COLLECTIVE BARGAINING AND STRIKES AMONG PHYSICIANS

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Unlike employees in other sectors of the economy, health care workers are directed toward one ultimate goal: making people well and keeping them healthy. The development of collective bargaining and union activities during this century has had a great impact on all industries in the United States and the western world. However, only in recent years have workers in the health care sector been affected by the organized labor movement. The history of collective bargaining and strikes among physicians, the key decision-makers in the health care sector, is even more recent. Because of their central position, physicians' collective activity has had and will continue to have tremendous implications for the viability of the present health care system and the quality of patient care. Even though most physicians continue to function as individual, entrepreneurial service providers and "professionals," physicians as a group are more frequently being seen as members of a utility-like industry. Their importance to individuals and society as a whole, it can be argued, is second to none; if physicians refuse to work there can be no worse set of outcomes. To estimate the potential future impact of growing collective action on the part of physicians, this article explores the general historical developments.

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LEGISLATIVE BACKGROUND

The Wagner National Labor Relations Act, adopted in 1935, guaranteed all workers the right to unionize and bargain collectively. In prior years, organized labor activity was neither condoned nor prevalent. Employees of health care institutions, whether those institutions were proprietary or nonprofit, were not specifically exempted from the act. The definition of health care institutions included all hospitals, nursing homes, and other inpatient facilities.

In 1947, the Taft-Hartley Act significantly altered the laws relating to labor and collective activities. The definition of an employer bound by this act and other labor laws was amended to specifically exclude "any corporation or association operating a hospital if no part of the net earnings inures to the benefit of any private shareholder or individual."[1] The reasoning behind the exemption included a general attitude that nonprofit hospitals were purely charitable institutions and not actually involved in interstate commerce. Nonprofit hospi-

tals, which constituted nearly all the inpatient facilities at the time, were local in character, serving only the immediate community. It was also thought that labor activity and strikes would have an unusually devastating effect on the care of the sick. Congress responded to these arguments by exempting workers in nonprofit hospitals from the major right-to-organize labor law, essentially removing the possibility of strikes.

In 1974, under intense pressure from organized labor and hospital employee groups, the nonprofit hospital exemption was repealed in the form of PL 83-360.

HISTORICAL BACKGROUND

The first mention of labor unions in government hospitals was made in an article in the San Francisco *Chronicle*, June 8, 1919.[2] Several hospitals in both California and Illinois had been organized by then. Labor organization in nongovernment hospitals was first noted in 1936.[2]

The first recorded work stoppage in a hospital came in 1937,[3] when Local 171 of the Hospital Employees Association struck the Jewish Hospital of Brooklyn. The hospital received an injunction, which was upheld in court, prohibiting the union from striking. The Hospital Employees Association was affiliated with the American Federation of Labor (AFL) at the time. The AFL, however, subsequently revoked the union's charter, indicating that it would not sanction strikes in hospitals.

Since that time, organized labor activity and strikes have increased markedly in the health care sector. In 1976, 71 work stoppages involving 49,500 workers and 609,400 idle days were noted (Table 1).[4]

In recent years, there has been a great upsurge in union activity in the health care industry, partly because unions need to increase their membership. Lublin[5] noted, "In the past, efforts by health care managers to keep unions out were aided by worker resistance. But unprecedented layoffs and wage cuts among health care workers are making the unions' task easier." Lublin further noted, "Many nurses, pharmacists, and other white-collar employees regarded union affiliation as unprofessional and potentially harmful to patient care. And the lesser-skilled, low-paid women who are typically found in nursing home staff know that they are disposable and fear that union affiliations will cost them their jobs during a strike."[5] Nonetheless, union activity has become prominent, especially with the Hospital and Health Care Employees Union, the American Federation of Teachers, the American Federation of State, County, and Municipal Employees, the Teamsters, the Service Employees International Union, and the United Food and Commercial Workers Union. With the increased competition among health care institutions and the upsurge in for-profit hospital chains, union activity will continue to grow.

Collective activity and strikes among physicians have occurred primarily among two groups. The first group represents physicians still in training—the interns and residents, or "housestaff." The second group is practicing physicians, whether practicing privately or salaried.

Union Activity Among Housestaff

From the early part of the 20th century up to the 1940s, housestaff generally was unpaid, worked long hours (24 to 48 hours a shift), and received no benefits other than meager housing and meals. Dissatisfied with these conditions, intern representatives from 26 New York City hospitals banded together as the Intern Council of Greater New York in April 1934. One year later, the Council was able to negotiate a salary of $15 per month for interns working in municipal hospitals.

Organized activity among housestaff did not resume until 1958, when interns and residents in New York City formed the Committee of Interns and Residents (CIR). The Intern-Resident Association was formed in Los Angeles in 1965. Several isolated instances of housestaff organizing and work stoppages, or "heal-ins," were noted in following years. The major demands were for increases in salary and benefits, improved patient care, and reduced patient loads for housestaff.

A national housestaff conference to establish a national organization was held in St. Louis in 1971. Representatives from hospitals across the

TABLE 1. WORK STOPPAGES IN PRIVATE-SECTOR MEDICAL AND OTHER HEALTH SERVICES, 1967-1976[4]

Beginning Year	No.	No. of Workers Involved	Total Worker Days Idle
1967	27	1,550	71,400
1968	28	6,000	59,500
1969	43	5,900	84,000
1970	49	6,000	102,400
1971	36	3,700	46,900
1972	47	9,100	116,600
1973	56	43,300	336,200
1974	44	14,300	263,700
1975	63	11,300	197,500
1976	71	49,500	609,400

United States drew up a "bill of rights" for patients and a "bill of complaints" for themselves. They also approved a uniform housestaff contract, a minimum wage with annual cost-of-living adjustments, and a list of minimum fringe benefits. The patients' "bill of rights" called for, among other things, an ombudsman at all hospitals. The following year, two more national meetings were held, culminating in the formation of the Physicians National Housestaff Association (PNHA). PNHA would designate itself as a labor union four years later.

In 1975, CIR struck 21 of the 23 hospitals of the League of Voluntary Hospitals in New York City. The four-day strike was the largest recorded walkout of its kind by physicians. Soon after the CIR strike, interns and residents struck the three major county hospitals in Los Angeles. The strike at two of the hospitals was settled in three days, but the strike at the Martin Luther King, Jr, Hospital lasted seven days. Housestaff won a 5 percent wage increase and binding arbitration of patient care issues. The agreement included the establishment of a $1.1 million fund to improve nurse staffing, interpreters for Spanish-speaking patients, and improved ancillary care services.

Later in 1975, interns and residents at Cook County Hospital in Chicago staged an 18-day walkout. This strike, like its counterparts in New York and Los Angeles, was primarily aimed at improving patient care. The walkout took place despite a temporary restraining order the hospital had obtained in court. The same court mediated a settlement of the strike, including increased housestaff salaries and new medical equipment for the hospital. However, seven of the union leaders were found in contempt and sentenced to ten days in jail. The medical attending staff of Cook County Hospital supported the housestaff, and one department chairman was fired for his outspoken sympathy. After several suits, the US District Court issued a permanent injunction against his dismissal.

In 1976, a movement led by large teaching hospitals culminated in a historic decision designed to thwart organizing and strikes by housestaff. In that year the National Labor Relations Board (NLRB) ruled that interns and residents were students and hence had no status under the National Labor Relations Act. Since that time, PNHA has confined its activities to public hospitals, where the NLRB has no jurisdiction, and has pursued reversal of the ruling in the courts.

The American Medical Association has gone on record as favoring the right of housestaff to bargain as employees, but the Association of American Medical Colleges and the American Hospital Association have continued to support the NLRB ruling. Arguments on both sides of the issue continue. Those supporting the NLRB ruling consider

housestaff mainly students, still learning their medical specialty under the direction of faculty or attending physicians. Those opposed to the NLRB ruling consider housestaff primarily service employees and cite their provision of patient care. Relman[6] has supported the NLRB ruling, writing that

> unionism, collective bargaining, and the industrial model of labor relations are not only irrelevant but inimical to the basic purposes of a residency . . . I believe in the fullest possible participation of residents in the institutional decisions affecting the conditions of their training and the care of the patients whom they treat. But this relation should be collegial, not adversarial; professional, not industrial; above all it should be tempered by the recognition that residents are both students and physicians. For the latter reason, if for no other, house officers should not contemplate the use of the strike.

Union Activity Among Practicing Physicians

The first recorded strike among practicing physicians took place in New York City in 1966, when the Doctor's Association, representing some 1,500 physicians, dentists, and optometrists, walked out on the city's health centers and clinics in a protest over wages. Within a few years, it became obvious that the formation of a physicians' union, as in industrial situations, was intended to protect the workers' status. However, unlike any other union movement, the impetus was to band together to maintain independence. Noting the increasing number of salaried, hospital-based physicians, and the increasing restrictions on private practitioners, Schwartz[7] has written:

> Taking these two trends together—the rapid increase of physicians who are simply hired workers and the increasing loss of independence of physician-entrepreneurs—the conclusion seems indicated that we are in the midst of a process of collectivization of American doctors, one aimed at a reduction of their status and of their economic well-being and perhaps eventually their full proletarianization . . . As I view these trends, I am convinced that they must inevitably persuade physicians that they need militant union protection as much as journalists, college professors, or auto workers. The question . . . is merely who will provide the needed vehicle. Will it be an American Medical Association changed and revitalized to meet the needs of a new era, or will it be one of the newer, militant groups now aspiring to fill the gap created by the AMA's reluctance or inability to meet the needs of a very new time?

In 1972, the Service Employees International Union announced the formation of a physicians' union in Nevada. Later that year the Union of American Physicians and Dentists was founded. To counter the formation of physician unions, the AMA adopted a resolution in 1975 stating that "it is appropriate for medical societies to aid, assist, or represent interns and residents and attending physicians individually and collectively in resolving disputes with hospitals and others."[8] The AMA subsequently established a department of negotiations to lead and assist physicians in bargaining. The concept of unions, collective bargaining, and strikes for practicing physicians had at last come of age. Since that time, several physician unions have been certified by NLRB.

The most significant development leading physicians to act collectively was the malpractice insurance crisis from 1975 through 1977. Because of significantly higher numbers of malpractice suits and amount of awards, physicians' malpractice insurance premiums increased up to fourfold. In response, many physicians, acting either as unofficial groups or under a union, refused to pay premiums and did not work except in emergencies. Actions were particularly prominent among surgeons and anesthesiologists, physicians who paid relatively higher malpractice premiums and were the hardest hit by malpractice suits. These strikes led to legislative intervention to limit malpractice awards and lower premiums. Some physicians began practicing without malpractice insurance, and others formed their own malpractice insurance companies.

ISSUES FOR THE FUTURE

The attitude among physicians toward unions, collective bargaining, and collective action has

changed dramatically. Faced with decreasing control over their professional careers, physicians have turned to the same tactics used by teachers and other work groups. In a study of graduates from a New York medical school, Wassertheil-Smoller et al[9] noted that 67 percent of intern and resident graduates believed that physicians should be allowed to strike. Sixty percent of physicians in private practice supported strikes by physicians.

However, the public policy issue remains: should physicians be allowed to strike? Their importance to society, communities, and individuals is certainly as much as that of police or air traffic controllers, two groups that are not permitted to strike. Can physicians be considered a public utility whose function is too important to allow strikes for resolving collective issues?

Despite their altruistic dedication to service and patient care, despite arguments that professionals should not feel the necessity to resort to laborers' tactics, and despite the critical importance of their contribution to maintaining the health of all people, physicians should continue to be able to act collectively to address and resolve issues. They should continue to bargain for their own betterment. Only as a last resort should physicians be able to withhold their services to emphasize their concerns, and then only with the exception of caring for emergencies. In truly critical situations, physicians must always respond.

Although intern and resident physicians are to an extent students, their contribution to patient care cannot be minimized. They too, in whatever hospital, should be allowed to collectively bargain and strike if necessary. As long as the consequences of their collective activity ". . . never do harm to anyone," as mandated by the Hippocratic Oath, physicians should have the same rights as other labor and professional groups in terms of collective bargaining, union activity, and strikes.

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