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Editorial

Voices in Orthopaedics™...The Residency Programs: The Unionized Orthopod: Apprenticeship, Labor, and the Changing Identity of Orthopedic Residency at Jefferson

Eric R. Tecce, M.D.[a], Jalen N. Broome, M.D.[b], Tyler W. Henry, M.D.[c], Gabriel I. Onor Jr., M.D.[d], Daniel A. Nemirov, M.D.[e], Daniel E. Davis, M.D.[f], James J. Purtill, M.D.[g]

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a Eric Tecce M.D. is a PGY-2 Orthopedic Surgery Resident at the Rothman Institute / Thomas Jefferson University Hospital Residency Program in Philadelphia, PA. He grew up in South Jersey, attended his undergraduate education at St. Lawrence University where he was a four-year member of the Men's Tennis Team, completed his medical school training at Jefferson Medical College / Sidney Kimmel Medical College at Thomas Jefferson University where he later stayed to complete his orthopedic surgery residency. He is still undecided on his subspecialty, but has a particular interest in resident culture and experience which is manifested by spearheading the @jeffersonortho Instagram Page!

Connect with Dr. Eric Tecce on LinkedIn

Conflicts of Interest Statement for Dr. Eric Tecce

b Dr. Jalen Broome is a second-year Orthopaedic resident at Thomas Jefferson University Hospital. He went to University of Virginia School of Medicine and Brown University for undergrad. He is currently interested in sports medicine.

Conflicts of Interest Statement for Dr. Jalen Broome

c Tyler Henry is a chief orthopaedic surgery resident at Thomas Jefferson University Hospital and the Rothman Orthopaedic Institute in Philadelphia, PA.

Conflicts of Interest Statement for Dr. Tyler Henry

d Dr. Gabriel Ikechukwu Onor Jr. is a PGY-5 orthopaedic surgery resident at Thomas Jefferson University Hospital who will be pursuing fellowship in sports medicine surgery at the Hospital for Special Surgery.

Conflicts of Interest Statement for Dr. Gabriel Onor Jr.

Visit the Open Payments Data Page for Dr. Gabriel Onor Jr.

e Daniel is a PGY-4 resident at Rothman/Thomas Jefferson University. Upon graduation, he will be completing his hand surgery fellowship at Emory University.

Conflicts of Interest Statement for Dr. Daniel Nemirov

f Daniel E. Davis, M.D., M.S., is a board-certified orthopaedic surgeon and Associate Professor at Thomas Jefferson University, specializing in the treatment of shoulder and elbow conditions.

After completing his Bachelor of Science in Chemistry at Wake Forest University, Dr. Davis obtained a Master of Science in Human Genetics from Tulane University, where he also earned his medical degree. He then moved to Philadelphia to complete his residency in Orthopaedic Surgery at Thomas Jefferson University Hospital, followed by a fellowship in Shoulder and Elbow Surgery at the Rothman Orthopaedic Institute at Thomas Jefferson University Hospital.

Dr. Davis's clinical focus is the treatment of all shoulder and elbow conditions in patients of all ages. His expertise includes the management of sports injuries, fractures, and degenerative diseases using both arthroscopic and open surgical techniques. He also performs a high volume of shoulder replacement procedures each year.

In addition to his clinical practice, Dr. Davis has published more than 100 journal articles, book chapters, presentations, and posters.

During his final year of residency, Dr. Davis served as Administrative Chief Resident and was awarded the Everett J. Gordon Award for Outstanding Clinical Achievement. Early in his career, he participated in the American Orthopaedic Association Emerging Leaders Program. He currently serves on the boards of both the Philadelphia Orthopaedic Society and the Pennsylvania Orthopaedic Society.

Dr. Davis continues to play an active role in the Thomas Jefferson Orthopaedic Residency Program as Associate Program Director and is dedicated to the education and mentorship of orthopaedic residents and shoulder and elbow fellows.

Visit Dr. Daniel Davis

Connect with Dr. Daniel Davis on LinkedIn

Conflicts of Interest Statement for Dr. Daniel Davis

Visit the Open Payments Data Page for Dr. Daniel Davis

g Dr. Purtill is a professor of orthopedic surgery and the Vice Chairman of the Department of Orthopedic Surgery and orthopedic surgery residency director at the Sidney Kimmel School of Medicine of Thomas Jefferson University.

Visit Dr. James Purtill

Conflicts of Interest Statement for Dr. James Purtill

Visit the Open Payments Data Page for Dr. James Purtill

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Resident physician unionization has accelerated across the United States in recent years, reflecting broader changes in healthcare systems, physician expectations, and the economics of medical training. At Thomas Jefferson University Hospitals, residents recently voted to unionize and are currently in the midst of contract negotiations, placing these national conversations directly into the daily lives of trainees across all specialties here. Within orthopedic surgery, these issues carry unique complexity. Orthopedic residency has historically embraced an apprenticeship model deeply rooted in long hours, graduated autonomy, mentorship, and personal sacrifice. Residents are not merely employees performing labor, but trainees undergoing professional and personal development. The emergence of organized labor within residency programs therefore raises challenging questions. Are orthopedic residents primarily learners or workers? Can surgical training maintain its apprenticeship ethos within increasingly contractual labor structures? Which aspects of residency hardship are educationally meaningful versus unnecessarily burdensome? This editorial explores the evolving intersection of unionization and orthopedic residency culture through the lens of modern orthopedic resident trainees at Rothman Orthopedics at Thomas Jefferson University Hospital.

Disclaimer: This article is an editorial commentary intended to explore evolving perspectives surrounding resident physician unionization and orthopedic training culture. The views expressed are those of the authors alone and do not necessarily reflect the official positions of Thomas Jefferson University Hospital, Rothman Orthopaedics, or affiliated residency programs.

INTRODUCTION

At 5:45 PM, the orthopedic resident has completed sign-out to the Night Float resident, which technically finishes the day. The sun is still out, and dinner plans briefly seem possible. Then, the trauma pager goes off: polytraumatized patient in the Trauma Bay with multiple open fractures.

The resident sighs dramatically to co-residents in the call room, while simultaneously agreeing to stay late and help the Night Float resident triage these injuries. This paradox captures orthopedic surgery remarkably well.

Orthopedic residents frequently complain about long hours, difficult call schedules, and exhausting workloads. Yet many of the same residents voluntarily stay late for operative cases, eagerly discuss complex fracture patterns with co-residents, and view difficult training experiences as defining moments in their residency career. Few orthopedic residents would willingly miss a rare operative opportunity simply because the clock has struck 5 PM.

For generations, orthopedic surgery has embraced the idea that residency is more than employment. It is apprenticeship, identity formation, and immersion into a profession. Long hours were not merely tolerated; they were viewed as integral to becoming a competent surgeon. The culture prized ownership over patient care, resilience, availability, and commitment to patients above personal convenience. Surgical training was not something one clocked into and out of. It was, in many ways, a way of life.

These themes are especially relevant at Jefferson, where orthopedic residents train in an environment defined by high operative volume, subspecialized mentorship, and significant clinical responsibility. The educational opportunities are extraordinary. Residents routinely participate in complex trauma, revision arthroplasty, multilevel spine surgery, sports procedures, etc. Like many orthopedic programs, however, this immersive training environment also requires substantial sacrifice from residents in the form of long hours, overnight call, and personal time surrendered in pursuit of surgical growth.

At the same time, medicine itself has changed dramatically. Residents now train within increasingly corporatized healthcare systems that are characterized by documentation burdens, rising educational debt, escalating cost of living, and heightened concerns surrounding physician burnout and wellness.

In 2024, resident physicians across Jefferson Health and its affiliates voted to unionize, joining a growing national movement among housestaff and entering formal contract negotiations that remain ongoing over a year later. Since that vote, resident-led efforts have included informational campaigns, tabling in hospital common areas, and organized outreach aimed at building awareness across training programs, alongside periodic engagement with local labor advocacy groups in Philadelphia. While the process has remained active and visible within the institution, bargaining has unfolded gradually, with no final agreement yet reached.

This development has sparked thoughtful conversations throughout training programs, including within orthopedic surgery. Some residents view unionization as a necessary mechanism to advocate for fair compensation, parental leave, meal access, and protection from unnecessary ad-

ministrative burden. Others worry about what may be lost if residency becomes conceptualized primarily as labor rather than apprenticeship.

The resulting questions are uncomfortable but important. What happens when a surgical apprenticeship becomes organized labor? Can orthopedic residency preserve its professional roots while adapting to modern labor expectations? And perhaps most importantly: which personal sacrifices among residents remain essential to surgical training, and which simply reflect outdated inefficiencies within modern healthcare systems?

RESIDENCY AS APPRENTICESHIP

The traditional structure of surgical residency traces its roots to the Halstedian model of medical training. Early residents quite literally "resided" within the hospital, often receiving room and board rather than significant financial compensation. Training emphasized total immersion, prolonged observation, graded responsibility, and absolute dedication to patient care. The expectation was not balance, but commitment.

Orthopedic surgery adopted this culture enthusiastically.

Much of orthopedic education still occurs through apprenticeship rather than formal instruction alone. Surgical judgment cannot be entirely learned from textbooks or lectures. It develops gradually through repetition, observation, and proximity to experienced surgeons. Residents absorb not only technical skills, but operative flow, efficiency, complication management, patient communication, and countless intangible habits that define surgical mastery.

At Rothman/Jefferson, many of the most valuable educational moments occur outside formal schedules and protected Friday education time. The trauma chief resident reviewing reduction strategies with the trauma intern after a difficult fracture-dislocation. The joint arthroplasty attending who stays late after Wednesday clinic to review implant positioning on postoperative x-rays. The trauma attending drawing fracture patterns on the whiteboard during weekly trauma lectures. These moments are difficult to quantify contractually, yet they form the foundation of surgical education and culture.

This apprenticeship mentality also shapes how orthopedic surgeons interpret hardship. Long call nights, demanding rotations, and exhausting operative days have traditionally been viewed not merely as burdens, but as formative experiences. Residents often speak nostalgically about rotations that were objectively grueling. The difficult trauma block somehow becomes a source of pride several years later and is marked by the formation of lifelong friendships with co-residents that comprise the team. Operative autonomy earned through the development of trust with attendings carries emotional significance precisely because it required sacrifice on behalf of the resident to achieve.

Importantly, many orthopedic attendings view this process not as exploitation, but as investment. The educational value of orthopedic training is enormous. Residents graduate with highly specialized technical expertise, substantial earning potential, professional autonomy, and the privilege of performing meaningful procedural work. From this perspective, residency represents a temporary but necessary period of intense personal investment in exchange for lifelong professional reward.

This mentality helps explain why some surgeons feel uneasy about increasing labor-oriented language within residency. To many attendings, medicine has always been more vocation than occupation. One of our attendings recently remarked that he worried about medicine becoming viewed as a "9-to-5 job" rather than a profession in which physicians felt privileged to stay late caring for patients and pursuing educational opportunities. Whether one agrees entirely or not, the sentiment reflects a longstanding surgical philosophy: that professionalism sometimes requires voluntarily giving more of oneself than a contract strictly demands.

And yet, modern residents increasingly train within large healthcare systems that themselves function less like professions and more like corporations.

WHY RESIDENTS ARE UNIONIZING

Resident unionization did not emerge overnight. It reflects broader structural changes within medicine and healthcare economics.

Modern residents face substantial financial pressures. Medical school debt frequently exceeds several hundred thousand dollars. Housing costs in cities like Philadelphia continue to rise, while resident salaries often struggle to keep pace with inflation. Meanwhile, many residents delay major life milestones such as marriage, home ownership, and starting families during prolonged training pathways.

Orthopedic residents are not immune to these realities, even if the specialty ultimately carries relatively high future earning potential.

Beyond salary concerns, residents increasingly advocate for issues related to parental leave, meal access during overnight call, mental health resources, childcare support, parking costs, and protected educational time. Many of these requests are not extravagant. Rather, they reflect growing expectations that healthcare systems support resident physicians as both trainees and human beings.

At Jefferson specifically, these issues have become particularly visible during ongoing contract negotiations between resident representatives and hospital leadership. Simultaneously, Jefferson Health — like many major healthcare systems nationally — has faced significant financial pressures and operating challenges in recent years. This reality further complicates discussions surrounding compensation and benefits. Residents understandably seek improved support and financial stability, while institutions face growing operational constraints and healthcare economic pressures of their own.

Importantly, residents today also function within healthcare systems that differ substantially from those in which many senior surgeons trained. Electronic medical records, administrative documentation requirements, in-

surance-related tasks, and regulatory compliance consume enormous portions of resident time. Some residents feel that large components of their workload provide limited educational value while primarily serving institutional operational needs.

THIS DISTINCTION IS CRITICAL.

Orthopedic residents generally do not object to working hard. In fact, many actively seek additional operative experience and increased autonomy. The issue is often not effort itself, but whether the effort contributes meaningfully to surgical education. Most residents willingly accept educational hardship. Fewer enthusiastically embrace non-educational inefficiency.

This tension may partially explain the appeal of unionization. Residents increasingly seek mechanisms to distinguish between valuable apprenticeship experiences and unnecessary systemic burdens. In many cases, unionization represents less a rejection of professionalism than an attempt to preserve educational priorities within increasingly industrial healthcare systems.

THE ORTHOPEDIC DILEMMA

Orthopedic surgery occupies a uniquely complicated position within discussions surrounding resident unionization.

Unlike certain specialties where clinical responsibilities may function more predictably in shifts, orthopedic surgery remains deeply tied to continuity, operative opportunity, and real-time decision-making. Fractures do not respect work-hour boundaries. Operative cases run late. Trauma arrives unexpectedly. Educational opportunities are often unpredictable and impossible to schedule neatly within contractual frameworks.

Many orthopedic surgeons therefore worry that excessively rigid labor structures could unintentionally undermine aspects of surgical training culture that residents themselves value deeply.

At programs like Rothman/Jefferson, education relies heavily upon discretionary attending investment. Residents benefit enormously from surgeons who voluntarily dedicate extra time teaching, mentoring, reviewing imaging, discussing cases, or granting operative autonomy. These relationships often transcend formal employment structures and resemble traditional mentorship models more than conventional labor hierarchies.

Some fear that increasingly transactional frameworks could gradually erode this culture. If residency becomes conceptualized primarily as employment rather than apprenticeship, does the educational relationship between attendings and residents change as well? Does a "clock-in, clock-out" mentality weaken ownership and continuity of care? Can surgical excellence truly develop within strictly shift-based structures?

At the same time, advocates of unionization raise equally important points. Exhausted residents may learn less effectively, communicate less clearly, and perform less safely. Protected educational time may improve operative preparedness. Fair compensation and institutional support may reduce burnout and improve morale. Mechanisms for resident advocacy may enhance psychological safety and strengthen programs rather than weaken them.

Furthermore, many residents argue that professionalism and labor advocacy are not mutually exclusive. A resident can remain deeply committed to patient care while still advocating for reasonable working conditions. One can believe medicine is a calling while simultaneously recognizing that hospitals rely heavily upon resident labor to function operationally.

Perhaps most importantly, unionization forces orthopedic surgery to confront a difficult but necessary question: Which hardships are genuinely educational, and which are simply remnants of inefficient systems?

Staying late to assist with fasciotomies for a patient with compartment syndrome may carry tremendous educational value. Spending hours navigating redundant documentation workflows likely does not. Overnight trauma call may sharpen clinical judgment and independence. Repeatedly performing purely clerical tasks at the expense of operative exposure may not meaningfully contribute to surgical development.

Distinguishing between these categories is challenging, but increasingly necessary.

THE MODERN ORTHOPEDIC RESIDENT

The modern orthopedic resident embodies a fascinating combination of seemingly contradictory values.

Residents desire autonomy while also seeking support. They crave operative independence while appreciating supervision. They complain about call obligations while simultaneously feeling pride in surviving those same difficult call shifts. They value wellness yet often derive meaning from intense shared hardship and team camaraderie.

Orthopedic culture itself remains remarkably identity-driven. At Rothman/Jefferson, residents often speak about training not simply as employment, but as becoming part of a profession and community. Shared experiences — difficult overnight reductions, post-conference breakfasts, late-night trauma cases, missed dinners with family and friends, intraoperative victories, catastrophic complications narrowly avoided — create unusually strong social bonds within surgical training.

This culture may explain why many orthopedic residents feel ambivalent about unionization even while supporting certain union goals.

Few orthopedic residents enter the specialty hoping to work less. Most chose orthopedic surgery precisely because they enjoy operating, procedural intensity, team dynamics, and technical mastery. Many willingly spend personal time reviewing surgical approaches, studying implant systems, or practicing boards-style questions.

The historical glorification of exhaustion within medicine has weakened substantially. Younger generations of physicians increasingly emphasize sustainability, psychological health, and long-term career fulfillment. Importantly, this shift does not necessarily reflect decreased pro-

fessionalism. Rather, it may represent changing definitions of what sustainable professionalism looks like.

THE FUTURE OF ORTHOPEDIC TRAINING

Resident unionization will likely continue expanding throughout American medicine, including within surgical specialties. The broader forces driving these movements — healthcare corporatization, rising educational debt, changing workforce expectations, and increasing awareness of physician burnout — show little sign of reversing.

Orthopedic surgery therefore faces an important challenge: preserving the strengths of traditional apprenticeship culture while adapting to modern realities.

This balance will require nuance from both residents and attendings. Residents must recognize that surgical mastery still demands immersion, repetition, sacrifice, and personal investment. Orthopedic surgery cannot become a purely shift-based profession without losing aspects of the experiential learning that define excellent training.

At the same time, institutions and attendings may increasingly need to distinguish between productive educational rigor and unnecessary systemic burden. Not all suffering is formative. Administrative inefficiency, excessive non-educational tasks, and inadequate institutional support do not inherently create better orthopedic surgeons simply because prior generations tolerated them.

Ultimately, the central question may not be whether unionization is good or bad for orthopedic residency. Rather, it is whether modern orthopedic training can preserve its professional identity while evolving alongside broader societal and healthcare changes.

Orthopedic surgery has always asked residents for extraordinary commitment. The challenge moving forward is determining which sacrifices remain essential to surgical formation and which reflect outdated, futile exercises that have remained in place for generations of orthopedic trainees simply because trainees have accepted the transient nature of residency and that those who trained before them had to deal with the system as it currently exists.

Unionization is inevitable. In the changing landscape of medical training, preserving the beauty of orthopedic training must occur with intentional effort and engagement from all involved parties. Hospital systems must realize that residents have long been used to provide the highly skilled care for patients with fewer benefits and less pay than mid-level providers. Training program leadership must realize that there are often duties expected of residents that do not improve patient care or the residents' educational experience. And above all, orthopedic trainees must realize that doing what we do is a privilege. Though there certainly is a great deal of room for improvement and elimination of systemic inefficiencies that burden resident wellbeing, unionization must not select out for the intrinsic drive of residents to be obsessively interested in learning orthopedics. Orthopedic surgery doesn't neatly conform to the constraints of shiftwork – not as a trainee, and certainly not as an attending. At all levels – health systems, attendings, trainees – the current challenge is to preserve the standard of orthopedic training that has worked for the past century while discarding outdated elements which in no way improve patient care or resident education.

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