Throughout medical history, physicians have rarely formed unions and/or carried out strikes. Today, the medical profession worldwide seems in a heightened state of discontent, but their chosen directions to fight back over their conditions of labor appear blurry and ineffective. As mentioned in previous chapters of this book, the profession of medicine has been facing ongoing threats to their professional practice for many years now. It was Carr-Saunders and Wilson who are credited with describing the transition of occupations into professions (Carr-Saunders & Wilson, 1933). The concept of a professional was defined as possessing the following traits:

- Specialized skill and training
- Minimum fees and salaries
- Formation of professional associations
- Code of ethics

The professional as defined above is supposed to act in the best interest of their client/patient, and they (along with their fellow professionals) determine what is good or bad, and the client/patient has no choice but to acquiesce to that judgment (Greenwood, 1957). Scott states that professionals participate in two systems, the profession and the organization they work in. The professional association place limits on what the organization the professional works in may or may not ask that member to do in carrying out its missions and goals (Scott W. R., 1966).

With the continual increase in corporatization schemes, physicians continue to be drawn into the role of employee of ever-larger organizations which leave the independent physician-run practice behind; it has become financially more and more difficult to maintain a practice while procuring sufficient reimbursement from insurance companies and patients (Rosenthal, 2014). As a result, they are not able to maintain their professional independence which would allow them to act as their patient’s agent in determining what would be done and where it would be done. Because they now have to obey the corporate mandate of cost cutting and revenue enhancement, they no longer have free rein to do as they wish in their professional practice.
Braverman describes the separation of “intellectual work from the work of execution” which he describes as a “technical condition” used by hierarchical organizations that controls “both the hand and brain worker,” improves profitability, and naturally serves everyone but the “needs of the people” (Braverman, Labor and Monopoly Capital, 1974). Thompson (1983) expands on that concept by enunciating the capitalist labor process as having the following tendencies:

- Deskilling
- Fragmentation of tasks
- Hierarchical organization
- Division between manual and mental work
- Struggle to establish the most effective means to control labor

The change of social form of labor from self-employed to employment within an organization is an inevitable outgrowth of corporate capitalism. As more and more physicians went from self-employment and loose associations through admitting privileges to actual employees of those organizations, such transitions completed the process of capturing all means of healthcare production within the organization itself. Krause describes the decline of medicine as a professional guild particularly as the profession lost the ability to control the numbers entering the profession with the federal government-enforced expansion in the 1960s (Krause, 1996). The leverage was primarily over federal research dollars that institutions would lose grant monies unless they increased the size of their graduating classes. Once they lost control of how many could enter the profession, they began to lose their uniqueness and regulation, so standardization became paramount subject to the bureaucratic machinery (Weber, 1978). Waitzkin further described the proletarianization of physicians that occurred in the 1980s (Waitzkin, 2016). He states that physicians were free to choose their working hours, the staff who supported that work, how much time and effort to spend on patients, and most importantly what they could charge for those services. Since doctors now mainly work for corporations, all of those decisions are made by their corporate bosses, which has led to loss of autonomy as well as satisfaction with the profession.

Freeman underscores this concept by pointing out that Marxists believe that the highly educated workforce will be “locked out of participation and decision making that they constitute the new working class” (Freeman, 1979). And as increasing uncertainty over changes occurring in health care accelerates more, more physicians are opting for salaried positions within organizations with its attendant loss of control over the conception of their work (Rosenthal, 2014). They find their bargaining power continually undermined and diminished by both the healthcare organizations in which they practice and insurance companies they must bargain reimbursement rates. In addition, as employees of organizations, they find themselves in “at-will” employment, which means they can be hired and fired at will, for good reasons, bad reasons, or no reason at all. Given organizational metrics performance often imposed without professional input, it is certainly not a stretch to believe that physicians may
find themselves having to meet productivity measures to maximize revenue often at the expense of patient care quality. The pressure to see more patients in a given day will increase as productivity pressures are pressed. Physicians will face removal from practice panels with interference in physician/patient relationships and then be subject to economic credentialing by hospitals (Black, 2012). The problem with economic credentialing is that it substitutes economic criteria over quality concerns and can remove physicians from practice for criteria that has little to do with a physician’s clinical competency (Dallet, 1994).

Given these ongoing threats to the profession of medicine, one wonders whether collective bargaining and striking would grant physicians leverage in dealing with their employers and whether they would be able to reconcile that choice with their oath to “do no harm.” A 2010 Physicians Foundation Report remarked that “most physicians will be compelled to consolidate with other practitioners, become hospital employees, or align with large hospitals” (Miller, 2010). Since that time, little has improved in the morale of physicians in employment practice. In a more recent report, it has been noted that 78% of physicians, surveyed sometimes, often or always feel burned out, while only 12% rarely or never feel burned out (The Physicians Foundation, 2018). The increasing time spent on paperwork vs. patient care is taking its toll with an increasing dislike of electronic health records, one of the primary causes of increasing dissatisfaction (Guwande, 2018).

But would unions and collective bargaining truly help physicians regain some measure of control over their work life? Malinowski, Minkler, and Stock believe that union membership “can help in defining health-related problems and solutions, reaching out to affected workers, disseminating research findings, and advocating needed changes” (Malinowski, Minkler, & Stock, 2015). Hagedorn et al. elaborate that concept in that “labor union contracts create higher wage and benefit standards, working hours’ limits, workplace hazards protections, and other factors. Unions also promote well-being by encouraging democratic participation and a sense of community among workers” (Hagedorn, Paras, Greenwich, & Hagopian, 2016). Their findings suggest that while health practitioners have not typically looked to labor organizations for promoting the public’s health, unions can address and improve the social determinants of health of their membership through better income, more job security, and a better work-life balance. For example, the National Union of Healthcare Workers (NUHW) went on strike at Salinas Valley Memorial Hospital in California to protest plans to cut more than 100 staff, while at the same time, the hospital was planning large payments to a departing CEO and outside consultants. Also at the same time, the hospital was cutting patient care staffing to increase operating surplus, which put the hospital’s patients at increased risk of an adverse event (Brenner, 2011). The daylong strike was followed by a 2-day lockout by the employer in what was deemed retaliation for union activity. These hard core tactics by employers have increased over time with outright refusals to recognize duly authorized bargaining representatives happening.
In 2016, when Advocate Health System in Chicago took over 56 Walgreens in-store clinics, the 160 nurse practitioners sent a demand to Advocate to bargain, but was met with a refusal to meet and recognize the union. Unfair labor practices were filed with the National Labor Relations Board (NLRB) after which the Board found sufficient evidence to file a complaint to the Federal District Court. Advocate’s response is typical of employers who value a “direct” relationship with their employees rather than have to meet with a third party union to negotiate terms and conditions of employment (Sweeney, 2017).

Barbash (1984) describes conditions that create worker proneness to unions, which are:

- Their bargaining power as individuals
- The threat which cost discipline presents to them
- The work groups’ ability to mount an effective response
- The employer’s ability to counter that response
- The ways in which the external economy and society abet or discourage the forces of cost discipline and protectivism
- Worker’s personal characteristics

But since 1979, national union membership, especially in the overall private sector, has declined significantly. On bread-and-butter issues, it appears that the decline in the labor movement has led to several phenomena that are not good news for labor itself (Rosenfeld, Denice, & Laird, 2016). Among the findings were:

- An annual wage loss of $2704 per worker which spread out over 40.2 million nonunion private sector men comes to $2.1 billion fewer dollars.
- An increase in weekly wages of about 2–3% for working women if union density had remained at 1979 levels.
- An estimated 8% higher wage for non-college graduate workers if union density had remained at 1979 levels (vs. 2015 levels) which meant $3016 less annually.
- Last, “union decline has exacerbated wage inequality in the United States by dampening the pay of nonunion workers as well as by eroding the share of workers directly benefitting from unionization” (Rosenfeld et al., 2016).

These findings support the notion that a strong union presence can set pay and benefit levels that nonunion employees tend to follow. One study found that unions can offer black workers “higher wages, and better access to health insurance and retirement benefits than their non-union peers” (Bucknor, 2016). An earlier study found that “unionization raised service-sector workers’ wages by 10.1% -- about $2.00 per hour -- compared to non-union service-sector workers with similar characteristics” (Schmitt, 2009). The report goes on to state that “service-sector workers who are able to bargain collectively earn more and are more likely to have benefits associated with good jobs. The data, therefore, suggest that better protection of workers’ right to unionize would have a substantial positive impact on the pay and benefits of service-sector workers.”
The Origins of Unionization and Collective Bargaining

The erosion of individual liberties in employment can be traced back to the Industrial Revolution, in which individuals became less self-sufficient and more beholden to others to earn a living. For the purposes of this chapter, we won’t include indentured servitude or slavery in this discussion but rather focus on that point in time in which free individuals routinely engaged in working for others, whereby they traded autonomy for a more consistent way to make a living. As industrialization grew, administration of an ever-complex workforce and economy became necessary (Dulles, 1966). Initially skilled workers formed craft guilds which allowed them to separate themselves from their overseers and the vagaries of the market (Krause, *Death Of the Guilds: Professions, States, and the Advance of Capitalism, 1930 to Present*, 1996). As differences between capital and labor became greater, workers responded by attempting to band together to protect themselves. Many of these attempts were doomed to failure primarily because of either legal action taken against them by employers (such as criminal conspiracies and restraints of trade and workers organizations became enjoined from their activities). A secondary reason for their failure was that they attempted to do too much, that is, they attempted to unify a workforce that had different needs and desires, not to mention different skills (Rayback, 1966).

Unions act as a hedge against economic insecurity caused by “part-time work and unpaid internships to the exploitation of student athletes to increasing number of Uber drivers and other “gig economy workers” (Bivens et al., 2017). Younger workers seemed to be more amenable to labor unions than their older colleagues primarily because they entered the workforce when these labor issues were becoming entrenched in the workplace (Breunig, 2015).

As previously mentioned, unionization and collective bargaining appear to be waning movements in the United States especially in the private sector. With the latest decision by the Supreme Court, they could be on the wane in the public sector as well (Janus v. American Federation of State, County and Municipal Employees, 2018). However, since that ruling in June 2018, it appears that public sector unions have not lost as many members as predicted and some have increased their membership (DiSalvo, 2019). Current union membership in 2018 is around 10.5% of workers, down from 35–40% in 1983 (Rho & Brown, 2019).

But it was noted in this report that the group with the largest growth in the private sector unionization was professional and related occupations, leading one to believe that unions and collective bargaining may be useful in gaining back power in the workplace to better control pay and conditions of work. Data from 2019 shows that the rate of unionization for private sector workers is 6.2% while public sector unionization rates are at 33.6% (Bureau of Labor Statistics, 2020).

So what about physicians? Could unions and collective bargaining be an answer to the ongoing threats of corporatization to their profession? It is clear that large
numbers of physicians have never sought out unionization in the United States, primarily because of the individualistic nature of American physicians, but also the result of antitrust concerns caused by individual and independent practitioners banding together to set prices and restrain trade. As physicians have evolved from independent practitioners to employees of large group practices, faculty foundations, and/or healthcare systems, this legal barrier to organizing has evaporated. However, the belief that a pursuit of collective solutions to what many consider an infringement of their individual rights and professional prerogatives continues to confront physicians.

Magali (1977) states that the very idea of an independent professional who is used to going it alone would join a union is a contradiction because it would cause one to surrender that autonomy which is at the heart of a professional endeavor. But to this point, professionals can and do join together to protect their professional autonomy against the “collective colossus” (Magali, 1977). It’s an odd conundrum in that physicians and their professional associations were hugely concerned with threats to their autonomy and the profession from the government so they never saw the corporate takeover of medicine and health care while at the same time rejecting collective bargaining, the one hedge that could effectively combat that corporate takeover, they rejected outright.

For those physicians who do consider collective action and the organizations who would represent them, Aronowitz warns that professionals demand more than dealing with the usual salary and working conditions issues; they also expect a union to act as a professional association to address the issues of knowledge as well (Aronowitz, 1998). Page states that collective bargaining, unions, and strikes can be helpful for employed physicians who have lost control of their workplace and profession; what remains unclear is who would avail themselves of the opportunity to participate and join these organizations (Page, 2016). Page suggests that the future of physician unions would likely involve more interest in control over the profession rather than pay raises and other bread-and-butter issues.

**What Exactly Do Unions Do?**

In a seminal text from 1970, Hirschman (1970) describes how an employer finds out about its shortcomings. The first way is through exit, either customers stop buying their product or employees leave the firm. Management is compelled to find out why revenues declined and how to fix the problems that exit represents. The second is through voice, that is, direct expression of dissatisfaction by customers and employees to management with the expectation that dissatisfaction will be actually addressed because customers and employees have sufficient leverage to get employers to listen and act.

In 1970 there were limited forums that one could articulate voice, but in 2019 there are multiple platforms in which to express one’s displeasure (e.g., using Yelp, Facebook, and Twitter to express displeasure with doctors online). It is through
this second mechanism of voice that unions can become an effective tool in both
enunciating employee’s collective voice not only over wages and conditions of
employment but, in the case before us, to the type of care a physician might provide
to an organization’s patients (Freeman & Medoff, *What Do Unions Do?*, 1984).
This enhanced voice function that a union could provide would reduce exit, which
would consequently reduce turnover costs, training costs, and work disruptions.
They found that the presence of a union enhanced loyalty, which coincidentally
increased the employer’s incentive to invest in their employees, which can in turn
lead to increased productivity (Freeman & Medoff, *What Do Unions Do?*, 1984).
When voice and loyalty were not present in sufficient quantities, then exit became
an increasingly viable solution. As Harmon pointed out in his article on the history
of resident and intern unions, “Intern and resident organizations were responsible
in part for persuading organized, medicine and medical education to listen to its
younger colleagues” (Harmon, 1978). He goes on to predict that “As with teach-
ers, nurses, and airline pilot, doctors persist in seeking a strong voice in decision-
making through negotiated contracts. This outcome seems to become inevitable
as institutions in our society continue to be larger and more complex.” Scheffler
reinforces the notion of voice “if physicians are to have an effective seat at the table
with the corporate executives and bean counters of today’s managed care world,
and warrant widespread public support in the process, their collective voice must be
backed by economic power and legal standing. As physicians are increasingly com-
ing to understand about the managed care market, where there is no exit [emphasis
added], a wise and disciplined voice is not only the best course of action, but also
the only viable one” (Scheffler, 1999).

Through the 1980s and 1990s with the growth of health maintenance organiza-
tions (HMOs) and preferred provider organizations (PPOs), it became clear that
discontent was building from physicians (Hadley & Mitchell, 1997). Physicians in
self-employed private practice were not able to organize for the purpose of collec-
tive bargaining since it would indicate an illegal restraint of trade because they are
not in a defined employer-employee relationship so there is no one employer with
whom they can theoretically bargain. Nevertheless, there were numerous incidents
of HMOs bullying practitioners, removing them from the practice panel, stealing
their patients, and telling them what decisions had to be made for economic pur-
ishes of professional autonomy because this historically was the rallying cry of the
bulk of the conservative profession. Yet there was no apparent strike activity related
to the managed care movement, and physicians had little alternative but to complain
in their periodicals and at their professional meetings (Berenson, 1991).

One professional group in the healthcare arena that has taken to unions and
collective bargaining is nursing. Nursing has been able to make great strides in
improving their practice situations and their economic remuneration as a result of
embracing collective bargaining as a solution to what ailed them. This included a
judicious use of the strike weapon to enforce their positions at the bargaining table.
It is the subject of this chapter to highlight why and how medicine and physicians
might do well to follow suit. Physicians as a rule have difficulties with the strike
weapon primarily because they see withholding services of any kind for any reason as appearing unethical. In order for physicians to get past this ethical issue, they might need to understand that striking could be an ethical response to protest organizational imperatives that violate their professional practices and norms, such that longer-term goals in patient care can be met and improved upon. For some on the academic side of nursing, unionization “conjures up not the image of Rosie the Riveter but rather that of a Handmaiden gone strident” (Gorman & Westing, 2013).

The question is: Would these nursing findings translate to the much higher paid profession of medicine? Other highly paid professions who are unionized may yield some clues on how that may work. For example, the Chicago Symphony Orchestra is a unionized orchestra that recently went on strike to protest a change in the retirement plan that would have shifted from a defined benefit plan to a direct contribution plan. Also at issue was salary as it relates to how comparable orchestras across the country were paid (Reich, 2019). The strike was settled after 7 weeks with the help of Chicago Mayor Rahm Emanuel, which included a 13.25% increase in base salary over 5 years, as well as maintenance of the defined benefit plan, but a shift to a defined contribution plan for those members hired after July 2020 (Johnson, 2019). University professors at the University of Illinois at Chicago have unionized in the past few years. As Janet Smith, a University of Illinois at Chicago professor and head of the union stated, while professionals do different kinds of work, they still remain laborers and thus have to resort to tools that laborers use to gain voice in the workplace (Rhodes, 2019). But Thompson cautions that “unions will be required to move off their traditional terrain if they are to challenge capital on its own terms of planning, investment, and resources, even to provide adequate forms of resistance to issues of jobs, skills, and living standards” (Thompson, 1983). Dobkin makes clear that “Unorganized physicians have had little influence on the public policies affecting patient care, hospital conditions, medical training, or working conditions. Although potentially powerful as agents of change in health care, most physicians typically have remained passive about social, political and economic matters in health, thus contributing greatly to the trend toward control of health services by business or by managerial or political interests” (Dobkin, 1975). While that was written roughly 45 years ago, it was prescient in describing the trend toward proletarianization of the profession of medicine and how physicians would acquiesce to that movement by remaining unorganized while unable to define their collective interest.

One such situation occurred in 2015 when a group of physicians of a non-profit parent health system that oversaw the hospital where they worked were being forced to spend less time with each patient so that they could see more patients or “speed up” (Scheiber, 2016). In 2012 a group of hospitalists were told that the corporation was considering outsourcing their practice because of what the system could get paid vs. what the care actually costs. The group decided to seek representation for purposes of fighting back. About a third of the group of 36 doctors said no thanks and left. Those that remained voted overwhelmingly to join an affiliate of the American Federation of Teachers who also happened to represent the nurses at
the hospital. The hospital eventually backed down from their outsourcing threat but continued to try and squeeze more productivity and concessions out of the physician group.

Brewbaker strikes a note of caution in that “Even if one agrees that consumers are in significant need of protection from their health plans, it does not follow that physicians are the one to protect them” (Brewbaker III, 2000). Mondore and Trivisonno found that unions in hospitals tended to lower both engagement and satisfaction because of “restrictive work rules, low employee morale, and unions activities such as contract campaigns, grievances and job actions that are designed to disparage organizations and drive a wedge between leaders and employees” (Mondore & Tivisonno, 2015).

There are fine lines between employees who use unions to protect their voice and position within the hierarchy to make sure that their views are heard and considered in the process of improving organizational outcomes and objectives and those who use unions as a cudgel to increase positions of self interest in terms of salary and benefits. Unions can be useful tools to obtain both, but the former must never be sacrificed for the latter. This distinction must be made unequivocally when using the strike weapon effectively to enforce one’s bargaining position.

**Physician Strikes**

Traditionally, unions utilize the strike weapon or work stoppages to enforce their bargaining positions with management. Thus, employers face industrial actions, refusals of certain duties, or slowdowns to provoke management into yielding to worker demands. Strikes usually are the last alternative after negotiations fail to seek the desired progress when parties have reached an impasse. Often times, strikes occur for one of several reasons, such as supporting another union who is out on strike, protesting an unfair labor practice of the employer (as defined in either the NLRA or various state statues, depending on the jurisdiction), forcing the recognition of the union as the employees’ exclusive bargaining agent, or causing economic harm to the employer organization and in today’s corporate market to their profit margins.

Strikes can be carried out for a variety of reasons, from using them to force an employer to recognize the union as the bargaining agent for its employees to a means to enforce a collective bargaining position to obtain concessions from an employer. Strikes or work stoppages are tactics that unions employ to extract concessions during the collective bargaining process. Strikes are often viewed as a failure of the process, but are used for a variety of reasons. Those reasons include sympathy for another striking union, protesting unfair employment practices, or forcing an employer to recognize the union as the employee’s exclusive bargaining agent. Strikes can also be used to cause economic harm to the employer being struck. It is that harm that can cause reservations on the part of physicians who may wish to strike as it may cause harm to the very population they wish to serve.
It is the patient who may be harmed by any employment action, and it is their interests that the parties to any labor dispute use to support their positions (Loewy, *Of Healthcare Professionals, Ethics And Strikes*, 2000). As Chima points out, “the right to strike is so important to the functioning of modern democratic societies that its suppression would be unjustified. The right to strike is now accepted as an indispensable component of collective bargaining and perhaps a fundamental human right” (Chima, 2013).

Overall, union membership has declined from a high of 40 percent in the mid-1950s to roughly 11% today of the US workforce (U.S. Bureau Of Labor Statistics, 2013). Of that 12%, 6.6% of the private sector is unionized, while 36% of the public sector is unionized. Consequently, industrial worker strikes in the United States are few and far between with strikes among physicians even more so. The number of strikes over the past 40 years has shown an even steeper drop-off as evidenced by the data represented in Fig. 6.1.

As the number of strikes among workers has diminished since 1960, it might be suggested that the more recent strikes by unions were for unions choosing to strike under desperate conditions and/or as a form of protest. As Yates points out, strikes may have substantially decreased because of the constraints under which unions and workers work in the current economy; there have been increases in striking seen in areas such as health and education (Yates, 2009). Unfortunately for union members, strikes recently have led to permanent unemployment and replacement of the strikers at the workplace as Reagan’s action against the air traffic controllers (PATCO) in the early 1980s indicated. Corporate entities, including those in health care, pushed back against workers and their unions in emboldened ways with little in the way of a response from the state and federal agencies designed to protect union members’

![Fig. 6.1 Work stoppages in the United States: 1947–2018 (Source: Bureau of Labor Statistics, United States Department of Labor, 2019)](image)
rights to collectively bargain. As a result, strikes had become less and less common, but they do happen; however, in 2019 there appeared to be an uptick in strike activity in the educational service industry with teachers in Los Angeles, Chicago, Denver, and Oakland walking off the job (Demanuelle-Hall & DiMaggio, 2019). This was in addition to the UAW at General Motors strike that involved 46,000 workers that lasted 29 days (Statistics, 2020). The surge was believed to have been caused by a low unemployment rate in that fired strikers could more easily find another job plus low unemployment (<4%) can give employees more leverage in pressing demands because employers don’t have a ready supply or replacements lined up (Shierholz & Poydock, 2020). The major reason that the authors found for the increase in strikes is the lag in wage growth that should have occurred as result of low unemployment. Teachers, in particular, have been willing to walk out, not just over pay and working conditions but also the very way in which public education is delivered including health and safety issues within the schools as well as how those schools should be staffed (Dampier, 2019). The high employment rate is said to allow workers to feel more secure in their jobs and thus more able to engage in strikes and job actions simply because there are not many options for employers to hire replacements (Castellucci, 2019).

For physicians the issue of striking is one of the largest reasons that they would never consider a union because of the ethical conflict between withholding labor and a commitment to treat all patients in need of medical care regardless of how they themselves are treated. As Brunton and Sayers point out in their study of a junior doctors strike in New Zealand, that “anti-strike ethical rhetoric is Kantian in its characteristics, while the pro-strike ethical rhetoric is Utilitarian in its characteristics” (Brunton & Sayers, 2011). What is a strike and why do unions withhold labor?

So while physician strikes are pretty rare, where can we look for guidance as to the use of the strike weapon in health care? Nurses provide many more examples of the use of the strike weapon in health care as nursing unionization has become more commonplace. For example, one such strike in Minnesota in 2010 saw 12,000 nurses walk out over nurse-to-patient ratios that were deemed too low to provide for safe and effective quality health care (Albers, 2010). Six years later roughly 4800 nurses went on strike at the Minneapolis-based Allina Health System (Gooch, 2016). The primary issues for the strike were over the usual issues of health benefits, staffing, and safety. The strike lasted 7 days and nurses returned to work under the terms of their previous contract. Several unfair labor practices were lodged against Allina (Olson, 2016). In April of 2019 10,000 nurses in New York City threatened to strike at three of New York City’s biggest hospital systems (McGeehan, New York Hospitals Reach a Landmark Deal on Nurse Staffing, 2019). The threat appeared to have worked as the union reached agreement with the hospitals that would lead to the hiring of 1450 more nurses as well as establish minimum ratios of nurses to patients.

A grocery store strike offers an important lesson on the power of strikes, and that is “After years and years where the number of strikes dwindled to a pitifully small number, accompanied by a barrage of negativity from media and political elites,
workers are beginning to see that it is one of the most effective ways to fight back. That’s true of teachers, nurses and other healthcare workers…” (Piascik, 2019). Nurses have gone on strike in many other places as well. At roughly the same time, nurses at Stanford Health Care in California voted to authorize a strike because contract talks had not been resolved over the issues of wages, workplace safety, and others (Ho, 2019). In September 2019, 2200 nurses went on a 1-day strike at the University of Chicago Hospitals which turned into a lockout for several more days due to the hospital contracting with outside sources to provide staffing for a set number of days (Schencker, 2019). The primary issue was over what the nurses’ union described as overtime and safe staffing ratios at the hospital. The strike itself caused no issues with patient safety or care as the hospital had gone on bypass as well as curtailed services for a few days until the nurse had returned to work. As the COVID-19 pandemic continues on, it seems that we can expect to see more job actions related to patient as well as practitioner safety with dire shortages of equipment, testing, and personal protective equipment becoming a greater and greater issue (Stockman & Baker, 2020).

Moreover, what other healthcare professionals do in the use of the strike weapon is important. Nursing usually has little say about their practice and is beholden not only to physicians but also to the administrators of the organizations which employ them. Nursing lacks autonomy and power due to gender problems in the culture of many societies, and in most nations, nurses are considered the “handmaidens” to the higher status, much higher paid physician staff. Outside of the United States where the profession comes from generally middle-class families, nursing internationally (even in Europe) has working-class origins and not university prepared so not appearing to be a “profession” but, as Friedson has noted, a “semiprofession” (Friedson, 1980).

Yet, from a number of case studies, nursing militancy usually has resulted from the administrative milieu that provides the conditions of their labor. In their employed wage-contract status, nurses (perhaps also by gender) find solidarity that differs from that among physicians (Muysken, 1982). There is a tendency among certain nurse groups for union membership, and the job actions normally include clear concerns for patient care that are ethically justified by the striking nurses based upon poor quality resulting from heavy patient loads, overcrowding, poor working conditions, and lack of material and psychological support by managers in the respective organizations (Breda, 1997). Hibberd and Norris found that “to strike places nurses in the dilemma of having to choose between loyalty to patients in providing uninterrupted services, and loyalty to peers in collectively pursuing improvements in working conditions and socio-economic status. Although nurses caring for seriously ill patients may prefer not to strike, there are certain circumstances, including the fear of peer alienation, which might compel them to take strike action” (Hibberd & Norris, 1991). Historically, collective bargaining and strikes has begun to level the playing field between nurses and their stronger adversaries in the healthcare system hierarchy (Kravitz, Leake, & Zawacki, 1992). In juxtaposition, pharmacists subject to corporate chain drugstores and pharmacy benefit managements firms have been reluctant to organize; there are few strikes over wages and speedups and the conditions of pharmacy labor (Zgarrick, McHugh, & Droge, 2006).
So why would physicians ever consider collective bargaining and striking as a solution to what ails the profession? In the United States, corporate and governmental cost containment strategies; overall marketplace schemes in health care, coupled with increasing clinical scrutiny and administrative dominance imposed under privatization by the insurance industry, managed care firms, governments, and now the Accountable Care Organizations; are rattling physicians who seem bewildered by the administrative obfuscation amidst rapid change.

This discontent across various countries has led to the consideration of strikes, amidst carrying out other job actions in opposition to the private and public control exerted upon physician autonomy (Thompson & Salmon, 2014). Braverman (1974) described these conditions almost 40 years ago as a continuous change in the labor process such that the unity of conception and execution is dissolved.

While the formation of labor unions and the threat of strikes might be a natural response to this process of rationalization in the medical field, both issues arouse intense debate from inside the health professions, as well as with the public and policymakers. Nevertheless, as physicians increasingly experience their wage-contract employment within healthcare organizations, they realize that their work is becoming more highly controlled by nonphysician administrators detached from long-standing professional ethics. As Thompson and Salmon have previously pointed out, physicians are losing their status as independent practitioners and are finding themselves in a traditional employer-employee relationship which further reinforces the imposed production norms of health care (Thompson & Salmon, 2003).

The question then becomes how do physicians utilize a strike weapon within the collective bargaining relationship to improve patient care and working conditions? Given the exacerbation of labor strife across national health systems across the world, it is important to explore the issue of what constitutes an ethical physician strike as we observe the trajectory of the profession’s discontent with the conditions of medical practice.

Second, theorists have posed descriptions of the forces of corporatization, proletarianization, and/or deprofessionalization of physicians (Salmon, 1990). These are not phenomena unique to the United States (Scarpaci, 1990); nevertheless, our for-profit delivery system (not-for-profit in name only) renders administrative control over escalating costs and dubious quality as an immediate imperative. Collective bargaining by physicians has arisen under many situations, but most efforts did not advance, or these instances were quelled in various ways (Thompson & Salmon, 2003). Of the over 900,000 American physicians dedicated to patient care, roughly 50,000 may belong to unions, and another 200,000 may be eligible to join unions due to their employment status. It is important to point out that there has to be a defined employer-employee role for a physician to join a union and have that union represent that physician as well as others vs. their employer. Nowadays, the growth of contract work by physicians, whether this be in hospitals, managed care organizations, or as junior partners in large group practices and/or academic faculty foundations, is becoming the dominant employment paradigm (Rama, 2019).

Physicians in labor organizations face an ethical dilemma over their wish to withdraw their labor in furtherance of their collective bargaining objectives. This
An ethical dilemma is directly in conflict with the state oath of providing for patient care to those in need. It is also highlighted in the American Medical Association (AMA) policy opinion E-9.025 on Collective Action and Patient Advocacy. This policy clearly states that “Whenever engaging in advocacy efforts, physicians must ensure that the health of patients is not jeopardized and that patient care is not compromised” (The Council on Ethical and Judicial Affairs of the American Medical Association, 2004). The report further states that “Physicians should refrain from the use of the strike as a bargaining tactic. In rare circumstances, individual or grassroots actions, such as brief limitations of personal availability, may be appropriate as a means of calling attention to needed changes in patient care. Physicians are cautioned that some actions may put them or their organizations at risk of violating antitrust laws” (The Council on Ethical and Judicial Affairs of the American Medical Association, 2004). But as 15 years have passed since this AMA edict, more and more physicians have been pulled into corporate employment and become just another cog in the healthcare machine.

However, prevalent physician strikes may become, can they be justified in light of the profession’s oath to “do no harm”? Sixty-three percent of physicians indicated in 1979 that they were in favor or physicians organizing, though only 55% thought they should be allowed to strike and less a number (46%) said that they would participate in a strike if they all agreed with the issues that led to the strike (Wassertheil-Smoller, Croen, & Siegel, 1979). In 2003 under hotly debated ethical issues, most physicians accepted that if he/she were going to join a union, the union needed the strike weapon for success in the collective bargaining process (Thompson & Salmon, 2003). It would seem that given the current state of the practice, it might be reasonable to infer that those percentages listed above have not decreased over time and that militancy might be on the increase as a result of the issues previously described. A study that asked medical students in Israel gives a slightly different finding in that 97% believe that striking is a legitimate tool for physicians and 43% said the suffering of patients caused by the strike was totally or near totally justified (Lachter, Lachter, & Beiran, 2007). Su-Ting explores how professional attitudes are formed in training on the concept of strikes that “create an ethical tension between an obligation to care for current patients (e.g., to provide care and avoid abandonment) and obligation to better care for future patients by seeking system improvements (e.g., improvement in safety, to access, and in the composition and strength of the health care workforce)” (Su-Ting, Srinvasan, Der-Martirosian, Kravitz, & Wilkes, 2011).

The provocation of physician militancy to consider striking seems to be an attempt to halt the ever-increasing encroachment of management prerogatives over their medical practice. Dissatisfaction with immediate supervision, outrage over the extent of corporate profiteering, and other imposed performance standards to enhance profitability and remove or lessen autonomous practice are aggravating conditions to the medical profession today (Loewy, Of Healthcare Professionals, Ethics and Strikes, 2000). This militancy takes place within an extremely complex and often misunderstood set of policies that befuddle even the experts in the field.
who devote their lives to untangling these policy issues. For example, in the heavily unionized professional sector of public school teachers, militant attitudes occurred most often if they were dissatisfied with their supervisor and if they felt little control over their jobs (McClendon & Klaas, 1993). Studies examining reasons behind strikes by both physicians and other healthcare workers point out that the strikes occur over concerns for the practitioner’s own welfare; secondly professionals may strike because of concerns for their patients. Couple these concerns with dissatisfaction over the current state of the practice of medicine and the loss of autonomy and control over the profession and their patients and the stage is set for increased militancy of physicians. As more and more physicians enter employer-employee positions, it becomes even more imperative for them to be the “champions” of their patients’ interests, especially when confronted with corporate bottom line mandates to the point of risking their livelihoods when patients are put at risk from those mandates (Manthous, 2012).

But unlike school teachers who inconvenience students and their parents by going out on strike, it would seem the stakes for causing greater harm would occur if physicians and other healthcare practitioners went out on strike. Concern for patient welfare raises the question of whether the striking can be permissible under certain circumstances. This contradiction between professional self-interest and patients’ welfare can vary depending upon the point of view. “When physicians within an organization are treated badly, it is clearly understood that this treatment might lead to substandard patient care. Strikes that bring about higher pay and better treatment of professionals might conceivably yield improved morale and thus better patient care” (Thompson & Salmon, 2014). Wolfe seems to support the notion that “if the rights and health of patients and the public are preserved, strikes can serve as an important catalyst in converting a rigid and conservative health system into a more flexible democratic organization for all its workers” (Wolfe, 1979). Most documented strikes by attending physicians were provided by economic concerns, yet mindful of public reaction; patient care concerns become touted as the reason for the job action. Nevertheless, the ethical issue over whether physicians should strike or not centers on doing harm to patients as a result. Our concern here is to examine professional job actions to distill their reasons and general outcomes: The United States and several examples internationally can bring these issues into better focus.

In the United States, it has consistently been deemed legal for physicians to strike, though the climate seems against eligibility of most physicians to collectively bargain because of restrictive interpretations of law by courts. In 1935, the Wagner Act (National Labor Relations Act) guaranteed most workers the right to unionize and bargain collectively, not excluding healthcare workers. Amended in 1947 by the Taft-Hartley Act, healthcare workers of non-profit hospitals were prohibited from forming unions and engaging in collective bargaining. By 1974 this exclusion was repealed, but a 10-day advanced written notice was required prior to any strike action (National Labor Relations Act, 2013).

Over the past 50 years, physicians’ strikes have arisen most commonly over wages, hours, malpractice insurance issues, as well as health insurance administrative and
financial controls. Each national health system operates within a different context, and these should be examined in order to understand the degree of self-interest versus concerns for patient welfare.

Strikes by physicians have been in evidence on the North American continent since 1962 when the Saskatchewan Medical Care Insurance Act became law. Badgley and Wolfe’s Doctors’ Strike diagnosed the Saskatchewan physician strike as a “medical profession, accustomed to not exercising its prerogatives without external constraint, [that] opposed legislation enacted by a government elected by its people.” What started out as an intent to protect patient rights resulted in a contest of wills between physicians and the provincial government over implementation of a single-payer insurance model that became the basis of Canada’s national health insurance program. Misjudging the mood of the public which favored the government and party in power was the downfall of this physician strike. The popularity of the provincial government and its Medicare program stood against the “lack of care” anecdotes, so the job action ended after a mere 23 days. It is instructive to recognize again the disunity among private practitioners and the difficulty in assessing where the public and patients end up in defining their professional interests (Badgley & Wolfe, 1967).

In 1966, approximately 1500 physicians, dentists, and optometrists in the Doctor’s Association in New York City went on strike to protest wages (Keith, 1984). Four years later in 1970, specialists in Quebec walked out in protest of the public insurance program in a similar way to the doctors actions in Saskatchewan (Baer, 1997).

In 1974 the house staff officers at Howard University went on strike for 12 days primarily over excessive hours and poor working conditions and thus gained a salary increase following a 12-hour strike. Management provided improved laboratory facilities and nursing coverage and a better fringe benefit package for the house staff (paying for malpractice insurance coverage) (The New Physician, 1975). In 1975 the Council for Interns and Residents went on strike against 15 voluntary hospitals and 6 affiliated public hospitals in New York City for over 3 days. Their complaints included excessive hours and performing out of title work. Significant public support including the New York Press and the American Medical Association and the public came for the CIR when the hospitals refused binding arbitration (Harmon, 1978).

In Chicago in 1975, Cook County Hospital had 500 house officers walk out for 18 days leading to the longest physician strike in US history. Their concern was the quality of patient care and working conditions, and their demands centered on patient care improvements and decreased working hours. The union defied a temporary restraining order issued by the courts and the final settlement provided for oversight of patient care improvements, such as more IV teams, faster lab and x-ray request processing, reduction of house staff work week, and Spanish language interpreters. Subsequently a Cook Country judge put seven strike leaders in jail and fined the union $10,000 (Harmon, 1978).

In 1976 Los Angeles County saw physicians partly withdraw services over medical malpractice insurance; 75% of Los Angeles County’s physicians went on strike.
for 35 days, beginning with just surgeons and anesthesiologists, but later joined by primary care physicians. Their objective was to pressure the state legislature for effective malpractice insurance reform. Most of the major issues remained unresolved, but some minor reform proposals occurred in the legislature. This incident is important to understand since the James study examined outcomes due to the withdrawal of services and found “no evidence of a significant impact on the general public in finding medical care” (James, 1979, p. 437).

Again in 1976, interns and residents in New York City conducted two strikes at two separate hospitals. Some 30 strikers were fired but eventually rehired, and the house staff was successful in obtaining a considerable increase in their salaries. They graciously turned 50% of that amount back into a patient care fund controlled by the house staff in order to buy equipment and hire essential healthcare staff (Harmon, 1978).

In 1980, physicians in Quebec protested government control of medicine by staging a 1-day strike. Specialists wanted to be able to opt out of the Canadian national health insurance scheme or to extra bill patients over and beyond the fee schedule. General practitioners did not support specialist demands, so the strike failed (Budrys, 1997).

In 1986 physicians in Ontario went on strike again over extra billing prohibition by the health ministry. This province had previously allowed them to opt out of the NHI plan and extra bill, but in 1984 this practice was ceased by the provincial health plan on direction of the federal government. The ban on extra billing was considered to be an impingement on their autonomy and on the doctor-patient relationship. Like the strike in Quebec, the Ontario physicians did not receive popular support, and the action failed. The public and the government did not want to compromise the Canadian right to health care even if physicians were not (on their terms) compensated adequately (Kravitz, Shapiro, Linn, & Froelicher, 1989).

In 1996 again in Canada, the 9-year-old practice of subsidizing physicians’ malpractice insurance was ended in Ontario province. Obstetricians and orthopedic surgeons stopped taking new patients, and general surgeons and family practitioners later supported them. There was a short withdrawal of services, but the government backed down and partially restored the malpractice insurance subsidy (Baer, 1997).

In 2000, physicians in New Brunswick, Canada, went on strike for 3 days after bargaining to gain equity with other provinces’ pay rates. The New Brunswick Province offered a lucrative increase, and the physicians returned to work reluctantly when the provincial offer was not increased as they asked (Walker, 2001).

In 2003, the United States saw several physician work stoppages over malpractice insurance premiums that were spiraling upward (Charatan, 2003). Jury awards in malpractice suits are usually blamed by physicians for increased premiums, yet trial lawyers correctly point to malpractice insurance companies raising premiums due to what are termed “hard markets” and falling investments in hard economic times, as most people realize these premiums for certain categories of physicians are extremely high and present an economic burden on practices (Baker, 2005). These work stoppages often included not holding office hours, protesting at state capitals, and not performing elective surgeries from time to time. Jones notes that
these physicians usually do not garner public sympathy particularly in states where physician incomes greatly exceed local residents’ incomes. Backlashes against physicians occur where there is resentment over highly paid professionals seeking to further their self-interest and not necessarily their patients’ benefit. This would be a failure of the strategy in conducting a work stoppage but not necessarily a condemnation of the tactic itself Jones (2003).

Since the early 2000s, there has been little activity in the area of physician strikes in North America. One Advocacy Blog on the American College of Physicians website reaffirmed the ACPs code of ethics in that “strikes, boycotts, and other collective actions to deny care to patients or to inconvenience them are flat out unethical” (Doherty, 2012). Interestingly there has been recent activity overseas, but it appears that did not have its intended effect. The British Medical Association in the United Kingdom went on strike over pensions. While the strike did appear to have about a third of the population behind it, most physicians apparently were not. Most physicians did not stop seeing patients which negated the effect of holding a strike in the first place as no one appeared inconvenienced (Praities, Low Turnout Blunts Protest, 2012). Physicians went on strike in Estonia for 2 weeks over poor working conditions. The government had taken the offensive to publish physician salaries in an attempt to paint physicians as greedy and out of touch. The two sides eventually settled with a decrease in physicians’ workload by 20% in outpatient clinics and 16% in inpatient settings. Minimum salaries also increased (Ermel, 2012).

In Korea, it was noted that striking by “hard to replace” physicians did have the ability to alter the trajectory of certain health reforms related to financing, pharmaceuticals, and provider payments. All of these attempted changes threatened physicians’ livelihood, and while they were unable to completely block all of the reforms, they were able to place themselves as an interest to be considered in future policy changes (Kwon & Reich, 2005).

In Ireland, doctors went on strike for 1 day, which resulted in the cancellation of 15,000 hospital appointments, but covered emergencies (Quinn, 2013). The strike was caused by austerity measures implemented by the European Union in response to the global economic crisis and involved a dispute over long working hours (100 hours per week), which violated EU employment laws and more importantly put patients’ lives at risk.

In sum, the above details of physician protests, job actions, and strikes indicate a common theme that is a fundamental discontent with the conditions over medical practice in both the United States and Canada, as well as overseas. Actions are taken as a result of the loss of physician welfare and autonomy against both government and corporate constraints as the impositions brought on by administrators.

As highlighted in Chap. 4 on malpractice insurance concerns, malpractice liability continues to be a significant concern for medical professionals. As described in that chapter, insurance carriers rebuild profit margins that lessen when their underperforming investments pass through tough economic times (Baker, 2005). The bulk of malpractice suits by patients is usually found to be attributable to a small group of physicians, and state medical boards seem to lack the ability for
more effective disciplining of so-called bad doctors by the profession itself (Levine, Oshel, & Wolfe, 2011). But one medical ethicist believes that striking over malpractice insurance rates cannot be justified primarily because of the perceived harm that would come to patients (Fiester, 2004).

It is important to recognize that across the globe, the health professions have various roles and relationships and different characteristics from what we see in the United States. The discontent that propels the situational factors in unionization that lead to job actions must be differentiated across national health systems, just as where corporate for-profit health care in the United States used to be differentiated from what we see in the “not-for-profit” sphere. Younger professionals struggling over what they deem to be inadequate remuneration, fewer hours and workloads of exploitation of their labor, and deleterious and declining working conditions that impinge on quality are important to consider. In most nations, disparities in physician ranks are significant, not just by specialty but also by age.

Essential to the investigation of the physician strike phenomena is the patient and population impacts. In short, what have been the effects of physician strikes on patient morbidity and mortality? Few studies examine the morbidity and mortality rates and how they changed pre- and post-strike, that being the 1976 Los Angeles County physician strike. James examined the period where elective surgery was abandoned with only emergency surgery continuing. He found that 55 to 154 deaths did not occur when elective surgery was postponed due to the strike.

This study ponders the question that physician strikes are inherently harmful to the population, and, if so, should they be avoided by all means? (James, 1979). Health workers have carried out short strikes in Kenya in both 2010 and 2016, and there were no discernable effects on overall mortality in the area covered by these workers (Ong’ayo et al., 2019). A junior doctor strike elicited similar results in that there was no appreciable increase in mortality during the strike, but they did find that the strike caused significant reduction in the provision of health care with 9% fewer admissions, 7% reduction in accident and emergency visits, and a 6% reduction in outpatient visits (Furnivall, Bottle, & Aylin, 2018). Naturally there are always anecdotal reports of a strike leading to increased mortality, and in one case where a strike was blamed for a patient’s death, it merited a brief report in The Lancet (Chapman, Doctors’ Strike Blamed For Patient’s Death in Germany, 2006). Cunningham, Mitchell, Venkat Narayan, and Yusuf (2008) describe this as a paradoxical pattern in that when health workers strike, the mortality level either stays level or decreases. While it’s difficult to know for sure if the strike was the cause, publicity such as this cannot help physicians make their case for striking for a future of better and safer health care.

In contrast an Israeli physician strike in 1983 led to greater involuntary admissions to psychiatric services since community interventions on behalf of striking doctors lessened during the strike. Increased hospitalizations resulted when community resources were diminished. No data on mortality was collected (Scholsber, Zielber, & Avraham, 1989). Thus, the lack of decent health services research that may be advisable to be in place when medical professionals consider job actions would be a worthwhile policy consideration.
In the United States, the general public and many health professionals have noted that marketplace medicine as health policy has created conditions that are majorly behind the rising professional discontent. It should be noted that both the Clinton and Obama health reforms relied upon corporate and entrepreneurial entities to seek profit opportunities in health care as a way of bringing about “reform.” Historically we have witnessed the neglect of the uninsured and the underinsured populations who do not yield sufficient returns on investments for profit-maximizing providers. Austerity measures taken by state governments in response to lower tax receipts and less support from the federal government create constraints upon reimbursement levels, growing patient “out-of-pocket” payments, and public sector provider cuts, with consumers suffering as a result. It is not clear that the mandated health insurance exchanges in states under Obamacare, along with the formation of Accountable Care Organizations that are supposed to contain costs and improve quality, are going to be able to solve the worsening practice situations that many healthcare professionals in the United States confront.

Privatization schemes have been promulgated across the globe in many national healthcare systems, mainly led by American ideology that marketplace medicine is more “efficient” and can find solutions better than the historical public sector medicine that serve many countries. Exporting the US system with its high-cost inflation, administrative dominance, and concentration of high-tech tertiary care (including costly supplies, equipment, information technology, and pharmaceuticals purchased by US and European firms) is not necessarily the best solution for the world’s citizens (Salmon, 1990). Increasing problems with access in these international settings and again growing administrative overhead and diminished funding of traditional public health services are not likely to yield improved population health in these respective nations. Marketplace reforms in essence have redirected health care from its social purpose away from improving overall population health and well-being and toward maximizing profits and increasing market share, under the guise of cost and quality improvement.

**Ethical Issues Across the Future**

Begun in the late 1960s, the increasing corporatization of medicine has changed the character of medical practice in profound ways. This transformation of the delivery systems of care altered working conditions, not only adversely affecting doctors’ job satisfaction in these enlarging corporate entities but, in effect, profoundly eroding past physician prerogatives (McKinlay & Stoeckle, 1988). With Obamacare’s continuance of the bureaucratization of health care with health insurance exchanges, Accountable Care Organizations, and the strength and role of both the centers for Medicare and Medicaid and large commercial insurance companies, physicians may find unionization as a way to fight back against what they perceive as the harmful alteration of the practice of medicine, with the ongoing transformation of the delivery system. The purpose of any strike actions would be to create discomfort
to employers who are eroding professional autonomy and prerogatives. The obvious impact on employer organizations through strikes will be reduced revenues and less profit. What remains unclear is how will patient morbidity and mortality be affected.

The profession’s ethical foundation in the Oath of Hippocrates fundamentally represents the core of the profession’s ethics. With the edict to do no harm, it gives rise to question whether unionization and strike actions may benefit patients in certain ways. Much discussion over ethics in medicine these days leads to polarized opinions. It can be generally stated that a number of recent activities involving physicians have been embarrassments (participating in torture, executions, certain clinical trials, promotion of pharmaceuticals after huge kickbacks, etc.). Linn highlights this moral dilemma of opposing positions with a quote from a physician (in Israel) who stated, “We are very strong when we talk about the patients, but when we face them alone, we just do the work. The government knows this is our weak point and all the years it took advantage of our conscience” (Linn, 1987).

Stepping back to view the issue of unions and strikes requires broader analysis concerning the long-term benefits to populations’ health and whether they may outweigh short-term losses to present patient populations. In other words, is a short-term disruption in care necessary to countervail corporate power in a for-profit healthcare system? The mere threat of a strike can be a potent weapon as Badgley and Wolfe (1965) surmised in their study of the Saskatchewan physician strike of 1962. They noted that unless the public is fully behind professionals, and their case is clearly portrayed as improving patient care, utilization of the strike may inevitably backfire and cause more harm than good. Thomasma and Hurley suggest criteria for the conduct of ethical strikes: provide a 30-day notice under the National Labor Relations Act, and demonstrate this to the larger public; maintain that improving patient care is the primary motive for the strike action; report that all other avenues have been exhausted; provide that emergency patient conditions will be cared for and not abandoned; assure that all current patients hospitalized will be cared for and also not abandoned; and relay that the terms for ending the strike will be subject to public scrutiny and further discussion (Thomasma & Hurley, 1988). It should be remembered that never was there a policy debate over whether the American people (or physicians) wanted a profit-based delivery system, nor whether such a corporate-controlled system was the best way to organize finance and delivery of health care to the American people.

The American Medical Association supports collective bargaining but opposes striking for any reason. They continue to defend the private practice of medicine which has fragmented its members and been found to be unresponsive of the new realities in health care and in particular medicine. Many physicians who work for organizations increasingly on a wage-contract basis are not as involved in AMA membership and politics. Up until AFSCME and SEIU began organizing physicians, the AMA opposed unionization; now it supports the Physicians for Responsible Negotiation, an unaffiliated organization that opposes striking for any reason; members of this union do not have leverage to support their positions through the collective bargaining process, and the AMA has since ceased support of this entity.
In contrast to the AMA, the British Medical Association (BMA) does support striking and has the force behind it with its right to strike and ability to do so to win demands from the British National Health Service. This has been exercised when government policy has changed conditions for maintaining the quantity and quality of health care in that nation, although recent history suggests a significant physician apathy toward the use of the strike weapon (Praities, 2012). Ultimately, it is the public who uses health care that determines the success or failure of any job action including a strike. Any strike action should be carefully considered to include gauging the level of public support for such an action. Without it, any strike is doomed to failure.

**Conclusion**

While few policymakers and observers predict that physician unions will be the wave of the future, nevertheless it is imperative that physicians consider the option of organizing that may help them regain their ability to speak for their patients and their quality of care within corporate structures that have different priorities. And while it becomes obvious to some observers that physicians will be rendered powerless to defend their professional values in the face of the corporate onslaught, no wave of unionization has ever materialized in response.

While physicians in the United States remain distrustful of government interference in their affairs, they did not appear to notice the encroachment of the corporate sector which was doing much more to undermine their professional well-being. Physicians still rant against payments they receive from Medicare and Medicaid, but a substantial number have now noticed that commercial insurance companies have followed Medicare’s lead in delaying and reducing reimbursements; several insurers have higher denial of care and prior authorization, which makes it difficult for maintaining their standard of living. Organized medicine’s resistance against Medicare-for-All proposals is a case in point. A majority of physicians do favor a single payer, Medicare-for-All system; the AMA continues to oppose a more simplified reimbursement system that would eliminate many reimbursement issues they face (Scott, 2019). Even if they could back a single-payer system in the United States, it will not, however, resolve their organizational woes as employees within healthcare organizations as more and more pressure would be put upon them to increase efficiency and decrease costs at the expense of patient care. Corporate domination in the US healthcare system may actually go for the increasing funding with little regulatory restraints as with Obamacare.

Collective bargaining could help in making sure their voice is heard. Perceived abuses of medical malpractice insurance companies, health maintenance organizations, preferred provider organizations, pharmacy benefit managers, and other corporate employers are additional encroachments on professional autonomy and heighten physician’s dissatisfaction with the practice of medicine. As the quest for cost control and quality utilization monitoring under Obamacare and whenever
Trumpcare moves forward, it is likely that discontent will rise even further. All payers are poised to reduce professional fees, demand care justifications, withhold payments, and apply punitive actions if clinical standards that they set are not met by practicing physicians. Attempts to “bend” the healthcare cost curve will most likely be borne by providers and in particular physicians and patients, some of which may actually be quality improvements (reduction of never events, low value procedures, churning, and other excess utilization). This is the prescribed direction of the federal government, by most state governments and by corporate employers who are trying to wrangle a much reduced outlay for benefits as health reform progresses.

Besides the bureaucratic interference with professional decision-making, it is noteworthy to look at physician practice patterns and physician salaries. Policymakers talk about rewarding high-quality primary care since newly enrolled patients under federal, state, and private health insurances need to be served. Attracting medical school graduates away from the high-earning specialties to primary care will be achieved if incomes in primary care medicine can be enhanced, as there remain significant discrepancies between specialty salaries and those in family medicine, internal medicine, psychiatry, and pediatrics. Substitution is happening now for nurse practitioners, physician assistants, and other health practitioners in retail and community practices.

What is the response of the medical profession which is besieged by the turmoil of all of this change coming down upon them to their professional lives and lifestyles? Will physicians resort to unionization for collective bargaining and the use of a strike to fight back against the array of corporate and government changes involved in the corporate transformation of the American healthcare system? Employment trends for physicians point toward less private practice and more opportunities housed within organizations, such as faculty foundations within an academic medical center. The future is quite uncertain as much of this shakes out in this mixtures of Obama health reform and the dynamics of marketplace medicine. Whither goes the profession and how attune it is to public sentiment will be key. If the American public shares the same dissatisfactions with the corporate healthcare system, their access, quality, cost, and accountability issues, it is likely that physicians might gain sufficient power. Will they then look to fight back with that unity of patients and population groups behind them? Ultimately, the use of collective bargaining and the strike tool is really a choice between potential harm to patient clienteles in the immediate term and longer-term improvement in patient care quality over the future. When this trade-off becomes acceptable to physicians, striking becomes a possible tool to use in supporting one’s interest in collective bargaining and changing the nature of the US profit-based delivery system.

Most practicing physicians are too busy with patient care, and, generally speaking, many are disgruntled since they are relatively unschooled in policy analysis and trends in medical care organization. The latter macro-analysis is normally difficult to achieve when one’s education and life in practice keeps one oriented to the micro-level, one patient at a time. Most doctors missed the changing auspice of corporate involvement in health policy planning and the actual delivery of services. This lack of clarity into what has been happening, how it came to be, and what are
the implications of the corporate transformation delimits the individual doctors’ range of actions. It also makes it precarious as to where factions of the overall profession may lead.

Will strategies to oppose overall conditions lead more physicians to consider collective bargaining and the use of strikes to protect their interests? As more and more physicians become employees within organizations, their status and ability to collectively bargain may become clearer. This leads to the more difficult decision on whether to unionize (if possible) and whether or not to threaten the strike weapon to further their collective bargaining goals. As this literature review reveals, there has been ample discussion of the surrounding issues for physicians to delve into the debate and choose directions that they as individual practitioners and the profession may consider.

Glick states that “health workers, and particularly physicians, are in a special class because they deal with human lives and because, upon joining the profession or accepting their job, they have voluntarily [emphasis added] undertaken a commitment to those they serve” (Glick, 1986). Fiester (2004) supports this rather dated stand, stating that “Because physician strikes intend to harm to patients, challenge the obligations of the physician to her patient, and risk decreasing the public’s esteem for the profession.” Perhaps the issue of protection of patient care in the face of corporate fealty to the bottom line is a case in point of why these two views should be considered quaint relics of the past.

Effectiveness of strikes is often determined by disruption to another party. Either the healthcare organization or its patients would be the disrupted party in a physician strike. It’s important that the disruption to the organization is maximized while minimizing the disruption to the patients themselves as long as provisions are made to take care of patient emergencies (Metcalf, Chowdhury, & Salim, 2015). One of the issues that commonly comes up in relation to the role of strikes for physicians is that patients will die if physicians walk off the job. Several studies have proven that not to be the case. They concluded that strikes may reduce mortality in several ways, including a reduction in elective surgeries and the reassignment of available resources to emergency care, and the strikes themselves didn’t last long enough to get a good read on whether or not this effect could be maintained over a longer period of time. In the United Kingdom, junior doctors went on strike in 2016 that was about the deeper dissatisfactions among professionals who feel “devalued and denigrated” (Penfield, 2018).

Physician strikes over demands for extra billing or reimbursement issues have not been successful because it is much more difficult to argue that the public’s health may be improved with higher doctor pay and the moral trade-off of little or no care for improved care later doesn’t seem to persuade the public of the righteousness of the action (Breslin, 1987). As Mechanic points out, “Doctors remain highly privileged professionals in our society, however, and they have much to lose by using the strike weapon capriciously and in a way that alienates the public. The large support and respect that patients give to their doctors—despite some erosion
in recent years—is still one of the major assets physicians hold” (Mechanic, 1989). To be more specific, patients tend to highly regard their personal physicians, but respect for the general profession has waned over time.

The notion of one ethical value (improvement of patient care) taking precedence over another (provide care no matter what) is at the heart of a decision to strike. The object is to improve the first without seriously compromising the second (Smith, 1980). This notion was used to justify a physician strike in Israel in 1983 (Grosskopf, Buckman, & Garty, 1985). Over 30 years ago, Wolinsky stated that he believed that the loss of professional dominance in medicine “will accrue from the benign neglect of maintain the public’s imputation of medicine’s original avowed promise” (Wolinsky, 1988). To the extent that he was correct that lost professionalism did occur, his take on their regaining self-regulation among physicians by a “return to stewardship and their role as fiduciary agency” to successfully combat intervention by the federal government seemed to understate the role of private insurance as well as healthcare organizations as employers of physicians. It also doesn’t recognize current reality of the administrative superstructure in health care provided by MBA-trained leaders.

Some useful guidance on how professionals can strike in the face of what might be termed a hostile environment for labor is the recent spate of teacher strikes, particularly in states that there is no collective bargaining for public employees. Even more important after the Janus decision, which limited public sector unions’ ability to collect fair share fees, the issue of union survival becomes paramount so that they can effectively represent their members’ interests at the bargaining table and the political arena. Teachers have been faced with decline in classroom conditions, pay and working conditions, as well as outright attacks on public education by anti-union advocates. In October of 2019, Chicago teachers went on strike because they realized that without the inconvenience and disruption caused by a strike, change would never occur (Wong, 2019). As Wong points out, there appears to be increasing support for labor unions and strikes to get them higher pay as well as funding increases for schools (Wong, 2019). Further job actions in Oklahoma and West Virginia (nonunion strongholds) have proven effective in getting concessions in terms of wages and conditions of employment improved. These “general” strikes were quite effective in highlighting how bad things were in the schools of those states.

It was noted by Gallup in 2019 that 64% of Americans approve of labor unions, which is the highest approval rating since 1999, up 16% from this nadir in 2009 (Jones, 2019). Perhaps the teachers and nurses can lead the way on the use of collective bargaining and striking to help physicians understand that major disruption may be necessary to regain professional power. This is a necessity for physicians to gain the ability to sufficiently advocate for their patients and the quality of care they and their healthcare organizations provide.
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