The NEW ENGLAND JOURNAL of MEDICINE

Perspective

JANUARY 16, 2025

Striking a Balance — Advancing Physician Collective-Bargaining Rights and Patient Protections

Tarun Ramesh, B.S., Carmel Shachar, J.D., M.P.H., and Hao Yu, Ph.D.

Since February 2024, more than 12,000 South Korean medical residents (80% of all residents) have been on strike, protesting a new government policy designed to increase medical school admissions, which they argue doesn t address their concerns about low pay and poor working conditions. The residents were eventually joined by attending physicians and medical students. The strike, one of the largest and longest medical strikes in the country s history, has led to substantial delays in surgeries, other medical procedures, and hospital admissions.

Similarly, in January 2024, medical residents in the United Kingdom went on strike for 6 days because of poor compensation; the strike was the largest in the National Health Service s history. In October 2023, primary care physicians in France initiated a strike to demand higher fees for general medical consultations. In the United States, emergency physicians in Detroit went on strike in April 2024 because of long wait times and low staffing levels; in September 2024, more than 800 University of Buffalo residents and fellows began a 4-day strike to demand better compensation and working conditions, the same goals sought in a May 2023 strike by more than 150 residents at a New York hospital affiliated with the Icahn School of Medicine at Mount Sinai.

Among countries in the Organization for Economic Cooperation and Development, South Korea and the United States have some of the lowest numbers of physicians per 1000 population. Collective bargaining and strikes could therefore have larger effects in these countries than elsewhere. Amid recent strike activity, U.S. policymakers could incorporate lessons from other countries to better balance physicians collective-bargaining rights and patient protections.

The treatment of hospital employees under U.S. labor law has been complex and inconsistent. The National Labor Relations Act (NLRA) of 1935 originally covered employees of all nongovernment hospitals; it was amended by the Taft Hartley Act in 1947 to exclude employees of nonprofit hospitals. The 1974 Health Care Amendments to the NLRA restored labor law coverage to employees of nonprofit hospitals. They also enshrined a right to strike for some U.S. health care workers and required that unions give 10 days notice before a strike at any health care institution.[1] The National Labor Relations Board (NLRB) subsequently determined that medical residents may form unions, but attending physicians are excluded

from legal protections related to labor unions if they are independent contractors rather than employees, are in private practice, are tenure-track or tenured faculty, or supervise other employees (physician supervision of nurses doesn t qualify for this purpose).[1,2]

Antitrust law has been applied to labor organizing by physicians since the Federal Trade Commission pursued enforcement action against the American Medical Association (AMA) in 1979, on the basis of the theories that all independent physicians are in competition with one another and that labor organization might result in anticompetitive behavior. Some state laws may provide additional protections beyond those established by federal policies for employees pursuing collective bargaining or engaging in strikes.

It s historically been rare for U.S. physicians especially as compared with nurses to carry out strikes. Norms may change considerably in the coming years, however, owing to increases in job dissatisfaction among physicians and the rise of medical trainee unions. Over the past two decades, physicians have expressed increasing frustration with high workloads, relatively low compensation, and deteriorating working conditions and distress about the financialization of the U.S. health care sector, including the prioritization of profit over clinical care quality.[1]

Unionization and subsequent collective-bargaining authority among medical trainees offer residents and fellows a legal pathway to counterbalance distorted priorities and advocate for improved working conditions and increased compensation. Unionization also provides another avenue to exercise power during contract negotiations: industrial action, including strikes. On the other hand, unionization may be associated with potential drawbacks, including higher societal health care costs, loss of autonomy for individual physicians, and the creation of inequities between employed and independent physicians. Alternatives to physician unions, including medical staff committees, which are composed of clinical leaders who support staff well-being and bring issues to hospital leadership, can allow employed physicians to have a collective voice in the absence of unionization.

Medical trainees in more than 60 U.S. programs have unionized.[3] With growing interest in unionization among other physicians, the potential for industrial action in U.S. health care will increase. Laws and regulations could be updated to better reflect the realities of modern health care and incorporate best practices from other countries.

Although physician strikes raise important ethical concerns about the potential for patient harm, especially in physician-shortage areas, few studies have examined such effects. A systematic review and meta-analysis of 14 studies from 10 countries found no significant difference in in-hospital mortality between strike and nonstrike periods.[4] A scoping review found a decrease in elective surgeries and an increase in outpatient-appointment cancellations during strikes.[5]

To address concerns about potential harms associated with physician strikes, policymakers in many countries have taken steps to protect patients. Although the health care systems of these countries differ from that of the United States, their experiences could offer useful lessons. For example, France, Italy, Ireland, and Spain have implemented policies that require employers and employees to establish a minimum-staffing level before a health care strike, and the United Kingdom has recently considered introducing minimum-staffing levels. Such policies are in keeping with those of the International Labor Organization (ILO), a United Nations agency that helps set labor standards. The ILO supports the use of minimum service levels when strikes could interrupt services in ways that endanger life, personal safety or health of the population.

The statutory 10-day notice for strikes against health care institutions in the United States is intended to provide a cooling off period and give the institution time to make arrangements to safeguard patient care. Adding a legally required minimum level of service could further protect patients, address some physicians concerns that striking conflicts with their ethical duty to provide care, and protect against potential allegations of patient abandonment by state medical boards.

Proactive steps could also be taken to prevent punitive actions against striking attending physicians or trainees. South Korean law permits penalizing by means of medical license suspension, fines, or even incarceration physicians who refuse government return-to-work orders. During the resident strike, the South Korean government started suspending the licenses of striking trainees but backed down after public outcry. Such punitive actions can damage employee employer relations, undermine public confidence in the medical system, and compromise physicians working conditions, thereby exacerbating burnout and job dissatisfaction. According to ILO labor codes,

workers should not be dismissed for engaging in strike action, and a legal strike doesn t terminate an existing contract, but rather suspends the contract until negotiation proceeds.

Although discrimination against employees because of union activities or sympathies is considered an unfair labor practice under the NLRA, trainees involved in such activities are more vulnerable than other physicians to career-related harm because they are in the process of obtaining licensure and board certification. State medical boards could ensure that legal charges associated with union activities don t affect licensure decisions. Similarly, professional societies could guarantee that union-related activities won t jeopardize board eligibility or certification. The AMA, which supports physicians right to unionize but discourages physician strikes,[2] could provide updated and more specific guidance to trainees about the benefits and risks associated with striking.

An audio interview with Carmel Shachar is available at NEJM.org

Finally, Congress and the NLRB could revisit the unionization eligibility of medical school faculty and supervising physicians. In an era of increased corporatization and hospital consolidation, attending physicians have less control over their schedules and practice.[1] In large health care systems, where administrators may drive decision making, unions can be an important counterbalance that protects employee interests. Labor policies could be updated to better reflect current trends and more closely align with policies in Spain, France, and the United Kingdom that allow supervising physicians to strike. By modernizing labor laws and strike regulations, in part by learning from other countries, U.S. policymakers could better support physicians, patients, and hospitals in times of unrest.

Disclosure forms provided by the authors are available at NEJM.org.

From the Department of Population Medicine, Harvard Medical School and Harvard Pilgrim Health Care Institute, Boston (T.R., H.Y.), and the Center for Health Law and Policy Innovation, Harvard Law School, Cambridge (C.S.) both in Massachusetts.

This article was published on January 11, 2025, at NEJM.org.

1. Bowling D III, Richman BD, Schulman KA. The rise and potential of physician unions. JAMA 2022;328:617-8.
2. American Medical Association. Collective bargaining for physicians and physicians-in-training. Advocacy Resource Center issue brief. 2023 (https://www.ama-assn.org/system/files/advocacy-issue-brief-physician-unions.pdf).
3. Ahmed A, Li X. Labor unionization among physicians in training. JAMA 2023; 330:1905-6.
4. Essex R, Weldon SM, Thompson T, Kalocs nyiov E, McCrone P, Deb S. The impact of health care strikes on patient mortality: a systematic review and meta-analysis of observational studies. Health Serv Res 2022; 57:1218-34.
5. Essex R, Ahmed S, Elliott H, Lakika D, Mackenzie L, Weldon SM. The impact of strike action on healthcare delivery: a scoping review. Int J Health Plann Manage 2023; 38:599-627.

DOI: 10.1056/NEJMp2411647

Changing Medicare Payment to Strengthen Primary Care

Douglas B. Jacobs, M.D., M.P.H., Christiane T. LaBonte, M.S., and Meena Seshamani, M.D., Ph.D.

Few relationships in medicine are as sacred as the relationship between patients and their primary care practitioners. Primary care supports people from childhood through old age, in cases of routine symptoms and obscure pathology, amid health setbacks and successes. Without primary care, minor illnesses can evolve into chronic conditions, opportunities for preventing illness can be missed, care can be uncoordinated, and health care costs can increase.[1] Having a greater supply of primary care physicians for a population is associated with more equitable health outcomes and longer life expectancy.[1] A recent report from the National Academies of Sciences, Engineering, and Medicine (NASEM) concluded that primary care is a common good and is foundational to the U.S. health care system.[1]

Despite the importance of primary care, visits to primary care practitioners have been decreasing,[2] fewer Americans than in past years report having a usual source of primary care,[3] and primary care workforce shortages are projected to increase.[4] The need to bolster primary care as the United States rebuilds from the Covid-19 pandemic is clear. Improved compensation for primary care practitioners could increase the number of medical students applying to enter primary care specialties and enhance access to care.[5]

As a primary care doctor and a surgical subspecialist who cared for patients referred by primary care clinicians, two of us have seen firsthand the importance of a trusted, longitudinal primary care relationship for a person s long-term health. A visit for sinusitis can involve not only a decision about whether to prescribe antibiotics but a discussion aimed at identifying and addressing factors, such as environmental mold,