physicians view the labor conditions of our patients and associated public policy. Because physicians typically have limited personal stakes in labor politics beyond our training years, many are more likely to accommodate exploitation than to protest it. Instead of fueling solidarity and attention to labor rights as a key political determinant of health, our own encounters with workplace abuse often inure physicians to it rather than provoke us to join with coworkers and patients to demand policy changes to protect workers across all industries.

The recent push for structural competency curricula has been attempting to nudge physicians into alignment with actual care.10 But we must move beyond hesitant subtleties. Medical trainees deserve an explicitly political education—one that breaks down and transcends simplistic partisanship—adequate to allow us to understand the history and economic ideologies shaping our everyday work.

We should prepare physicians to embrace care as a practice that extends well beyond the clinic and that necessarily hinges on power and policy—and thus on political organizing and struggle. Resident unionization is a key training ground for this work that, to rebuild US health, must continue beyond residency. If medical institutions are to have any ground on which to stand as they preach health equity, they should support residents’ organizing efforts and begin giving substance to their rhetoric by guaranteeing their workers proper protections rather than continuing to exploit them.
ARTICLE INFORMATION
Published: June 27, 2023. doi:10.1001/jamanetworkopen.2023.20447

Open Access: This is an open access article distributed under the terms of the CC-BY License. © 2023 Reinhart E. JAMA Network Open.

Corresponding Author: Eric Reinhart, MD, Department of Psychiatry and Behavioral Sciences, Northwestern University, 676 N. St. Clair, Suite 1100, Chicago, IL 60611 (s.ericreinhart@gmail.com).

Author Affiliations: Department of Psychiatry and Behavioral Sciences, Northwestern University, Chicago, Illinois; Department of Anthropology, Harvard University, Cambridge, Massachusetts.

Conflict of Interest Disclosures: Dr Reinhart reported receiving personal fees from the Association of State and Territorial Health Officials, Columbia University, The New York Times, The Nation, Slate, The New Republic, TIME Magazine, USA TODAY, Undark Magazine, The Lancet, and Health Affairs and grants from the University of Chicago, National Institutes of Mental Health, and Harvard University outside the submitted work.

REFERENCES