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The 2024 Medical Crisis : Challenges for Medical Education

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On February 6, 2024, the Minister of the Ministry of Health and Welfare announced a plan to increase the medical school enrollment quota by 67%, raising the number from 3,058 to 5,058 students annually over the next 5 years, starting in 2025. In reaction to this significant increase, 10,034 out of 12,464 medical residents, or 80.5%, submitted their resignations. Additionally, 13,698 out of 18,793 medical students, representing 72.8%, applied for a leave of absence. On March 3, the Korean Medical Association (KMA) organized a large-scale rally to oppose the enrollment expansion [1]. In response, the Minister of the Ministry of Health and Welfare issued an order that prohibited the acceptance of these resignations and mandated that residents return to work, warning that those who failed to comply would face a suspension of their medical licenses for at least 3 months [2]. The Minister of the Ministry of Education also directed universities not to approve any collective leaves of absence for medical students. Despite these directives, as of June 10, 2024, most residents and medical students had not resumed their duties.

The crisis was precipitated by a sudden increase in medical school enrollment, but the intense opposition from residents and medical students highlights deep-seated structural contradictions in the Korean healthcare system. Such contradictions are uncommon in the healthcare systems of other modern democratic nations. This sharp rise in medical school enrollment is likely to thrust future generations of doctors into fierce competition amid these systemic contradictions.

However, mainstream public opinion in Korean society is critical of the residents' resignations and the medical students' leaves of absence. A lawyer criticized the KMA and its leaders, comparing doctors to privileged scions of wealthy families and questioning their civic virtue as citizens of the Republic of Korea. In contrast, World Medical Association (WMA) President Lujain Alqodmani stated that doctors have a fundamental right to collective action and noted that the Korean government's harsh response is uncommon globally. She also warned that prohibiting resignations and denying leaves of absence could establish a dangerous precedent for potential human rights violations.

These divergent views highlight the significant contrast between the perspectives of a lawyer representing mainstream Korean public opinion and the WMA President concerning the collective actions of medical residents. Although it is expected that Korean doctors adhere to the norms respected by citizens of the Republic of Korea, it is unfair to criticize the rights that are generally recognized in modern democratic countries as though doctors are demanding special privileges.

The turbulence in Korea's medical education sector in 2024 is expected to eventually subside. When this occurs, what should medical educators communicate to the returning medical students and residents? Should they be told that they did well, or that they were wrong? What key lessons should medical educators learn from this experience?

Medical educators need to understand the structural contradictions in Korean healthcare that have precipitated the current crisis. Specifically, they must identify the issues within the explicit or implicit contract between doctors and society in Korea and articulate a vision for the future of Korean healthcare to residents and medical students. To achieve this, it is crucial to first understand the foundational structures of healthcare systems in modern democratic countries. Furthermore, educators must comprehend the inherent contract between doctors and society within these structures. Similarly, just as the principle of one person, one vote was instrumental in establishing democracy in Korea, the contract between doctors and society, as observed in modern democratic countries, can aid in the reconstruction of Korean healthcare.

1. The contract between doctors and society in modern democratic countries

The concept of the social contract originates from modern political philosophy. Philosophers such as Hobbes, Locke, and Rousseau explored the legitimacy of political institutions and state power, not through the divine right of kings, but from the perspective of social contracts. Their classical theories of the social contract suggest that free and equal individuals consent to establish and adhere to state power

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*The Korean version of this Opinion is presented in Supplement 1.

through mutual agreements, aiming to protect their rights.

Of course, the contract in classical social contract theory is more of an implicit agreement rather than an actual one. Nevertheless, classical social contract theory has made a significant contribution to the establishment of modern democracy by starting with the rights of free and equal individuals to determine the legitimacy of political institutions and state power [3].

The concept of a social contract was developed by thinkers of the European Enlightenment and was eagerly adopted by the citizens of the newly founded United States in the 18th century. This adoption was driven by their desire to base social relations on a more explicit contract, rather than on ambiguous notions such as noblesse oblige or gentlemanly honor [4].

The first professional code of medical ethics, established by the American Medical Association in 1847, clearly embodies the concept of a social contract. The initial chapter of this Code of Medical Ethics is titled "Duties of Physicians to Their Patients and Patients' Duties to Their Physicians." The subsequent chapter addresses the "Duties of Physicians to Each Other," and the third chapter covers the "Duties of the Profession to the Public and the Public's Duties to the Profession [5]." This pioneering American Code of Medical Ethics was designed to establish mutual obligations, reflecting a social contract perspective, rather than imposing unilateral duties on one party.

Generally, by examining the expectations that society has of doctors and the expectations that doctors have of society, we can broadly define the terms of the social contract between them. Society expects doctors to provide the services of a healer, guarantee competence, offer altruistic service, exhibit morality and integrity, maintain transparency, and ensure accountability. Conversely, doctors expect autonomy, trust, monopoly, status and rewards, self-regulation, and a functioning healthcare system from society [6].

In modern states, however, the social contract related to doctors is not entirely implicit. The healthcare system has become integrated into the national framework, firmly established through laws and institutions. While the specifics of healthcare systems may vary based on social and cultural traditions, as well as history, there is a fundamental framework common to the healthcare systems of modern democratic countries. It is within this framework that the universally accepted social contract is embedded in the healthcare systems of these countries.

For example, the structure of the UK healthcare system is organized as follows: First, all citizens are entitled to receive public care (National Health Service [NHS] treatment) at no cost when it is needed. Second, accessing free NHS treatment requires waiting in line. While emergency patients are treated promptly, those with non-emergency conditions face longer wait times. This waiting period is a drawback of the free healthcare system. Thirdly, the sequence in which patients receive free NHS treatment is determined by general practitioners (GPs), who operate as independent contractors. If a GP deems hospital treatment unnecessary, the patient will not be eligible for such treatment, regardless of their personal preference. Essentially, GPs serve as gatekeepers. Lastly, patients who are unable to wait for NHS treatment have the option to seek private care at their own expense. Importantly, the use of private care does not affect a patient's eligibility for NHS treatment [7].

Understanding the structure of the UK healthcare system reveals the framework of the social contract between doctors and society. First, doctors have the option to practice either in public or private care, meaning they are not obligated to work in the public sector. Second, they can either be employed by public healthcare institutions or work as private practitioners who contract with the public healthcare system, with both roles being integral to public care. Third, doctors employed in public institutions are permitted to engage in private practice during their free time, provided they meet their contractual obligations to the public system. Finally, the state promotes doctors' involvement in public healthcare through various policies, such as subsidizing their pensions and covering liability for compensation in the event of medical accidents.

Western democratic countries' healthcare systems can be divided into those funded through taxes (e.g., the NHS in the United Kingdom) and those funded through insurance premiums (e.g., the National Health Insurance). Despite these differences, the social contract between doctors and society in these countries closely resembles that of the UK healthcare system. For instance, in 36 of the 37 Organization for Economic Cooperation and Development (OECD) member countries, with the exception of South Korea, doctors employed in the public healthcare sector are also permitted to work in the private sector during their free time [8].

2. The distorted structure of Korean healthcare and the consequences of a sudden increase in medical school enrollment

Korean healthcare has achieved significant accomplishments in a relatively short time. According to OECD statistics, the quality and accessibility of healthcare in Korea are outstanding relative to the country's healthcare spending. At first glance, the Korean healthcare system seems to be thriving. However, it raises the question of whether there is an appropriate contract between doctors and society in Korea. For a long time, the Korean government has overlooked the basic rights of doctors, implementing policies that are both unilateral and authoritative.

The Korean healthcare system is globally unique and has substantial distortions. Through a mandatory designation system, Korea integrates all doctors and private medical institutions into its public health insurance system. This system enforces predetermined health insurance fees, resulting in a series of obligatory audits and fee reductions. The imposed low fees are unsustainable without subsidization from treatments not covered by insurance or from practices that rely on high volume and low margins. Additionally, the system requires doctors to participate without offering compensation for their extensive training and experience. This is akin to setting the same salary for both entry-level and senior officials, such as directors and ministers.

Moreover, the criminalization rate of medical malpractice in Korea is notably high. Research indicates that between 2011 and 2015, the average number of criminal prosecutions for medical malpractice per 100 doctors was approximately 265 times higher than in Japan. With the government's enforcement of ultra-low fees and the soaring compensation costs for medical accidents, there is a rapid exodus of young doctors from high-risk essential medical fields.

Meanwhile, the government provides minimal support for medical education and residency training. Medical school tuition falls solely on the students and their families. Due to strict government regulations on university tuition fees, many medical schools are forced to fund their educational activities through profits generated by their affiliated hospitals. Resident working hours are particularly grueling. The Korean Labor Standards Act stipulates that employers cannot mandate employees to work more than 52 hours per week. Despite this, residents are often required to work up to 88 hours per week, with many reporting nearly 100 hours of work. To maintain extremely efficient treatment systems at low cost, university hospitals depend heavily on the inexpensive labor provided by residents, exacerbated by the government's strict control over hospital fees.

In this context, the government has significantly increased medical school enrollment, a move that appears to lack rational basis. Despite claims of extensive discussions with the medical community, these assertions have been refuted, with several authors of the reports used to justify the policy stating that their findings were misrepresented. Furthermore, the government has not provided a scientific rationale for the increase in enrollment. The criteria and processes used to allocate additional slots to individual medical schools were not transparent. There was no assessment of the schools' capacity to effectively educate the increased number of students. Additionally, the implications of this abrupt increase in national healthcare expenditures were not analyzed. Similarly, there was no consideration of the potential increased burden on the younger generation, particularly in the context of rapid aging and extremely low birth rates.

The government pushed the policy of a rapid expansion of medical school enrollment under the pretext of reviving essential and regional healthcare, based on the perception that the collapse of essential healthcare stemmed from a disproportionate emphasis on lucrative cosmetic procedures and indemnity insurance, which skewed earnings among doctors. Therefore, the government posited that by expanding the number of medical professionals, the cosmetic medical field would become saturated. This saturation, in turn, was expected to compel medical personnel to transition towards essential and regional healthcare services.

However, the challenges facing essential and regional healthcare in Korea are not due to a shortage of doctors. Instead, they stem from enforced ultra-low fees, the criminalization of medical accidents, and a rise in civil compensation for medical accidents, all without sufficient support for essential and regional healthcare. Without addressing these issues, a rapid increase in medical school enrollment could devastate rather than revive essential and regional healthcare. Young doctors are likely to abandon high-risk essential medical fields and regions with low patient populations.

3. The need for a new social contract in Korean healthcare

The social contract between doctors and society is not fixed. It varies among countries and is influenced by cultural, economic, and political factors. Paul Starr observed that during the 1970s, as healthcare costs in the United States skyrocketed, there was a process of renegotiating the social contract between the medical profession and society.

Currently, South Korea is experiencing demographic shifts characterized by a rapidly aging population and ultra-low birth rates, along with rapid advancements in medical technology. These changes are intensifying social tensions surrounding healthcare coverage. Korean doctors find themselves at a crossroads, necessitating the formation of a new social contract with society.

However, the government has failed to support a reasonable social contract between doctors and society. Instead, it has fueled public animosity towards doctors with high earnings. Nonetheless, the financial struggles of the trauma center led by the esteemed Dr. Lee Guk-jong illustrate that essential healthcare services are sustained by doctors committed to working under difficult conditions. While it is true that some doctors earn significant incomes from cosmetic procedures or indemnity insurance, it is unjust to impose policies that place additional burdens on those dedicated to essential healthcare. This strategy will not address the underlying issues.

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Healthcare policy frequently aims to achieve goals that may conflict with one another. The Korean healthcare system is tasked with providing universal healthcare coverage to all citizens, curbing the rapid rise in national healthcare expenditures, and ensuring patients' individual choices. To meet these objectives, it is essential to establish a reasonable social contract both between doctors and society and between doctors and patients.

The distortion in Korean healthcare primarily stems from the government's unilateral and authoritarian policies. Without a fundamental restructuring and the establishment of a social contract that respects mutual rights and responsibilities, proper reform of Korean healthcare remains unattainable. Korean doctors should not seek privileges beyond those available to other citizens, nor is there a need for such privileges. Instead, they should recognize and promote the social contract typical of healthcare systems in modern democratic countries. Although the journey may be long and challenging, it represents the only path toward normalizing patient care and restoring the dignity of doctors.

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Conflict of interest

No potential conflict of interest relevant to this article was reported.

Authors' contribution

Hyoung Wook Park: collected data, wrote the manuscript, wrote the references, and conducted the overall writing of the paper.

Supplementary materials

Supplementary files are available from https://doi.org/10.17496/kmer.24.021

Supplement 1. Korean version of "The 2024 medical crisis: challenges for medical education"

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