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**Professional unionization: A case study of the Committee of
Interns and Residents**

Wolff, Evelyn Susan, Ph.D.
City University of New York, 1990

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**PROFESSIONAL UNIONIZATION:
A CASE STUDY OF THE COMMITTEE OF INTERNS AND RESIDENTS**

by

EVELYN S. WOLFF

A dissertation submitted to the Graduate Faculty in
Sociology in partial fulfillment of the requirements
for the degree of Doctor of Philosophy, The City
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Abstract

PROFESSIONAL UNIONIZATION: A CASE STUDY OF THE COMMITTEE OF INTERNS AND RESIDENTS

by

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Adviser: Fred H. Goldner

The Committee of Interns and Residents (CIR) is a labor union of housestaff (medical school graduates at their last stage of training). Through a case study analysis of the union, including interviews with a sample of members, as well as with leaders and other pertinent participants, issues regarding the changing role of the professional, the professional-bureaucratic conflict, and professional union as a mechanism for social change were analyzed. The question of whether the union aspires to greater physician autonomy, the betterment of the physician's individual situation, or a return to the community orientation of the professional was explored.

The history of the CIR demonstrates that although self-interest motivated its formation, it was insufficient to legitimate its existence. "Patient care" provided legitimation, but proved a difficult goal to realize within the context of the labor contract.

Abstract

The heterogeneity of CIR's membership contributed to varying degrees of commitment to CIR's goals and activities. "Segments" based on demographic characteristics such as country of birth, sex, and marital status as well as segments based within the medical profession, including specialty, and year of residency, determined the salient reference groups.

In addition to the composition of the housestaff becoming more diverse, the residency itself had changed in the past forty years. As specialization became the norm, the length and significance of the residency increased. The work itself involved a greater dependence on technology, more tasks regarded as "out-of-title," and a sense that conditions could be improved for both patient and resident, if necessary equipment and staff were available. Thus, CIR focused on "patient care" conditions that they claimed would better the lot of both groups. However, CIR's resolution to enforce these standards through contractual guarantees, ultimately illustrated the limits of the union approach to patient care.

Thus, the CIR, a union of transient, heterogeneous resident physicians, representing trainees in one of the most prestigious professions, focuses attention on the strains within the medical profession and the role of the physician in response to these strains.

Table of Contents

Abstract.....	iii
List of Tables.....	vi
1 Introduction.....	1
2 The History of the CIR: 1957-1975.....	29
3 The History of the CIR: 1975-1981.....	69
4 The CIR Membership.....	117
5 The Resident's Work Situation.....	142
6 The CIR: Labor Union or Professional Association.....	191
7 The 1981 Strike.....	257
8 Conclusion.....	328
Epilogue.....	355
Appendix - Resident Interview Schedule.....	358
Bibliography.....	373

List of Tables

2a	Percent of Practicing Physicians by Specialty in U.S....	37
2b	Percent Distribution of Federal and Non-Federal Physicians by Specialty for Selected Years 1965-1986....	37
2c	Percentages in the Specialty between the Postgraduate Years of (1980).....	38
2d	New Hospital Housestaff Membership: 1970-1975.....	47
4a	Hospital Characteristics.....	119
4b	Bellevue Housestaff Sample.....	122
4c	Kings County Housestaff Sample.....	123
4d	Montefiore Housestaff Sample.....	125
4e	Bronx Lebanon Housestaff Sample.....	127
4f	Housestaff Sample Data: 1980-1981.....	130
4g	FMG's by Percent Minority Patient Population and Income.....	135
4h	FMG's by Specialty.....	138
4i	Resident Physicians by Sex, Marital Status, Number of Children and Age.....	140
5a	Housestaff Participation and Approval of Pyramids.....	145
5b	Housestaff Participation in Learning Activities.....	149
5c	Perceptions of Respondents' Training as Compared to that Given in Municipal and Voluntary Hospitals.....	150
5d	Range of Salary from 1957 to 1980.....	151
5e	Resident Salaries in the U.S. and Northeast.....	152
5f	Ratings of Salary and Fringe Benefits.....	152
5g	Weekly Hours Worked by Housestaff.....	154
5h	Weekly Hours Worked by Housestaff by Hospital, PGY Level, FMG Status, Specialty, and Sex.....	154
5i	Dissatisfaction with Hours Worked by Hours Worked.....	159
5j	Frequency of Nights on.....	165
5k	Frequency of Nights on by Dissatisfaction with Night Duty.....	166
5l	Frequency of Performance of Four Out-of-Title Tasks....	169
5m	Significance of Problems for Housestaff in AMA Survey..	170
5n	Housestaff Preference for Aligning with Other Workers..	176
5o	Rationales for Aligning with Other Workers.....	176
6a	Respondents' Views on Benefits of CIR.....	203
6b	Circumstances under which Respondents would Grieve.....	209
6c	Housestaff by Type of Hospital on CIR Tactics.....	213
6d	Priorities for Next Labor Contract by Hospital.....	222
6e	Housestaff Sample on Appropriateness of CIR's Tactics..	226
6f	Housestaff Sample on CIR as Representative of FMG's....	237
7a	First Municipal Housestaff Strike Poll.....	266

Chapter 1

Introduction

The subject of this study is the unionization of one part of the medical profession, housestaff or interns and residents. (Housestaff are medical school graduates who, in order to qualify for specialty licensing continue their education in a hospital setting, while simultaneously caring for patients as hospital employees.) It is a case study of the Committee of Interns and Residents (CIR), a labor union of housestaff in the New York metropolitan area. The union, which is the first and largest of its kind, provides a unique opportunity to explore questions regarding the changing role of the professional, the professional-bureaucratic conflict, and professional unionism as a mechanism for social change or social stability. More specifically, the question of whether this union is a response to encroachment on physician autonomy, a return to the community orientation of the physician, or an economically motivated bread and butter union can be explored. The possibility that these alternatives exist simultaneously with differing degrees of salience for different "segments" and in different types of hospitals, will be investigated.

Background

Observers of the medical profession would agree that, since World War II change has permeated every aspect of health care

Chapter 1 Introduction

delivery in the United States (Starr, 1982, 335-338). From the technology and methodology of medicine, to the settings in which care is delivered, to regulations of outside agencies governing the conditions under which health care is delivered, to the medical ailments themselves, there has been a revolution in health care. The resident, emerging from the ideal, theoretical world of medical school, finds himself in the midst of a situation in which he must sink or swim. Frequently, the sophisticated techniques and treatments learned as a student can not be implemented: the equipment, medications, or funding for them are unavailable. Although interns anticipate long hours, they find them filled with scutwork, tasks that they expect others to do. Their professional self image is only that. Patients do not seem to appreciate their work, use the hospital to treat symptoms, disregard the physician's recommendations, and return repeatedly with the same conditions. The doctor-patient relationship can not function in isolation. Medical conditions are often social conditions as well. Physicians find themselves fighting uphill battles against alcoholism and drug dependency. Increasingly prevalent diseases, such as cancer and AIDS, as well as a general increase in chronic disease, compel physicians to confront their feelings about death and the quality of life. Although some succumb to the cynicism that characterizes disillusioned and burned out professionals, others cling to the altruistic goals that originally motivated them to be doctors.

Chapter 1 Introduction

Although in the past residencies were arduous for other reasons, residents had a different perspective. They lived in the hospital, and sacrificed outside interests and social life to the demands of the residency. This single-minded loyalty to the hospital was accepted as a short term rite of passage into the most esteemed profession in the United States. Housestaff officers were trained by mentors who protected the interests of their proteges. Although financial rewards were meager, and the work difficult, housestaff were accorded the respect and prestige in other ways such as eating meals in dining rooms with waiter service.

In addition to the changing pressures of the resident's daily work situation, the type of person opting for a medical career has changed. Demographically, the American-trained, single, childless, white upper middle class male no longer typifies the resident of today. It is not unusual for housestaff officers to be minority group members, female, foreign-trained, married, and with children.

Coupled with this change in the demographic characteristics of residents was the changing role of hospital health care. As medical technology increasingly established itself as essential to diagnosis and treatment, the hospital became the focus of health care in the community. Residents were required in greater numbers to provide health care. The intimate mentor-resident relationship became less prevalent, especially in the medical specialties. "The

Chapter 1 Introduction

faculty and housestaff have become estranged. . . . House officers have role models but few heroes." (Hardison, 1714.) Residents, particularly those in municipal hospitals, functioned more and more on their own. However, autonomy was a mixed blessing. Although it provided the opportunity to manage a "case" (patient) from admission to discharge, the decision making process for the contemporary resident was complicated by factors not confronted by his counterpart of thirty years before. Medical knowledge had expanded rapidly. Technology in medicine had revolutionized health care. However, not all technologies were available in all hospitals, nor were they sufficient to meet the demands of the patient population. In addition, cost became a factor. Did the patient's insurance cover a particular test? How long was the patient permitted to remain hospitalized, according to the dictates of the insurance carrier? Some concerns raised ethical issues as well, e.g., should surgery be recommended regardless of the patient's age or social situation? Ethical issues became more complex as more treatments became available: should patients be kept alive if the quality of life is unacceptable to the patient? Whereas, once medicine's inability to provide solutions could be compensated for by a physician's bedside manner, residents increasingly had to cope with an array of medical solutions, each with its risks and drawbacks.

Chapter 1 Introduction

The character of the doctor-patient relationship was affected by the changing nature of illnesses presented to physicians. Illnesses that required long term care, such as cancer and heart disease became increasingly prevalent:

In terms of the medical armamentarium available, what was mostly necessary was for the doctor to do, to dose, to purge, to cut and the patient to cooperate and for the most part suffer in silence. (Zola and Miller, 1973)

In addition to the stress resulting from these changes, residents have had to cope with the management of new technologies. Technology in medicine appears not to have decreased the workload, as in other industries, but rather demanded a more precise and constant supervision. Monitors had to be overseen and sufficient staff available to take whatever action was required.

The workload, more intense due to changing technology, is also more tedious, due to bureaucratic exigencies. Responding to health care cost increases that exceed inflation, government, private insurers, and others' attempts to contain costs have funneled down to more paperwork for physicians. Thus, hours that could have been spent studying, resting, and talking with patients' families were consumed with paperwork.

Finally, seemingly permanent shortages of staff, especially nurses, have resulted in residents' doing the work of others in order to get their own work done. The end result of these changes has been frustration: frustration that residents could not do the

Chapter 1 Introduction

job they have been trained to do; frustration that patients were not receiving the care to which they were entitled; frustration that in addition to doing a less than perfect job, their lives outside the hospital suffered; family life was difficult, personal time infrequent.

The Research Issues

In March, 1975 one outcome of these frustrations was a residents' strike under the auspices of the CIR. The CIR, organized in 1957, initially represented municipal hospital housestaff in New York City, but a National Labor Relations Board ruling in 1974 extended the NLRB's coverage to voluntary hospital employees. The 1975 strike of voluntary hospital housestaff (to be discussed in greater detail in Chapter 7) challenged a previously accepted condition of housestaff training, long hours. This strike attracted the attention of several colleagues and myself who were intrigued by the notion that there existed a labor union of professionals, representing physicians in their last stage of training. By attending meetings of their governing body, the House of Delegates, I learned that the housestaff was not a single-minded, unified group, but rather a conglomeration of sub-groups with a variety of backgrounds, goals, and agendas. When the data collection was expanded to include the views of the rank-and-file, these differences and their sources became significant issues in

Chapter 1 Introduction

understanding the nature of the housestaff and its relationship to the CIR.

Originally the question that emerged and formed the basis of this study was: what factors give rise to the formation and growth of a trade union of elite professionals whose status as employee/student permits only a limited tenure in the union? This question led to an examination of the history of the CIR (Chapters 2 and 3), the demographic characteristics of housestaff (Chapter 4) and their working and training conditions (Chapter 5).

The literature on professionals and professionals in bureaucratic settings suggested some models. The professional model distinguishes a profession from other occupations on the basis of a "prolonged specialized training in an abstract body of knowledge and a collectivity or service orientation." (Goode, 1960: 903). The corollaries of these characteristics include educational and training standards set by the profession; licensing administered by the profession; autonomy from the pressures of clients, non-professionals, employing organizations, and the state; professional association; and a code of ethics. On the attitudinal level, a professional is thought to have a sense of calling. Carr-Saunders and Wilson as well as Parsons' elaborations are still the models for the professional viewpoint.¹

Chapter 1

Introduction

However, the criticisms of this perspective and the empirical work done in this tradition, (Merton et al., The Student Physician) have implications for this study of housestaff. Bucher and Strauss suggest that a picture of a profession as a "relatively homogeneous community whose members share identity, values, definitions of roles and interests" (1966:186) including analysis of the socialization process as a crucial determinant of professional norms, values etc. has an inherent bias against conflict of interests within a profession. They assert that professions are "loose amalgamations of segments (coalitions which develop around patterned, shared interests) pursuing different objectives in different manners and more or less delicately held together under a common name at a particular point in history." (Bucher & Strauss, 186) This suggests that an analysis of a profession that assumes all its members were typical overlooks differences that may develop as a result of differences such as specialty, political outlook, background, organization of work. Relevant distinctions might be group practice, fee-for-service or salaried hospital employee; client oriented work vs. researcher), sex, medical school, type of hospital, stage and place of training. For this study, it became clear that the heterogeneity of the housestaff was significant. Certain "segments" play a role at different points in time. For example, at the time of the data collection, foreign medical graduates (FMG's), who are residents educated abroad most of whom

Chapter 1

Introduction

are foreign born, accounted for 20% of the total housestaff in the U.S. (Crowley, 1983: 1547) and 50% of the housestaff that CIR represented at that time. The question to explore is whether the CIR addresses any of the problems or issues that are specific to FMG's and how FMG's view their role in CIR.

Another segment differentiation might be based on specialty. Stephen Miller, in his study of interns' experience at Boston City Hospital, observed that specialization in medicine

produces subgroups whose members are more like one another than like members of other subgroups in medicine. Thus we see not one but many groups of physicians, each with a purpose and typical career of its own. (1970: 4)

Coser (1958) suggested differences between medical and surgical specialists. For example, a former CIR President characterized the medical residents as the "thinkers" and the surgical residents as the "doers." (Interview - coincidentally, he is a surgeon.)

The workplace could be the basis for a third group of segments. Freidson (1971) has suggested that the organization of the work setting is a key variable in understanding medical practice. Here comparison by hospital is called for. Mumford's study (1970) of the socialization of interns at "Community Hospital" and "University Hospital" found a difference in the values emphasized in each setting. Interns at Community Hospital valued efficiency, whereas those at University Hospital stressed learning and thoroughness. Thus, extensive diagnostic testing at

Chapter 1 Introduction

Community Hospital was regarded as wasteful, whereas in University Hospital it was expected.

Voluntary and municipal hospitals have distinctive reputations. From the housestaff officer's perspective a residency in a municipal hospital offers comparatively more autonomy over one's work than in a voluntary counterpart. This issue of autonomy has become a prevalent theme in the analysis of the medical profession. Freidson argues that the one distinguishing feature of the profession is the ability to be autonomous, at both the group and individual levels. The profession is free from control by non-professionals so that it may develop and enforce standards without interference; the physician is autonomous (in varying degrees, depending upon the nature of the work setting) in his control over the work and patient's diagnosis and treatment. The medical profession's defense of this privilege is that by virtue of their extensive education and training, only their members have the judgement to address issues of medical care. Thus, anyone without the requisite training can not possess the skills to dictate to the physician.

Another assumption made by functionalists is that medicine is an altruistic, albeit income-producing profession, and therefore, we as a society have granted physicians extensive power in that capacity. According to Carr-Saunders, the physician is endowed with a great sense of responsibility. However, as more cases of

Chapter 1 Introduction

physicians violating this trust for economic motives reach our attention, the more difficult it is to accept this model, thus causing us to question the credibility of the profession.

Similarly, Parsons' assertion that physicians make decisions based on "rational-scientific" considerations comes into question when factors such as third-party insurance, Medicaid and Medicare, and rising malpractice insurance rates dictate or influence the decision making process. What is the role of these considerations in light of allegations of unnecessary surgery, "drug pushing," and numerous other accusations that the medical profession is not as community oriented as the image of the altruistic family doctor suggests. The CIR attempted to resurrect this notion of altruism through its "patient care" ideology which will be discussed in detail.

Another issue raised by Parsons concerns the role of universalistic criteria in the treatment of patients. The contention that physicians treat all patients equally regardless of social differences such as race, sex, and social class has been challenged by those that argue that criteria of "social worth" are invoked by physicians. For example, are distinctions made between municipal hospital patients who are more likely to be poor, minority group members and voluntary hospital patients who are inclined to be white, middle class and insured. A recent study found racial differences to be a factor in the treatment of heart

Chapter 1 Introduction

patients. (Stevens, 1989:1)

Another hypothesis asserts that, in the case of residents, a patient's worth is not determined by socio-economic characteristics, but rather by the "uniqueness" of the illness. Patients whose conditions are rare or "exotic" are considered more valuable than those with "routine" conditions because of the learning opportunities they provide. This assertion would be predicted by the literature on medical school socialization (Merton, 1957; Becker et al., 1961).

The significance of whether housestaff employ "universalistic" or "particularistic" criteria in servicing patients focuses on the relationship between CIR's emphasis on patient care and residents' perspective on treatment of patients. The analysis of how "patient care" is operationalized as a union philosophy and to what extent it coincides with the assumptions of individual housestaff officers in their daily work becomes significant.

In sum, this study will examine the role of the CIR in terms of the role of the professional. Is CIR attempting to restore the physician's image as an altruistic figure, whose concern about all patients is sufficiently far-reaching to be a major union issue? To what extent does membership in a housestaff "segment" affect one's perspective on CIR's goals?

The CIR, as a labor organization, illuminates aspects of the medical profession that may be in the process of change. CIR,

Chapter 1 Introduction

through its emphasis on organizing housestaff, enforcing labor contracts, and promoting a seemingly altruistic program of patient care, confronts the needs and priorities of its members. This study will investigate the influence of segments on residents' priorities in labor contracts, their willingness to support CIR, their definition of what CIR's goals should be, and their perspective on patient care.

However, residents differ from physicians in practice in that they all are trainees in a hospital setting, subject to the professional standards of medicine, as well as the bureaucratic rules of the hospital. The bureaucratic model, often portrayed as contradictory to the professional model, is characterized by position based on technical expertise, a hierarchy of authority, and governance by rules and regulations (Weber, 1958). Residents, as professionals in a bureaucracy, are affected by both professional standards and bureaucratic rules. One perspective argues that the relationship between these two jurisdictions is intrinsically a conflicting one. (Kornhauser, 1962) For example: a) goals of the organization differ from that of the professional employee. Discussions with housestaff reveal an awareness of the legitimacy of financial considerations on the part of the hospitals, but find budgetary cuts resulting in cuts in their programs to be intolerable in light of medical considerations, such as patient care and physician training.

Chapter 1 Introduction

b) Necessity of administrative work. Housestaff resent the increasing paperwork required by bureaucratic organizations, as well as any tasks they feel inappropriate to their status and therefore, more suitable to other hospital personnel. This "out-of-title work" has been a negotiating point in contracts as well as a basis for striking. How this issue is handled is central in following an ongoing "negotiation" of the division of labor among occupational groups. c) A third strain develops from the "cosmopolitan-local" conflict (Kendall, 1965), i.e., the "cosmopolitan" desire to be recognized by one's profession for professional accomplishments vs. the "local" requirement for recognition by persons within the local organization. For housestaff the conflict emerges as a tension between career aspirations that are perceived to be directly affected by recommendations from one's mentor and putting oneself "on the line" by participating in union actions, designed to change the situation in one's hospital. The range of housestaff activism by hospital will be explored. d) Finally, decision making is problematic in terms of the professional taking on a management role and allocating less time to his professional duties. This is less of a problem for residents because although they move up the hierarchy, as residents they never reach the level of management. However, since they may aspire to administrative positions in the future they may identify with management and be reluctant to

Chapter 1 Introduction

jeopardize their positions. Hall's analysis of the "inner fraternity" of medicine (1946) suggests that there is an informal elite network which controls the appointments to medical institutions which would not look favorably on a "renegade" doctor.

This framework suggests that bureaucratization and professionalization exist in a conflicting relationship to one another. Thus placing the professional in the bureaucratic organization will result in problems for both the organization (inefficiency, low productivity, and conflict) and the professional (low morale, job anxiety, and alienation). However, Benson's review (1973) of the existing literature on these problems indicate that none of the anticipated difficulties occur as expected. In fact, a study of the implementation of the British National Health Service, a move toward the bureaucratization of medicine, suggests that "the implementation of health service was a high watermark of security and status for the medical profession." (Parry and Parry, 1977:830)

Benson's alternative paradigm is an approach emphasizing:

- 1) conflicts of interests concerning issues such as goals or vested interests which always exist as bases for change; 2) a view of the social order of organizations as politically negotiated where the emphasis is on the distribution and control of focal commodities (financial rewards, prestige, authority, and autonomy) and 3) a processual approach conceptualizing the organization as a

Chapter 1 Introduction

constantly changing entity due to the changes within it, e.g., changing social background of participants, socialization patterns etc. Therefore, the goal of this type of analysis is to relate bureaucratic-professional aspects to other contradictions in the organization. This allows for a new perspective permitting a separation of housestaff from other physicians in the hospital setting as well as an investigation of the significance of the heterogeneity of "segments" of the housestaff. By separating out the housestaff as a distinct physician group we can see how the professionals and the bureaucracy can align themselves, such as when the chief of service and the administrator can both oppose a housestaff group on certain issues since they are both in dominant positions in the dual authority system (Smith, 1955). Similarly, a professional housestaff strike might be supported by a hospital workers union since they are both in a subordinate position in the context of the hospital.

The bureaucratic-professional conflict is not merely a problem of professional and organizational development, but has implications for the political economy of health care as well.

Alford argues that:

both the expansion of the health care industry and the apparent absence of change are due to a struggle between different major interest groups operating within the context of market society-professional monopolists controlling the major health resources, corporate rationalizers challenging their power and the community population seeking better health care. (1972:128)

Chapter 1 Introduction

The "professional monopolists," including physicians, researchers, and others advocate reform on a market basis whereby the consumers choose and evaluate health care thus driving out bad physicians. They favor a system in which physicians are the core, and the hospitals, medical schools, and public health agencies provide the organizational backup. "Corporate rationalizers," the new cadre of hospital administrators, medical school and public health officials, favor bureaucratic reform in which the hospital is the focus of care and physicians are salaried and controlled by medical boards and hospital administrators. "The greater supervision and checking of medical decisions in the hospital context is seen as far outweighing the possible loss of personal contact." (Alford, 1972:131) The health care system would be regionalized and physicians would lose control over areas that they traditionally governed, e.g., length of training, allocation of manpower etc. (The third group, consumers, is not dealt with as they either are not organized to the extent of the first two groups or have been co-opted by them.) Alford concludes that neither group is interested in reform in terms of making health care less expensive and more accessible and equal. Rather the professional monopolists, by using a "symbolic screen of legitimacy," are attempting to maintain their position of power and the corporate rationalizers are attempting to expand the bureaucratic structure and increase their power. In the final

Chapter 1 Introduction

analysis, Alford dismisses both groups as working within the system representing the upper middle class and the private sector, and asserts that in order to integrate the health care system a major upset of the existing power base would be required. A housestaff union then, according to Alford, may merely be professional monopolists in training, seeking to maintain their autonomy in the face of corporate rationalization. Are housestaff organizing to gain more control over the environment in which they work, and for whose benefit?

Role of the union

More specifically, an issue that requires examination is what are the roles of a white collar union, in general, and a housestaff union, in particular? (Chapter 6) Although there has been a decrease in the overall rate of unionization in the U.S. (23% to 18% between 1980 and 1985) the rate of white collar unionization has remained relatively stable (16% to 15.2%, Monthly Labor Review, 1986:44).

Mills argued that a "specific kind of job dissatisfaction" - the feeling that as an individual he cannot get ahead in his work - is the job factor that predisposes the white collar employee to be pro-union (Mills, 1956:307). In the case of professional employees, this dissatisfaction may result from a lack of control over the allocation of resources considered necessary to work up

Chapter 1 Introduction

to professional standards. "In that sense, they are organizationally impotent even though technically autonomous." (Freidson, 1986: 178) In addition, Mills cites political party affiliation and exposure to unions as additional factors that promote pro-union attitudes. Blackburn and Prandy (1965) add such factors as the attitude and behavior of the employer (pro or anti-union), the growth of bureaucracy which treats the employee as a member of a category rather than an individual, and the degree of control the individual has over work. Oppenheimer, who agrees that the loss of autonomy is a major factor in professional unionization, asserts that there is a "two tier" professional labor force consisting of: 1) older workers who are less employable as a result of not having necessary technological skills and 2) younger workers who are "overeducated for jobs that becoming more segmented, less autonomous, and less professional" (1975:38). Although residents, as new entrants into medicine, do not precisely fit into either category it could be argued that although they are not overeducated for the constantly changing state of medical knowledge, the work is becoming more specialized and increasingly subject to regulations of outside agencies while the work settings are "undersupplied" to meet their professional needs. Lack of equipment, drugs, and support services lead to frustration.

An additional issue that needs exploration is how a union which is itself a bureaucracy and is "anti-professional," in that

Chapter 1 Introduction

it advocates collective rather than individual action can combat the ills of the professional in a bureaucracy. "Professional matters become legislated, nothing remains sacred or exempt. . . In the process of having autonomy taken away by administrators, the professional becomes deprofessionalized; in defending what remains of autonomy, further deprofessionalization can result." (Oppenheimer, 1975:40) From the perspective of the professional worker a union offers economic advantages (wages, hours, benefits) at the expense of prestige because the distinction between themselves and other workers is blurred. (Mills, 1956:311-314)

Only if other influences (for example, a high level of professional commitment which stimulates criticism of inadequate service-delivery systems) move white collar organizations in the direction of challenging the fundamental rule of work, including the nature of the product or service and the process of decision-making, will professionals move beyond bread and butter unionism. (Oppenheimer, 1975:40)

This returns us to the question of what the role of a housestaff union will be. Can it have an impact on residents as they pass through their training as well as on the delivery of health care? The transient status of resident distinguishes housestaff from most other unionized workers who join a union in anticipation of a lifetime career. One possibility is that although membership in the CIR or other organizations is transient, it can be part of a medical career characterized by activism. Resnick, (1976) in a study of activists in the Student Health Organization, medical school curriculum committees, housestaff

Chapter 1

Introduction

organizations and participants in national health centers, implies that this may be case as they found participants remaining active in several stages of their careers. He ends his study on a note of optimism with respect to the "vanguard" of the new physicians. Among the norms cited as part of the new ideology are team work and the demystification of the doctor, personal care and generalism, i.e., the role of the physicians becomes one of patient advocate in a framework that emphasizes prevention and comprehensive care, community control, humanitarianism, and equality (1976). Fitzhugh Mullan, a physician who was active in several of the organizations mentioned, was a CIR president, and was a participant in related political-medical activities, such as providing medical care for civil rights demonstrators, wrote an account of the events of the sixties and seventies (1976). He found that, of the colleagues he had contact with, none had become solo fee-for-service practitioners, but rather remained in medicine in work settings that allowed them to continue to attempt to effect change. (1976)

However, given that it is beyond the scope of this study to determine if the CIR has created or contributed to a "new breed" of physicians, perhaps its effects can be measured in changes in the role of the resident and "local" changes in the delivery of health care.

It appears that as the service orientation of housestaff unions increases throughout the country, the possibility that

Chapter 1 Introduction

"patient care" can be negotiated through collective bargaining becomes more viable. Consequently, whether or not individual residents' motives are altruistic, the consequences of union activity can affect patient care in hospitals where housestaff are organized. For example, one action taken by local CIR housestaff has been to testify at hearings by the Joint Commission on Accreditation of Hospitals. These hearings present an opportunity to expose hospital conditions to a body which has the authority to mandate change. (In this way housestaff unionization is similar to the youth movements of the sixties in that the members were transitory and may subsequently have joined the "establishment," yet their activities resulted in lasting social change.)

Secondly, unionization has been a cause and an effect in the changing role of the resident. Previous generations of housestaff devoted themselves to accumulating as much medical knowledge and experience as possible while receiving a "stipend" to support themselves in a situation that ruled out "extracurricular activities" such as marriage and family. Today's resident defines her role as worker as well as student. The consequences of this definition are that "privileges" can be redefined as "rights." A stipend becomes a salary; housestaff marry and have children before they complete their training; treatment regarded as unfair becomes a grievance, rather than a rite of passage; and housestaff belong to an organization that defends their interests. The CIR stresses

Chapter 1 Introduction

the ongoing dynamics of these changes as housestaff in various hospitals gain and lose these rights.

Thus, by belonging to an organization that protects them, residents may be more willing to question the conditions of their socialization process. For example, the issue of long hours as inherently necessary in a residency has been questioned by the CIR for many years. Previously there were no specific guidelines or regulations to determine the appropriate number of hours a resident was required to work. As students, residents accepted this. As workers, hours become an issue that affects the health and welfare of residents as well as patients. And it was not until 1988 that the State of New York chose to regulate this matter. Establishment physicians can no longer enforce the cliché "If I went through it, you should too." This suggests that the traditional authority structure of the profession may be in the midst of change.

Research Methods

Methods

In order to obtain historical data about the CIR and data on its current operation, as well as the views of the rank-and file, it was necessary to implement a variety of data collection methods. The CIR was very cooperative in allowing access to its files, its Executive Committee and House of Delegate meetings, some negotiating sessions, and all pertinent documents. Among these

Chapter 1

Introduction

documents were official union documents such as memos, position papers, newsletters, meeting minutes, contracts, Constitution and By-Laws etc. Secondary sources such as newspaper accounts, scholarly analyses, and autobiographical descriptions were also consulted.

Participant observation included attendance at meetings of the House of Delegates (Spring, 1975 to Spring, 1981), the Executive Committee (Fall, 1979 to Spring, 1981), and the national housestaff organization's annual meeting (May, 1980), observing the strikes of 1976 and 1981, and working unpaid in the CIR office one day per week for a period of approximately seven months (Fall, 1979 to Spring, 1980). Being involved in the CIR allowed me to observe the workings of the organization on a daily basis.

Interviewing entailed talking with previous CIR leaders and participants (Fall, 1979-Spring, 1980 for CIR members before 1975 and Spring, 1975 for participants in the 1975 strike), a CIR attorney who was instrumental in its formation (December, 1979), current leaders and delegates to the House of Delegates (Spring, 1981), as well as a randomly selected rank-and-file sample chosen from four CIR hospitals representing a range of working conditions (Fall, 1980-Spring, 1981). The purpose of the random sample was to examine the relationship between the structure of work and perceptions regarding the union. For example, the discontent produced by the bureaucratic-professional conflict would be greater

Chapter 1 Introduction

in more "undesirable" hospitals than in "desirable" ones.

The CIR knew of all my research activities and provided lists of CIR members at the hospitals. The respondents were promised anonymity.

Research questions

Because the size of the sample did not permit extensive statistical analysis and hypothesis testing, the data were analyzed in a descriptive manner, providing evidence for the examination of issues of housestaff unionization. The following questions will be discussed in subsequent chapters for that purpose:

1. Why does a group of seemingly high status physicians, in a transient status as residents with lucrative futures, opt to unionize?
2. What role does membership in "segments" such as specialty, hospital, or year of training (postgraduate year or PGY level), play in the formation and/or activism in the CIR?
3. Have changes in the demographic composition of residents influenced the role of the CIR?
4. Have working conditions changed or become more unacceptable so that unionization appears to be a more viable option?
5. What are the consequences of CIR's actions on the traditional labor issues of wages, hours, and conditions of work?

Chapter 1 Introduction

6. What are the consequences of CIR's actions on patient care issues?

7. How does CIR resemble a traditional labor union and in what ways is it different?

8. How do changes in the delivery of health care affect the future of physician unions?

An event that helped clarify these issues was the CIR strike of 1981.

The 1981 Strike

The 1981 municipal housestaff strike was an unanticipated event when this research began. It allowed for further examination of the use of union strategy in the pursuit of altruistic goals (Chapter 7). The goal of "patient care," empirically defined in the 1981 strike as minimum standards of staffing and equipment, provided an opportunity for the union to define its own goals and test the utility of striking to further a typically non-union goal. Through participant observation at strike sites and at local hospital meetings, as well as CIR central office meetings, followed by interviews with housestaff leadership these concepts could be further investigated. As it happened, although two of the hospitals in the sample were voluntary, they both opted to join the municipal strike. In addition, the one municipal hospital that did not participate in the strike was also part of the sample. Thus,

Chapter 1

Introduction

a range of attitudes and actions could be explored. The leaders were able to comment in retrospect about the 1981 strike and striking in general.

Summary

The area of professional unions has been a relatively unexplored phenomenon. A housestaff union appears to be an anomaly in a society where medicine, in spite of individual attacks on the ethics of some of its practitioners, remains one of the most respected and well paid professions. Yet, changes in the social composition of housestaff (and consequently, practicing physicians), as well as changes in the structure of the delivery of health care have compelled physicians to reexamine their own aversion to trade union membership. Although CIR is not the first union of physicians - it was preceded by others in Belgium, Sweden, Israel, France, and Canada (Craven, 1964; Kassalow, 1969; Ben-David, 1965; Dobrinski et al, 1983; and Badgeley and Wolfe, 1967) - comparisons will not be addressed due to the differences in the health care structure in those countries from that of the United States. However, although these unions preceded CIR, CIR was one of the first housestaff unions, whereas the unions referred to here have been unions of physicians in practice.

In addition to the previously mentioned changes in health care, the changing social problems that infringe on the practice

Chapter 1 Introduction

of medicine present challenges that a professional union may choose to focus on in its role as a agent of change. The issues to be explored here are how CIR members conceptualize the role of CIR and how the CIR chose to define itself. Perhaps the answers to these questions will provide further insight into the future role of physician unionization.

Footnote

1. Both Carr-Saunders and Parsons, in their early analyses of the professions, defended this special status of the professions. Parsons (1949: 37-41) argued that 1) based on rational-scientific considerations of what to do, the professional will make the "best" choice, 2) the work of the professional is based on functionally specific technical competence so that a "contractual" arrangement spells out the rights and obligations of the parties involved (physician-patient). The technical competence is the basis of the authority of the professional. Carr-Saunders agrees that the "possession of a technique" is the dominant characteristic of the profession and

the more its practice is likely to arouse a sense of responsibility, the closer will be the approach of the vocation to the centre. . . . Practice which involves direct and personal relations to clients evokes a special feeling of responsibility. . . . In general the salaried status implied that there is no direct relationship, and on that account it has been doubted whether any but fee-takers can be professionals. (Carr-Saunders and Wilson, 1933: 285)

Finally, Parsons suggests that universalistic criteria form the basis of the professional-client (doctor-patient) relationship so that the client will receive attention based on his problem, not who he is.

Chapter 2

The History of the CIR: 1957-1975

This chapter shall concern itself with the origins of the Committee of Interns and Residents in 1957 through the strike of 1975. It was the strike that caught the attention of the writer and it is from this event up to 1981 that data were collected in the form of observations of meetings, daily office work, formal and informal interviews, as well as reviews of CIR documents and other secondary sources. The data in the period up to 1975 are based on interviews with Murray Gordon, the CIR lawyer from 1957 to 1979, CIR leaders, and CIR members, as well as secondary sources.

Housestaff organizing prior to 1957

Prior to the organization of CIR other attempts had been made to organize interns. As early as 1934, sixty-six intern representatives from twenty-six hospitals formed the Interne Council of Greater New York. They came together to alleviate such conditions as lack of teaching rounds, salary, and dangerous working conditions, such as ambulance riding. In 1935 the New York Board of Estimate awarded them \$15 a month. The following year they reconstituted themselves as the Interne Council of America (ICA). They published a monthly journal with a circulation of 7,000 and \$1 membership dues. Among their accomplishments were the inclusion of interns in the New York State Workmen's Compensation Law, and the upgrading of medical libraries in many hospitals. They supported national health

Chapter 2

The History of the CIR: 1957-1975

insurance and criticized the AMA for its opposition to national health insurance. By 1939 they claimed a membership of 3,000 with affiliated chapters in New Jersey, Baltimore, Chicago, and Boston.

ICA merged with the Association of Medical Students (AMS), an organization of activist medical students, in 1941, forming the Association of Internes and Medical Students (AIMS). They supported the war effort, the draft of physicians, and argued against discriminatory admission policies of medical schools. After World War II they argued for postgraduate training for military veteran doctors, focused on working conditions such as a salary of \$12,000, limitations on laboratory and clinical chores, better food and housing, and elimination of discriminatory practices in medicine and medical education, as well as international cooperation. By 1946 AIMS had fourteen chapters and in 1947 their convention was attended by 307 delegates and observers from 63 medical schools and hospitals.

However, in 1948 there was a shift in AIMS' good fortune. Increased specialization among interns led to a fear of jeopardizing careers: specialization meant increased selectivity for positions and greater dependence on recommendations for future jobs. (This relationship between increased specialization and decreased union activism will be explored further.)

Chapter 2

The History of the CIR: 1957-1975

In June, 1948 the AMA Convention initiated an investigation of AIMS as a communist organization. Although AIMS denied the charges and cooperated in the investigation, two years later the AMA Council on Medical Education and Hospitals concluded that AIMS was a left-wing organization and wrote letters to all interns citing an article which attacked AIMS as leftist. The lines were drawn for an "ideological battle" (Harmon, 505) between the AMA and AIMS regarding elimination of racial discrimination in medicine, salaries for interns, and national health insurance. Eventually against the background of McCarthyism, in conjunction with a lack of funds, declining membership, and competition from the Student American Medical Association (SAMA), an AMA sponsored group, AIMS went out of business in 1952.

The formation of CIR

In the 1950's organizing remained dormant on a national level until 1957. The event that precipitated the formation of the CIR was the deduction of social security by New York City from the municipal housestaff's paycheck. In 1957 municipal interns were paid \$71 a month and residents received \$105 a month, plus room and board. Several Jacobi Hospital housestaff officers, Herbert Vaughan, Sam Switzer, and Mark Levine, approached Murray Gordon, a prominent labor lawyer, known to one of them personally, for help on this matter. As Mr. Gordon put it, "I didn't think the problem

Chapter 2
The History of the CIR: 1957-1975

was the size of the bite, but the very small pie from which the bite was taken." (interview)

Consequently, the focus shifted from the social security problem to the larger question of the wage structure, in general. There were meetings with housestaff from the other municipal hospitals, including Saran Jonas, the representative from Bellevue Hospital. (Altogether there were twenty-eight municipal hospitals.) In preparation for a presentation to the Board of Estimate of a detailed analysis of the wage structure of municipal housestaff, there were meetings with Mayor Robert Wagner and Comptroller Abraham Beame, as well as with the borough presidents. A New York Times editorial supported the housestaff position. Essentially, the argument was made that their advanced education and skills merited more than the current \$.13 per hour. Additionally, the low pay made it difficult to attract American medical students to the municipal hospitals; thus, training suffered because training programs for foreign graduates often did not exist. Mayor Wagner was very receptive and simply directed Comptroller Beame "to do something about this." The CIR had asked for a salary of \$4,000 a year; they were given \$1,200 to start, a 45% increase. This initial campaign was likened by Dr. Vaughan to a "holy crusade because it was so obvious that house physicians were underpaid for what they were doing." (Interview)

Chapter 2

The History of the CIR: 1957-1975

This victory set the stage for organizing the city housestaff around a variety of issues. In order to pay Murray Gordon, housestaff were asked to give \$5.00 each. According to Dr. Jonas they succeeded in collecting this amount from one-third of the city housestaff. This supported the leadership's contention that they did indeed represent housestaff throughout the city system. In addition, an awareness was created among the housestaff that there was a union available to them, the CIR.

In retrospect it appears that each new housestaff cohort believes itself to be in the vanguard by fighting for patient care, as well as housestaff rights and benefits. It seemed that "almost from the beginning there was as much a concern with patient care issues as there was with matters of self aggrandizement." (Gordon interview) Thus, the CIR was conceptualized as an organization that could be utilized for ongoing dialogue with the Department of Hospitals on a variety of issues, including the delivery of medical care in the municipal hospitals. Dr. Vaughan, the first chairman of the CIR, submitted a report to the Mayor's Commission on Health Services, entitled "Hospital Organization and Patient Care: a Survey of the New York Municipal Hospital System with Proposals for Increased Efficiency of Service." Without seeing the report, the Commissioner of Hospitals, Morris A. Jacobs admitted that the housestaff knew the problems of the hospitals, since they were "on the operating level." (New York Times, 6/19/59, "Municipal

Chapter 2
The History of the CIR: 1957-1975

Hospitals under Attack," : 1) The New York Times, in an editorial, agreed that the housestaff were credible sources: "No one knows better about hospital conditions than those who work in them and it is the professional staff who can best be their judge - such as are those who have made this report." (New York Times, "City Hospital Medical Care," 6/22/59) The report demonstrated that affiliated municipal hospitals, i.e., those whose training and supervision was the responsibility of medical school staffs, delivered higher quality medical care than those that were unaffiliated. Among the affiliated hospitals were Bellevue, Kings County, Bronx Municipal, and Metropolitan. For example, although Bellevue and Gouveneur Hospitals both served the same catchment area, Gouveneur (unaffiliated) had a mortality rate of about 33%, whereas Bellevue (affiliated with Cornell-NYU-Columbia) had a rate of 11%.

Affiliation, however, was not a guarantee of quality care, as the nature of the affiliations varied. Thus, although Lincoln Hospital had an affiliation agreement with Cornell University, the extent of the affiliation was to provide an opportunity for medical students to do physical exams. Cornell apparently did not provide any further services so that, in addition to poor physical conditions for patients, "we saw diseases that should have not existed in modern times." (Vaughan interview)

Chapter 2

The History of the CIR: 1957-1975

Thus, it was argued, that the lack of consistent affiliation contracts and a "stipend" for housestaff among the lowest 15% in the country accounted for poor quality care. Although 80% of intern positions in affiliated municipal hospitals were filled, less than 1% were filled in non-affiliated hospitals by American graduates. The remaining positions were filled by foreign graduates who, in addition to often having language problems, presumably had "substandard" training. (This claim, that FMG's provide poorer quality medical care than their American counterparts, has been stated repeatedly, yet no study has clearly demonstrated this.) Nevertheless, in 1960, the AMA threatened to withdraw accreditation for housestaff training programs where foreign graduates were not certified by an AMA examination in both linguistic and medical competence. This exacerbated the fear that the competence of housestaff would decline even further.

The proposal focused on an affiliation program based on a survey of medical needs in the various regions of the city. The attractiveness of the proposal, from the city's point of view, was a predicted increase in the quality of medical care, as well as a more efficient citywide system of health care. The eventual outcome was an affiliation system under the HHC that was a great disappointment to Dr. Vaughan, among others. First, not all affiliations were with medical schools, but rather some were with

Chapter 2

The History of the CIR: 1957-1975

"strong voluntary hospitals." Vaughan attributed this change to political maneuvering by Dr. Martin Cherkasky, a significant figure in the NYC health scene who wanted the advantages that could be gained by affiliation, such as alternate sources of financing and a greater influence in health care decision making in New York City. Dr. Vaughan, and others, felt that this was one of the factors that led to abuses in the affiliation program. Secondly, the concept of regionalization was ignored: Mt. Sinai and Elmhurst Hospitals were affiliated although geographically they were unrelated. Nevertheless, the education of housestaff officers in municipal hospitals was upgraded.

Working and training conditions for housestaff in 1958

Specialization

In 1958 the medical profession was in flux: specialization was increasing and consequently, the number of medical school graduates that went on to extended residencies was also increasing. During World War I the average physician's training included a one and one-half year internship, followed by entrance into medical practice at age twenty-eight. (Ludmerer, 1985) Prior to World War II less than 25% of medical school graduates went on the further training. In 1945, 80% of all physicians identified themselves as general practitioners; in 1972, it was 18.6%. (Martin, 1972) (See Table 2a). Advances in drugs, surgery techniques, and medical

Chapter 2
The History of the CIR: 1957-1975

knowledge in general, prompted medical students to specialize. This required a minimum three year residency for specialties such as internal medicine, pediatrics, and family practice, while the remaining specialties required four or more years of residency.

Table 2a. Percent of Practicing Physicians by Specialty in U.S.*

	<u>1931</u>	<u>1940</u>	<u>1949</u>	<u>1960</u>	<u>1963</u>	<u>1969</u>
<u>PT Specialists</u>	83	77	64	43	35	23
<u>& GP's</u>						
<u>FT Specialists</u>	17	24	36	57	65	77
<u>Medicine</u>	5	7	11	19	21	24
<u>Surgery</u>	10	13	18	26	29	30
<u>Psychiatry/</u>	1	2	3	5	7	8
<u>Neurology</u>						
<u>Other</u>	2	3	4	7	8	15

*Data from Rosemary Stevens. American Medicine and the Public Interest. Table 2., p. 181.

More recent data indicate a continuation in the trend to specialize:

Table 2b. Percent Distribution of Federal and Non-Federal Physicians by Specialty for Selected Years 1965-1986.**

	<u>1965</u>	<u>1970</u>	<u>1975</u>	<u>1980</u>	<u>1983</u>	<u>1986</u>
<u>GP's</u>	24	17	11	7	5	4
<u>Family Practice</u>	N.A.	N.A.	3	6	7	8
<u>Internal Med.</u>	13	13	14	15	16	16
<u>General Surgery</u>	10	9	8	7	7	7
<u>Psych/neurology</u>	7	7	7	7	7	7
<u>Pediatrics</u>	5	5	6	6	6	6
<u>Other specialties</u>	41	49	51	52	52	52

**Source: Physician Characteristics and Distribution in the U.S. 1986 Edition. Department of Data Release Services, Division of Survey and Data Resources, American Medical Association, 1986. (This data is presented using different specialty categories due to the limitations of available data. Thus, in Table 2a, the category "Medicine" includes medical specialists, whereas in Table 2b, "Internal Medicine" only includes that specialty while other medical subspecialists are included in "Other specialties.")

Chapter 2
The History of the CIR: 1957-1975

What is evident from these data is that the category of "general practitioner" is being phased out. "Family practice" is the specialty developed in the late sixties, replacing the general practitioner functionally, but not numerically. However, in general terms, virtually all residents specialize and thus spend a minimum of three years in their residencies.

In addition, there is a tendency to subspecialize, thereby increasing the years of training to between five and seven. Although there appears to be no specific statistics regarding the proportions that go on to subspecialize, the following table demonstrates a trend to change away from primary care specialties to other specialties.

Table 2c. Percentages in the specialty between the postgraduate years of (1980):*

<u>Specialty</u>	<u>1-3</u>	<u>3-4</u>	<u>4-9</u>
<u>Internal Medicine</u>	35/32**	32/20	20/16
<u>General Pediatrics</u>	12/11	11/9	9/8
<u>Family Practice</u>	11/10	10/10	10/10
<u>Total Primary Care</u>	58/53	53/39	39/34
<u>Other specialties</u>	42/47	47/62	62/66

*Source: U.S. Department of Health and Human Services. Third Report to the President and Congress on the Status of Health Personnel in the United States. March, 1984, p. 154.

**In each cell, the figure on the left indicates the percentage in the first postgraduate year of the column heading and the figure on the right indicates the percentage in the last postgraduate year of the heading.

Here, the evidence indicates that the primary care specialties, which are the only ones (in addition to public health) requiring less than four years of residency, are losing residents to the

Chapter 2

The History of the CIR: 1957-1975

secondary specialties, which include subspecialties of medicine and pediatrics, as well as surgical and other specialties.

The training programs

Thus, the increase in the number of residents in the hospital had an impact on the nature of the training program itself.

According to Gordon:

The city hospital system was a great health care system prior to World War II. It was preeminent. . . They (the residents) were the elite; they were the cream of the crop. And they really were the disciples of the great men who were running the service. . . It was a tutelage relationship and that had certain merits and a great many drawbacks. Certainly, with the attitude towards family, toward authority after World War II that kind of system, if it didn't break down completely, was greatly diluted. So that meant there was more of an impersonal relationship between Chiefs of Service and people in their training program. They were no longer disciples and so there was some quality that was lost in their training. . . It's clearly now a relatively depersonalized apprenticeship. (Interview)

Nevertheless, at some hospitals there remained a residue of the "genteel collegial relationship." Saran Jonas, a Bellevue resident and founder of CIR, related the reaction of an assistant administrator, who was also a physician, to the change from dining room service complete with white tablecloths to a self service cafeteria:

He was very upset over that because he felt that the interns and residents worked exceedingly hard, which they did. . . the administration was really quite considerate of the housestaff and very courteous to us and really did the best they could and he tried very hard to keep the dining room

Chapter 2

The History of the CIR: 1957-1975

staff going. He said it was the only bit of grace available to the house officers who were working in really filthy circumstances. (Interview)

According to Jonas, housestaff at Bellevue were satisfied with their working conditions which he described as "conventional." Everybody had a room in the housestaff quarters, was provided with meals and laundry and worked every other night and every other weekend. A HHC administrator, who had been a housestaff officer at that time, described the work as hard and the lack of facilities and supplies as necessitating "innovation:"

I worked on one ward where there was one AC outlet for a forty bed ward. You wanted to do an EKG, you had to wheel the patient into the bathroom. . . I stole and made a one hundred foot extension cord so we could get to the bedside. We used to steal light bulbs, syringes. It was terrible. (Ed Rothschild, interview)

Although there was frustration with the equipment, physical surroundings, and lack of staff, which prevented the delivery of optimal medical care, there was an acceptance of other conditions that most directly affected housestaff, such as hours:

Working conditions in those days were not working conditions. You have to understand that there's a tradition which still exists that when you're a house officer there's a combination of hard work and learning and you learn by working. It's kind of an initiation process, certain rituals - if you didn't collapse in a heat you weren't really getting out of it what you should. The harder you worked the better doctor you would be . . . We used to sleep on wards. I used to sleep in treatment rooms. You sack out anywhere you could. It was brutal. (Rothschild interview)

Chapter 2

The History of the CIR: 1957-1975

We weren't concerned so much that we were working one hundred hours a week. I don't think that there was ever any real feeling that we worked too hard. Sometimes we were concerned that we didn't go to bed for three days and that kind of thing. But that was sort of part of the game, you knew that was the way. (Vaughan interview)

Structure of the CIR

The CIR, initially, was an informal group, with a Constitution and by-laws, and an elected president and Executive Board. There were five to ten members who were active. However, since interns and residents were all in training programs, and since residency is a temporary status (average three years), they depended on Murray Gordon's office to administer the everyday activities of CIR. In fact, Gordon's office was the headquarters for CIR until 1974. For the first twelve to fifteen years:

we handled their grievances, we helped them organize, we helped collect dues. We instituted a health program, a life insurance program. . . We helped administer that through our office. In our office we provided the full range of staff activities as well as legal activities. (Gordon interview)

Additionally, the lawyers carried on an ongoing dialogue with the Department of Hospitals on issues pertaining to patient care in the municipal hospitals. According to Gordon, "we persuaded the Commissioner of Hospitals that we were important to him as feedback; that he could get from us a clearer picture of what was happening in the hospitals than he could get from his administrators who had vested interests of their own to serve." (Interview) Vaughan, for example, wrote a position paper on

quality of care issues in the municipal hospitals. The Trussell Commission incorporated it into their recommendations, which ultimately resulted in the formation of the HHC. CIR worked with DC 37 (the hospital workers' union), the nurses' association, and the HHC on recruitment and retention of nurses in the municipal hospitals.

Although most reports of the initial formation of CIR concur that the city was receptive to such an organization, it did not go unnoticed by those who perceived it as a threat. There were several cases of individual harassment. At Greenpoint Hospital an active resident was threatened with termination of contract; the attending staff was concerned over the affiliation proposal, fearing loss of their own jobs. Vaughan reported the New York State Medical Society threatened to prevent him from joining. This would have precluded him from taking his specialty board examination since membership in the AMA or local medical society was a prerequisite. Indeed, Saran Jonas, who generally felt the housestaff-attending relationship was very open and collegial, reported the following: an attending from Mt. Sinai Hospital invited Jonas to his home to warn him that his union activity would be considered communistic and therefore, endangered his career.

Since I was a registered Republican I felt that it was an interesting situation and I do suspect that I was the only registered Republican who was the head of a union in the United States, which makes it the world and the universe. So I personally did not at all feel uncomfortable with the situation. (Jonas interview)

Chapter 2

The History of the CIR: 1957-1975

On the organizational level, the New York County Medical Society and the AMA did not respond to any overtures from the CIR founders. Additionally, administrations at certain voluntaries, such as Columbia-Presbyterian and Mt. Sinai, effectively kept CIR out, so that initially the CIR remained confined to New York City municipal hospitals.

Before proceeding with the highlights of CIR's development, a statistical overview of CIR's history may add perspective to the narrative.

Table 2d CIR: Number of Housestaff, Budget, and Staff by Year*

<u>Year</u>	<u># of Housestaff</u>	<u>Budget</u>	<u># of Full Time Staff</u>
1957	1,885	NA	0
1970	2,000	NA	0
1974	5,000	\$100,000	4
1975	6,000	367,250	7 (1975 strike win)
1977	4,000	307,650	8 (1976 srike loss)
1979	4,500	470,500	15
1980	4,500	629,400	21
1981	3,900	795,000	17 (1981 strike loss)
1989	4,800	2,000,000	24

*The sources for this information are diverse and often unofficial. Therefore, the data should be used for comparison purposes, rather than as an accurate representation of fact.

Voluntaries

In the early sixties, hospital workers began to unionize across the country. In New York City, Local 1199 of the Drug and Hospital Workers Union struck unsuccessfully in 1959 to win union recognition for voluntary hospital workers. In 1962, after a second strike, Governor Nelson Rockefeller agreed to push the State

Chapter 2

The History of the CIR: 1957-1975

Legislature to broaden the domain of the State Labor Relations Act (SLRA) to include non-profit (voluntary) hospitals. The Act was so amended in 1963. Thus, without any agitation on the part of housestaff, they were protected by New York State law. If they chose to unionize, the hospitals were compelled to bargain in good faith with them. They were, however, prohibited from striking and picketing and impasses were subject to binding arbitration.

Bringing housestaff at voluntary hospitals into CIR, although legally possible, proved then, as it does now, to be a complex matter. Gordon, independent of CIR, had begun to represent housestaffs at various hospitals by facilitating the formation housestaff associations and then representing them for the purposes of collective bargaining and implementation of contracts. The issue of whether CIR should organize voluntary housestaff focused on assumed differences between the two types of hospitals. Due to affiliation agreements between the municipal hospitals and the voluntaries, most municipal housestaff rotated through the voluntaries, thus giving them the opportunity to meet their housestaffs and experience their working conditions. According to Gordon the feeling among the municipal housestaff was that "the voluntaries were more elitist; they were not considered to be as reliable in giving primacy to patient care problems; . . . they thought there were different kinds of problems in the voluntaries."

Chapter 2
The History of the CIR: 1957-1975

(Gordon interview) According to Rothschild, in 1957, conditions were significantly better in the voluntaries with regard to food, rooms, hours, and support services, although pay, benefits, and job security were worse. Given that the typical contractual conditions of salary, benefits, and job security were not as good as those in the municipals it would be expected that the voluntary housestaff would be amenable to joining the union. However, according to F. Mullan, CIR President, 1970-1972, (1970, p. 1011), it is this very situation which fosters the professional self-image of the housestaff officer. "Pride of belonging and realization of low rank conspire to make activism and concern with change still more unacceptable." This "pride of belonging" encouraged an elitist ideology among housestaff, especially in the more prestigious hospitals. According to a former CIR president (Mandeville):

If you go to a place like Mt. Sinai, in which there is a very strong elitist tradition among the housestaff, they are very, very happy to be where they are. They consider it a privilege and they are told they are joining a very select medical fraternity. . . . these people are less interested in joining a union because the term union is an anathema to them to begin with and because in the real sense the pressure can be put on them much more directly to do otherwise. (Interview)

The "pressure" here refers to the dependence on faculty for recommendations for fellowships and positions in the future. The nature of the relationship between the faculty member and the housestaff officer was conceptualized as one that was based on

Chapter 2

The History of the CIR: 1957-1975

merit. Thus, if a housestaff officer performed s/he was rewarded appropriately. However, the faculty did not welcome unionization for the housestaff. They had controlled the conditions of residency and were not receptive to the potential power of a union in this situation. Consequently, the faculty members were often able to pressure housestaff against CIR. It seemed that this dependence on faculty was strongest among the most elite hospitals and therefore, they were least likely to unionize.

In addition to this anti-union bias, attributed to the comparative elitism of the voluntary housestaff, the CIR leadership feared loss of control of CIR to the voluntary housestaff because they were "higher in the pecking order of housestaff." (Gordon interview) Nevertheless, the practical reality was "the more housestaff you recognized, the more dues you collected, the greater your resources, the greater your capacity to deal with a lot of problems and the more your importance on the health care scene." (Gordon interview)

However, in spite of obstacles, between May, 1970 and November, 1974, voluntary hospital membership included Albert Einstein, Bronx-Lebanon, Brooklyn, Brookdale, Brooklyn-Jewish, Catholic Medical Center, Hospital for Joint Diseases, Long Island Jewish, Mt. Sinai, Maimonides, Methodist, Flower-Fifth Avenue, Montefiore, New Rochelle, New York University, and Wyckoff Heights. (see Table 2d) According to Gordon, the turning point in

Chapter 2

The History of the CIR: 1957-1975

organizing voluntaries came when Mt. Sinai and Montefiore joined CIR (July, 1970 and February, 1971, respectively). Presumably their leadership role stemmed from their reputations as high quality, prestigious institutions.

Table 2d New Hospital Housestaff Membership : 1970 - 1975*

<u>Year</u>	<u>Hospital (and affiliates)</u>	<u># Housestaff</u>
1970	Flower Fifth Avenue (Metropolitan, Bird S. Coler)	146
1970	Mount Sinai (Elmhurst)	721
1970	Brooklyn (Cumberland)	179
1970	Maimonides (Coney Island)	287
1970	Long Island Jewish (Queens Hospital Ctr.)	334
1970	Catholic Medical Ctr. of Brooklyn & Queens (St. John's, St. Mary's, Mary Immaculate, Holy Family)	196
1970	Brooklyn Jewish (Greenpoint)	216
1970	Albert Einstein (Bronx Municipal)	181
1970	Methodist	120
1971	Montefiore	471
1972	NYU (Bellevue)	198
1973	Arthur C. Logan	42
1974	Bronx Lebanon	167
1974	Brookdale	179
1974	Joint Diseases	74
1974	Wyckoff Heights	72
1974	Kingsbrook	103
1975	Staten Island	50
1971-1975		1,356

*Source: CIR Bulletins.

Simultaneously voluntary hospital administrations in the city had formed the League of Voluntary Hospitals and Homes of New York (LVH) in order to represent them in negotiations with 1199, and

Chapter 2
The History of the CIR: 1957-1975

thus bargain a single uniform contract with the hospital workers. Similarly, the LVH negotiated with the CIR in 1970 and 1972.

Initially, the negotiations with the LVH revolved around standard economic issues such as wages and benefits. However, when negotiations began for the 1972 contract, housestaff leaders had drafted a new set of demands that included the issue of hours. After polling housestaff the CIR's demands were abolition of every other night on duty, as well as a limit to the number of hours a medical or pediatric resident was to be on duty in the emergency room (ER). According to the CIR president at that time: "an every other night tour of duty schedule for any house officer is unacceptable, indefensible, and jeopardizes patient care. . . .it is inconsistent with the training program, unfair to housestaff members and their families." (CIR Bulletin, vol. 2, #1, March-April, 1973, p.3) After seven months of negotiation, the LVH and the CIR agreed to the following article entitled "work schedules":

The parties recognize the undesirability of excessive work hours for House Staff Officers inconsistent with optimum patient care and high standards of training and will make every effort to resolve problems in furtherance of these principles." (Article XVIII, CIR-League Contract: Oct. 1, 1972-Sept. 30, 1974).

The grievance mechanism defined this as a medical matter under the jurisdiction of the Medical Board at each hospital. This apparently unsatisfactory and virtually unenforceable compromise set the stage for the next contract negotiations.

Chapter 2

The History of the CIR: 1957-1975

This was not the first time the CIR had attempted to include "patient care" demands in its contract. During Fitzhugh Mullan's tenure as president, the CIR's delegates approved two new clauses as part of the municipal contract for 1970. The first clause dealt with "out-of-title work" or work considered outside of the purview of a housestaff officer. It requested a given ratio of nurses and messengers to housestaff officers be on duty at all times. The second clause addressed the issue of laboratory tests: requesting a minimum set of lab tests be available at all times in all hospitals so that "standardized, up-to-date medicine" could be practiced. The city negotiators rejected these demands immediately, arguing that they were "management issues." Gordon, who had argued against this strategy initially, advised the CIR leaders to drop the issue, fearing that further attempts would jeopardize the remainder of the contract. The delegates voted to eliminate this demand. (Mullan, 1976:87)

The early seventies brought changes both internal and external to CIR. In 1972, an Executive Director, was hired to manage CIR, independent of the attorneys. He was a former resident who was replaced, two years later, by Edward Gluckmann, who was the first "lay leader" (Gluckmann interview, 4/11/75) of CIR. Although his background was in health administration, he was not a physician. According to Gluckmann, until 1975, CIR was a one room operation, whose staff consisted of Gluckmann, one secretary and one part time

Chapter 2
The History of the CIR: 1957-1975

clerk. In addition, from 1973 to 1976 there was an Assistant Executive Director whose title was "liaison coordinator" and whose role was to "maintain direct communication with local housestaffs throughout the area." (CIR Bulletin, July-Aug., 1973, p.26)

The National Labor Relations Act

The other significant change, that influenced the future of the CIR, was passage by Congress of the Health Care Amendments to the National Labor Relations Act (NLRA), in July, 1974. Whereas previously only employees of proprietary hospitals were covered under the Act, the Amendments extended coverage to ~~voluntary~~ hospital workers. This change occurred in recognition of the rapidly expanding non-profit segment of the economy, which employed large numbers of white collar and professional employees. Four years previous to this change coverage was similarly extended by the NLRB to employees of non-profit colleges and universities. (Angel, 1982)

Thus, unionized workers in voluntary hospitals, including residents, would be protected and subject to the rules of the NLRA. Specifically, labor disputes would ultimately be resolved through mediation and fact finding. If the results of these attempts proved unsatisfactory, the union had the right to strike after giving ten days notice. Either side could request mediation from

Chapter 2

The History of the CIR: 1957-1975

the Federal Mediation and Conciliation Service (FMCS). The union was prevented from striking for sixty days once the request was made. The fact finder once agreed upon by both sides, had fifteen days to hear evidence from both sides regarding demands and then make recommendations. Though the findings were not legally binding, if they were regarded as reasonable, pressure might be put on the side that disagreed, to settle. However, if no settlement was reached the employees then had the right to picket and/or strike.

The 1975 Strike

The 1975 strike was the first of its kind in the United States. A strike by a group of interns and residents was virtually unheard of in this country and consequently received national attention. Therefore, it will be addressed in some detail in order to understand it more fully. It was at the conclusion of this strike that the writer and others became interested in studying the CIR.

Negotiations

The CIR presented a list of thirty-three demands, covering eighty issues, to the League in October, 1974. According to a CIR negotiator, "the people who were most interested in the contract . . . were probably interested in improvements in patient care conditions in hospitals when we started out." (Jay Dobkin

Chapter 2

The History of the CIR: 1957-1975

interview) Similarly an article in the CIR newsletter stressed the dual concerns of the demands: " . . . these comprehensive demands show the concern by CIR to improve the life of the housestaff officer and to improve the quality of patient care at our member hospitals." (CIR Bulletin, vol. 3, #5, September, 1974, p. 1)

Thus, the initial demands included salary, job security, meal allowance, anti-discrimination clause for FMG's, adoption of the AMA Essentials on training, moonlighting, parking, as well as hours, translators, evening and weekend clinics, and out-of-title work provisions.

The negotiations, though frequent, brought no results. The only movement was on economic issues. While the League claimed it had dealt with the hours issue in the previous settlement, the CIR stressed its dissatisfaction with the grievance mechanism, which involved going to the Medical Board. There the housestaff had little representation and little chance of success. In addition, there was a fear of utilizing the grievance mechanism since their Chiefs of Service, who wrote their letters of recommendation, often sat on the Boards.

Ultimately, the CIR did resort to both mediation and fact finding. At the fact finding hearing CIR presented evidence on the effect of sleep deprivation on performance, on projected cost of living increases, and further explained their positions on their demands.

Chapter 2

The History of the CIR: 1957-1975

The League's approach, according to one of its negotiators, was to impress on the fact finder that he was dealing in a unique and complex employee-employer dispute, i.e., housestaff were being trained as physicians, as well as working in the hospital, and thus, the fact finding was not appropriate to deal with this dispute:

We depended completely on (the testimony of) prestigious men who were responsible for the education of doctors . . . He (the fact finder) was going to be asked to judge programs of some of the finest, if not the finest, hospitals training doctors in the world. (Norman Metzger, LVH negotiator, quoted in Bartlett and Kuechle, p.15)

After seven days of testimony the fact finder attempted to mediate. This resulted in agreement on twenty-seven demands, leaving the following unresolved:

1. prohibition for residents working without pay
2. increase in meal allowance to \$900 a year
3. anti-discrimination clause for FMG's
4. adoption of the AMA Essentials
5. hours limitation
6. out-of-title work prohibition

Of these six issues, both sides were close to agreement on all but hours and out-of-title work. The fact finder recommended that the League contract model itself on the HHC contract which stated that out-of-title work "cease to the extent that it is

Chapter 2
The History of the CIR: 1957-1975

possible, taking into consideration proper patient care and the demands of the training program." (ibid, p. 17) The fact finder, claiming lack of expertise on the matter, did not make any recommendation on hours.

The CIR response, at a House of Delegates meeting (January, 1975), was that, in order to sign a contract, all the outstanding issues had to be resolved. They made preliminary plans to strike by organizing a strike committee, authorizing strike votes at League hospitals, and hiring a public relations firm.

Up to this point the membership had been informed of the demands, which were the result of a housestaff questionnaire drafted by housestaff, in the monthly Bulletin. Simultaneously, they were informed of the progress of negotiations.

Gordon, who continued bargaining informally with the League's lawyer, reached agreement on four of the remaining issues. The League would not accept the fact finder's recommendation on out-of-title work, nor would they negotiate on the hours issue.

According to Gordon, the League provoked CIR in negotiations and "they really didn't know how to bargain their way out of a paper bag." (Interview) Based on their negotiating experience with Leon Davis, president of Local 1199, their position had been "non-bargaining": rather than negotiate, they forced the union to give in or strike, so that the State would be forced to finance a money agreement. Gordon's interpretation was that the League waited

Chapter 2

The History of the CIR: 1957-1975

until the last minute, confident that CIR would not strike, and anticipating making an offer to CIR that they would have to accept:

What they didn't know was that . . . once the momentum got started and the radicals* were provided with the perfect vehicle for it because there was absolutely nothing on the table . . . once the housestaff was persuaded to strike that faucet couldn't be turned off.
(Gordon interview)

The League issued statements to the housestaff stressing that only two demands remained and all others that were agreed to would be implemented immediately after the signing of the contract.

Meanwhile, the first strike votes were taken at the hospitals by mid February. Overall, in seven voluntary hospitals, 80% supported the strike. In the "big four" hospitals, (by size and prestige), the initial votes were:

New York University (NYU): against the strike

Mt. Sinai and Montefiore: 50% for the strike; 50% against

Long Island Jewish (LIJ): for the strike

CIR continued a two pronged approach: strike activity was intensified, both at the rank-and-file level and through the use

* The "radicals" referred to were several residents at Montefiore, who appeared to be the most radical group - Progressive Labor Party members, advocates of the violent overthrow of the government. An example of their "radical" views was that of a CIR vice-president, who had written articles on "how racial and class bias in American medicine have obscured the conventional understanding of the environmental and social influences on disease." (CIR Bulletin, vol. 3, #5, September, 1974, p. 8) The CIR President, on the other hand, was somewhat conservative.

Chapter 2

The History of the CIR: 1957-1975

of the mass media. Secondly, binding arbitration was offered to the LVH (which was not part of the NLRA), in order to settle without a strike. The League refused.

On March 4 the CIR strike committee voted to strike on March 17, on the issue of hours and out-of-title work: a maximum of eighty hours a week and no more than fifteen consecutive hours and no out-of-title work. The next day the press reported this and the CIR notified the Federal Mediation and Conciliation Service (FMCS), as well as the affected hospitals: Brookdale, Bronx-Lebanon, Jewish Hospital of Brooklyn, Hospital for Joint Diseases, Maimonides, Montefiore, Mt. Sinai, Flower-Fifth Avenue, and Long Island Jewish. Since many of these hospitals had affiliation contracts, and therefore, also staffed municipal affiliates, and/or had several divisions, the total number of struck hospitals was twenty-two. The only resident group that refused to strike was the NYU housestaff.

In the next few weeks negotiations continued intermittently and unsuccessfully. The issues which had begun under the rubric of "patient care" were transformed into hours. According to one of the strike leaders the reasoning was twofold: 1) under standard labor law the employee had no right to have input on the quality of the product or service, in this case, patient care. The problem, according to Gordon, was that "in a union, professionals are nonetheless professionals and, when at the bargaining table,

Chapter 2 The History of the CIR: 1957-1975

professionals with a licensed and career-oriented responsibility for the welfare of others cannot be expected to place that responsibility in a closed and forgotten compartment." (Gordon, 1979, pp. 63-64) Nevertheless, to use collective bargaining to negotiate professional issues was only possible within the confines of wages, hours, and terms and conditions of employment. 2) The other problem was public relations. Hours was a straightforward issue for both housestaff and others to comprehend. It could be reduced to a quantifiable and tangible demand.

In a meeting with Leon Davis of 1199, he also advised the CIR of the utility of stressing the hours issue. According to the CIR President's report of the conversation, Davis said of out-of-title work: "What you are doing is saying you are too good to do this slop work. My people have got to do the slop work - right? So now you are really being elitist bastards." (Bartlett and Kuechle, pp. 20-21) He emphasized that hours was something that everyone could comprehend and have sympathy for and CIR had already documented the problem for the fact finder.

The Strike

The strike lasted four days, March 17-20, 1975. Reports of housestaff that did not report for work varied from 50-85%. Part of the difficulty in determining the figure accurately was that some housestaff chose neither to work nor to picket, but remained

Chapter 2

The History of the CIR: 1957-1975

at home. Others did not walk out the first day, but joined on subsequent days. Additionally, reports indicated that first year residents walked out in greater numbers than their senior counterparts. Some residents were reported to have left picket lines to see patients or attend to emergencies.

Reactions to the strike ranged from seeing it as unethical, unconscionable, and unnecessary to viewing it as the only ethical, responsible alternative left to housestaff. Among the supporters of the strike were Leon Davis, the president of Local 1199, who implied that 1199 might join CIR if the League "persists in this callous and arrogant" refusal to go to arbitration. ("3,000 Doctors Strike at 23 Hospitals," New York Post, 3/17/75) The superintendent of registered nurses at Elmhurst Hospital said: "We're all actively supporting the strike and we'll be out there during our lunch hour or coffee breaks. ("A Strike Would be Bitter Medicine," Daily News, 3/17/75). The biggest surprise was that the AMA supported the strike. ("AMA Supports Striking Docs," Daily News, 3/19/75, p. 1) Murray Gordon, on seeing the headline, thought it was a joke. The AMA argued that quality of care was in jeopardy and therefore, they supported CIR's action. According to Jay Dobkin, a strike leader:

Once it (the strike) got going and it was successful in a black and white kind of situation - the hospitals looked so bad and we looked so good, the AMA really had nothing to lose at that point by supporting us and figured they had something to gain in terms of impressing young doctors, and doctors in general, that they were

Chapter 2

The History of the CIR: 1957-1975

responding now to the needs of doctors and they were waking up a little bit and were capable of tuning in on what was happening, instead of this ossified stupor that they've been in for umpteen years. They really had nothing to lose; they couldn't have come out being critical - that wouldn't have done them any good. And to say nothing wouldn't do them any good. I don't think they could have lost anything by saying what they did so it seems to me like a politically sound thing to do. They're obviously fishing for support for members. (Dobkin interview, 5/27/75).

Nevertheless, although newspaper editorials deplored the fact that doctors were not in the hospitals treating patients, they blamed the League, for refusing to arbitrate. Editorials also expressed some sympathy for the issue of hours itself, comparing a physician's responsibility to that of other workers responsible for the lives of others: "Why can't a nation that demands alert, well-rested bus drivers ask the same of its doctors?" (New York Times, letter to the editor, 3/29/75)

Hospital administrators, such as League President Jess Solivan of NYU, argued against the strike due to "the total incompatibility of the industrial relations process in solving problems that are professional and educational in nature." ("Doctors Go Back to Work," New York Post, 3/21/75)

Dr. David Pomrinse, Mt. Sinai's director, typified many of the "old school," who argued that if there "were really anything wrong with the way we train doctors we'd have realized it during the hundred years or more that we've been doing it this way." ("Two Views of the Strike: Intern vs Hospital," New York Post, 3/18/75) Although

Chapter 2

The History of the CIR: 1957-1975

the managements of NYU, LIJ, and Mt. Sinai were reported to be "standing most firmly" against CIR demands ("Mediator Seeks Talks in MD Strike," New York Post, 3/18/75) the outstanding exception was Dr. Martin Cherkasky, director of Montefiore Hospital, who conceded that administrators and CIR should work jointly to consider the effect of hours on patient care and housestaff and establish work schedule guarantees.

Among housestaff, the majority expressed support for the strike; they emphasized the deleterious effect of long hours on patient care. The media followed housestaff through a typical day, describing in detail the rigorous schedule of a resident. However, there was division among housestaff, as well as management. When a housestaff leader at the non-striking NYU was interviewed he expressed another view of the strike:

We have some radicals here who, I was sure, would strike, but no one did. I think in the end, it's a question of not violating something that has been a tradition among doctors since Hippocrates. To abandon one's patients for any reason whatsoever is contrary to the principles we hold." ("21 Hospitals Here Hit by a Walkout of House Doctors," New York Times, 3/18/75)

Others agreed with the administrators' argument that hours was an issue that should be confined to housestaff and their attendings. The resident-attending relationship was significant for some housestaff in deciding whether to strike:

We establish a relationship with attending physicians

Chapter 2

The History of the CIR: 1957-1975

and we do not want to antagonize them. . . . If he doesn't like you, then you can end up in the operating room holding a retractor for the duration of your residency. . . . Competition in gaining admission to a hospital affiliated with a medical school such as NYU is very tough. . . . I elected to come here, knowing the hours were long, and I regard it as a privilege to be here rather than at a hospital where the hours might be better but the training worse. (Second year resident in orthopedic surgery, quoted in "NYU Hospital Internes Bar Strike, Saying They Won't 'Forsake' Patients," New York Times, 3/19/75)

In addition to the altruistic reasons for not joining the strike, housestaff, indeed, did feel threatened if they participated. Reported threats included firing, damage to careers, and, in the case of FMG's, deportation, although the NLRA stated that these threats were illegal.

However, in spite of the apparent support from diverse sources, Murray Gordon described the strike as:

the most traumatic experience I've had as a lawyer. . . . I'm worried about the consequences for their (housestaff) careers or perhaps legally for them. The union could be devastated. . . . I didn't know how many patients were going to die. . . . The activists didn't want to settle and it didn't make any difference what the settlement was. The question was how long can we keep the settlement going. The more conservative people were persuaded to take a risk with their careers and we were dealing with crazy people in the League I can't tell you some of the incidents which occurred. . . . These are professional negotiators and they simply do not know how to negotiate. They never had bona fide negotiations because it was always a game for third party payers. . . . Here's housestaff who have never been in a strike before. They're not knowledgeable and they have all these different agendas going. It was crazy. It was a miracle to get the results that we did get. (Gordon interview)

Chapter 2

The History of the CIR: 1957-1975

While the bargaining continued between the League and the CIR, some hospital administrators were attempting to negotiate with their housestaffs on the individual hospital level. Although it seemed several hospitals were ready to settle on the union's terms, CIR's view was that enforcement of separate contracts would have been more difficult and ultimately bargaining would be a longer process.

As the strike progressed, there was disagreement among the housestaff concerning the significance of settling the strike. According to Gordon, the radicals in the CIR, several of whom had leadership positions in the union, wanted the strike to continue for as long as possible. They felt it would be an "educational" experience, as well as an opportunity to demonstrate "class solidarity." Others feared that the longer the strike went on, the greater the chance of patients' health being adversely affected. The biggest fear was that if a patient died, the union would be blamed, and publicity would be unfavorable. Finally, there was the fear that housestaff would return to work on their own, and thus the strike would end without a settlement.

Dobkin, the chief negotiator, agreed to accept the League's last offer on the evening of the fourth night of the strike. Since the strike committee had been given the power to ratify, the membership was not required to vote and thus the strike ended.

Chapter 2 The History of the CIR: 1957-1975

The Outcomes

The contract

1. Night duty - a maximum of one night in three would be required as of July 1, 1976.

2. Standards and grievances committees would be formed by May 1, 1975 at each hospital. They would consist of an equal number of housestaff officers and attending physicians, plus one additional physician member from the Medical Board. These committees would be instructed to "formulate guidelines for work schedules by August 1, 1975 consistent with optimum patient care, high standards of training, specialty board considerations, the health and well-being of housestaff officers including their reasonable social needs and providing for adequate rest." (CIR Bulletin, vol. 4, #3, March, 1975, p. 1)

Additionally, the committees would be the final deciding bodies in grievances involving out-of-title work or work schedules.

3. Housestaff have the right to grieve "regular and recurrent assignment of housestaff officers to perform duties not appropriate for a housestaff officer." (ibid, p. 2)

"Latent" results

According to Dobkin, "lots of people are looking at us to see what would happen in this kind of confrontation between a group

Chapter 2
The History of the CIR: 1957-1975

which previously had not exercised much power or self control." (interview) He described how hospitals were responding to housestaff complaints after the strike, where previously they had been ignored.

Richard Knutson, the President of CIR, reported that a number of non-CIR hospitals, including Columbia-Presbyterian, Lenox-Hill and St. Luke's made changes modeled on the CIR contract in order to keep up with the union's gains. "They don't want CIR; they don't want trouble."

Additionally, according to Knutson:

Most of the hospitals that went on strike were not affected by the settlement. At most of the hospitals we already had what we were trying to get in writing. We were striking for the lowliest foreign medical graduate, at the lowliest part of the totem pole, and in the worst hospital, working every other night, and there were some of those around, but because a third of us leave every year and we gave them a year and one-half to implement the hours, most of the people who were on strike would have gone into the upper years of their training where the hours aren't so bad anyhow. The people we were really striking for were still in medical school. (Bartlett and Kuechle, p. 29)

If striking housestaff would not reap the benefits of the strike why were they willing, in the first place, to take such a dramatic, and potentially, risky step? According to Ed Gluckmann, the Executive Director of CIR, because the League refused to negotiate, "the main thing was the dignity of a human being - that was the motivating goal. . . .the strike gave notice that if you

Chapter 2
The History of the CIR: 1957-1975

beat someone into the ground, they will rebel. We went on strike to support the idea of human dignity. . . . it was the revolution against Papa." (interview)

Power was also an issue. According to Jose Corvalan, a FMG, who served as a CIR vice-president: it was "time for us to say what we want and how we want it." (interview) He felt that, prior to the strike, the administrators were the ones with total control. It was considered an important victory by some that the newly formed standards and grievances committees did not have any administrative representation. Some felt that the significance of the strike was that "it forced the League to admit hours were a negotiable item and that the number of hours related to patient care. It forced them to recognize us as a viable unit." (Interview with Elmhurst Hospital delegate) This struggle for control over conditions in the workplace, that had traditionally been administration's and faculty's prerogative, continued to be evident in subsequent strikes by both the CIR and other housestaff groups.

The overwhelming success of the 1975 strike generated optimism at the CIR about the future of housestaff unionism.

". . . a loose confederation of house staff groups and house staff officers. . . (had) achieved unification. . ." (CIR Bulletin, President's Report, March, 1975, vol. 4, #3, p. 2) A similar consequence occurred in 1959, after a forty-six day strike of 1199,

Chapter 2

The History of the CIR: 1957-1975

the hospital workers' union. Although the union's leaders considered the final settlement to be a defeat in terms of contractual gains, its success was that it survived and proved itself as legitimate mechanism for improving the plight of minority workers ((Fink and Greenberg, 1989).

Similarly, CIR had demonstrated itself to be an established force on the New York hospital scene, and its energies were then directed to issues as "improved training, protection of housestaff rights and better patient care. Dobkin, the new CIR President, indicated two immediate CIR goals: fighting the dismantling of New York's public hospital system, and defending the rights of Foreign Medical Graduates. (CIR Bulletin, June, 1975, vol. 4, #6, p. 1)

Impact on the national scene

Although CIR's strike received national attention, it was preceded by other housestaff actions in other cities. In the mid-sixties in Los Angeles, Boston, and Washington, D.C., housestaff associations had conducted "heal-ins," refusing to discharge patients in protest over salary. In the early seventies, housestaff associations turned their attention to issues surrounding the work situation: the Association in Los Angeles sued the county over patient loads, overcrowding of patients, and staff shortages; in 1971 sixty interns at San Francisco General Hospital held a four day strike over work related issues.

Chapter 2

The History of the CIR: 1957-1975

By 1973, four housestaff associations were recognized as unions, the collective bargaining agents for the housestaffs of Cook County Hospital in Chicago, Los Angeles County Hospital, the University of Michigan, and CIR. (Harmon)

Following CIR's strike in 1975, there were housestaff strikes in Los Angeles and Chicago. The Joint Council of Interns and Residents of Los Angeles County struck on May 8, 1975. At two hospitals, Los Angeles County and Harbor General, the strike was settled after three hours, resulting in a 10 1/2% economic package, of which 5% was designated for a patient care fund. This patient care fund of \$1.1 million was to be administered by a housestaff committee for the purpose of hiring staff and purchasing equipment. At a third hospital, Martin Luther King Hospital, housestaff struck for a week, during which time over thirty housestaff officers were fired and rehired. (CIR Bulletin, vol. 4, #6, June, 1975, p. 2 and Harmon, 1978: 515)

In Chicago a housestaff association was formed to incorporate residents at Cook County hospitals throughout the city. Their demands for improved working and patient care conditions resulted in an eighteen day strike by five hundred Housestaff Association members in November, 1975. The strike was settled through court mediation. The union won its first contract, which included union recognition, a salary increase, and the establishment of a committee of equal numbers of housestaff and attending physicians

Chapter 2
The History of the CIR: 1957-1975

to supervise patient care improvements, including translators, increase in IV teams, speedier processing of lab X-ray requests, and a workweek of no more than eighty hours, including maximum night duty of one night on every four nights. However, the judge did sentence seven housestaff leaders to ten day jail sentences and fined the union \$10,000 for violating a temporary restraining order, issued at the onset of the strike. (Harmon, ibid and CIR Bulletin, vol. 4, #11, November, 1975, p. 1)

The PNHA, the national association of housestaff founded in 1972 by the president of SAMA (Student American Medical Association), and a former president, also responded to these strikes. In October, 1975, at its national meeting, the delegates voted unanimously to change the structure of the organization so that it would be a national union, which would pursue its goals through collective bargaining. It affiliated with the Coalition of American Public Employees (CAPE). (PNHA flyer) This was considered to be a major transition for the organization and prompted the CIR leadership to recommend formal membership status to its housestaff.

With victory behind them, CIR went on to confront other issues that pervaded the daily work of housestaff officers.

Chapter 3
The History of CIR: 1975-1981

Between strikes: April, 1975 - October, 1976

Although the CIR had won a dramatic victory in the voluntary sector, in the months that followed CIR returned to the daily business of processing grievances, monitoring hospital conditions, electing new delegates, and organizing new hospitals, as well as dealing with impending and actual cuts in the budgets of the municipal hospitals.

New York City's Financial Crisis

The city of New York was in the midst of a financial crisis that resulted in budget cuts in all city services. The impact on the Health and Hospitals Corporation, according to HHC President, Dr. John L.S. Holloman, was the "worst crisis" ever, resulting in "devastating cutbacks which may be ultimately measured in unnecessary sickness and death." (Barbara Yuncker, "Where \$ \$ Cuts Hit Hospitals," New York Post, Nov. 13, 1975, p. 2) The first budget, of \$85 million, resulted in the closing and curtailing of services, a wage freeze, job attrition, a ban on prescribing new and expensive drugs, and the closing of the HHC operated nursing school. (David Bird, "City Hospitals' Role A Fiscal Crisis Issue, New York Times, 10/22/75, pp. 1 and 51) The consequence was decay in all services, including indefinite postponement of elective

Chapter 3 The History of CIR: 1975-1981

surgery, seventeen week waits for outpatient appointments and a decline in the quality of the ~~mod~~.the October, 1975 meeting of CIR's House of Delegates, a CIR lawsuit against the planned wage freeze was approved. Other approved tactics to fight the budget cuts included pressuring licensing and accrediting institutions to implement high standards of medical care, testifying at Joint Commission on Accreditation of Hospitals (JCAH) surveys on hospital conditions, housestaff recording effects of cutbacks on patient care, and informing the press as to what "atrocities" were taking place in the hospitals. According to Jay Dobkin, the president of CIR, CIR was "the only group committed and mobilized to do anything about dismemberment of city hospitals." (House of Delegates meeting, 9/16/75, notes)

Although there was some discussion about striking the city hospitals over the budget cuts, the illegality of such a strike (the Taylor Law forbids strikes by municipal workers), as well as the vagueness of such an action, quashed the idea. However, at the November House of Delegates meeting it was announced that the HHC was closing its Well-Baby, Venereal Disease, Dental, Family Planning, and Podiatry Clinics on January 1, 1976. The discussion that night focused on the closing of the dental and oral surgical clinics. The issue that appeared to underlie the this emphasis was that the closing of the other clinics did not jeopardize housestaff training programs because housestaff in

Chapter 3 The History of CIR: 1975-1981

medicine, pediatrics, obstetrics, and gynecology rotate through these clinics, but did not depend on their existence for training or jobs. On the other hand, the loss of the clinics was regarded as a serious threat to the viability of the training programs. Oral surgeons had to complete three consecutive years in their residency in order to be Board certified. Thus any interruption of training would have required that the resident start a program over again. The proposed closing were therefore, considered to be a contract violation.

The strategies considered centered on whether to wage the fight in defense of the dentists alone or rather, to take a broader stance against cutbacks and closings, in general. The final outcome was the following resolution:

Whereas: hospital services, clinics, and training programs are deteriorating the CIR House of Delegates authorizes the formation of a strike committee to poll the membership, and should it be necessary, to organize and lead such a strike. (Minutes, House of Delegates, November 18, 1975, p.9)

This was followed by a motion that:

The House of Delegates officially supports the dentists and Oral Surgeons in their fight to preserve the integrity of their contracts, training programs, and patient care. The CIR will fight by whatever means necessary to assure the continuation of high quality dental care and training programs. (ibid)

Emergency weekly meetings followed in order to clarify the issues and positions, assess hospital strength, and plan strategy.

Chapter 3
The History of CIR: 1975-1981

As discussions progressed, it became clear that there were divisions by department (non-dental versus dental housestaff), by hospital, i.e., some residents interpreted the closing of another hospital as an opportunity to better their own hospitals, and by preference for inclusion of "outside groups" in any action or strike, e.g., voluntary hospital housestaff, other health workers, patients etc.

As plans developed for a strike, specific demands were formulated: hiring of more nurses, no housestaff layoffs, no clinic closings, no attending layoffs, full staffing of ancillary personnel, and no contract violations. However, as it became clear that a citywide strike did not have sufficient support (strike meetings often had a dozen or less housestaff in attendance), the union changed its tactics. CIR organized and participated in demonstrations at hospitals, in Washington, D.C. etc. and initiated a lawsuit against the HHC on the grounds that "clinic closing in mid-year will break the obligations of the various hospitals to provide an adequate training program as stipulated in the house officer's and individual contract." (CIR Bulletin, November, 1975, vol. 4, #11, p. 1) At the December meeting, of the House of Delegates, it was announced that the CIR had won its lawsuit. A "Clinic Task Force" under the auspices of the American Dental Association was authorized to recommend cuts. It recommended a 30% cutback by attrition. This action was deplored by delegates and

Chapter 3 The History of CIR: 1975-1981

discussion around a strike continued. Jay Dobkin, the CIR President, especially encouraged it, emphasizing the responsibility of housestaff to fight the cuts that he felt "make no sense." He predicted the closing of smaller hospitals and reiterated the impact on patients. Nevertheless, by the following House of Delegates meeting, the Strike Committee had fizzled out.

The Lincoln 27

At the January, 1976 House of Delegates meeting, the Lincoln Hospital delegate described a series of events at the hospital that again put patient care in the spotlight. In August, 1975, in response to an ongoing attrition policy, emergency room staff called a sickout, with the support of housestaff. Housestaff had also attempted to meet with the Executive Director, during the sickout, and were refused. On December 24, 1975, Lincoln Hospital served twenty-three medical housestaff officers, one attending physician and three health workers with charges ranging from "abusive and disrespectful manner" to attacking and assaulting administrators and threatening patient care during the August action. Some housestaff officers who were charged were not present during the action and others, who had participated, were not charged. Various disciplinary actions were threatened, including suspension without pay and dismissal. The result was a six month series of hearings, in which both sides were represented by legal

Chapter 3

The History of CIR: 1975-1981

counsel. Various issues were raised concerning the role of the CIR, relationships between housestaff and other hospital workers, and the motives and ability of hospital administrators to take action with regard to outspoken and dissenting housestaff. In addition to the legal action, there were housestaff "educational campaigns" at other hospitals, informing other housestaffs of the situation and its relationship to hospital cutbacks. Rallies and demonstrations of community support were held.

Jay Dobkin and others interpreted the action as a "malicious" act by administration to get rid of troublemakers and deter others from speaking out. Others argued that it was a "political" act: since no other hospital administrations had taken action against housestaff officers participating in job actions, this signified a political attack on a hospital whose dominant patient population was black and Puerto Rican.

Strategy was also an issue for the House of Delegates. In general, they preferred an adamant stand, not to give in to the Lincoln administration or the HHC. Recommendations ranged from not attending any hearings, thereby not acknowledging that the charges were valid, to letters of apology to the administration (which were written by several residents who felt particularly threatened).

The hearings themselves were a major source of contention between the CIR and Lincoln Hospital and the HHC. According to

Chapter 3
The History of CIR: 1975-1981

the collective bargaining agreement with CIR, a disciplinary procedure had been established which called for a hearing before the Housestaff Affairs Committee (HSAC), an attending-housestaff committee, whose decision could be appealed to the Medical Board. In March, the HHC succeeded in changing the membership of the HSAC, asserting that the "Committee is biased in favor the housestaff." (CIR Bulletin, February, 1976, vol. 5, #2, p. 4) The new chairman of the HSAC changed the hearings procedures that had been established by the HHC and the CIR counsel, thus eliminating cross examination, rebuttal, and subpoena of witnesses. One CIR administrator called this rules change the "biggest kangaroo court since Scottsboro." (CIR Bulletin, April, 1976, vol. 5, #4, p. 6)

The final majority report of the HSAC did question "the use of these charges by the administration in an attempt to silence dissent." (CIR Bulletin, July, 1976, vol. 5, #7, p. 5) In addition, the report concluded that:

some administrative witnesses were overzealous in their willingness to identify those who had been present, actually pointing out attending members of the committee and even the wife of one of the accused. . . . The fact that this large proportion (about 70%) of the charges were so clearly unfounded gives much weight to the view that they arose from reasons other than that of simple justice. (CIR Bulletin, July, 1976, p.5)

The committee also admitted to the serious problems in the delivery of patient care and found that the housestaff officers' actions were "in an effort to improve patient care, when normal

Chapter 3 The History of CIR: 1975-1981

channels of communication had failed." (Ibid.) Thus, the committee found the housestaff officers not guilty and Lincoln Hospital did not appeal the decision to the full Medical Board.

The budget cuts in the municipal hospitals continued to be experienced on a daily basis by the housestaff. Through the use of press conferences, demonstrations, meetings with politicians, and housestaff documentation of incidents where patient care appeared to suffer due to the cuts, CIR remained in the public eye and kept their opposition active. CIR also had a suit pending on the constitutionality of the city wage freeze.

While focusing on these daily problems of providing quality care with limited resources, an unanticipated ruling forced CIR to revert to the issue of the legitimacy of housestaff unionism. The National Labor Relations Board (NLRB) redefined housestaff status as student, rather than employee, thereby removing their right to unionize under the aegis of the NLRB.

The NLRB Ruling

. . . we find that interns, residents, and clinical fellows are primarily engaged in graduate educational training at Cedars-Sinai and that their status is therefore that of students rather than employees. They participate in these programs not for the purpose of earning a living; instead they are there to pursue the graduate medical education that is a requirement for the practice of medicine. . . . While the housestaff spends a great percentage of their time in direct patient care, this is simply the means by which the learning process is carried out. The number of hours worked or the quality of care rendered to the patients does not result

Chapter 3

The History of CIR: 1975-1981

in any change in monetary compensation paid to the housestaff members. The stipend remains fixed and it seems clear that the payments are more in the nature of a living allowance than the compensation for services rendered. Nor does it appear that those applying for such programs attached any great significance to the amount of the stipend. Rather their choice was based on the quality of the educational experience and the opportunity for an extensive training experience. The programs themselves were designed not for the purpose of meeting the hospital's staffing requirements, but rather to allow the student to develop, in a hospital setting, the clinical judgement and the proficiency in clinical skills necessary to the practice of medicine in the area of his choice. ("United States of America before the National Labor Relations Board: Cedar-Sinai Medical Center (employer) and Cedar-Sinai Housestaff Association (petitioner) - Case 31-RC-2983)

On March 22, 1976 the National Labor Relations Board (NLRB) issued this finding in a 4-1 decision, the dissenting voice being that of John H. Fanning. This decision meant that because the primary status of the housestaff officers within the hospital was that of student, they were not protected by the National Labor Relations Act, as it applied to other employees in the health care system. In the specific case of Cedars-Sinai, the finding in favor of the hospital clarified the employer's position: the hospital was under no obligation to bargain with the housestaff association (nor was it prevented from doing so).

This decision affected housestaff throughout the country. It forced the CIR to once again concentrate its efforts on the more narrowly defined "union" issue of survival and less so on "patient care" issues. The CIR, despite the strength it gained after its

Chapter 3

The History of CIR: 1975-1981

successful strike just a year before, now found itself in a precarious position with respect to organizing and negotiating new contracts. At the next House of Delegates meeting alternative courses of actions were considered: pressuring administrators to bargain voluntarily, requesting the State Labor Relations Board (SLRB) to reassert jurisdiction (which prohibited strikes, solving impasses by binding arbitration), and initiating a letter writing campaign to Congressional representatives to propose legislation to cover housestaff, job actions, and strikes. In July, 1976 the SLRB ruled that they would not reassume jurisdiction in light of the NLRB decision. Hospital administrators, led by William Abelow, Executive Director of the League of Voluntary Hospitals, opted not to bargain with the CIR, there being no legal mandate to do so. Thus, the housestaff delegates were encouraged to establish local bargaining committees in the event that individual hospital administrations would bargain. However, one by one, hospitals declined to negotiate with CIR, including Brookdale, Catholic Medical Center, Joint Diseases, Beth Israel, Albert Einstein, NYU, Brooklyn-Jewish, and Bronx Lebanon. In August, the members of the League officially rescinded authority from the League to bargain for them. Activity escalated to gather support through press conferences and appeals to legislators and other unions. The New York Post did support the CIR in an editorial. (New York Post, "Preventive Medicine," August 26, 1976, p. 26) In a housestaff

Chapter 3
The History of CIR: 1975-1981

bulletin, Dobkin threatened to have the housestaff "play doctor":

There are a number of important differences between students and doctors: housestaff stay up all night with their patients, students go home and study or sleep at night; housestaff are responsible to do whatever a patient needs, students should only do what's educational; housestaff can fill out certification forms and perform services for which the hospitals are paid, students shouldn't fill out forms and must tell the patients to disregard any bills that may be sent them for professional services like visits to a clinic run by housestaff; housestaff must staff the hospital year round while students usually take a big vacation all at once, perhaps a big CIR trip to Fort Lauderdale could be planned for next October when our contracts expire (in the old employee days it would have been a strike). . . . So the situation is pretty clear: the hospitals seem to be challenging housestaff to a showdown and housestaff may in fact have to really start acting like students to convince the hospitals it's better to deal with us as employees after all. (CIR Weekly Blunt Dissection - Delegate-Staff Newsletter, July 15, 1976)

Flyers, sent to housestaff, reminded them of the gains CIR had won for them in the past, as well as the implications of the student status. By the September, 1976 House of Delegates meeting a voluntary hospital strike was set for October 5, 1976 "which would be terminated when a new city-wide contract effective October 1, 1976 has been agreed upon by CIR and the hospitals." (Minutes, 9/5/76, House of Delegates meeting) Among the reactions of the voluntary hospital administrations were the following: Maimonides and Brooklyn-Cumberland agreed to recognize CIR and bargain; Long Island Jewish and Mt. Sinai agreed to bargain with local bargaining units, but not CIR; Bronx Lebanon agreed to recognize CIR as the

Chapter 3 The History of CIR: 1975-1981

bargaining agent, in exchange for a no-strike clause; the other hospitals refused to either recognize CIR or bargain a contract. Murray Gordon interpreted these differences among hospitals as indicative of their relative strength: those that gave in were the weaker, unaffiliated, non-teaching hospitals which relied on the housestaff to provide "cheap labor." (interview)

Thus, the CIR intensified its organizing efforts in the affected hospitals, as well as efforts to gain support from other groups. Thirteen Congressional representatives from New York City (including the then Congressman Edward Koch), did send a letter to the League, stating that "the hospitals' refusal to bargain collectively with these notoriously overworked professional people is a retrogressive step." (letter to Mr. William Abelow, Executive Vice President, League of Voluntary Hospitals and Homes, from Congress of the United States, House of Representatives, signed by thirteen representatives, September 23, 1976) The letter extensively cited Fanning's dissent from the NLRB's position as the correct interpretation of the NLRA's Health Care Industry Amendments. Letters from the presidents of both unions of hospital workers, DC 37 and 1199, were sent to CIR, confirming their support, and acknowledging their commitment to patient care.

Finally, in a last minute attempt to reaffirm their belief that housestaff were employees, and avoid the "needless tragedy" (Press release from Rep. Jonathan Bingham, October 2, 1976) of a

Chapter 3
The History of CIR: 1975-1981

strike, Representative Frank Thompson, Chairman of the House Subcommittee on Labor Management Relations, and four other New York Congressmen, introduced legislation that would correct a "mistaken interpretation of the will of Congress . . . by specifically citing interns and residents as under the protection provisions of the act." Representative Bingham continued:

We know that this bill will not pass today. We are taking this step to dramatize the determination of the Congress that interns and residents be included under the Labor Relations Act and to show the hospital administration that they have to negotiate - better now than later. . . . there is no question that it will easily pass when the new Congress convenes. It would be a crime to allow patients to suffer now while the hospital administrators wait for a new decision from the NLRB which will undoubtedly go against them. Negotiations to prevent this strike must begin at once."
(ibid)

In spite of this dramatic attempt to pressure the administrators to negotiate, they did not. At a press conference on the eve of the strike, October 4, it was announced that a five hospital strike would take place the next morning. There were last minute attempts at several of the hospitals to stave off the strike. On October 1, at Beth Israel, which had only recently joined CIR, the housestaff received copies of a statement by Judge Abraham Gellinoff, the State Supreme Court judge, who was deciding the appeal regarding the SLRB's decision not to reassume

* In fact HR 2222, the Congressional bill designed to overturn the NLRB decision, was defeated in the House of Representatives in November, 1979.

Chapter 3
The History of CIR: 1975-1981

jurisdiction. Although he had not reached a decision, nor could he legally forbid the strike, he argued that the "court can exhort. And it does so most fervently. Do not strike. Wait at least until the Court has rendered its determination." (CIR Bulletin, vol. 5, #11, "CIR Wins Court Fight to Force State Labor Board Recognition," p. 1)

The hope for a legal, orderly settlement of the recognition issue, without a strike, pervaded other housestaffs as well. At a Mt. Sinai housestaff meeting, two weeks prior to the strike, the housestaff voted to negotiate until the strike date with "provisional recognition of CIR" (meeting notes) while awaiting the court's decision. The goal was to avoid confrontation. Mt. Sinai did not join the strike.

Ultimately three hospitals struck: Brookdale, Flower Fifth Avenue, and Albert Einstein College of Medicine (AECOM). At Flower and AECOM, local issues, in addition to the recognition of CIR, pervaded the strike. At AECOM, the contracts with psychiatry fellows (residents who have completed their training in their specialty and are continuing training in research or clinical subspecialty) were terminated. At Flower, the housestaff changed its policy to self-insure its physicians for malpractice; the housestaff wanted assurances of adequate coverage. Patient care specifically was not an issue in this strike; however, when the picketers were interviewed by the writer

Chapter 3 The History of CIR: 1975-1981

and several colleagues, at the three hospitals, patient care issues were frequently mentioned as their motivation for striking. One resident, at Flower, felt striking was a demonstration of responsibility to patients. She claimed that the hours she worked were not in the best interests of patients; she described her feeling of dread each day when she left the hospital and her nightmares about the patients.

The Media Coverage

The media, having followed several hospital strikes at the time, was divided in its sympathy to the residents' choice of strategy, though sympathetic to its goals. The New York Post, six weeks prior to the strike, published an editorial putting the onus on the voluntary hospitals to prevent a "totally avoidable disaster." (New York Post, August 26, 1976, "Preventive Medicine," editorial) The first day of the strike the Post reiterated its position, focusing on "the struck hospitals' decision to strip recognition from the Committee" as "an act of dangerous pointless provocation" which "jeopardized patients." (New York Post, October 5, 1976, "Behind a New Hospital Crisis," editorial)

Though the New York Times was less sympathetic, questioning "these young doctors' sense of responsibility toward the innocent patients," it nevertheless supported their "right to act collectively to promote their own common interests - which include

Chapter 3
The History of CIR: 1975-1981

the interests of patients." (New York Times, October 7, 1976, "Another Hospital Strike," editorial)

The Strike Ends

The strike ended differently at each of the three hospitals. Brookdale Hospital housestaff returned to work, after being out a week, without a contract. AECOM housestaff also returned to work without a contract, after a nine day strike. However, the interns and residents were shifted to HHC contracts; HHC was still bargaining with CIR, in spite of the NLRB decision. The fellows were not included in this coverage. At Flower Fifth the housestaff won a contract, with CIR recognition, after a nine day strike. (Coincidentally, on the last day of the strike, Judge Gellinoff ruled that the State Labor Relations Board should reassert jurisdiction over the interns and residents.)

Aftermath

The net effect of the strike was a membership loss of nine voluntary hospitals, constituting about one-third (2,500) of the total housestaff membership. Among the hospitals no longer in CIR were several large, prestigious institutions: Long Island Jewish, Mt. Sinai, New York University, Beth Israel, and Joint Diseases. Murray Gordon's analysis of this defeat, in contrast to the victory of a year and a half before, was that the significant difference was the relationship of the strike issue to the daily lives of

Chapter 3 The History of CIR: 1975-1981

housestaff officers: CIR recognition was nebulous and removed from them; working long hours affected their lives directly and pervasively. (interview) Larry Boxt, CIR President from 1977-1979, referred to the housestaff objections as "selfish complaints" and attributed the failure of housestaff participation in the strike to a lack of consciousness on the part of housestaff as to what the union is and what it does for housestaff. (interview)

Jay Dobkin, then president of the CIR, summarized the strike's impact:

the lesson of these events is a sobering one: housestaff have to stand up to hospital administrations in brutal power plays if we are to protest our rights. Outside help like newspaper editorials and Congressional support only occurs in response to clear determination by housestaff to strike back and fight if we have to. Even the favorable court ruling may have been influenced by the knowledge that if legal protection of bargaining rights was denied, many interns and residents were determined to take direct action of their own. Clearly no one and nothing can or will help housestaff regain the right to organize if we don't seem to care enough to do anything about it ourselves. (CIR Bulletin, November, 1976, vol. 5, #11, p. 2)

Rebuilding

This somewhat militant statement forecast the position of the CIR for the next several years: reliance on the legal route would be secondary in its effectiveness and significance to "taking to the streets." Though the 1976 strike was a significant loss to CIR in membership and morale, it refocused CIR's direction to rebuilding on several fronts.

Chapter 3 The History of CIR: 1975-1981

First, the housestaff at the former member hospitals, referred to as "captive nations," were solicited by CIR to join the union and submit their dues voluntarily. The October/November, 1977 CIR Bulletin announced a "captive nation dues drive." According to the article, the housestaff officers in question "want to pay their dues because they know that CIR members are paying for the continued legal, administrative, and enforcement costs during their captivity without a CIR contract." (p. 3) However, this drive was insufficient to enable CIR to recoup its losses in revenue. Consequently, it began to streamline its operation and then proceeded to rebuild by organizing new hospitals. In the fall of 1977, Robert Wollk was hired as a contract administrator. With twenty-five years of experience with labor unions, his new job entailed organizing new hospitals. In June, 1978 two more part time contract administrators were hired, in order to concentrate on New Jersey housestaff. Jersey City Medical Center (100 housestaff) and the College of Medicine and Dentistry of New Jersey (800 housestaff) had joined CIR in the first half of 1978. SA CIR membership continued to grow, more staff was required to provide services. In June, 1978 Irwin Geller was hired to be the "in house counsel," in addition to Gordon and Schectman, the legal firm that had served CIR since its inception. By the beginning of 1979, the CIR House of Delegates had voted to terminate the services of Gordon and Schectman. This decision emanated from a

Chapter 3 The History of CIR: 1975-1981

legal-medical schism that had been developing for several years. According to Larry Bost, the "seeds for the break with the lawyer were probably always there but they sprouted in the 1975 strike." (interview) It was clear that the lawyers had played a prominent role in the planning and execution of the strike. Ed Gluckmann felt that Murray Gordon's experience, in combination with the staff and leadership, made the strike a success. However, when the organization became involved in an action as significant and intense as the strike, underlying differences and tensions inevitably came to the surface. According to Bost, "They (the lawyers) played a role in the organization which was just contrary to a democratically run organization. I see the role of a lawyer to say: look, we've got a problem - what are the alternatives: a, b, c, or d? Lawyers were taking a position without telling us what our alternatives were." (interview) Bost asserted that the lawyers opposed the strike and, when the strike appeared to be ending, opted for a negotiating committee to be empowered to vote on ending the strike, rather than a membership vote.

Gordon, found himself dealing with a union leadership unlike that of any other he had known:

Some people in the CIR really wanted that strike. It would show class solidarity; it was going to be an educational experience for housestaff. I was terrified of it. Jay (Dobkin) felt that there was no way to plan exactly how the strike would go. I'm worried about the consequences for their careers or perhaps legally for them. The union could be devastated, wiped out, for a whole variety of reasons. He said, and I think he turned

Chapter 3
The History of CIR: 1975-1981

out to be right, that the strike would develop organically. Now that's an expression that comes from the sixties, which was a new concept for me. When I represent unions in other situations and they take a serious action as a strike, there are plans which are drawn up to cope with every conceivable contingency - legally, politically, and in every other way. There is not much margin for error and I don't believe in taking risks when careers are at stake and lives are at stake. And that's what was involved in this strike. And there was nothing like that happening here. We just played right off the hip. It was a terrifying experience. It was the single most traumatic experience that I've had as a lawyer and I've represented people in death cases. (interview)

From Gordon's perspective, he was dealing with an inexperienced group, that had a "campus perspective," not a "union perspective," and therefore, was not necessarily acting in its own interest. Having seen the union through various crises, since its inception, he felt obligated to save it from disaster. The union leadership, however, wanted to control the situation. Unlike Gordon, they did not feel bound by legal limitations. In spite of their differences, Gordon respected the leadership:

The men who were going to make the revolution through the CIR were the most able leadership. They were brilliant; they were extraordinarily articulate, charismatic, and particularly resentful of the role of lawyers. (Interview)

Gordon particularly admired Dobkin, whose picture was prominently displayed in his office at the time of the interview.) Once the strike occurred, Gordon and his associates were supportive, playing a significant role. However, the schism that surfaced in 1975 eventually resulted in CIR's termination of the

Chapter 3 The History of CIR: 1975-1981

services of Gordon and Schectman. Gluckmann and others described the shift from Gordon to Geller as a shift in "image." Gordon's image was that of a fatherly figure, protecting his "boys" from ruining their careers. This was contrary to the leaders' perspective. In their professional lives they attempted to gain as much autonomy as possible; similarly they wanted to be in charge of their own union. Gluckmann described this ouster as an "adolescent rebellion." It was apparent that the union's own attorney would not be a policy maker. For example, when the attorneys (a second attorney was added in 1979) were overburdened with work, they requested that the Executive Committee order their priorities. According to Jonathan House: "the answers to our policy questions do not lie in the range of the interpretation of the law. . . . It's the role of lawyers to advise us on . . . the legal consequences of things. It's not the role of staff, legal or otherwise, to make policy." (interview)

Organizing Foreign Medical Graduates

In 1979 and 1980, CIR continued to organize new hospitals. As opposed to the prestigious voluntary hospitals that were organized in the seventies, such as Mt. Sinai, CIR was being approached by smaller, less prestigious hospitals. Among them were Jamaica Hospital, Catholic Medical Center, Flushing Hospital, St. John's Episcopal, North General, and Methodist

Chapter 3
The History of CIR: 1975-1981

Hospital. All of these hospitals were located in Brooklyn and Queens and their housestaffs were predominantly foreign medical graduates (FMG's). At an Executive Committee meeting, the issue of CIR's initial involvement in organizing smaller hospitals, when in the past the CIR did not approach them, was raised. The response was that the FMG leaders responded to a FMG organizing conference. In addition, some of these hospitals were in the process of exploring CIR when the 1976 NLRB decision was made. Apparently, the FMG "market" was seriously being explored for the first time by the CIR in order to expand its ranks. Perhaps, without the support of the law, the more prestigious housestaffs feared the repercussions that unionizing might have on their careers. Although it is sometimes asserted that FMG's are more vulnerable, because they are not American citizens and are therefore easily intimidated, Ed Gluckmann countered with the following argument:

The reason is all the problems that need organizing exist there (in FMG dominated hospitals) and the FMG's come. . . A lot of FMG's come from countries where doctors' unions, student unions are not atypical, not aberrations, not abnormal, so it's not a big shake. They're also treated like shit. . . Many of them are not all that involved or interested in all of the bullshit that's thrown at Americans. Never be able to practice at the better hospitals. Most FMG's don't expect it so it's not a threat. You won't get certified for your Boards. Some of them are just waiting for an immigration visa so whether they are ever board certified or not is not the issue for them. The first thing is to make sure they don't have to return to their country of origin. . . . So you have some ingredients there, potential issues, people that have the ability to do mind set as a

Chapter 3 The History of CIR: 1975-1981

collective - unsympathetic Americans treating everyone else in a denigrating way. It leads to a set of circumstances that can lead to organizing. (interview)

Thus, the problems that FMG's encountered were more likely to be ones that required help while in their residencies, such as changes in immigration law. Since they did not typically expect prestigious positions, when in practice, they were not intimidated with threats about the future. Thus, CIR, with a prepaid legal service with expertise in immigration law, appealed to FMG's.

Municipal hospitals

Although the relationship in the mid-seventies between the CIR and the voluntary hospitals was more dramatic than that with the municipal hospitals, the ongoing business of negotiations was taking place with the HHC. The HHC, whose original decision to bargain with CIR was not governed by the NRLB decision, continued to recognize CIR. It was not until January, 1978 that the HHC and the CIR agreed to a contract for 1976-1978. Part of the delay could be accounted for by CIR's resolve that "patient care" items be included in the contract. Among the original demands were maintenance of minimum standards pertaining to staff, training, and facilities, as required by four different health agencies; a working EKG machine on every floor; adequate medical and surgical supplies in every unit of each hospital; hours be limited to sixteen consecutive hours and eighty hours a week on

Chapter 3
The History of CIR: 1975-1981

primary care wards and twelve consecutive hours on and at least forty-eight consecutive hours off duty per week in the Emergency Rooms. (Committee of Interns and Residents Demands as Drafted by City-Wide Negotiating Committee for Submission to Health and Hospitals Corporation) The HHC at times implied that something could be worked out on these items, but consequently refused to include them in the contract. Due to the lateness of the contract (it was signed, pending Emergency Financial Control Board approval, as it was about to expire) CIR conceded, with the understanding on the part of the leadership and membership that these items would play a significant role in negotiations at the next contract.

At the January, 1978 meeting of the House of Delegates the "Brooklyn Hospitals Report" was read. The "Political Action Committee of CIR," which presented this report, was "charged with developing ideas and modes of action which the CIR can take in response to worsening health conditions in the City of New York." (attachment to Minutes of January, 1978 House of Delegates meeting)

Its recommendations were to:

1. strongly oppose all cuts in City health services. . .;
2. strongly oppose and work against all cuts in City services (such as schools, sanitation). A union of personnel involved with health care should realize that the maintenance of such services directly effects the health of the City population;
3. go on record for improving the City hospital system until such time as a National Health Service (not insurance) is established in the U.S., thus ending the two class health care

Chapter 3
The History of CIR: 1975-1981

system;

4. begin to work with organizations that support a National Health Service, and recommend that its national union, the Physicians National Housestaff Association be asked to join CIR in this effort;

5. that maintenance and improvement of the City hospital system be funded by a cut in the debt service the City is presently paying to the major banks in the country. . . . Rather than having staffing cuts in the hospital in the form of "productivity clauses" the City should end the usury presently being perpetuated on it by the banks;

6. actively work with DC 37 and 1199 in areas of common interest. The possibility of strong support of, or even a joint strike when contracts are up should be discussed;

7. . . . collect data on the supposed extra hospital beds in the City. . . . In debunking what we feel are myths concerning the availability of hospital beds the CIR staff should attempt to identify who is involved in making decisions on bed cuts, what is their relationship to the Emergency Financial Control Board, the HHC and the voluntary hospitals. We think some surprising relationships will be found. CIR members should also begin to collect data at their own hospitals on how many days the ICU and CCU units are full and how long a wait there is for a monitored bed . . . etc.

8. CIR should . . . publicize the information . . . on hospital cuts . . . so that the public can be made aware of the many myths surrounding health care in this City; and

9. at each House of Delegates meeting set aside time for a discussion of these issues.

Chapter 3 The History of CIR: 1975-1981

Although the House of Delegates did not act on any of these recommendations at that meeting, the stage was set for various discussions and actions in response to actual or anticipated budget cuts in the HHC, culminating in a one day walkout by the CIR on January 17, 1979. By April, 1978 a "Demands Committee" had formulated an outline of demands for upcoming negotiations. It specified that there should be no cuts in housestaff or service, nor any closing of hospitals or services. Additionally, certain minimum standards for personnel, equipment, records, hours, patient supplies, and on call rooms were set. Attendings were to be present for all surgical procedures and patients were not to be refused treatment for non-payment of fees (which were to be rolled back to 1977 levels). This preliminary list, once again, focused on issues considered non-negotiable by the HHC, entailing demands other than wages, hours, and conditions of work. These demands were revised and expanded several times so that by July they included a demand that housestaff be on duty a maximum of every fourth night and that the pyramid system (a system that decreases the number of housestaff on each successive year in a service) be eliminated. Also a "Patient Care Fund," a sum of money to be used for "patient care needs " in lieu of part of a raise for housestaff, was discussed. Overall, there was very little discussion of the basic "bread and butter" issues such as wages, vacation, and holidays and, when there was such a discussion at the

Chapter 3

The History of CIR: 1975-1981

September meeting, there was some opposition from housestaff who objected to the CIR sounding like the "longshoremen." The feeling was that the CIR should not appear to be like a typical labor union in its contract demands. (This sentiment pervaded the CIR membership who felt their professional status compromised by being like "other unions." Consequently, the CIR is the Committee of Interns and Residents and its national organization was the Physicians National Housestaff Association. This will be discussed more fully later.)

In the meantime, housestaffs at some of the HHC hospitals engaged in job actions (or were considering doing so) involving non-signing of charts, Medicare and Medicaid reimbursement forms, and paperwork slowdowns, in order to pressure the HHC to consider the patient care demands. Where there were pressing local issues, there more likely was a job action. At Lincoln Hospital a job action took place when promised blood drawing teams were six months overdue. The job action was called off when the teams showed up. At Kings County, where the housestaff had parking problems, they were threatened for not signing charts. At Bronx Municipal psychiatric emergency room, housestaff, in response to a \$300,000 cut in the hospital's budget, released patients who, although finished with their treatment, would normally have remained in the hospital; emergency patients were also referred to state and private hospitals after being treated initially. The faculty gave

Chapter 3
The History of CIR: 1975-1981

their support to the housestaff, both in a statement and by not performing any of the residents' work, except in life threatening situations.

However, the CIR leadership changed its strategy to more massive actions in light of the HHC's position that patient care demands were non-negotiable, and due to the housestaff exposure to threats where they were involved in job actions. On December 6, at a CIR sponsored rally at City Hall, speakers from various hospital unions addressed a group of 250 demonstrators. ("Rally Draws 250 Protestors," CIR Bulletin, November/December, 1978, vol. 7, #5, p. 1) Petitions were distributed, reiterating CIR's position on budget cut issues. Rallies were also held at individual hospitals.

At the December, 1978 House of Delegates meeting it was suggested that "a season of political activity" be planned. Support for a possible strike varied from unanimous approval at Metropolitan (which had been slated to be closed) to complete apathy (Bellevue). However, the delegates decided to proceed with a strike after the Mayor announced new hospital cuts on January 15. Originally the plan was to close outpatient clinics first; then, a week later, close emergency rooms and stop admissions and finally, two weeks after that, shut the hospitals down. A strike committee was formed and rallies were planned to escalate support from the community and co-workers.

Chapter 3
The History of CIR: 1975-1981

What appeared to be significant about this plan was that it would be the first citywide strike of housestaff in the municipal hospitals. Nevertheless, the possibility of legal repercussions was not discussed at the meeting. In this case, as opposed to that of voluntary hospital housestaff, municipal housestaff were covered as city workers under the Taylor Law, which forbade strikes. Punishment for violation of the law could include loss of two days' pay for every day on strike.

The following Sunday the Mayor's plan to cut the number of municipal hospitals in New York City by 50% was announced. The CIR publicly condemned the plan and announced its plan for job actions and a strike. By January 10, the New York Times reported CIR's plan for a one day strike on January 17.

On the eve of the strike the House of Delegates met, with the press in attendance. The Mayor and the HHC had won a temporary injunction in State Supreme Court, barring the strike. The judge, in issuing the restraining order said:

. . . no matter how laudable or public spirited the Committee of Interns and Residents may be, I believe that a strike of Interns and Residents is an action which looks toward the partial paralysis of an essential function of our society and such an action would be intolerable and unthinkable. (Judge Hortense Gabel, quoted in CIR Bulletin, January, 1979, vol. 8, #1, p. 2)

In view of the restraining order, CIR's lawyer informed the housestaff that penalties could include a fine to the CIR as well

Chapter 3

The History of CIR: 1975-1981

as jail terms. In spite of this, the delegates voted to strike the following day. At the press conference that followed, the leaders stressed that the strike was an appeal for a rational health care plan for New York City. They argued that the Mayor's plan would not save money for the city due to insurance coverage for costs, but rather that the motive for the closing was a ploy on the part of the voluntary hospitals to take away business from the municipals. In response to the charge that they were using the city system to train, but would practice in the suburbs (a charge made by Mayor Koch), they hissed, stating they were ready to go to jail.

The walkout of January 17, 1979 was regarded by CIR as a "striking success." Although the judge who issued the restraining order feared for the safety of the patients, only clinic patients were not treated; emergency rooms were open and staffed by senior physicians; residents left picket lines in emergencies. Support came from other hospital workers, as well as groups such as the NAACP, the Medical Society of Brooklyn, and the Doctor's Council, a union representing attending physicians in the HHC. The significance of the action was in gathering support and bringing the issues to the forefront for the public. In addition, the CIR's image as patient care advocate was reaffirmed. In response to Mayor Koch's charge that residents' idealism was only temporary and that they would "flee to Connecticut" (New York Times, January 16,

Chapter 3
The History of CIR: 1975-1981

1979) the New York Times interviewed one of the strike leaders, from Kings County Hospital. Citing his background of social activism in college, the resident said he "had not let the desire to be of public service slip away from him over the year. I don't want to go into private practice. . . I want to be at a large hospital and take care of patients. I don't want to restrict myself to an upper middle-class population. I don't care about making a lot of money." (New York Times, January 18, 1979)**

The overriding issues that became the focus for the CIR were:

1. "Rational Health Care Plan for NYC - a moratorium on cuts and building and 2. Patient care in our contract." (CIR Bulletin, January, 1979, p. 1)

At the next House of Delegates meeting, a motion was passed calling for unions and community groups to develop a coalition to fight the cuts. The Strike Committee "reported that the January 17 symbolic strike had produced the needed political response." (CIR House of Delegates minutes, February 20, 1979, p. 4) This "response" was that other groups, concerned with the hospital cuts, were in agreement with the CIR's approach.

There was consensus that they should continue to demonstrate, engage in job actions, and push for patient care in their

**Currently, this physician is a hematologist, with a secondary specialty in oncology, engaged in medical research and direct patient care at a cancer hospital in a major metropolitan area.

Chapter 3
The History of CIR: 1975-1981

contracts. The leader of the strike, Jonathan House, was elected by acclamation, as the new CIR President upon the resignation of the previous president. It seemed to be a mandate to continue the "struggle." However, at various HHC hospitals, the housestaff were experiencing demoralization as negotiations lingered and job actions, such as not signing charts, degenerated due to disinterest or pressure from departmental chairmen.

The long range effects of the walkout were difficult to pinpoint. According to Larry Boxt, a former CIR President, it was a:

smashing victory, an unmitigated victory. . . . we beat them. They didn't close a single hospital; they're not going to close a single hospital. I mean, health care is absolutely an issue in New York now. . . . The community and the medical staff is now working together; the hospital workers, including the nurses, the attendings and the housestaff are working together. . . . The strike itself wasn't the end; the strike was a means to getting an issue before the public eye, to have it discussed by the public. . . . It was a media hype. . . . People did a political action as a means to an end rather than a political action in and of itself. . . . It gave us momentum; it taught us that tactic works and set us out in that direction. . . . we crystallized in our own minds what our end is: more patient care. Patient care is the be-all and end-all of CIR because of the way working conditions and housestaff conditions relate to patient care. (Interview)

It was clear that the CIR believed that their impact was decisive in keeping the city hospitals open. It's unclear how much credit should be granted to CIR, especially in light of Mayor Koch's view of their motivations and the active opposition of a number of other

Chapter 3
The History of CIR: 1975-1981

more powerful groups.

Nevertheless, this perceived victory became a springboard for renewed activity at CIR. Leaders returned to HHC negotiations, for the 1978-1980 contract, as well as to those at voluntary hospitals, confident that patient care would be on the agenda.

However, realizing the HHC was adamant about not including patient care demands in their contract, CIR modified their proposal in March, 1979. They asked for grievable staffing and equipment levels. The HHC would only accept a patient care fund. In April, in order to pressure the HHC, CIR passed a motion for a "Malpractice Committee: that a committee to investigate those instances of malpractice at hospitals where inadequate staffing and/or lack of functioning equipment or adequate supplies as the cause of the incident be created. The purpose of this Committee is to protect housestaff and insure adequate staffing and equipment levels in order to prevent injury to patients." (minutes, 4/17/79, House of Delegates meeting, p. 3) The underlying intent of such a committee was to use documented information as publicity and in negotiations. Instead of the housestaff being culpable for patient care delivery problems, the hospital would be at fault.*** One housestaff officer hoped that such a committee would help to "demystify medicine." (notes) The chairman of the Malpractice

***Mizrahi (1984, 1986) found a norm existing among housestaff regarding medical mistakes, which was justify them as unavoidable or deflect blame for them to others.

Chapter 3
The History of CIR: 1975-1981

Committee felt this was the "only tactic we have other than all out strike to negotiate." (House of Delegates meeting, 6/16/79, notes) Nevertheless, in spite of the enthusiasm for this tactic, which resembled the "Registry of Abuse" of 1970, its implementation presented problems. A Kings County Hospital delegate, in discussing the reporting of incidents of "malpractice," mentioned the use of "body counting cards."

These little cards were meant for documentation, a little 3 x 5 thing, just to document an occasion in which a doctor was called upon to do out-of-title work, a place for the doctor to sign, and a place for a member of another service, such as a nurse, or an aide, or a transport or whatever, to countersign, as documentation. They were to hand it to me. I had a box full of these 3 x 5 cards; I handed them out all over the place, and I didn't get one back. And I'm not blaming the housestaff. They've got enough to do. To them, they just feel such a sense of helplessness and hopelessness, what the heck good is it going to do us?" (Interview, Kings County delegate)

Clearly, the housestaff were getting disillusioned with the "struggle." By December, 1979, the House of Delegates found itself between a rock and a hard place. Still committed to patient care in the contract, its choices were limited. The HHC had reversed itself, after agreeing to allow deficiencies cited by the JCAH to be grievable in the CIR contract. CIR negotiators said they would consider anything "with a little patient care that was enforceable." (notes) Finally, the HHC submitted a request to go to impasse. This, in effect, would have initiated

Chapter 3 The History of CIR: 1975-1981

a process whereby an impasse panel would decide what issues were bargainable and, in all probability, patient care issues would not be considered bargainable. During a lengthy discussion at the House of Delegates, the delegates expressed their commitment to patient care, but also expressed the frustration of the rank and file at not having a contract. As 1980 approached, they were still without a contract for 1978-1980, and therefore, could not obtain the raises due them in the new contract. A Metropolitan Hospital delegate said the housestaff felt patient care was an "albatross." The consensus was, at that point, that patient care was symbolic rather than real, and the contract should be signed. Then the CIR could focus on other strategies to promote patient care issues. Although the leaders, who were "close to the struggle" (Met delegate) were ready to fight, the rank and file was not. Thus, the HHC contract was approved by the CIR without any patient care clauses, regarding staffing and equipment levels. However, a Patient Care Fund, of \$200,000 was included. This sum was to be used to purchase equipment; the CIR was to propose which equipment was to be bought.

Thus, the CIR concluded the HHC contract, without the patient care provisions to which they had been committed. They proposed to pursue other methods, such as revitalizing the institutional malpractice committee, pursuing out-of-title grievances, considering new alliances with other unions, and preparing for new

Chapter 3
The History of CIR: 1975-1981

contract demands for the 1980-1982 contract.

The Voluntary Hospitals

CIR had some successes in negotiating patient care provisions in voluntary contracts. At Brooklyn-Cumberland, Kingsbrook, and Maimonides Hospitals contracts were accepted with some patient care provisions, such as blood drawing teams and, at Kingsbrook, a patient care fund.

At Montefiore, when the administration refused to include patient care items in the contract, the housestaff considered a strike. At the House of Delegates meeting, they suggested the following strike slogan: "professionalism means standing up for good care for our patients and tolerable conditions for ourselves." (notes) A month later Montefiore housestaff accepted the administration's offer: changes in the composition of the Standards and Grievances Committee, presumably resulting in the housestaff getting a better edge in out-of-title arbitrations; no pyramid in medicine and more pediatric housestaff.

United Salaried Physicians and Dentists (USPD)

Although CIR only represented interns and residents, attending physicians from Flower Fifth Avenue Hospital approached Ed Gluckmann, the CIR's Executive Director, in the fall of 1979, to explore the possibility of joining CIR. Several physicians' labor

Chapter 3
The History of CIR: 1975-1981

unions were already in existence. Among them were the Doctor's Council, a union representing physicians employed by the municipal hospitals; the American Federation of Physicians and Dentists, considered to be a conservative group; and the United Federation of Teachers, which had expressed interest in organizing physicians. However, of the fifteen attendings on the payroll of Flower Fifth Avenue Hospital, twelve opted to join CIR as an affiliate. (There were no residents at Flower in 1979.) Flower had become a voluntary, long term hospital of the Archdiocese of the City of New York, servicing severely retarded patients and handicapped children. When Gluckmann approached the CIR Executive Committee, they authorized him to meet with the attendings and extend his help in their efforts to organize. Upon raising the issue with the larger House of Delegates, questions arose as to the role of attendings in a housestaff organization. Problems were anticipated, both with the perceived interests of attendings versus those of housestaff, as well as structural problems that might put attendings in opposition to residents. Comments ranged from: "the central theme for attendings is his money and his behind" and "we take care of people not money" (12/11/79/ House of Delegates meeting) to "it's in our interest that attendings organize; we represent a union with soul that fights for patient care even if they have an image of themselves as professionals." (11/20/79 House of Delegates meeting, Jonathan House, president)

Chapter 3
The History of CIR: 1975-1981

There was a consensus among the housestaff that any attending union that was linked to CIR had to be a "union with a conscience."

Interestingly, in spite of the fact that the attendings that expressed interest in CIR were mostly CIR graduates and therefore, presumably pursuing CIR membership because of its philosophy and track record, the residents were suspicious of their motives and interests. They did not identify with these attendings, nor see themselves in their position a few years down the road. Their comments indicated that their perceptions of the attendings they encountered were that they were not patient care oriented, but rather predominantly interested in financial gain. In addition, their distrust may have been a consequence of the transiency of residents in the CIR, giving them an "ahistorical" view of CIR. Consequently, they believed that their commitment to patient care was new and unique.

In addition, there was a fear that the role relationship that existed between housestaff and attendings in the hospital might result in a conflict of interest, in situations such as a housestaff strike.**** Therefore, the decision was made:

**** In fact, the issue of whether attendings, and perhaps even residents, were in managerial positions, and therefore, in private institutions, not eligible to unionize, was the substance of the Supreme Court's "Yeshiva decision;" in February, 1980, it upheld the right of Yeshiva University to refuse to bargain with a faculty union. This decision was based on the faculty's role in decision making on personnel matters, curriculum, academic priorities, and tenure.

Chapter 3
The History of CIR: 1975-1981

that CIR offer assistance and its name to any attendings' groups that wish to participate in an organizing effort. CIR would ally with such attending groups based on their desire and interest in supporting those principles of concern to housestaff and CIR. Request for affiliation will be denied, but an alliance will be made on a case by case basis. Requests for staff and counsel time will be reviewed on a timely basis. (House of Delegates, notes, 12/11/79)

CIR's Executive Director was authorized to function as Acting Executive Director of USPD, and utilize some of CIR's resources to help USPD organize. CIR's lawyers became USPD's lawyers and USPD's Constitution and By-Laws were modeled after those of CIR.

In April 1980, USPD had its first unit's election at Flower, winning the right to represent their attendings. By August negotiations were deadlocked. Following a refusal by doctors to work unpaid overtime, the administration cut their wages and locked them out. The strike that ensued was marked with difficulties. It lasted nineteen days, and according to the CIR News, "was marked by unprecedented employer violence against doctors." (October, 1980, vol. 9, #3, p. 1) Hospital vehicles, while bringing scabbing doctors out of the hospital, ran down picketing doctors and USPD staff. Ed Gluckmann was hospitalized after being knocked unconscious.

However, the conclusion of the strike was regarded as a victory by USPD. They felt they had "brought the Archdiocese to its knees." (CIR Executive Committee, notes, 9/9/80) The issue of concern to the strikers, attendings working at night being paid

Chapter 3
The History of CIR: 1975-1981

less that those working in the day, was dealt with in the contract. The contract provided salaries based on a forty hour week, 14% and 8% raises, and overtime for any time over the forty hours. In addition, USPD agreed to drop charges against the hospital of attempted murder on behalf of Ed Gluckmann (when he was knocked unconscious). However, the real issue for the doctors involved, who were mostly not American, was not dollars and cents:

This was a test of the fundamental rights of doctors as employees in the hospital industry. We work in very difficult conditions. We work up to twenty-five hours overtime a week. We deserve to be paid decent salaries for our work. But more important, we deserve to be treated with respect as workers and professionals.
(Dr. S. Lahiri, USPD President, CIR News, *ibid*)

Although the strike proved to be a victory for the first USPD "local," according to the President of CIR, it also "sucked in the entire staff" (notes) of the CIR, which served as USPD's staff. In a discussion of priorities it was decided that CIR and USPD should focus on organizing more hospitals to bring in revenue.

In order to do this USPD explored the options for organizing physicians at various hospitals. Psychiatrists employed by New York State had approached CIR before USPD was established. Already in a union, the Public Employees Federation (PEF), they wanted to break out. Many were FMG's and former CIR members. According to Gluckmann, they expressed support for CIR and its goals: many were concerned about patient care, staffing ratios etc. and a small

Chapter 3
The History of CIR: 1975-1981

group focused on more money and less hours. He described them as "strong, determined, and looking for someone to help them." They claimed to represent 500 of 2,500 state attendings. A year after their initial encounter with CIR, they were still not USPD members. In order for them to join CIR, a long, expensive legal procedure was necessary. Apparently, this never occurred.

However, USPD did succeed in organizing attendings at Greenpoint Hospital, a municipal hospital. In February, 1981, the Association of Salaried Physicians, the local attendings' group, representing the seventy attendings at Greenpoint, voted to join USPD. According to Ed Gluckmann, "most of them (attendings) are impressed by our victory at Flower Hospital, our experience with all types of doctor-labor relations and our honesty." (News release, 2/10/81).

Apparently, USPD's advantage over other unions organizing physicians was that it represented salaried doctors exclusively. According to Dr. Swapnadip Lahiri, the President of USPD:

We have found dissatisfaction among doctors represented by unions which primarily cover other types of workers. Doctors report a lack of concern for their unique characteristics, a lack of knowledge about clinical and patient care issues, insensitivity to their professional rights and most of all, a lack of impact in a union where they are only a minor unit. (CIR News, January, 1981, vol. 10, #1, "An Open Letter - Salaried Physicians Organize," p. 6)

Chapter 3 The History of CIR: 1975-1981

The USPD based its attraction to physicians in continuing to portray their status as unique. Although professionals, the nature of their work was depicted as special and therefore, their need for a union was similarly special. As with Flower Hospital, the attendings at Greenpoint turned to the CIR offshoot, USPD, because many of them were former CIR members who knew they had successfully won gains for their members. USPD had since organized attending physicians at Rockland County Hospital and Bergen Pines Hospital.

For some CIR leaders, the creation of USPD represented an historic turning point in physician unionization: the creation of a new category, salaried physicians. Potentially, both housestaff and attendings, although distinct groups in the medical hierarchy, could fall into this category and in the future be a powerful group with similar interests in unionization.

CIR's Organizational Development

In the 1979-1980 period, the bureaucracy of the CIR expanded both in size and specialization. In the summer of 1979 a "contract administrator and community liaison" (Luis Lopez) was hired. As his title suggested, he was to concentrate on servicing the members at his assigned hospitals, as well as establishing contact with the community in areas where there were CIR hospitals. In March, 1980 Robert Wollk, who was already working as a contract administrator, was given the title of "organizing coordinator," in order to focus

Chapter 3

The History of CIR: 1975-1981

on the recruiting of new hospitals. In July, 1980 Ann Bastian was hired as a "communications coordinator" to handle public relations between the CIR and the outside as well as between the union and its membership. She became the editor of the new CIR newspaper. In addition, several lawyers were engaged to work either for the union itself or for its prepaid legal plan, a benefit which was added in early 1980. CIR opened a separate New Jersey office in October, 1980.

This rapid growth of CIR brought with it a variety of problems, such as allocation of resources. As with the USPD strike at Flower, in which the staff focused exclusively on this action, other activities diverted CIR's resources. The CIR supported a nurses' strike by permitting the nurses to use of the facilities of the CIR office; CIR supported housestaff organizing in California with funds and CIR staff. The staff and officers of the CIR were becoming uncomfortable with seemingly unplanned allocation of resources, perhaps at the expense of servicing already existing membership. Ann Bastian referred to this problem as "outreach versus consolidation." (Executive Committee notes, 10/7/80) It became apparent to the Executive Committee that CIR, in becoming absorbed by the details of managing a large bureaucratic organization, was losing sight of their goals. At a more informal meeting, at the home of the President, it became clear that more "consolidating" was necessary: the issues required more careful

Chapter 3 The History of CIR: 1975-1981

thought and more attention needed to be directed to servicing membership. Two members of the Executive Committee, in a proposal of guidelines for the Executive Committee and the House of Delegates, expressed dissatisfaction with the decision making process of the union. Underlying their proposal (Executive Committee meeting, 12/4/80) was an awareness of not being consulted on projects that were significant for policy and/or resource allocation. They requested periodic reviews of union activity in the form of written reports to the Executive Committee and House of Delegates, as well as a formal mechanism for approval of all union activities. The purpose of the guidelines was to "insure that the necessary communication occurs, and that decisions made by the delegates are based on a full knowledge of the issues involved." Although there was never a formal vote on these guidelines, Executive Committee discussions revealed that a number of people agreed there was an "inattention to detail and some degree of sloppiness" (delegate at meeting). Needless to say, the opposing argument to the guidelines was that housestaff did not have spare time to read endless reports and could easily reach their "boredom quotient." The staff seemed especially put off by this proposal. In any case, the proposal did bring to the forefront a more generalized discomfort with the impact that the rapid growth of CIR had on its operation.

Chapter 3
The History of CIR: 1975-1981

1980

CIR faced a variety of challenges in 1980. The city was continuing to cut back, including the planned closing at Sydenham Hospital, a municipal hospital serving the Harlem community. Negotiations resumed for the next contract at both the municipal and voluntary hospitals. Patient care became the focus of a number of actions designed to bring attention to conditions in the hospitals. Traditional union tactics were implemented to generate changes. In February, 1980, the Health Systems Agency, which reviewed NYC health programs requiring state approval, recommended that NYC eliminate 1,000 beds, rather than the 2,500 that had been previously recommended. This issue of excess beds was one that the CIR and others had been debating. From an economic perspective, any unfilled bed in a hospital was a loss of revenue. The previous summer Mayor Koch had proposed the closing of four municipal and seven voluntary hospitals to deal with this situation. The CIR, in order to demonstrate that there was a situation of overcrowding in the municipal hospitals, held a news conference on February 17, 1980. A number of instances were cited in which seriously ill patients waited long hours for a bed or to be transferred to another hospital with an available bed. Also cited was the high occupancy rates at six of the hospitals. (New York Times, 2/18/80, p. B1)

Chapter 3
The History of CIR: 1975-1981

Filing grievances as a mechanism for change was uncommon. In the sample interviewed only seven housestaff officers had filed grievances. According to the delegates it appeared that housestaff officers often chose not to grieve something even when they were aware it was a contract violation. (discussion, House of Delegates meeting, 7/15/80, notes) Anecdotes of residents being threatened or having letters put in their file, for matters such as their "respectfulness," were related.

However, the "Pat Hart arbitration" was an example of the successful use of the grievance mechanism to obtain patient care goals. Dr. Hart was a renal fellow in nephrology at Lincoln Hospital. She filed an out-of-title work grievance because she was doing the work of half a dialysis nurse for one and one-half years. In the settlement the HHC had to maintain nursing levels so that Hart or any other doctor would not be required to do nurses' work. It was felt that a precedent was set, mandating a minimum level of staffing. Jonathan House, the President of CIR, described this as "one of the more exciting things on the legal front." Needless to say this did not eliminate out-of-title work, but it did establish its "grievability" for residents.

As the year progressed, the CIR readied itself for a new round of contract negotiations in the voluntary and city hospitals. At the September, 1980 Executive Committee meeting there was agreement that, although housestaff groups at the various hospitals had

Chapter 3 The History of CIR: 1975-1981

different priorities for their contracts, CIR would attempt to use similar language on certain issues, such as out-of-title work. The Committee felt that the HHC housestaff was solidly behind the patient care issues. However, the voluntaries varied: from Maimonides, where patient care issues were used to accomplish monetary demands, to Montefiore and Bronx Lebanon, where there was more commitment to improving the hospital conditions. As the negotiations continued throughout the fall, those who had been there for previous negotiations felt a sense of deja vu. Once again the HHC refused to bargain on patient care issues, and said no to demands for one night in every four, and maternity leave. At the January, 1981 House of Delegates meeting, the delegates considered their options. There was a feeling that housestaff at some hospitals were quite militant on the patient care issue. Harlem and Kings County Hospitals were characterized as particularly committed to achieving patient care in their contract. Among the voluntaries, Montefiore housestaff were also felt to be militant on the patient care issue. As discussion continued, the delegates realized that they could not predict what actions the rank and file were willing to engage in to compel the administrations to include patient care demands in their contracts. As the Kings County delegate put it, there was a need to communicate with the housestaff to determine if a "silent, not satisfied majority" could be mobilized. The delegates agreed there

Chapter 3 The History of CIR: 1975-1981

was a need for a housestaff poll to determine what actions they were willing to take. The options that were selected for the poll were to take no action or to strike on March 17, 1981.

At the following month's meeting the poll results were reported. Of the approximately one-third of the housestaff who voted, the majority were in favor of striking. Several housestaffs were adamant in their support of a 100% strike, in which the housestaff would walk out and not provide a skeleton crew to service the patients. Although there was much to be done to further poll the housestaff (some polls were conducted during the holiday schedule, others did not reach a fragmented housestaff) and educate them as to the possible legal consequences of striking (a violation of the Taylor Law for municipal housestaff), the House of Delegates voted to strike on March 17, 1981, unless staffing provisions were included in the contract. The strike that took place brought to the forefront many of the strengths, weaknesses, priorities and problems of the CIR.

Before discussing the strike in detail, it is necessary to examine other aspects of the CIR, such as the nature of the membership itself, the issues that pervaded the work situation of the residents, and the evolution of the union itself.

Chapter 4

The CIR Membership

This section will examine the characteristics of the CIR population by focusing on the residents in four CIR hospitals.

A resident, or housestaff officer, is a medical school graduate, engaged in advanced medical or surgical training at a hospital in order to become board certified. Board certification is a prerequisite to take exams in one's specialty for a license to practice. Although most residencies entail three years, some, depending on the specialty, are longer. In addition, a resident may continue in a clinical or research fellowship program, upon the completion of the residency, in a subspecialty. The year in which a resident is training is referred to as the "postgraduate year" or PGY. Up to 1975 the first year of training was the internship; since 1975 it is called the first postgraduate year or PGY 1.

Sample selection

The CIR bargained collectively for over 4,000 residents in twenty-five hospitals in 1980-1981. Selecting an appropriate sample to include the range of experiences and views of physicians in the various categories of sex, age, race, place of medical education, PGY level, specialty and hospital was problematic. Bronx Lebanon, Montefiore, Bellevue, and Kings County Hospitals were selected in order to tap a range of variables that affect residents: hospital reputation, prestige,

Chapter 4

The CIR Membership

ownership, patient care conditions, populations served, significance of CIR's role within the hospital, working and training conditions, and housestaff "mix", especially with regard to FMG status. This information was gathered by researching available reference material on hospitals (COTH Directory 1980 - Educational Programs and Services, American Association of Medical Colleges, and the American Health Association Guide to the Health Care Field), observing CIR meetings and the early strikes, and interviewing CIR staff and leaders about all the CIR hospitals. Non-CIR hospitals were not considered for this study due to the limitations of the research that was feasible at that time. Because of the long hours entailed in residents' schedules, the interview format was chosen as the most efficient to obtain a maximum response rate. The interviews were conducted between May, 1980 and June, 1981. The four hospitals, although not "ideal types" which would uniquely capture a particular set of conditions, did exemplify a broad range of situations that existed in CIR hospitals. Documented hospital characteristics included the following:

Chapter 4
The CIR Membership

Table 4a Hospital Characteristics (1980-1981)*

	<u>Bronx</u>	<u>Lebanon</u>	<u>Montefiore</u>	<u>Bellevue</u>	<u>Kings</u> <u>Cty.</u>
Control	Voluntary	Voluntary	Municipal	Municipal	
Beds	552	1,312	1,258	1,473	
Census	2,687	1,228	985	1,197	
Admissions	21,985	39,285	26,132	41,669	
ER visits	70,963	61,488	102,000**	260,369	
Outpatient visits	131,436	137,654	NA	486,548	
Expenses (thousands of \$)					
Total	55,634	161,684	134,611	109,779	
Payroll	35,671	93,979	4,952	90,037	
Personnel	2,203	5,546	NA	6,231	
Total Hs***	171	378	345	399	
Med. School Affiliation	Einstein		New York University	Downstate S.U.N.Y.	
Residents in training					
First year filled	51	129	NA	117	
First year FMG filled	36	4	NA	58	
Total filled	143	598	NA	609	
FMG filled	114	78	NA	260	
First year % FMG	71	3	NA	50	
Total % FMG	80	13	NA	43	
# of approved graduate & undergraduate educatnl. prgms.	9	23	NA	27	
Occupancy rate	NA	95	78	91	

Chapter 4

The CIR Membership

***Sources:** All Bellevue information taken from American Health Association Guide to the Health Care Field, 1978 ed. Chicago. All other information, except occupancy rates, which are also from the AHA Guide, were taken from COTH Directory 1980 - Educational Programs and Services. Council of Teaching Hospitals. Association of American Medical Colleges. Committee Structure and Membership Directory.

**** Source:** David Kotelchuck (ed.) Prognosis Negative. New York: Vintage Books, 1976.

*****Total housestaff:** calculated by counting official hospital lists of housestaff during 1980-1981.

Bellevue and Kings County are municipal hospitals, under the aegis of the Health and Hospitals (HHC) of New York City, whereas Bronx Lebanon and Montefiore are voluntary (not-for-profit) hospitals. This fact alone conjures up images, both in the medical community and in the population at large, that may or may not be true. Municipal hospitals are often thought of as last resort, second class institutions, both in terms of medical care and patient care conditions, serving the poor; in general, they are undesirable places to be. Voluntary hospitals are thought to be more desirable with respect to all those issues. However, a recent study, using JCAH hospital surveys, found HHC hospitals equal, or superior to, voluntary hospitals in the areas of safety (buildings and ground, sanitation, infection control), support (lab services, dietetic services, pharmaceutical services), and direct functions (emergency, ambulatory care, medical and nursing services). (Hyman, 1986) Similarly, the stereotype did not hold up for the four sample hospitals.

All the hospitals are affiliated with medical schools, which

Chapter 4 The CIR Membership

provide the supervision and education of the residents; all are classified as short term stay (average length of stay for all patients is less than thirty days or over 50% of all patients are admitted to units where the average length of stay is less than thirty days) providing general medical and surgical services. (COTH, op cit.,1980).

Bellevue

Bellevue has been referred to as the "jewel" of the municipal hospital system. It is considered the most desirable hospital in which to train, work, and be a patient, in the city system. Its reputation as an educational institution for residents is well known and the "pathology" of the patients is varied and frequently "exotic." Although Bellevue's popular reputation is as a psychiatric institution, it has forty-five facilities and services. It is also well known for its treatment of trauma victims. One of the oldest public hospitals in the nation (founded in 1736), it is located in a middle class community in Manhattan, adjacent to New York University Medical Center, its affiliate, and the Manhattan Veterans Administration Hospital. Housestaff get experience treating patients in all three institutions, but are on the payroll of only one institution at a time. The sample chosen included only housestaff on the Bellevue payroll so that they would all be

Chapter 4
The CIR Membership

covered by the same CIR contract (in this case the HHC contract for municipal hospitals). In some cases housestaff had been on other contracts previously, or knew housestaff officers on other contracts, and thus were able to compare their benefits with those offered by other contracts. The problems that emanate from this arrangement will be discussed later.

Housestaff at Bellevue

There were 345 housestaff officers on the Bellevue payroll in 1980-1981. Of the thirteen residents who were interviewed at Bellevue, the following applies:

Table 4b Bellevue housestaff sample (N=13)

<u>PGY</u>	<u>N</u>	<u>%</u>	<u>Specialty</u>	<u>N</u>	<u>%</u>	<u>Age</u>	<u>N</u>	<u>%</u>
1	3	23	Medicine	2	15	26-28	5	38
2	1	8	Pediatrics	2	15	29-31	4	31
3	6	46	Surgery	3	23	32-50	4	31
4+	3	23	Psychiatry	4	31			
			RAN*	2	15			
<u>Sex</u>	<u>N</u>	<u>%</u>	<u>Marital Status</u>			<u># of</u>		
<u>Children</u>			Female	4	31	Single	7	54
Male	9	69	Married	6	46	0	10	77
						1-3	3	23
<u>Ethnicity/race</u>	<u>N</u>	<u>%</u>				<u>FMG status**</u>	<u>N</u>	<u>%</u>
American born, white	13	100				American trained	8	62
American born, non-white	0	0				American born,	5	39
Foreign born, white	0	0				foreign trained		
Foreign born, non-white	0	0				Foreign born & trained	0	0

*RAN = radiology, anesthesiology, and neurology

**As opposed to the samples selected at the other three hospitals, this is the only group where there were no foreign born FMG's. The proportion of FMG's in the total Bellevue housestaff population is thought to be small; the data were unavailable.

Chapter 4
The CIR Membership

Kings County

Kings County Hospital was chosen because it is considered to be the "typical" municipal hospital. One CIR staff member who was quite familiar with Kings County said "all the problems in municipal hospitals are in Kings County and more so." It is an extremely large hospital, both in terms of the physical plant, as well as personnel and patient load. It is one of the two municipal hospitals serving Brooklyn, the largest borough in New York City, with a population of 4 million. Training is available in 27 specialties and subspecialties. It is affiliated with SUNY Downstate Medical Center, which is across the street. Residents train at these two hospitals, as well as at the Brooklyn Veterans Administration Hospital. As in the case of the Bellevue sample, all the residents chosen for the sample were on the HHC Kings County payroll.

Housestaff at Kings County

There were 399 housestaff officers on the Kings County payroll at the time of the study. For the sixteen residents that were interviewed the following apply:

Table 4c Kings County housestaff sample (N=16)

<u>PGY</u>	<u>N</u>	<u>%</u>	<u>Specialty</u>	<u>N</u>	<u>%</u>	<u>Age</u>	<u>N</u>	<u>%</u>
1	2	13	Medicine	3	19	26-28	5	31
2	5	31	Pediatrics	4	25	29-31	7	44
3	3	19	Surgery	5	31	32-50	4	25
4	6	38	Psychiatry	2	13			
			RAN	2	13			

Chapter 4
The CIR Membership

						<u># of children</u>		
<u>Sex</u>	<u>N</u>	<u>%</u>	<u>Marital status</u>	<u>N</u>	<u>%</u>		<u>N</u>	<u>%</u>
Female	7	44	Single	4	25	0	10	63
Male	9	56	Married	12	75	1-3	6	37
<u>Ethnicity/race</u>			<u>N</u>	<u>%</u>	<u>FMG status</u>		<u>N</u>	<u>%</u>
American born, white			5	31	American trained		3	19
American born, non-white			2	13	American born,			
Foreign born, white			4	25	foreign trained		7	44
Foreign born, non white			5	31	Foreign born & trained		6	38

Clearly, the composition of the housestaff at Kings County was more heterogeneous than that of Bellevue. Whereas the Bellevue housestaff could be described as largely male, white, and American trained, the Kings County housestaff is half male, mixed in terms of place of birth and race, the majority having trained in foreign schools. More of the Kings County housestaff had families as well.

Montefiore Hospital

Montefiore, is affiliated with Albert Einstein College of Medicine of Yeshiva University and North Central Bronx Hospital, a municipal hospital, located next door to Montefiore. It is in the Bronx in a "community in transition." It was a stable, middle class, predominantly Jewish community, whose population in recent years has become more mixed with Hispanics and blacks. Montefiore is known in the medical community as a progressive, innovative medical center. Dr. Martin Cherkasky, the executive director at the time of the data collection, has a reputation on

Chapter 4
The CIR Membership

the national scene for his liberal stances on medical issues. Montefiore has departments in both social medicine and pediatric social medicine. The housestaff chosen for the sample were all on the Montefiore payroll, although most rotated through North Central Bronx, its municipal affiliate. There were forty facilities and services and twenty-three approved undergraduate and graduate educational programs.

Housestaff at Montefiore Hospital

Of the 378 housestaff officers on the Montefiore payroll at the time of the study, fifteen were interviewed. The following apply:

Table 4d Montefiore housestaff sample (N=15)

<u>PGY</u>	<u>N</u>	<u>%</u>	<u>Specialty</u>	<u>N</u>	<u>%</u>	<u>Age</u>	<u>N</u>	<u>%</u>
1	7	47	Medicine	5	33	26-28	9	60
2	4	27	Pediatrics	5	33	29-31	4	27
3	2	13	Surgery	3	20	32-50	2	13
4	2	13	Psychiatry	1	7			
			RAN	1	7			
<u>Sex</u>	<u>N</u>	<u>%</u>	<u>Marital status</u>	<u>N</u>	<u>%</u>	<u>Number of children</u>		
Female	5	33	Single	5	33	0	12	80
Male	10	67	Married	10	67	1-3	3	20
<u>Ethnicity/race</u>	<u>N</u>	<u>%</u>	<u>FMG status</u>	<u>N</u>	<u>%</u>			
American born, white	13	87	American trained	15				
100								
American born, non wh	0	0	American born,	0	0			
Foreign born, white	2	13	foreign trained					
Foreign born, non wh	0	0	Foreign born &	0	0			
			trained					

As with the Bellevue sample, this is a very "American" group. In the total Montefiore housestaff population, the FMG's constituted

Chapter 4

The CIR Membership

13% of the total housestaff group and 3% of the first year housestaff officers. This sample is also slightly "weighted" in favor of first year residents: half of the sample falls in that group, whereas only 22% of the total Montefiore housestaff population were PGY 1's. Thus, the impact of the burdensome first year of residency may be expressed by the Montefiore sample to a larger extent than was experienced by that population.

Bronx Lebanon Hospital

Bronx Lebanon Hospital is considered unusual among voluntary hospitals: it is sometimes described in the manner that one would expect a municipal hospital to be described: it is in a poor community of the Bronx (located at two sites); it has funding problems; conditions for patients are not considered desirable etc. Most housestaff do not rotate to other hospitals, although a few rotate through Jacobi Hospital (a municipal hospital in the Bronx) and Einstein. It has nine approved graduate and undergraduate educational programs for residents and thirty-seven facilities and services.

Housestaff at Bronx Lebanon Hospital

At the time of the interview there were 171 housestaff on the payroll. The following describes the sample of thirteen:

Chapter 4
The CIR Membership

Table 4e Bronx Lebanon Housestaff Sample (N=13)

<u>PGY</u>	<u>N</u>	<u>%</u>	<u>Specialty</u>	<u>N</u>	<u>%</u>	<u>Age</u>	<u>N</u>	<u>%</u>
1	2	15	Medicine	5	38	26-28	1	8
2	4	31	Pediatrics	2	15	29-31	5	38
3	2	15	Surgery	5	38	32-50	7	54
4	5	38	Psychiatry	1	8			
			RAN	0	0			
<u>Number of children</u>								
<u>Sex</u>	<u>N</u>	<u>%</u>	<u>Marital status</u>	<u>N</u>	<u>%</u>		<u>N</u>	<u>%</u>
Female	3	23	Single	1	8	0	6	46
Male	10	77	Married	12	92	1-3	7	54
<u>Ethnicity/race</u>	<u>N</u>	<u>%</u>	<u>FMG status</u>	<u>N</u>	<u>%</u>			
American born, white	1	8	American trained	1	8			
American born, non-wh	0	0	American born,					
Foreign born, white	2	15	foreign trained	0	0			
Foreign born, non-wh	10	77	Foreign born & trained	12	92			

The Bronx Lebanon housestaff was predominantly FMG's: the total housestaff population was 80% FMG. This housestaff sample was more male, married, with more children than the other hospital samples.

Social class

Social class standing was ascertained by father's occupational prestige score, using the occupational classification scheme developed by the National Opinion Research Center (NORC) of Chicago. Occupation, rather than family income, was opted for as the measure of socioeconomic status, as family income is often not known or can only be approximated. In addition, it has been established that prestige is closely correlated with income and education, the other most commonly used measures of social class. However, since the NORC survey

Chapter 4

The CIR Membership

reflects prestige ratings of Americans by occupation, the data are limited for the foreign medical graduates, who immigrated from a variety of cultures. Nevertheless, as the following data illustrate, Bronx Lebanon's housestaff had the highest mean occupational prestige. In addition to the cultural differences, the resources necessary to live and train in the United States would eliminate the less affluent foreign graduates. Mother's occupational prestige was not included as twenty-eight of the respondents' mothers were not traditionally employed.

The mean occupational prestige scores were as follows (keeping in mind the N's are low):

Bellevue:	58
Kings County:	50
Montefiore:	48
Brx. Lebanon:	63
Total:	54

The range for the housestaff sample was 13-82 (physicians are scored 82).

The sample

A random sample of twenty to twenty-five residents was selected within each hospital from the housestaff lists. The method used to draw the sample was to simply count off every xth name to obtain the desired sample size. Unfortunately, the timing of the interviews was such that they could not be completed before some of the housestaff left their training

Chapter 4 The CIR Membership

programs and/or the area. Others opted not to participate in the interview due to lack of time or interest. Finally, some could not be contacted. (However, one resident, who had moved to California, participated by tape recording his responses to the questionnaire). The initial response rates by hospital were:

Bellevue: 38% Kings County: 53%
Montefiore: 32% Bronx Lebanon: 38%

It is difficult to identify variables the non-respondents had in common, other than lack of time or assigning a low priority to such a project when their time is limited. However, it can be speculated that they did not hold any strong opinions about the CIR or related issues, such as working conditions. In addition, some may have been fearful of how the data would be used, perhaps threatening their careers in some manner.

In any case the low response rate necessitated a second random sample which was drawn from the same lists. In the second round a larger sample was drawn to obtain as many participants as possible. The response rates were:

Bellevue: 15% Montefiore: 28% Bronx Lebanon: 25% (Kings County's sample from the first draw was sufficient and therefore, no second sample was selected.)

Of the fifty-seven respondents, forty (70%) were selected in the first sampling and the remainder, seventeen (30%) in the second sampling.

Chapter 4
The CIR Membership

The following table summarizes the data on the housestaff sample, including national data, where available. The national data is taken from, Anne C. Crowley, "Graduate Medical Education in the United States," JAMA, Sept. 23/30, 1983, vol. 250, No. 12, pp. 1541-1553. The national data applies to housestaff on duty September, 1980, unless otherwise indicated. The sample data, by hospital, is presented in percentages. The source for the HHC data is NYC Health and Hospitals Corporation, Fact and Series Issue, No. 3 : "Analysis and Recommendations: Number, Country of Training and Visa Status of Housestaff Physicians in the Municipal Hospitals of New York City." April, 1977 and applies to 1977 housestaff.

Table 4f Housestaff Sample Data: 1980-1981.

	<u>Sample</u>	<u>Totals</u>	<u>Nat'l</u>	<u>NYC</u>	<u>Belle-</u>	<u>Kngs</u>	<u>Monte-</u>	<u>Brx</u>
<u>PGY</u>	<u>N</u>	<u>%</u>	<u>-</u>	<u>(HHC)</u>	<u>vue</u>	<u>Cty</u>	<u>fiore</u>	<u>Leb</u>
1	14	25	NA	21	23	13	47	15
2	14	25	NA	28	8	31	27	31
3	14	25	NA	26	46	19	13	15
4+	15	26	NA	26	23	38	13	38
<u>Specialty</u>								
Medicine	17	30	40	30	15	19	33	39
Peds.	11	19	10	14	15	25	33	15
Surgery	16	28	31	34	23	31	20	39
Psych.	8	14	7	10	31	13	7	8
RAN	5	9	11	12	15	13	7	0
<u>Sex</u>								
Female	19	33	22	NA	30	44	33	23
Male	38	67	78	NA	70	56	67	77

Chapter 4
The CIR Membership

<u>Table 4f</u> (cont'd)	<u>Sample</u> N	<u>Totals</u> %	<u>Nat'l</u>	<u>NYC</u> (HHC)	<u>Belle- vue</u>	<u>Knqs</u> Cty	<u>Monte- fiore-</u>	<u>Brx</u> <u>Leb</u>
<u>Marital status</u>								
Single	18	32	NA	NA	54	25	33	8
Married	39	68	NA	NA	46	75	67	92
<u># children</u>								
0	38	67	NA	NA	77	63	80	46
1-3	19	33	NA	NA	23	37	20	54
<u>Age</u>								
26-28	20	35	NA	NA	38	31	60	8
29-31	20	35	NA	NA	31	44	27	38
32-50	17	30	NA	NA	31	25	13	54
(Sample mean = 29.7)								
<u>Ethnicity/race</u> (national data for 9/82)								
Amer. wh.	32	56	72	NA	100	31	87	8
Amer. non white	2	4	9	NA	0	13	0	0
Forgn. wh	8	14	9	NA	0	25	13	15
Forgn. non-wh	15	26	10	NA	0	31	0	77
<u>FMG status</u>								
American trained	26	46	80	54	62	19	93	8
US born,	13	23	8	5	39	44	7	0
<u>FMG</u>								
For. born	18	32	12	41	0	38	0	92
<u>Socioeconomic status</u>								
NORC means		54	NA	NA	58	50	48	63

Foreign Medical Graduates

Although the various subgroups within CIR merit consideration in terms of their contribution and effect on CIR's operation and direction, only a few will be examined here due to the limitations of this study, as well as the size of the sample itself. Foreign medical graduates (FMG's) are significant due to

Chapter 4

The CIR Membership

their special position in the medical establishment, as well as their numbers. At the time the data were collected, over one-fourth of all FMG's in this country trained in New York City and they constituted close to half of the residents in the CIR. There are two types of FMG's: those born in the U.S., but trained outside of this country, and those both born and trained in foreign countries. As the above table demonstrates, over half the sample was composed of FMG's, 23% American born and 32% foreign born.

History

Foreign medical graduates first came in significant numbers to the U.S. during the Korean War, when the U.S. experienced a shortage of professionals, especially physicians. Money was available to enlarge medical institutions, but available staff was insufficient. Consequently, the federal government eased immigration requirements for foreign doctors in the 1965 amendments to the Immigration and Naturalization Act, exempting them from immigration quotas. In addition, restrictions that "J" visa holders had to return to their country of origin for two years, after two years in the U.S., before applying for immigrant visas, were lifted. The Smith-Mundt exchange program for leaders and specialists overcame the shortage of professionals. Housestaff were granted "exchange visitor visas" in order to remain in the U.S. and complete their training. A greater demand

Chapter 4 The CIR Membership

for doctors in the U.S. reoccurred during the Vietnam War. Consequently, between 1965 and 1975, an average of 7,375 FMG's came to this country annually, resulting in a total of 63,000 FMG's by 1979: of the 28,000 in hospitals, 17,000 were housestaff officers. They constituted about 1/3 of all the housestaff in this country. In 1977, New York State's housestaff was 42% foreign trained, with 49% of the hospitals staffed by more than 50% FMG's. In New York City, in 1978, FMG's constituted 38% of the housestaff officers and accounted for 25% of all the FMG's in this country. The situation was one that fulfilled the needs of the FMG's, who wanted the training, and the hospitals, that needed their services.

However, in 1976, Congress passed the Public Law 94-484, the Health Profession Education Assistance Act, including amendments to the Immigration and Naturalization Act, designed to reduce the number of FMG's entering the U.S.

This curtailment was deliberately, not accidentally, decided upon by the Congress and reflected the heightened concern of Congress, various study groups, and the medical establishment about the wisdom of continuing the flow of FMG's that had begun in the post World War II period. This concern was particularly directed at (a) the inconsistency between our foreign policy objectives and the "brain drain" from developing countries, (b) the quality of foreign medical schools and the care delivered by their graduates, and (c) the rapid increase in U.S. medical school graduates to a level approximating the first year hospital residency positions. (New York State Health Planning Commission, "Foreign Medical Graduates in Graduate Medical Education Programs in New York City Hospitals, May, 1979, Albany, New York, p. 3)

Chapter 4

The CIR Membership

In effect, stiffer requirements were to be enforced to significantly decrease the number of FMG's in this country. It was predicted that the law would not be put into practice for several years, to avoid disruption of delivery of services in hospitals. By 1980, in New York City, hospitals were still dependent on FMG's, so that if they were suddenly unavailable medical care would have suffered significantly. Legislation was proposed by Senator Jacob Javits to permit waivers for a five year period in order to prevent such a disruption of services. (New York Times editorial, "The Coming Shortage of Foreign Doctors," 2/25/80)

The Health Care Management and Health Care Personnel Distribution and Improvement Act of 1980 (S2378) was introduced to Congress in the Spring of 1980. It included proposals to postpone to December 31, 1985 restrictions which would affect the number of FMG's in this country so that the hospitals that needed them could continue to depend on FMG's, while preparing to eventually do without them.

Role of FMG's in American Hospitals

FMG's, historically filled positions that could or would not be filled by American graduates. Consequently, they were not randomly distributed throughout the health care system, but, rather, were concentrated in the hospitals and specialties that required their services.

Chapter 4
The CIR Membership

Hospital

"Elite Manhattan hospitals can easily attract interns and residents from top medical schools, but attempts to enroll these students for graduate training in aging and deficit-ridden, inner-city hospitals have been difficult in the past and are not getting easier." (Office of the City Council President, 1980, p. 10, referred to here as the "Bellamy report") "Hospitals most dependent upon FMG's tend to be small voluntary and municipal hospitals with secondary affiliations to medical schools." (New York State Health Planning Commission report, p. iii)

Additionally there is a correlation between the number of FMG's in a hospital and the socio-economic status (income) and the proportion of minority patients in the community: (ibid, p. 21)

Table 4g FMG's by Percent Minority Patient Population and Income

<u>Group</u> (from most dependent on FMG's to least)	<u>Percent minority</u>	<u>Income (less than \$5,000)</u>
I (more than 75% FMG's)	Top 1/3 N.Y.C.	more than 40%
II (51-75% FMG's)	Middle 1/3 "	30-40%
III (26-50% FMG's)	Bottom 1/3 "	20-30%
IV (less than 26% FMG's)	" " "	less than 20%

<u>Hospitals in study</u>	<u>Percent minority</u>	<u>Income</u>
Bronx Lebanon	I	II
Kings Cty/Downstate*	III	II
Bellevue	III	IV
Montefiore/NCB	III	IV

* Data for King County are represented only by data for its affiliate, SUNY Downstate, which serves a more middle class population than Kings County.
To reiterate, the FMG breakdown for the sample was:

Chapter 4
The CIR Membership

<u>Hospital</u>	<u>% Amer grad</u>	<u>% Amer born FMG</u>	<u>% For. FMG</u>
Bellevue	62	39	0
Kings County	19	44	38
Montefiore	100	0	0
Bronx Lebanon	8	0	92

According to the Health Planning Commission study, Bronx Lebanon was one of 12 hospitals in which FMG's accounted for more than 75% of the housestaff; Kings County/Downstate was one of 13 hospitals in which FMG's constituted 26-50% of the housestaff; and Bellevue and Montefiore were 2 of 14 hospitals where FMG's were less than 26% of the resident population. (p. 14)

Consequently, the sample appears to have had the expected percentages of FMG's in each of the four hospitals. Bronx Lebanon is clearly an "FMG hospital:" its catchment area, patient population, the facility itself, and its loose medical school affiliation typify its comparative undesirability as a place to work and train.

Kings County, an "average" municipal hospital, depended largely on FMG's to fill its resident positions. Bellevue, also a municipal hospital, attracts American graduates to a much greater extent. As previously mentioned it is the flagship hospital of the municipal system, well known for its trauma unit.

Finally, Montefiore is also dominated by American medical graduates, having a reputation as an excellent place to train. It has a wide diversity of departments and is known for its

Chapter 4
The CIR Membership

community orientation.

Specialty

According to the Health Commission Report, there is a similar principle of selection operating with regard to specialty choice as there is with hospital choice. Certain specialties are considered to be more desirable for a variety of reasons, such as intellectual challenge, attractiveness of the subject matter, benefits to patients, comprehensiveness, and patient preference. (Beale and Kriesberg, 1959; Calahan et al., 1957) Future earning power, hours, and control over the work situation were usually not significant. However, recent changes such as the increasing cost of medical school and the increasing dependence on technology, appear to be instrumental in a trend away from internal medicine and the primary care specialties, such as family practice and pediatrics to more technologically based specialties as radiology and ophthalmology.

". . . internal medicine held a privileged position, largely because of its tradition, broad intellectual appeal and close relationships with patients." (Lawrence K. Altman. April 19, 1988. "Students Find Internal Medicine Less Alluring." New York Times, p. C3) However, although

medical school faculties stress how critical cognitive skills are. . . young doctors very quickly discover the differences in fees. The financial rewards are in doing procedures, not thinking . . . they learn that the societal message is at cross purposes with the faculty message. (ibid, Dr. Frank Davidoff of the education division of the American College of

Chapter 4
The CIR Membership

Physicians in Philadelphia)

Thus, the traditional "professional" criteria for specialty choice are yielding to more concrete concerns.

Among the respondents in the CIR sample, almost half (47%) cited the intellectual challenge or the problems involved in the specialty as the reason for their choice, followed by opportunity to help patients (23%), preference for the activities involved in the specialty (16%), no choice (11%), dislike for other specialties and hours (2% each). No one cited the potential income as the reason for specialty choice.

Regarding FMG's, the Health Commission Report confirmed previous findings, both nationally and locally, that:

- (1) certain hospital-based specialties, e.g., anesthesiology and pathology, tend in all hospitals to be relatively most dependent upon FMG's, while
- (2) several clinical specialties, e.g., general surgery, pediatrics, will be absolutely most dependent upon FMG's. (NYS Health Planning Commission Report:18)

In New York City, in 1978, the nine specialties with the largest absolute number of FMG's were: (ibid)

Table 4h FMG's by Specialty

<u>Specialty</u>	<u>Number of FMG's</u>	<u>% FMG's</u>
Internal medicine	770	30%
General surgery	631	43
Pediatrics	461	47
Anesthesiology	233	79
Psychiatry	191	34
Ob/gyn	189	38
Pathology	184	65
Diagnostic radiology	117	38
Rehabilitation medicine	112	81

Chapter 4

The CIR Membership

In Brooklyn, where dependence on FMG's was greatest, 90% of the pediatric housestaff, 80% of the child psychiatry housestaff, 77% of the general surgery housestaff, and 52% of the medicine were FMG's in 1978. At Kings County, in 1979, FMG's constituted 98% of the pediatric housestaff, 90% of the pathology housestaff, 88% of the anesthesiology housestaff, 39% of the surgery housestaff, 38% of the psychiatry housestaff, 32% of the ob-gyn housestaff, and 23% of the medicine housestaff. (Bellamy report, p. 14) Bellevue, on the other hand, had a predominance of FMG's only in the rehabilitation medicine (79%) and anesthesiology departments (52%). (ibid p. 16)

FMG's, currently, continue to fill voids in training programs. The number of FMG's in internal medicine programs has approximately tripled between 1978 and 1988. (New York Times, 4/19/88)

Sex

Another demographic change than might impact on the CIR is the increase in women in the medical profession. Between 1970 and 1986 the total number of physicians in the U.S. increased by 70%, while the number of female physicians did so by 241%. The increase in female residents was 304%. In addition, the proportion of total residents that were female grew from 11% in 1970 to 27% in 1986. (American Medical Association, 1987, p. 12)

The significance of the increase in female residents could

Chapter 4
The CIR Membership

be hypothesized to be similar in impact to the general increase of women in the professions. One of the salient issues for women is the role conflict that emerges in combining the roles of professional and homemaker. For example, in a study of male and female physicians, 2% of the men and 47% of the women experienced conflict due to the pressures of career and family. (Heins, 1979) Although this issue was not specifically addressed in the interviews, the data reveal that the potential is there:

Table 4i Resident Physicians by Sex, Marital Status, Number of Children and Age

<u>Marital status</u>	<u>Female</u>		<u>Male</u>	
	<u>Single</u>	<u>Married</u>	<u>Single</u>	<u>Married</u>
	47%	53	26	74
<u># Children</u>	<u>0</u>	<u>1-3</u>	<u>0</u>	<u>1-3</u>
	63%	37	68	31
<u>Mean Age</u>	27.6		30.8	

Although in both groups the percentage having children is approximately the same, women are younger and less likely to be married. Thus, over one-third of the female residents will have to cope with the conflicts mentioned previously, as they relate to the work situation of the resident. By contrast male residents with families are not in the same situation. They are more likely to be in traditional marriages "where the husband has a full time career, and the wife is a housewife or does part time or volunteer work," whereas the female resident is in a "dual

Chapter 4

The CIR Membership

career marriage, where both husband and wife have careers that demand high levels of professional commitment." (Lorber, 1984: 81.) Thus, the parent/physician role combination is qualitatively different for men and women. The issue is whether it affects the resident in the workplace in ways that would be translated into union issues. In other words, as in the rest of society, the acceleration of women's participation in the workplace creates needs for day care, part-time residencies, and maternity leave. The concern is whether they will be addressed as union issues: will the union address them as contractual issues; will the hospital administrations consider them as valid issues.

Summary

The composition of the resident sample exemplifies some the demographic changes that are occurring in the housestaff population. The "new" housestaff officer is more likely to be a woman, a parent, and (in 1980) a FMG than her predecessor. The questions that are significant here are whether these trends will have an impact on the work situation and if so, will repercussions be felt by the CIR.

Similarly, will factors such as membership in a specialty, type of hospital setting, or PGY level affect the residents' framing of issues that would be in the domain of a union.

Chapter 5

The Resident's Work Situation

Two unique characteristics of the resident's role are the dual student/employee status and its transient nature. S/he is both a student, learning largely by experience, in the final stage of training; as well as an employee of the hospital, receiving a salary and benefits, providing services for the hospital. The predominance of one role over the other was the issue that the NLRB considered in its 1975 decision. Seventy-four per cent of the housestaff sample disagreed with the Board's decision that housestaff are primarily students. They either agreed that they were both students and employees or that they were mainly employees, doing a job, paying taxes, entitled to organize. However, because they are still in the midst of professional training, they are subject to evaluations and recommendations that affect their future careers. The status of resident is transient, unlike that of employees who wish to maintain their positions at the workplace. The impact of transiency on the CIR will be discussed Chapter 6.

In addition to transiency, other elements in the structure of the hospital residency that require examination are groupings by specialty/department and PGY level, as well the use of pyramid systems.

Structural factors

Housestaff, in reality, join the department of their specialty. Because of the nature of training in a residency, i.e.,

Chapter 5

The Resident's Work Situation

senior housestaff train junior housestaff, one factor that unites housestaff is departmental affiliation. However, the structure within each department may vary. For example, a resident in ob-gyn at Kings County reported:

My department runs on a very hierarchical basis and there's a real army sort of thing so who you talk to depends on what level you're at. In terms of the more formal stuff, if you're a junior housestaff, the person you should be talking to is the person immediately above you and you are not expected to take problems to attendings (if you are) at a junior level unless you've already consulted with a senior housestaff. That's a pretty well established route for people to approach things. In general, only the most senior resident level on a service will take problems to attendings. That's the general approach in this department and if the most senior resident or chief resident is not available he'll generally designate that the next resident down should get these problems assessed by an attending, which includes - we have a daily conference with the chairman of the department where the chief residents present their cases. If the chief is in the OR the next resident down goes. Everything else is not as formal as that but you work the same way. (Interview, resident, Kings County Hospital)

In a two year study of doctors and staff at a private hospital, it was found that medical housestaff tended to view each other as "equal fellow sufferers," while the surgery department was clearly hierarchical. As one surgeon reported:

When I have to give an order or request information about a patient from the thoracic house officer, I always page them on the loudspeaker using the name of the senior resident. In fact, I know it will be the intern who will run the errand of answering the telephone page for resident, so you might think that I would just page them using the intern's name. But that is not done in surgery. . . . He (the senior resident) enjoys the recognition, and likes being able to send the intern to answer his call. (Millman, 1976: 5)

Chapter 5 The Resident's Work Situation

Pyramids

Thus, departments may be more or less formal, more or less congenial, and more or less competitive. Pyramid systems can contribute to the degree of competition. A pyramid system is one in which there are less residents at each successive level of a departmental training program. Consequently, housestaff officers in pyramid systems do not know whether they will complete the program. Pyramid systems can be unofficial or official policy. In the Bronx Lebanon and Montefiore contracts the following restriction on pyramids was imposed:

An incumbent resident shall not be prevented from completing his/her residency program because of the Hospital's decision, for budgetary reasons, to reduce the number of residents in the program or to make the program, if it is pyramidal in structure, more pyramidal. (emphasis mine, Article XII, "Employees' Security," 12)

Twenty per cent of the respondents reported pyramid systems in their training programs. Although the delegates reported pyramids in all the surgery programs, only 13% of the surgery housestaff reported pyramids in their programs. No resident at Bellevue or Montefiore was involved in pyramids. No psychiatry or RAN housestaff were in pyramids. The residents who were most affected by pyramids were FMG's from other countries, 50% of whom were in pyramids. Not surprisingly, more than half of the residents at Bronx Lebanon said they were in pyramids. The Bronx Lebanon delegate was the only delegate to report pyramids in

Chapter 5

The Resident's Work Situation

departments other than surgery, although he noted that the pyramids were unofficial. In the total sample, 40% of the medicine housestaff and 25% of the pediatric housestaff were in pyramids.

As housestaff began to question elements of their training programs, pyramids was one aspect about which they expressed dissatisfaction. Of the sample, 25% approved, 70% disapproved, and 5% had no opinion. Of the eight delegates, all but one disapproved. Those who were affected by pyramids did not necessarily disapprove of them:

Table 5a Housestaff Participation and Approval of Pyramids

	<u>#</u>	<u>%</u>		<u>#</u>	<u>%</u>
Bronx Lebanon	7	50		4	33
Medicine	7	40		6	33
FMG's	16	50		10	33

The group that was most supportive of the pyramid system was PGY 4's (56%), although only 13% of them experienced it.

Perhaps this is due to an "I made it" philosophy: 75% of PGY 4's were in subspecialties and 44% were chief residents. They had succeeded in situations in which they had competed with their peers. They had become part of the elite and often identified with attendings rather than housestaff.

Although recent national survey data found women residents to be more dissatisfied with their work environment than their male counterparts, (Rizzo, 1986) this was not the case with regard to the pyramid system for this sample. Both male and female respondents opposed the pyramid system to the same degree (71% and

Chapter 5
The Resident's Work Situation

68% respectively).

For those that did approve of the pyramid system, there was a belief that a competitive system results in better performance by the resident and thus, the best qualified make it to the top of the pyramid:

If you go into a pyramid system, you kind of know you have to do your best from day one. I think you get more out of the training when there's a little more pressure on you. Also . . . there's got to be some limitation on how many people get out of the program. I don't think it's right that everybody that goes through the program is going to be guaranteed finishing, whether worthy or unworthy. (Bronx Lebanon delegate, interview)

The assumption of those who opposed the pyramid was that competition, especially at this final stage of training, is unhealthy and adds to a very difficult situation:

I think it's terrible. . . it's bad enough to be under the pressure you are to begin with just to take care of patients under abysmal conditions that we have to work with and the demands that we have to worry about it . . . like breaking your back for a year or two and then being cut from the program altogether because that's just the way it is. . . you need as much camaraderie as you can get. (Bellevue delegate, interview)

It instills the wrong values in housestaff. It breeds competition, hostility, distrust. It makes for miserable working conditions. (Montefiore delegate, interview)

It puts the chairman in a very, very powerful position. (KC delegate, interview)

Some housestaff perceived the residency as a "do or die" situation, whereas others felt the training programs had a

Chapter 5

The Resident's Work Situation

responsibility to help a resident who was having difficulty,* although no one approved of maintaining an incompetent resident. The options for those who were dropped, other than to leave medicine, included entering another residency program elsewhere, perhaps in a different specialty.

Thus, the consensus seemed to be that the training programs "owed" it to them to judge them by their performance, not a pyramid system that could lead to somewhat arbitrary decisions and enhance the power of an already powerful chairman.

PGY level

The PGY level is a status that takes on some significance within a department. It is a continuation of one's relative status in medical school. Thus, the interns, or first year residents, are the new kids on the block. They, typically, are in a very insecure position as they enter the training program. In addition to learning to be physicians, i.e., this is the first time they are given responsibility for patient care, they are learning the protocol and routines of a residency. They are adapting to long hours and often difficult working conditions. They are most likely to do the "scutwork", i.e., the out-of-title work that officially is the responsibility of other hospital

* In a recent pilot study of medical student abuse, it was found that mistreatment occurred most often at the hands of residents, interns, and clinical faculty. (Sheehan et al., 1990)

Chapter 5

The Resident's Work Situation

personnel. This can set the stage for some sort of a bond among each cohort of interns which may be sustained throughout the residency. When the total resident sample was asked if they had problems working with various groups in the hospital, they were more likely to report that they never had problems with their peers (30%) than with housestaff junior (12%) or senior to them (11%).

The work situation

Needless to say, understanding the daily work situation that the resident encounters is intrinsic to examining his/her relationship to the CIR. The more acceptable the conditions of work, the less likely one is to perceive the need for a union. In addition, the more one perceives his/her situation to be like that of others, the more likely one might be to seek out an organization such as a union to alleviate one's grievances. Since the resident is part of a teacher-student relationship, as well as an employee in a work situation, both will be discussed in order to determine the acceptability of the resident's situation.

Teaching

Overall, the residents were satisfied with both the teaching and supervision in their training programs. At Bellevue there

Chapter 5
The Resident's Work Situation

was slightly more dissatisfaction with the teaching (31%) than at other hospitals (23%); at Kings County there was more dissatisfaction with supervision (25%) versus 14% at the other hospitals. When asked how often they participated in specific learning activities the results were the following:

<u>Table 5b</u> <u>Activity</u>	<u>Housestaff Participation in Learning Activities</u>	
	<u>Daily -</u> <u>few times/week</u>	<u>Every few</u> <u>weeks or less</u>
Grand rounds	62%	38%
Lectures, conferences by attendings	81	19
Informal talks with attendings re patients	88	12
Informal talks with housestaff re patients	93	7
Journal clubs	5	95

When asked if they preferred more or less of any of the above activities, about one fifth of the sample wanted more contact with attendings, both informally and through lectures. Journal clubs, in which residents discussed current literature in medicine, seemed to be a luxury which most residents were unable to make time for. About 1/4 of the sample would have preferred more journal clubs.

There was also consensus that up-to-date medicine could be practiced at the hospitals (84% agreed). At Montefiore 100% of the sample agreed, whereas at Kings County 69% agreed. Perhaps, this was due to problems with lack of functioning and up-to-date equipment, tests etc., a problem intrinsic to many of the municipal hospitals.

Chapter 5

The Resident's Work Situation

In general, when respondents compared their training to that given in other voluntary or municipal hospitals the results were the following:

Table 5c Perceptions of Respondents' Training as Compared to that Given in Municipal and Voluntary Hospitals

<u>Type of Hospital</u>	<u># of hospitals where training is perceived as equal to or better than respondent's</u>		
	<u>0-1</u>	<u>2+</u>	<u>DK</u>
<u>Municipal</u>	58%	25%	18%
<u>Voluntary</u>	21	58	21

Both municipal hospital samples felt their training was equal or superior to that given in the other municipal hospitals. When compared to voluntary hospitals, half of Bellevue residents still maintained their training was superior, whereas only 1/4 of Kings County residents felt this way. Of the Montefiore residents who had an opinion on the question, all felt there were a few hospitals, mostly major teaching institutions, offering training superior to that at Montefiore. Bronx Lebanon residents seemed most unaware of programs at other hospitals (perhaps because of the high number of FMG's who are less familiar with American teaching hospitals). However, when asked if they would recommend their residency programs, 75% of the total sample said yes and an additional 14% same yes, with reservations. Only three residents in the sample would not recommend their programs.

In sum, although there were some specific problems with the quantity and quality of teaching at the sample hospitals, in

Chapter 5

The Resident's Work Situation

general, there was no great dissatisfaction. In addition, since the residency experience emphasizes a "hands-on" learning experience, the actual conditions of "learning by doing" seemed to take precedence for the housestaff. Sixty-five per cent of the sample asserted that the housestaff at their hospitals were responsible for patient care. Montefiore residents were the only group to say that housestaff in combination with attendings assumed this responsibility most of the time (67%).

Working conditions

Working conditions are the "bread and butter" of trade unions. Typically, the subjects of concern are wages, hours, and conditions of employment.

Wages

Although wages was a concern when the CIR was founded, it has never been an issue over which the CIR was unable to come to some amicable agreement. A brief history of housestaff salaries under CIR contracts demonstrates the steady increases over the years:

Table 5d. Range of salary from 1957 to 1980*

	<u>1957**</u>	<u>1967</u>	<u>1968</u>	<u>1973</u>	<u>1980</u>	
					<u>HHC</u>	<u>MT, BL</u>
Interns	\$852	5,430	9,000	13,500	17,000	19,251
Residents	1,260	7,330	12,000	19,200	23,590	26,876

*Source: CIR Bulletin, v. 4, #1, January, 1975, p. 5; 1980 contracts for HHC hospitals (includes Bellevue and Kings County) and Montefiore and Bronx Lebanon hospitals.

** Single residents were usually provided rooms to live in the hospital; there was no living-out allowance.

Compared to their counterparts nationally (1979)**:

Chapter 5
The Resident's Work Situation

Table 5e. Resident salaries in the U.S. and Northeast (1979)

	<u>U.S.</u>	<u>Northeast</u>
Interns	\$13,900	14,500
Residents	17,000	18,000

** The data on the U.S. and the Northeast were median annual salaries of residents in 1979, according to the Survey of Resident Physicians. May, 1979. Center for Health Services Research and Development, American Medical Association.

Although CIR residents, compared to their peers, appeared to have been doing well financially, they were not all satisfied with their income:

Table 5f. Ratings of salary and fringe benefits

	<u>Excellent</u>	<u>Good</u>	<u>Fair</u>	<u>Poor</u>
Salary	12%	30	47	11
Fringe benefits	5	42	47	5

Thus, about half the sample was satisfied (excellent or good) and half dissatisfied (fair or poor) with the monetary benefits of their contracts. When stratified by hospital, the municipal housestaff were more likely to rate their salaries as fair or poor, whereas the voluntary housestaff rated their income as excellent or good. This reflects the real variations in their incomes, which, on the average, was about \$2,500.

The differences in the respondents' satisfaction with their incomes can be attributed to historical changes in the makeup of housestaff, the high cost of medical school, and the increased length of residency, on the one hand, and the recognition that residency is temporary and future income will compensate for

Chapter 5

The Resident's Work Situation

education and expertise. Contemporary housestaff, compared to their predecessors, have longer residencies, and therefore, are less willing to delay marriage and children. Sixty-eight per cent were married and 33% had children. Thus, they had greater financial responsibilities. Many incurred significant debts from student loans. Consequently, salary and fringe benefits were important to them. However, the transient nature of the residency, is a mediating factor. When asked to anticipate what their maximum incomes might be, 90% of the sample estimated their incomes to be at least \$40,000 (in 1980 dollars), with one fifth of the sample looking forward to a minimum income of \$100,000 annually.

Hours

In contrast to wages, hours is a very salient issue for housestaff. Because residency is not a job with specified hours, and residents are not required to punch a clock, ascertaining the number of hours residents work was problematic. The respondents could only estimate the hours worked in a week and the figure varied by the service they worked in at the time, i.e., in one service they might work 85 hours a week and the following week, in another service, it could be 65 hours.

Nevertheless, 80 hours will be used as a basis of comparison as this was the maximum number of hours per week recommended by

Chapter 5
The Resident's Work Situation

CIR in 1975, and in 1989 will be the maximum as set forth by state regulations in New York (this will be discussed in a subsequent section). The results are the following:

Table 5g Weekly hours worked by housestaff

<u>Hours worked per week</u>	<u>% of the housestaff</u>
40-80	40
81-100	39
over 100	21

Sixty per cent of the sample worked over 80 hours. The mean number of hours worked was 85. When the sample was stratified the results were:

Table 5h Weekly hours worked by housestaff by hospital, PGY level, FMG status, specialty and sex

Per cent working over 80 hours

<u>Hospital</u>		<u>PGY</u>		<u>FMG status</u>	
Bellevue	38%	1	93	Amer. grad.	59
Kings County	63	2	79	US FMG	42
Montefiore	73	3	31	FMG	72
Bronx Lebanon	61	4	38		

<u>Specialty</u>		<u>Sex</u>	
Medicine	60	Female	63
Pediatrics	84	Male	55
Surgery	75		
Psychiatry	0		
RAN*	40	*RAN = radiology, anesthesiology, and neurology	

Although 60% of the sample worked over 80 hours, when the differences among the groups are analyzed, the determining factors are PGY level and specialty. Some of the differences

Chapter 5

The Resident's Work Situation

between the sub-groups are more easily understood than others. The pattern of decreasing hours as a resident ascends from one PGY level to the next is expected. The internship year (PGY 1) is traditionally the most demanding on a resident's time. PGY 4's are engaged in specialty training, which again may require more hours.

Specialty - The structure of work in each specialty, to some extent, dictates the number of hours a resident is expected to work.

Psychiatry - In psychiatry, where no resident reported working over 80 hours a week, there are few emergencies of the type found in the other specialties, so that most patients can be cared for within the framework of a 9-5 day.

RAN residents are often either not administering direct patient care or are not responsible for the total care of the patients i.e., they are most likely to function in a consulting capacity or are responsible for conducting a particular discrete procedure. For example, an anesthesiologist may see a patient before and during an operation, but typically is not involved with follow-up care. A radiologist may never see the patient whose X-rays he is interpreting.

Medicine residents are responsible for their patients' care. They usually follow the progress of their patients for as long as

Chapter 5 The Resident's Work Situation

they require treatment.

Surgeons have a reputation as workaholics who want to be in the hospital as much as possible so they don't miss any of the "action." One resident claimed that there's a "certain surgeon at N.Y.U. who has a favorite saying that the only problem with being on every other night is that you miss working up half the patients." (interview) Time in the operating room is at a premium. Surgical residents also claim that, due to the critical condition of many of their patients, they often need ongoing surveillance. Consequently, 75% of the surgeons in the sample worked over 80 hours per week. (This is not to imply that all surgical residents work long hours voluntarily. Other factors will be discussed later.)

Pediatricians - Finally, although it may seem surprising that pediatricians worked the longest hours, in this sample it may be accounted for by the fact that all but two pediatric residents were PGY 1's and 2's who are most likely to work the longest hours anyway. In addition, some pediatric residents felt that children often need extensive supervision and might have special problems that should be dealt with by their own physicians, e.g., procedures such as inserting IV's may be more difficult with children than adults because their veins are so small. Consequently, a pediatrician may do a procedure that is ordinarily done by a nurse (out-of-title work). Thus, as the

Chapter 5 The Resident's Work Situation

role of pediatrician is expanded so is the workload in hours.

Hospital

The differences in hours worked between hospitals seem to be better explained by the previously discussed differences in PGY level. The hospital samples that have more lower level PGY's e.g., Montefiore's sample consisted of 75% PGY 1's and 2's, were more likely to report more hours worked and the converse is true as well.

FMG status

There is a belief that there is discrimination against foreign medical graduates and superficially the data seem to support that contention. (% working over 80 hours: American graduate: 59%; US FMG: 42%; foreign born FMG: 72%) Here, perhaps, the dominant factor is specialty. Two-thirds of the foreign born graduates were training in either pediatrics or surgery; of the American born FMG's none were in pediatrics, 1/4 were in surgery, and 42% were in psych or RAN, where hours tend to be shorter; among the American graduates 52% were in pediatrics or surgery. In addition, the majority of American FMG's were either PGY 3's or 4's.

Chapter 5 The Resident's Work Situation

Gender differences

Although the differences between hours worked by male and female residents, over eighty hours a week was not great (55% and 63% respectively), specialty again seems to be the operating factor. Thirty-seven percent of male residents and 58% of female residents worked in pediatrics or surgery.

Attitudes toward workload

Long hours have been an intrinsic part of housestaff training as long as most physicians can remember. However, the appropriateness of long hours and the rationales for long hours has been repeatedly questioned. Recently, the New York State Department of Health formed a Committee on Emergency Services to investigate the current system of residency training. The catalyst for the formation of this committee was the publicized death of a young woman, Libby Zion, after an eight hour stay in a teaching hospital in New York City. A grand jury cited inadequate care and mistakes made by overtired and unsupervised residents as the cause. In June, 1988 the State Hospital Review and Planning Council adopted the Committee's recommendations, effective July 1, 1989, to limit shifts to 24 hours, the work week to 80 hours, and establish a minimum of 8 free hours between shifts and at least one full day off every week. In addition, emergency room doctors' shifts were limited to 12 hours. CIR

Chapter 5
The Resident's Work Situation

took an active role in the deliberations, maintaining input at each stage. When the new regulations were announced an officer of the CIR commented that this was "clearly a great day for patients and doctors." (New York Times, "Hospital Interns' Long Hours to Be Reduced in New York," p. B3.)

Sixty-one per cent of the sample claimed the hours were too much and 60% of the sample did, in fact, work over 80 hours per week. In general, it appeared that those who worked over 80 hours were the ones who felt the hours were too long. By hospital, the comparisons are:

<u>Table 5i</u>	<u>Dissatisfaction with Hours by Hours Worked</u>	
	<u>% working > 80 hrs.</u>	<u>% said hours too much</u>
Bellevue	38	46
Kings County	63	69
Montefiore	73	73
Bronx Lebanon	61	46

Of the four hospital samples, only in the case of Bronx Lebanon was there less complaining about the hours than there were residents working long hours.

When stratified by specialty, 75% (12) of the surgeons worked over 80 hours, whereas only 56% (9) felt it was too much. One explanation for surgeons' acceptance of long hours is their preference to be involved in as many surgical procedures as possible. In view of this, it was somewhat unexpected that over half of the surgeons, in spite of the desire to be in the OR,

Chapter 5

The Resident's Work Situation

still maintained that their workday was excessively long.

As might be expected, as residents move up the hierarchy through the PGY levels and work less hours each year, the complaints decrease. At the PGY 1 level, 93% of the sample felt their hours were too long; by the time they were at the PGY 4 level only 25% felt this way. Of the PGY 3's, 31% worked over 80 hours, yet 58% felt their hours were too much. However, although PGY 4's worked over 80 hours in only 7% more cases than PGY 3's, the PGY 4's were more accepting of the workload, i.e., 75% of them felt it was appropriate. Perhaps, because PGY 4's are doing something new, in the sense that they are training for a subspecialty, they are willing to put in more time, whereas PGY 3's are finishing up their specialty training and no longer feel the necessity of working hours to gain experience. In addition, according to one resident, training in orthopedic surgery, subspecialty training is significantly different, both structurally and interpersonally:

Subspecialty is kind of a different ball game altogether. It's not like being an anonymous intern in a huge institution. Departments are much smaller and you're given one year contracts. It's easier: everybody makes mistakes and you can always find a reason not to hang on to somebody that you can justify. So there's waiting lists to get into subspecialties. So once you're in a subspecialty your tendency to rock the boat is a lot less because the power that is held over you is a lot more. So if the chief of a department tells you "even if there's a strike tomorrow you don't strike, and even if your contract says you work over 100 hours a week minimum, you're going to work as many as you have to." You don't object to

Chapter 5

The Resident's Work Situation

things like that, you just go ahead and take care of it. I can not imagine anyone in this program fighting a grievance that they had to work too many hours because when that became known life would be hell after that. (interview, Montefiore resident)

Residents in subspecialties find themselves in a more intimate apprentice-like settings with more visibility. Looking toward finishing their residencies and finding desirable positions, they believe themselves to be more vulnerable. Thus, they may be less likely to "rock the boat."

Rationales for long hours

In the medical literature rationales for long hours are made asserting their importance for training and the hospital. The respondents were questioned about these rationales:

Tradition: This argument suggests that it has always been done that way, so why change it. It is a rite of passage into the medical profession that all entrants must endure. Forty-two per cent of the sample agreed with this argument. Interestingly, the group that was most critical of this argument was the Bellevue residents. Although they were most likely to work within the 80 hour limit (62%), they were most adamant about disagreeing with this argument (85%). FMG's tended to agree with this argument slightly more than their counterparts.

Stamina: This argument maintains that the long hours endured in training will prepare housestaff officers for the erratic and

Chapter 5

The Resident's Work Situation

sometimes long hours to be expected when one is in practice. Only 9% agreed with this argument. Among the subgroups that agreed more often with this notion were the Bellevue residents (23%) and the foreign born FMG's (17%).

Necessity for training: The rationale here is that residents only have a limited time to learn it all and a 40 hour work week would not be sufficient. Thirty-two per cent of the sample agreed with this argument. By hospital, Bellevue residents agreed a little more strongly than their counterparts (46%), whereas at Montefiore only one resident agreed with this reasoning. There was little variation by specialty or PGY level except for PGY 4's who were split on this issue. Finally, foreign born FMG's were split on this issue, as well.

Although the delegates generally disagreed with this argument, a Bellevue delegate pointed out that there was some educational value to "being on" for an extended period of time:

. . . being able to follow a particular patient through a particular series of complications. When one is an intern in the hospital one is literally never away from one's patients for more than 36 hours. And that occurs only once in three weeks. Other than that, the longest you're away from your patients is 12 hours. And I think that doing that for some period of time is necessary to get a sense of the course of illness. Do you have to do it for a year? Do you have to do it for that many patients? Do you have to do it for 3 years? Probably not, but you do have to do it for some time. (Interview, Bellevue delegate)

Patient care: The respondents were asked to agree or

Chapter 5

The Resident's Work Situation

disagree that residents are needed by the hospital to assume patient care responsibilities. In contrast to the previous explanations, which focus on the educational value of long hours to the resident, here (and for the next rationale) the emphasis is on the value of long hours to the hospital. The issue is the role of employee, not that of student. Eighty-nine per cent of the sample agreed with this argument. By hospital, the notable exceptions were Kings County, where 100% of the sample agreed and Bellevue where only 1/3 of the sample agreed. By specialty 100% of the RAN residents agreed and 71% of those in psychiatry agreed. PGY 4's agreed unanimously, as did U.S. FMG's. In general, the delegates also agreed with the statement. Clearly, if they did not do the work, the hospitals would be forced to hire other workers or, if their hours were reduced, to hire other residents, or ancillary staff.

Residents working long hours are a source of cheap labor for the hospital. This has been documented by studies of the health care system:

Interns and residents provided hospitals with relatively inexpensive professional labor. The hospitals with ample house staff could do more thorough workups of patients and perform a variety of functions for busy private practitioners. Without house staff hospitals could not easily secure coverage at nights and on weekends. (Starr: 358)

Chapter 5

The Resident's Work Situation

This argument focuses on the economic value of residents to the hospital. Eighty-one per cent of the sample agreed that they were utilized to fulfil the needs of the hospital cheaply. By hospital, Bellevue residents agreed most strongly with this argument (92%). This was surprising as Bellevue is considered to be the most prestigious of the municipal hospitals, where residents tend to be conservative. One hundred per cent of the RAN residents agreed as well. Perhaps, because they are most removed from direct patient care, they feel most like employees in big institutions. When asked how they felt about the NLRB decision which categorized residents as students, 100% of the RAN residents disagreed (compared to 80% of the total sample).

By PGY level, PGY 1's and 4's agreed most strongly that they are a source of cheap labor (86% and 94%). This would be expected for PGY 1's: 93% of them work over 80 hours and half work over 100 hours. In addition, the nature of the work they do often consists of non-medical chores or "scutwork" (out-of-title work), which would more likely make one feel like cheap labor, rather than a valued resource.

Night duty

Needless to say, medical care in a hospital must be available 24 hours a day. Consequently, the lifestyle of the resident is one in which s/he expects to live in the hospital for

Chapter 5
The Resident's Work Situation

a good part of the residency. The CIR, in its 1975 strike, won a maximum of every third night on, so that no housestaff officer would have to be on duty in the hospital more frequently than every third night. Although this became part of the CIR contract, some residents were still on duty more frequently:

Table 5j Frequency of nights on:

<u>Once a week or less</u>	<u>Every 4, 5, or 6th night</u>	<u>Every 3rd night</u>	<u>Every 2nd night</u>
19%	12%	60%	9%

Nine per cent of the sample was working in violation of the contract. These residents were distributed, almost equally, in all four hospitals; they were all surgeons; they were PGY 1's and 4's and they were almost equally distributed among FMG's and American graduates.

The groups that had particularly light schedules, one night a week or less, were Bellevue residents, psychiatry and RAN residents, PGY 3's and U.S. FMG's.

Finally, although the contract stipulates that no resident must work more than every third night, it is customary that, as a resident ascends the PGY hierarchy, s/he is on less frequently. This pattern was consistent except for PGY 4's: 38% worked every third night and 25% worked every second night. Ninety-two per cent of pediatricians were on every third night (but they were also mostly PGY 1's and 2's) and 83% of foreign born FMG's were on every second or third night. In most cases these patterns paralleled those regarding hours.

Chapter 5
The Resident's Work Situation

Interestingly, although about half of the sample felt the amount of night duty was too much, the majority felt it was either relevant (50%) or very appropriate (43%) for training as a housestaff officer.

When stratified by hospital, the residents that worked the most nights were not necessarily the ones that most often felt it was excessive:

Table 5k Frequency of nights on by dissatisfaction with night duty

	<u>Frequency of nights on:</u>		<u>Amount of night duty</u>	
	<u>Every 3rd or 2nd</u>		<u>Too much</u>	
	<u>N</u>	<u>%</u>	<u>N</u>	<u>%</u>
Kings County	13	82	11	69
Montefiore	12	80	9	60
Bronx Lebanon	9	70	3	23
Bellevue	5	39	4	33

Bronx Lebanon stands out as the group that works nights frequently and complains the least. The significance is that as long as working conditions are acceptable (only 8% of the Bronx Lebanon residents worked more nights than the contract demanded) it is unlikely that the residents involved would readily take any action to protest it.

By specialty, medicine, pediatric, and RAN residents were most likely to object to night duty, whereas surgical and psychiatry residents were least likely to object. Medicine and pediatric residents were on every third or second night in a majority of the cases and RAN residents were on every third night

Chapter 5

The Resident's Work Situation

in 40% of the cases. Psychiatry residents were on at night infrequently. However, surgical residents were on every second night in 31% of the cases, and every third night, in 56% of the cases. Nevertheless, only 40% felt this was too much. Here surgeons' behavior is consistent with their reputation of working around the clock and not complaining about it.

By PGY level, residents complained less as they went up the hierarchy, including the PGY 4's, who worked every second night in 25% of the cases. This appears to be consistent with the resident's comment concerning the privilege of subspecialty status.

Foreign born FMG's tend to work the most at night (83% work every second or third night) and complain least (39% said it was too much). Foreigners who have residencies in the U.S. are in a similar position to residents in subspecialties, i.e., they feel fortunate to have their positions and do not wish to threaten them by rocking the boat.

In summary, the necessity of traditionally long hours, involving frequent night duty, was questioned by this sample. It has also been questioned in the literature in studies of the relationship between sleep deprivation and resident performance. Although the literature has been evaluated as inconclusive, it appears that there is some consensus on the connection between sleep deprivation and the increase in mistakes, as well as an

Chapter 5 The Resident's Work Situation

increase in the time required for task completion. In addition, the psychological harm appears to be significant, sometimes leading to drug and alcohol abuse (Asken and Raham, 1983).

An underlying issue for many residents was not merely the quantity of hours, but the quality. The concern was the nature of their role as physicians in the hospital.

. . . the nature of residents' work and responsibility has changed dramatically. The days when residents slept while on call and had time to think and reflect about their patients' care are gone. We are now manipulators of technology and bureaucracy. (Testimony of Dr. Janet Freedman, President, CIR, Before New York State Department of Health Ad Hoc Advisory Committee on Emergency Services, August 17, 1987, p. 4)

One of the results of the demands of technology and bureaucracy is an increase in out-of-title work.

Out-of-title work (OTW)

"Out-of-title work" is a familiar phrase among housestaff officers. It refers to the "regular and recurrent" assignment of duties "appropriate to other positions such as laboratory technicians, clerks, messengers, aides, blood drawing technicians or transportation workers." These duties include such "tasks as mixing intravenous or chemotherapeutic solutions, taking of routine vital signs and weights, retrieving patient records from record rooms, transporting laboratory specimens, escorting patients." (taken from contract demands for Montefiore: 1980-

Chapter 5
The Resident's Work Situation

1982 and contract demands for HHC, 1980). In sum, these are duties considered "not appropriate to House Staff Officers." (CIR League contract, 1974-1976)

The respondents in the sample were asked how frequently they performed four tasks that are generally considered OTW: starting intravenous tubes (IV's) or transfusions, drawing blood, transporting patients, and messenger work, e.g., transporting specimens. The results were:

Table 51 Frequency of performance of 4 out-of-title tasks

<u>Frequency of:</u>	<u>1/day or more</u>	<u>Every few days</u>	<u>Rarely/never</u>
Start IV's/ transfusions	56%	12%	32%
Draw blood	51	19	30

Transport patients	21	26	53
Messenger work	37	9	54

These four tasks can be broken down into two categories: those tasks that could be performed by other health workers or medical technicians, i.e., starting IV's and drawing blood and ancillary chores that are non-medical in nature, i.e., transportation of patients and messenger work. The data demonstrate that the respondents were more likely to do medical OTW (over 50% did it at least once a day) than non-medical OTW (about 1/3 did it at least once a day).

Residents questioned in an AMA survey about the extent of problems they encountered, reported the following:

Chapter 5
The Resident's Work Situation

Table 5m Significance of problems for housestaff in AMA survey

	<u>Major Problem</u>	<u>Minor Problem</u>
Lack of facilities	14.3%	32.9
Lack of support personnel	23.3	32.6

Thus, although they were not specifically asked about out-of-title work, the sources of the problem, lack of facilities and personnel were identified as issues in about half of the cases.

In this sample, there were only a few subgroups that varied from the total sample in their performance of medical chores. By hospital Bellevue residents, in 46% of the cases, rarely or never started IV's. By specialty, pediatricians, in 92% of the cases, do both medical tasks at least once a day. On the other hand, most psychiatrists rarely or never engage in medical OTW and most RAN's never draw blood. This difference by specialty may be due to the characteristics of the specialty involved. Pediatricians may have felt, as previously mentioned, that because of the size of children's veins, inserting a needle is a more delicate procedure and opt to do it themselves. In addition, 62% of the pediatrician sample were PGY 1's, who all claimed to perform these tasks at least once a day. Psychiatrists and RAN's were less likely to engage in these chores because their specialties may not require them very often.

In general, as one ascends the PGY ladder, less "scutwork" is mandated. This was confirmed by the data. There were no great differences by FMG status except that foreign born FMG's

Chapter 5 The Resident's Work Situation

drew blood a little more frequently than their counterparts. (61% vs 42 and 48%)

Non-medical tasks (ancillary chores)

Although non-medical OTW is a less frequent occurrence than medical OTW, it was more prevalent in some groups than others.

By hospital, Bellevue and Bronx Lebanon residents were least likely to transport patients or do messenger work. On the other hand, Montefiore residents were engaged in these chores most frequently: 53% did messenger work at least once a day.

By specialty, pediatricians were most likely to be involved in these tasks, while RAN and psychiatry residents were least likely.

By PGY level, as expected, the frequency of these chores decreased between the first and third years of residency, but 25% of PGY 4's said they engaged in these tasks at least once a day.

American FMG's were most likely to be involved in these activities, followed by foreign born FMG's, and then American graduates.

Attitudes toward out-of-title work

Although most residents prefer not to do any OTW, they object more to ancillary chores (which they do less often) than to medical chores. When asked which tasks others should do, the results were the following:

Ancillary chores	25%
Medical OTW	12
Both	62

Chapter 5 The Resident's Work Situation

Clearly, the majority prefer not to engage in any OTW. In addition, to the open ended question: "What is the most

frustrating thing about working here?" the response was:

OTW	18%	
Workload	19	
Staff & equipment functioning would	16	(Lack of sufficient, equipment and adequate staff result in more OTW)

Thus, OTW, which the responses all refer to, is a central issue for residents.

One resident's rationale for being more tolerant of medical OTW was the following:

. . . these (medical tasks) are things which are on the border of being out-of-title work. The physician is, basically, a skilled individual; he should know how to draw blood and how to start an IV. And basically, it would fall somewhat within his job description. It would be more efficient if this were considered out-of-title work, but we'll let that pass. Now there are other things which are absolutely out-of-title which a physician really does not need any of his training to perform: they could be performed by somebody else just as easily and perhaps even better, because the other person would have more time and only be doing this - such things as transportation. (interview, KC delegate)

Nevertheless, since OTW does fall outside of the resident's job description, and so much of the resident's time is taken up with it (some residents estimated about 50% of their work is OTW, especially at the PGY 1 level, although this information was not sought directly), the concern for patients becomes their justification for doing it.

Chapter 5

The Resident's Work Situation

We can't refuse to do it because when it comes right down to it, despite legal responsibility and any other kind of responsibility, . . . this is your patient. And if the patient doesn't get good care, it's your responsibility. (Ibid)

. . . the fact that there isn't anybody else around to do it is not an adequate explanation for it not being done. (Interview, Bellevue delegate)

Essentially, the resident's role is interpreted as a "residual" role, i.e., the duties of a resident include fulfilling the medical needs of the patient, as well as any other requirements involved in the care of the patient that other staff in the hospital may not have attended to. There is no one else for the resident to pass the buck to. Since the medical condition of the patient is affected by a multitude of factors, the resident takes responsibility for as many of these factors as s/he can control. Thus, if a diagnosis depends on the patient being X-rayed, and no one takes him to get the X-ray, the resident can't do his job. If the patient is cold and doesn't have a blanket, the resident, not wanting his condition worsened, gets the blanket.

In Mizrahi's study of internal medicine residents at a southern medical school she identified "compulsiveness" or the need to take into account all the details in the analysis and treatment of cases, as one of the dominant norms of the resident subculture (Mizrahi, 1986). The importance of thoroughness was also identified in an earlier study of interns at a university

Chapter 5 The Resident's Work Situation

hospital (Mumford, 1970). This norm appeared to permeate this sample's perspective as well, and contributed to the housestaff's notion that out-of-title work was a necessity.

The issue is that, given that there is no job description for residents, and the physician role encompasses out-of-title work, due to his own definition of responsibility for his patients, under what conditions does he draw the line? According to Ed Gluckmann, the former Executive Director:

. . . take it to its logical conclusion. Let's say the roof leaks. They don't have a roofer. There's the tar, doctor. What are you kidding? I'm a doctor. What's the difference if you go up on a roof and put the tar on it, or go into the basement and the clean the basement, cook the food, or take the patient to the X-ray? The patient needs an X-ray, so the patient needs a roof. It needs food. They've been conditioned to do it. (Interview)

Perhaps they don't draw a line at all. If they are asked to do something and there is no one else to do it, it becomes the province of the resident. However, it also is part of the rite of passage that is endured disproportionately by interns (first year residents). So, in addition to interns' hours being long, they are also filled with scutwork. The internship year has been characterized as "hazing at best and systematic desensitization at worst." (Cousins, 377, 1981, quoted in Asken and Raham, op. cit., p. 4) As the years progress, even if the hours may not diminish significantly, the nature of the work changes:

Chapter 5

The Resident's Work Situation

I've worked all night as an intern. I've worked all night as a resident. I find when I work all night as a resident, I don't get as zonked as I used to get as an intern. And the difference is not the amount of hours I spent on. . . But the thing is, I don't have to do all the leg work. The intern's doing all the leg work: he's running the patient's blood scan; he's starting the I.V.;. . . What I'm doing is sitting down, speaking to the patient, giving the patient an exam, writing down, and the interns, and indirectly the patient, gets the benefits of the knowledge I've acquired as an intern and as a student. And, this is not exhausting. (Interview, KC delegate)

Relationship to Co-workers

Additionally, the issue of out-of-title work impacts on the other employees in the hospital. By demanding an end to out-of-title work for the residents, someone else has to take up the slack. If, as in the case of the 1975 strike, the hospital administrators are unwilling to hire more ancillary staff, the tasks in question would have to be performed by existing staff. One outcome of this scenario would be increased tension between housestaff and ancillary staff, who may already consider residents to be elitist. An alternative would be to utilize the union as a mechanism to align with other unions in the hospital for common goals. One way to reduce or eliminate out-of-title work would be increased and improved staff and equipment. This has been framed as a "patient care demand." This question, then, is whether the CIR and other hospital staff unions could unite on this, or any other, issue. When the respondents were asked if the CIR should align itself with nurses' organizations such as

Chapter 5
The Resident's Work Situation

the State Nursing Association or non-professional workers' groups as DC 37 or 1199), the results were the following:

Table 5n Housestaff preference for aligning with other workers

	<u>Yes</u>	<u>No</u>	<u>DK/NP</u>
Nurses	65%	26	9
Non-professionals	26	63	11

When asked for what purpose would alignment be beneficial:

Table 5o Rationales for aligning with other workers

	<u>Patient care*</u>	<u>Economic</u>	<u>Leadership</u>
Nurses	74%	11	16
Non-professionals	60	13	27

*The responses were: 1. Similar goals in the work setting, e.g., patient care; 2. Similar economic interests e.g., job actions, strength; 3. Provide leadership to other groups, mutual understanding, communication, strength, contacts.

Nurses

The majority of the sample felt the CIR should align itself with the nurses to address the patient care issue. There may be a methodological problem, i.e., this question may be biased toward a positive answer: what physician would be against combining forces with fellow professionals to enhance patient care? According to Ed Gluckmann, former CIR Executive Director, there are factors that would both promote such an alliance as well as those that work against it:

They're both doing other people's work; both underpaid and overworked. (However) as a rule many housestaff and nurses don't get along. The doc's going to try and assert himself or herself. The nurse has been there for years, has experience and no place to go. You get a

Chapter 5
The Resident's Work Situation

black/white dichotomy at some hospitals. You get a male/female dichotomy at others or a combination of the two. (Interview)

In addition, according to Gluckmann, the nurses' unions tend to be dominated by management and therefore are not interested in creating a bond between themselves and housestaff.

In general, the union leadership agreed that alignment with the nurses would be beneficial for patient care. A Kings County delegate described the nurses as "fellow workers." He regarded the nurse's role as one that has advanced and expanded due to changes in nursing education that have followed advances in medical technology. Consequently, the doctor and nurse become part of a team, attempting to bring together their expertise to evaluate and treat patients. "Instead of having doctor and nurse there will be medical health practitioners." (Ibid) This vision of the delivery of health care would require surrendering the advantages of superior status that physicians now have. The reality is that many of the housestaff officers, as well as physicians in practice, would probably agree with the resident who said "physicians are a professional group and should be aloof from these things." (interview)

The CIR president, Jonathan House, believed that nurses and doctors should align because of his belief in industrial unions. He asserted that much could be accomplished by such an alignment, but again realized that significant problems of class, race, sex,

Chapter 5

The Resident's Work Situation

and status aid in keeping the two groups apart. Nurses are typically lower-middle class, increasingly minority group members, female, and in an occupation that traditionally has been subservient to the physician. In contrast physicians are middle-upper class, male, white, and in an occupation that has been deemed very high status in this society. However, as the manpower shortage for nurses becomes increasingly critical, changes may be necessary in both the nurse's role and relationships with physicians. The need to attract personnel into the nursing profession may require an upgrading of the tasks and rewards of nurses so that their responsibilities are more "professional," allowing more input in the decision making process. Consequently, the traditional social distance between nurses and physicians may have to diminish to allow for this new role relationship.

Non-professional health workers

The sample was much less enthusiastic about the non-professional workers in the hospital. About 1/4 of the sample felt there was something to be gained by aligning with this group. They believed that, unlike the nurses, their role was less concerned with patient care, and therefore, they had little in common with this group. One resident, who in contrast to a perceived commonality of interest with nurses, said this of CIR's support of 1199:

Chapter 5

The Resident's Work Situation

. . . physicians and nurses should not be on the same level as the janitors and the messengers etc. I think the interests of the workers is different; the devotion of the workers is different; motivations would be completely different; professional ambition is completely different. . . . It's not equivalent. It's like saying a doctor, a chief of staff at a hospital is on the same level as a janitor. . . . Bring it down to a resident: his problems are two different problems right away because a resident, his hours are different, his responsibilities are different, his patient care responsibilities are totally different. How can you equilibrate them with a janitor whose main responsibility is to have everything clean and to have supplies stocked? (Interview, Bellevue resident)

Another resident, at the same hospital, summed up the differences between residents and their co-workers this way:

We're professionals; we're not nurses, we're not aides and that means that we could do their work but they can't do ours. . . . We are professionals - even if they physically could do the operations they couldn't get the judgement of when to do it and when not to do it. (Interview, Bellevue resident)

The leadership of the CIR tended to be in agreement with the rank-and-file. One delegate said "they're not a professional organization." The implication of this statement is that their interests are distinctly different from that of housestaff. The non-professional, according to the housestaff, is not concerned with patient care. If they strike, it is for money and the housestaff do not approve of withholding services in the hospital for strictly economic reasons.

. . . The further away in the hospital you get from the patients' bedside, the less and less people feel that they have anything to do with taking care of patients.

Chapter 5

The Resident's Work Situation

I think that . . . my greatest frustration about working here is that people are not in touch with why they're here. When I find that lab technicians or the clerks or the transport people seem to have no sense of why they're there and seem not to be at all interested in taking care of the sick people in the hospital, I find that I don't have any interest in aligning with them. (Bellevue delegate, interview)

Of course, not everyone agreed with this perspective. Several delegates felt that there could be some sort of relationship with the workers that could benefit patient care. One delegate believed that "if you benefit the workers you can't help but benefit the patients and give better patient care, which is basically what we're here for." (Interview, Kings County delegate)

Paperwork

One of the resident's tasks is paperwork. Although, technically, it is not considered to out-of-title, it is often thought of as a necessary, but onerous and time consuming task. With increasing bureaucratization, comes increased paperwork in the form of insurance, legal, and medical documentation. A little over 58% of the sample complained that it was too much, although only 26% thought doing paperwork was inappropriate to their role as housestaff officer. Although there were few variations among the sub groups, those that most frequently said they did too much paperwork were the Bronx Lebanon housestaff, psychiatrists, and foreign born FMG's. Perhaps part of the

Chapter 5

The Resident's Work Situation

explanation could be due to cultural differences, i.e., in this society paperwork is intrinsic to almost any endeavor. For FMG's (Bronx Lebanon was 94% FMG) the paperwork may entail linguistic, as well as cultural adjustments.

The main objection, as with out-of-title work, to paperwork is that it is too time consuming and thus takes time away from "being a doctor." CIR delegates acknowledged that much of the paperwork was necessary for good medical care, i.e., a patient's chart needs to be complete and up to date in order to properly diagnose, treat, and evaluate progress. They also recognized the significance to the hospital of proper completion of reimbursement forms so that the hospitals would be paid by Medicaid, Medicare, and third party insurers. What they sometimes questioned was the necessity for some of the information required on some forms and the methods implemented to ensure that residents completed the paperwork. For example, in certain cases, the residents were required to go through long checklists of symptoms for each patient, many of which might be irrelevant to the case in question. One delegate complained that they were required to "make up the tubes," i.e., take blood samples and label the tubes to go to the lab (and sometimes take the samples to the lab), yet the lab often did not use the information which they required:

One of the things you get frustrated about is . . .
you're filling out a laboratory requisition. There's a

Chapter 5

The Resident's Work Situation

place on it where it says "doctor's name." And let's say you take the time and write those things in. And let's say that when the laboratory runs the specimen, they discover some dangerously abnormal result. You know that they won't look on the lab slip and call you. So you find it distressing that you're asked to provide this information that nobody seems to care about or use. (Interview, Bellevue delegate)

Residents talked about the requirement to enter progress notes on patients who were awaiting disposition, i.e., it wasn't clear where the patient was to be sent, but in the meantime he remained on the ward and therefore notes had to be written in his chart although "they really don't belong, medically speaking." (ibid)

The residents who had to write the charts themselves felt that they should be able to dictate them (as some 70-100 charts could accumulate in a week) and of those who had the facilities to dictate them, some reported that they often got lost.

More recently, the issue of paperwork seems to have taken on an even greater significance:

Daily notes, discharge summaries, home care orders, etc., are lengthier and have very specific requirements. Residents now attend seminars to learn how to correctly document hospital care for medicolegal purposes as well as to insure reimbursement. These requirements often seem to conflict with proper medical documentation, and the resident is constantly torn between these separate demands. In my last year of residency at Bellevue discharging a patient required rewriting the same information in different formats seven times. This was unheard of even during my own internship. Residents spend almost as much time learning and relearning to correctly fill out forms as they do learning diagnosis and therapeutics. (Testimony

Chapter 5 The Resident's Work Situation

of Dr. Janet Freedman, President, CIR, Before New York State Department of Health, Ad Hoc Advisory Committee on Emergency Services, August 17, 1987, p. 5)

Not doing out-of-title work, especially paperwork, became a CIR tactic. Its purpose was to slow down the reimbursement process, thus calling the administration's attention to their grievances or contract demands. In 1979 a job action at Kings County involving non-signing of charts, resulted in threats of firing by departmental chairmen. Here the housestaff capitulated because "it's different when department chairmen threaten you rather than administrators threatening you." (House of Delegate meeting, Kings County resident)

The charts are also sometimes used as a platform to express discontent:

We write things on the charts which they don't like. Like the blood drawn in the morning, that I drew myself, that I brought down myself, the results are still not back at 10 o'clock at night. They refuse to give us the phone report on the phone. I write that on the chart and for some reason, administration doesn't like that too much. (Interview, Bronx Lebanon delegate)

Finally, although housestaff were not adamantly opposed to paperwork, per se, they did object to related chores, such as making appointments, finding carbon paper, scheduling tests etc. Some were equally adamant that nurses should also not be doing this type of work. Clearly, the feeling was that health professionals should concentrate on patient care.

Chapter 5 The Resident's Work Situation

The work itself: caring for patients

Having reviewed the conditions of work that seemingly impinge on the effectiveness and efficiency of the delivery of patient care, and as patient care has been at the forefront of most CIR activities, a brief review of the sample's attitudes toward the patients and their work with them is appropriate. Mizrahi (1986) found that residents, often disillusioned by the "scut/skill ratio" or the relationship between one's workload and the payoff in learning, focused on "getting rid of patients" (GROP). "Because there were so many patients who had to be treated in a short amount of time, the housestaff was obligated to treat and GROP as quickly as possible." (Mizrahi, 166) They developed a perspective which emphasized minimal contact with patients.

Patient care, defined empirically by the CIR revolve around issues of equipment and staffing. Because of their transience and elite status, residents are open to accusations of trying to improve their own situations, without concerning themselves with the welfare of the patients. The "emotional distance" medical students acquire while involved in clinical work (Miller, 1970) can be interpreted as indifference. A related matter is whether their frustrations with their work are attributed to the patients or to broader social conditions. Mizrahi found that residents did develop negative attitudes toward patients:

Feeling exploited, they often projected their perceived

Chapter 5

The Resident's Work Situation

dehumanization on the only group who was less powerful - the patients - especially when those patients were members of a stigmatized social category: poor, black, derelict, drug addict, alcoholic, street dweller, and so forth. (Mizrahi, 1986, 40)

The socialization process has been purported to get the housestaff officer to regard patients as cases and regard those with challenging or unusual conditions as more "valuable" for learning. Here the term "patient care" may more closely approximate the CIR definition, i.e., if patients are valued for the rarity of their medical conditions and the challenge is to properly diagnose and treat them, ideal conditions for diagnosis and treatment, e.g., functioning state of the art technology, drugs, and support personnel would be required to effectively do the job.

When the respondents were asked to describe patients they did not like, 34% cited those that were aggressive, uncooperative, or tried to compromise the doctor. Another 21% talked about self-abuse patients (drug addicts or alcoholics) who used the hospital as a revolving door. Their concern was that medical intervention did not effect change. Although some assigned blame to the patients themselves, most exhibited concern for them, some focusing on the social problems. At Montefiore several residents discussed their treatment of elderly patients who did not require the medical services of a hospital, but were there due to lack of vacancies in nursing homes.

There is one kind of problem I like least and it's not

Chapter 5

The Resident's Work Situation

because I don't like the problem. It's because I find it so frustrating in this city and that is the patients who have disposition problems. They have no place to go. (Montefiore resident in family practice - interview)

Some expressed their preferences in terms of social class or personality traits: "I guess I like the 'YAVIS' patient: young, attractive, verbal, intelligent, and successful." (Interview with Bellevue psychiatry resident)

Of the few who expressed a preference for patients from the lower socio-economic strata, one resident painted a picture of the lower class patient in terms that differed from the unreliable, unappreciative characterization given by his peers:

I like people from the lower socio-economic range although it's fun to have people from the upper ranges. My clinic is composed probably 90% of the lower socio-economic. The reason that I enjoy it so much is that probably for the first time for many of these people this is the first opportunity to have a physician which is their doctor - they really appreciate that. So often many of the people get their health care from the emergency room and they're really surprised when I hand them my card and I say "here's my telephone number, here's my home phone number - if you really have problems call me" and they really appreciate that and I've found that they really respect it and they don't abuse it; they only call me at home when they really need me and they really like having the security almost of knowing that when they come to the clinic they're going to have the same doctor who knows them and they don't have to deal with telling their story over and over again which often happens in the city hospital where they become an interesting case instead of an individual. (Interview, Montefiore family practice resident)

Chapter 5

The Resident's Work Situation

In the case of this resident and several others, they were able to see beyond the specifics of the one-to-one doctor-patient relationship to the context of the large bureaucratic hospital. By dealing with his patients in a manner that demonstrated his trust, as well as his availability he attempted to personalize the situation for his patients. He identified the source of their reluctance in participating in their care as their experience with a large impersonal health care system in terms of the system itself, rather than in terms of personalities and backgrounds.

Although this resident had innovatively intervened in patient care, others implied that involvement with patients was not condoned:

. . . the ones with social problems that you can have an impact on: dying patients, for instance or patients where there is interaction going on with the family, can be very satisfying but those are very time consuming. The one or two patients that I had where I really had to sit down with the family - I got bad reviews from other housestaff that I was spending too much time and neglecting other work. (Interview, Montefiore social pediatrics resident)

One variable that emerges as critical in understanding how residents judge patients is time, i.e., patients that "waste their time" by not cooperating or requiring help that is not "medical" in the strictest sense, such as counseling, are devalued.

Because residents are in a learning situation, many find

Chapter 5

The Resident's Work Situation

patients whose conditions are "challenging" (46%) or "interesting" (21%) to be the most fascinating. Twenty-one percent referred to the "solvability" of the problem. "The fun part of being a house officer is being involved in rapidly changing situations of patients that are sick but salvageable" (Interview with Bellevue resident) was a typical comment. Residents value the opportunity to intervene successfully. In that sense, the rewards of the job can be a sense of personal satisfaction:

Doctors are human beings. They're like everyone else. They want some sort of remuneration. Although it's funny; your remuneration doesn't have to be financial - it can be emotional as well. I remember the first time I did a total hip. I saw that patient a year later. . . he was walking painlessly. I told my wife about it. . . . I told her it gave me more satisfaction than if someone gave me \$10,000. I really meant it. I still do. (Interview, Bellevue orthopedic surgical resident)

In summary, "patient care" is a loaded term. Clearly, residents are learning on the job and therefore, value variety and challenge in their work. They aspire to work in ideal conditions to be able to do that. Their allegiance to the welfare of the patients themselves may be difficult to measure. However, their desire to successfully intervene unquestionably benefits patients.

Summary

The issues that surface in an examination of the work environment address the changes that have occurred in the

Chapter 5

The Resident's Work Situation

demands of the housestaff officer's role, as well as the nature of the housestaff population itself. The bureaucratic structure of the hospital has been a double edged sword for housestaff. On the one hand, it demands much in the way of documentation for services rendered, resulting in extensive paperwork. In order to achieve economic viability it reduces costs; one tactic to accomplish this is to have a medical labor force of housestaff that are relatively inexpensive, when their hourly rate is computed. According to the current CIR Executive Director, Janet Freedman, an intern working 100 hours a week, does it at a rate of \$5.20 per hour; 70 hours a week would raise the rate to \$8.00 per hour. (Freedman, op. cit., p. 3) The salary, per se, is not a paramount issue for housestaff. Even paperwork, although tiresome is somewhat acceptable. However, long hours, often filled with scutwork are less acceptable. The bureaucratic structure demands much from housestaff, but at the same time has been lacking in providing a clear definition of the resident's role. The resident, anxious to learn by gaining experience in medical procedures, ends up spending much of the day engaged in out-of-title work. This situation has evolved as the exigencies of medicine have expanded. With changes in drugs, technology, and procedures, there is more for the resident to do and learn than his predecessors. Whereas once cardiac patients could expect no more than comforting bedside manner from their

Chapter 5

The Resident's Work Situation

physicians, there are now complicated surgical techniques to prolong life. Technological advances demand new testing procedures. Consequently, the resident's role constantly expands as medicine becomes more of a science than an art. One consequence is the personal side of patient care becomes devalued as the resident struggles to master medicine.

Simultaneously, the makeup of the housestaff population has changed over the years. The increase in women, FMG's, and married residents with families has changed the expectations and needs of housestaff. As the length of housestaff training has increased, more housestaff officers have families. The exclusive dedication to the residency, virtually eliminating all other interests, has been questioned. As more women enter medicine needs for child care and maternity leave, raise questions concerning the structure of the residency, such as whether it can be part time or interrupted. FMG's, as a group, also raise special issues surrounding cultural adjustments, discrimination, and related issues.

One study of physicians concluded that "both men and women doctors work too hard, suffer from overload, and do not seem to have enough time for personal growth or their families." (Heins, p. 234) Thus, the changes in the world of the resident call for change in the conditions and structure of the residency. The question is whether the CIR can fulfill these needs.

Chapter 6

The CIR: Labor union or professional association

The CIR is a paradoxical organization, addressing both professional and labor issues. An examination of CIR policies, accomplishments, tactics, leadership styles, and roles, will facilitate an analysis of the extent of CIR's success at merging the dual functions, as well as its success in dealing with the issues raised by a changing housestaff population in a changed workplace.

The diversity of the organization is illustrated by the following statement, summarizing the accomplishments and goals of CIR:

CIR was formed and continues to grow as a union because it offers us a means to express our needs and concerns far more effectively than we could as individuals.

We have had many recent successes: establishing a \$200,000 Patient Care Fund in our last contract with the City, affiliating housestaff from five new voluntary hospitals, opening an office in New Jersey, adding pre-paid legal services and other new benefits.

We have fought alongside patients, communities and other health workers to preserve health services against cutbacks, hospital closings and mismanagement. CIR is an important voice for defending health care as a right of all people.

For the future, our goals remain to improve working conditions, to bring unorganized housestaff into the union and to work for better patient care.

We have a vigorous, open and democratic organization. Further progress depends on our collective efforts - as doctors and as union members. (Jonathan House, M.D., CIR

Chapter 6

The CIR: Labor union or professional association

President, "CIR: Where we Stand," CIR Handbook: 1980-1981, Eighth Edition, 1980, p.3)

This statement illustrates the diversity of the organization. It encompasses more than the dictionary definition of a "labor union," which is "an association of workers to promote and protect the welfare, interests, and rights of its members, primarily by collective bargaining." (Webster's New World Dictionary, Second College Edition, p. 786.)

Traditionally, professional groups have organized through professional associations, such as the American Medical Association (AMA), rather than through labor unions. According to Paul Montagna, the distinction is:

professional associations are groups of professionals organized to initiate and promote general objectives of the entire occupation or of segments that the organizing persons represent. The functions of unions are directly opposed to professionalized occupations. Such efforts on the part of union leaders as attempting to reduce the autonomy of management by negotiating terms of remuneration and worker security, by developing a collective force through the threat of strike, and by fostering a class consciousness are antithetical to a professionalized environment. (Montagna, 1977: 175.)

Unionization, historically, was the process by which non-professional workers could collectively pressure management for guaranteed wages, hours, and working conditions. It was assumed to be inappropriate for professionals who, for the most part,

Chapter 6

The CIR: Labor union or professional association

were not employed in large settings such as factories or corporations. Rather they set up individual practices and were relatively unhampered in setting fees, hours, and conditions of work.

In the case of employed professionals, such as engineers, attempts to unionize met with limited success. "The problem of engineer unionism is that of reconciling the professionalism of its members with the ideology and practices of a labor organization." (Seidman, 1969: 235) Although engineers and housestaff officers had some common grievances, such as engineers' complaints of being "underutilized," i.e., assigned to tasks appropriate for technicians with less training. (Ritti, 1970), among the reasons given for opposing union membership were: 1. they would not be rewarded for their individual contributions i.e., salaries would be standardized; 2. productivity would be reduced; 3. relations with management would suffer (the literature often cited engineers' identification with management); and 4. some of the activities associated with labor unions were objectionable to them. (Kemper, 1967)

Physicians unionized when they became employees in settings such as a health maintenance organizations, private organizations, and government. It has been estimated that 75% of

Chapter 6

The CIR: Labor union or professional association

doctors involved in patient care belong to private practices, while 208,000 physicians are salaried. (Peter Waldman, "More Doctors and Lawyers Joining Unions to Fight Large Institutions," Wall Street Journal, 5/23/88, p. 21) Housestaff traditionally received stipends, in keeping with their student status.

However, in the case of residents training in New York City's hospitals in 1957, their stipends were subject to social security tax deductions as if they were receiving salaries. Thus, there emerged a basis for the formation of a union to address the needs of the residents as salaried employees.

Structure of CIR

CIR is modeled after various democratic representative organizations. It has a By-Laws and Constitution which governs its operation. Each member hospital elects one delegate per 150 residents and up to two alternates, annually. The delegates meet at monthly House of Delegates meetings. "The powers, property, business and affairs of the CIR shall be exercised, managed, conducted and controlled by the House of Delegates." (By-Laws and Constitution of the Committee of Interns and Residents, Article IV, 4.1) The officers: President, First, Second, and Third Vice-Presidents, the Secretary-Treasurer, and two Officers-at-Large are elected by the House of Delegates, and meet monthly as the Executive Committee. Dues are deducted from the resident's

Chapter 6

The CIR: Labor union or professional association

paycheck.

Since all the officers of the CIR are working housestaff, the daily workings of the organization are conducted by a paid non-housestaff officer staff. At the time the data were collected the staff members included the Executive Director, Senior Contract Administrator, Contract Administrators, Organizing Coordinator, Benefit Fund Staff, General Counsel, and Associate Counsel.

Attitudes toward unionization of housestaff

The issue of the appropriateness of unionization as a mechanism to address the needs of the professional remains the kind of controversial issue that hospital management uses in fighting housestaff unionization. For example, Richard Epstein, an American Hospital Association vice president, challenged unionization as a means to deal with external regulations imposed on hospital physicians, because it would divide loyalties between their unions and their professional responsibilities. (Riffer, 1986: 82) The implication is that there is an inherent contradiction between one's professional responsibility of caring for patients and union obligations, which, in the case of a strike, might demand withholding one's services. This will be discussed in more detail in a later section.

Chapter 6

The CIR: Labor union or professional association

The housestaff sample was questioned about the appropriateness of unionization for residents, in light of their own experience with the CIR. Eighty-four percent agreed that housestaff should be represented by CIR. The question of legitimacy of a union to bargain collectively for residents was not an issue. When asked why hospital housestaff should join the CIR, the modal response (35%) was that CIR gives housestaff strength through unity. Several other responses, totaling 38%, essentially supported CIR for doing its job effectively so that housestaff who were too busy and inexperienced could be represented and protected. Another 9% felt that by representing both municipal and voluntary hospitals in the same union, there could be more uniform salaries, schedules, education and care, thus minimizing competition between hospitals and programs. Finally, 8% felt that CIR could go beyond strictly "union" affairs and look out for professional and patient interests as well. When asked if unionization threatens a physician's autonomy only 16% of the sample agreed.

The delegates representing the four sample hospitals were questioned as to whether all housestaffs in the metropolitan area should belong to CIR. Six of the eight delegates agreed that they should. Of the two who did not agree, one argued that housestaffs were too diverse to be served by one union and the other felt that a personal relationship between a housestaff

Chapter 6

The CIR: Labor union or professional association

association and a sympathetic administration was preferable to an adversary relationship between union and management.

The remaining six delegates agreed that the more support a union has, the stronger it is. Two delegates identified the relationship between housestaff officer and hospital as worker/employee and as such identified a need for a union to intervene on behalf of the employee:

. . . no matter if it's a high powered prestigious academic institution or a small community hospital, there still exists a relationship between house officers as employees and the hospital administration as employers, and a relationship between house staff, as residents in teaching programs and their department chieftains as directors of teaching programs. In both those relationships there is ample opportunity, unfortunately, for exploitation, abuse, neglect, of house officers and it happens time and time again in every teaching hospital . . . that I've heard of.
(Interview, Montefiore Hospital delegate)

Transiency of housestaff

The transient nature of a hospital residency is a distinguishing characteristic of the CIR. When former and current leaders of the CIR were questioned about CIR's weaknesses, the most common response was the turnover of the membership. A typical resident spends three years in the residency. Unlike members of most unions, who anticipate a tenure of many years to a lifetime, a residency is an intermediate period between medical school and a medical

Chapter 6

The CIR: Labor union or professional association

practice. Most residents expect compensation for years of sacrifice after the residency. In the sample the mean expected income, in 1981 dollars, when in practice was \$83,000 although 56% expected to earn between \$40,000 and \$80,000. Thus, residents who anticipate prominent positions in the medical hierarchy at the completion of their residencies might be less likely to be attracted to a union. CIR membership is viewed as unnecessary by someone who is accustomed to delayed gratification and perhaps, as endangering the achievement of their goals. So, from the point of view of an ongoing organization, transiency is a significant issue:

There's a structural problem of involving doctors and keeping them informed. Because of the hours they work, the rapid turnover, all of that - this makes the job of what we call contract administration, involving people, organizing people who are in organized hospitals, very difficult. . . Leadership is still weak . . . I'm full time now for almost a year, but I'm the first person who's done that and we clearly need more people to do that. (Interview, Jonathan House, former President of CIR)

However, several respondents referred to the turnover situation as a "mixed blessing." According to Murray Gordon, former CIR attorney:

The turnover, while it's a great disadvantage to the integrity and strength of an institution, also keeps it fresh. It's like our jury system. If we had a single jury sitting all the time on all the cases it would become really inured to the problems of defendants. By having new people sitting as jurors all the time you constantly refreshen that process. And that's true for

Chapter 6

The CIR: Labor union or professional association

CIR too. They could always be bringing a fresh outlook and an uninhibited outlook on how to deal with problems. The other side of that coin is they rediscover the wheel. Each new group of housestaff people that come into CIR are convinced that those that preceded them sold out housestaff and couldn't care less about patient care. Their view is because we were so successful from the financial end that must have been our exclusive concern and therefore, they alone, and for the first time, will bring in patient care concerns. Well, that's not true because the CIR was more involved in patient care concerns than their self interest from day one. (interview)

Thus, one consequence of transiency is that CIR has a somewhat "ahistorical" character. This became apparent at various critical events in CIR. The history and accomplishments of CIR were usually reviewed at meetings of new delegates. In order to elicit support for strikes or other actions, delegates were encouraged to remind their constituencies of the significance of CIR. In 1975, the CIR's first strike was universally regarded as an overwhelming success, yet in 1976, when the union was literally fighting for its survival, there was great difficulty drumming up support for another strike. Perhaps, the membership was wary of striking or they did not comprehend what the issue was. Nevertheless, even at a meeting of Einstein housestaff, who had been out on the picket line for two days, a delegate felt compelled to remind those present of the significance of CIR to fight for health care:

The fight is for the union and principles. We need a collective body to pursue aims. We can not do it as individuals. The more people in the union, the better.

Chapter 6

The CIR: Labor union or professional association

(delegate at Einstein housestaff meeting, 10/7/76)

In 1980, during an Executive Committee meeting, those present agreed that their own members were not aware of their successes. They proposed "teach-ins" to get people involved in CIR. It was suggested that the "biggest organizing tool is the history of CIR." (notes, Executive Committee meeting, 10/7/80)

In fact, when the housestaff sample was questioned as to their knowledge of the most conspicuous of union activities, the strikes, 30% admitted to having no knowledge of any of the strikes; 12% gave some information, all or most of which was inaccurate; 18% had a general idea of at least one strike; 28% had a good idea of at least one strike; and 12% knew the issues, hospitals involved, and outcomes of 2 or 3 strikes. Thus, there existed a lack of knowledge on the part of the membership about the union activities.

Another perspective, suggested by a former CIR president, was in terms of power. While he recognized the disadvantage of turnover to be a lack of continuity in the CIR, the concurrent advantage was a lack of opportunity for any individual or group of individuals to abuse a position of power in the organization:

. . . doctors who are notoriously and traditionally very, very independent individuals who wouldn't allow the kind of situation which occurs in many unions in which the paid staff becomes traditional leaders and developers of policy. So there's always a continuity problem. . . . The obvious advantage is that nobody can stay around to collect enough power to corrupt over a long period of time as in the teamsters, for instance.

Chapter 6

The CIR: Labor union or professional association

And periodically we'd have somebody who got so caught up in the CIR that he would do things like take a fellowship program or extend his residency a year so that he could stay in the union. . . . the people I saw do that happily were not power brokers or empire builders; they were just people who got so caught up in the fun of politics. (Ed Mandeville, former CIR president)

This situation occurred in the case of Jonathan House, who was able to serve as President of CIR, after he was no longer a resident due to a change in the CIR Constitution. After his terms as CIR President expired he continued as CIR's Executive Director. He was paid by the HHC through its release time program, which allows one full time employee per 2,000 city employees represented by a public employee union, to be paid by the city.

Finally, the relatively brief tenure of a housestaff officer does not permit her the time to be socialized as a CIR member. A resident's first priority is to be socialized into his role as resident. After the long hours, demanding working conditions, and pressures of the role, residents value their personal time. Consequently, the ones who do find time to participate often are those who were social activists already. The task, then, from the perspective of CIR, is to stimulate the interest and involvement of the remaining residents.

The biggest weakness we have is transiency of membership. . . . A housestaff officer, statistically, spends two and a half years as a housestaff officer and then out. By the time you've got someone who really

Chapter 6

The CIR: Labor union or professional association

understands how the thing works, by the time you've built an organization a nucleus of people in a hospital, they're all gone. (Interview, Larry Bost, former CIR President)

Thus, organizationally, transiency tends to be disruptive, although "refreshing." From the point of view of the housestaff officers themselves it can be disillusioning. One delegate described his experience:

I think the CIR's strategy has been to get the senior most person in the program (as delegate). And I think that's where they've been wrong. . . . For example, when I became delegate this was my last year in this hospital. When I negotiated the contract I had just three more months in the hospital. Now when the contract will be signed, I won't even be here. . . . Most of the residents don't even know what the contract was, what it was signed about and that's the reason they went for eighteen months without a contract. (Interview, Bronx Lebanon delegate)

Given, then, that the CIR is unique, serving a population of transient professionals in training, the next issue requiring examination is how the CIR carves out its role as a professional union.

The roles of CIR

As a professional union CIR assumes multiple roles which can be categorized as the trade union role, the professional organization role, and the social advocacy role.

Chapter 6

The CIR: Labor union or professional association

CIR as a trade union

A labor union's dominant functions are to protect employees from arbitrary actions and better their wages, benefits, and conditions of work. This has been accomplished through contract negotiation and enforcement and, to some extent, through political activity. When the housestaff sample was asked, in an open-ended question, in what ways are they better off because CIR is at their hospital, the responses regarding CIR's role as a labor union were the following:

Table 6a Respondents' views on benefits of CIR

Wages	60%
Benefits	42
Protection from arbitrary action	33
Hours	30
Better working conditions	25

Wages and benefits, the most visible of union accomplishments, were viewed as CIR's most prominent successes. In fact, CIR's record in those areas is sound. As mentioned previously, CIR housestaff are among the highest paid in the country. Salary has never been an issue that led to a standoff in negotiations or a strike. Benefits have been steadily increasing over the years. Municipal housestaff, employed by the Health and Hospitals Corporation received supplemental benefits through the House Staff Benefits Plan (HSBP) of the CIR, including life insurance, long term disability, psychiatric coverage, dental coverage, and optical benefits. In April, 1980

Chapter 6

The CIR: Labor union or professional association

a fund, the Voluntary Hospitals House Staff Benefits Plan (VHBP) was established to provide the equivalent benefits as above for the voluntary hospitals housestaff. In January, 1980 a prepaid legal services plan, the CIR Legal Services (CIRLS) was initiated, financed by employer contributions. It provides housestaff and their dependents with free legal assistance in personal matters such as will preparation, divorce proceedings, and immigration proceedings.

Protection from arbitrary action, a fundamental tenet of unionization, was mentioned by one-third of the sample and alluded to again by 9% of the sample, when asked what they liked about the CIR leadership. There are contractual guarantees regarding discrimination, contract renewal, disciplinary procedures, and grievances. A resident, because of his dual status as employee and student, is potentially vulnerable, both in terms of training for a career and maintaining his job. Thus, the safeguards of the contract play a significant role.

Grievances

However, the contract is meaningless unless it is enforceable. To test its enforceability, residents must file grievances when their contractual rights have been violated. According to the collective bargaining agreement at Bronx Lebanon Hospital, which closely approximates other contracts, the

Chapter 6

The CIR: Labor union or professional association

definition of a "grievance" is a "dispute regarding: (a) misinterpretation or application of the terms of the instant written contract; (b) regular and recurrent assignment of a House Staff Officer to duties not appropriate to a House Staff Officer; or (c) a question regarding the non-renewal of the appointment of a House Staff Officer." (Bronx Lebanon Hospital Center, Collective Bargaining Agreement, 1978-1980, p. 17) The Health and Hospitals Corporation adds "a claimed violation, misinterpretation, or misapplication of the rules or regulations, authorized existing policy or orders of the Corporation affecting the terms and conditions of employment and training program." (Collective Bargaining Agreement between Committee of Interns and Residents and Health and Hospitals Corporation, October 1, 1976 to September 30, 1980, p. 28) The contracts outline the specific steps involved in filing a grievance. This grievance mechanism is somewhat similar at Bronx Lebanon and Montefiore Hospitals. The Health and Hospitals Corporation (which encompasses Kings County and Bellevue Hospitals) has a somewhat different procedure.

At the voluntary hospitals, there is a three step grievance procedure: 1) The housestaff officer and the CIR, or the CIR alone, presents the grievance to the Chief of Service or Administrator. If it is not resolved within 15 days to everyone's satisfaction, it can be appealed to the House Staff

Chapter 6

The CIR: Labor union or professional association

Affairs Committee (HSAC) of the Medical Board for "evaluation and determination." The HSAC has consists of 25% housestaff, i.e., at least two voting residents. 2) The HSAC may be appealed to the Medical Board itself, if it is a medical issue, which also has two voting housestaff officers. This decision is "final and binding."

If the issue is of an administrative nature, a HSAC decision may be appealed to the President of the hospital or his designee. If a satisfactory is not reached within 15 days, it may be appealed to an arbitrator. 3) The decision of the arbitrator is also "final and binding" according to the rules of the American Arbitration Association.

At the HHC hospitals, there is a complex three step grievance procedure which applies to all grievances except work schedules, which have their own grievance procedure.

- 1) The housestaff officer and/or the CIR presents the grievance to the Chief of Service or the Executive Director or his designee within ninety days of the date on which the grievance took place. If it is not resolved satisfactorily within 10 days, for all grievances except non-renewal of contract for which it is 5 days, an appeal may be made to the HHC's Director of Labor Relations.
- 2) The Director of Labor Relations has ten days to respond to any grievance, except a non-renewal grievance. a) If this decision is appealed it proceeds to the Office of Collective Bargaining of

Chapter 6

The CIR: Labor union or professional association

New York City (OCB) for impartial arbitration within 30 days.

This decision is "final and binding." b) A non-renewal grievance submitted to the HSAC of the Medical Board. The HSAC has voting housestaff representation that is the equivalent of just under 50%. All decisions of the HSAC may be reviewed by the full Medical Board, which has two voting housestaff members, for a final decision.

The procedure for work schedules is identical for Steps 1 and 2 to that of other grievances, as outlined above, except that there is another appeal to a panel consisting of one CIR representative, one physician and/or dentist selected by the HHC and the Vice-President of Health Care Planning, Policy and Standards or his designee as chairperson. The decision of the majority of this panel must be made within 10 days and is "final and binding."

This is the procedure on paper. What is at issue here is whether it is utilized by the housestaff and if so, under what circumstances.

The housestaff sample, when asked about the grievance process, said the following: 63% felt it was effective; 86% felt it was an appropriate action for housestaff to take; and 21% had participated in a grievance. (This 21% response rate seems somewhat higher than the expected rate of filing grievances. In

Chapter 6

The CIR: Labor union or professional association

a response to a subsequent question only 11% of the sample reported filing a grievance. Perhaps this disparity can be attributed to the manner in which the earlier question was asked: respondents circled responses on a card, allowing for more error.) There were no significant differences between the housestaff at the municipal hospitals and those at the voluntaries. However, according to the delegates, there were differences among the hospitals in filing grievances.

At Bellevue, grievances were almost never filed. According to one of the delegates:

the only grievances to come out of here have been by and large instigated by CIR (administrators) rather than the other way around (by individual residents). . . (A CIR contract administrator) pushed me a couple of times to have some meetings with administration about various things and we never actually filed grievances but we raised some issues. I would never have picked that format. If it were not for (the contract administrator) I would never have met the Director of Labor Relations. (Interview, Bellevue delegate)

Bellevue's housestaff, by and large, was not an active union group. One Bellevue delegate described the relationship between the CIR and the housestaff this way:

At Bellevue, housestaff has really not been involved in CIR. . . . they're very grateful for the monetary benefits that they've been able to get but they don't really go to meetings and things like that. (Interview)

When the sample was asked under what conditions would they file a grievance the results were the following:

Chapter 6

The CIR: Labor union or professional association

Table 6b Circumstances under which respondents would grieve

	<u>Bell</u>	<u>KC</u>	<u>Mont</u>	<u>Brx Leb</u>	<u>Total</u>
Don't know	31%	25	7	15	19
Extreme action*	23	19	53	39	33
Contract violation**	46	56	40	46	46

* "Extreme actions" included a severe or extreme action against a housestaff officer, such as firing, threatening one's career, disciplinary action, abuse of patients, as well as unwillingness to grieve under any circumstances.

** "Contract violations" included violations of housestaff rights and benefits, poor working conditions, unfair treatment, and administrative problems.

Bellevue's residents were slightly more ignorant than the rest of the sample about their relationship to the grievance procedure. However, almost half of the Bellevue sample did claim they would grieve contract violations. One grievance was filed by the psychiatric residents, as a group, regarding a change in their on-call schedules. When the chairman of the department intervened, by restoring the residents to their former schedules, the grievance was dropped.

At Kings County grievances were filed concerning money, e.g., a resident having been assigned to the incorrect PGY level consequently received less money than she was entitled to; on-call schedules, out-of-title work, meal tickets (a city-wide grievance). According to one delegate, grievances tend to be successful if they are obvious infractions of the contract, e.g., on-call schedules. Out-of-title work is problematic. According to the HHC contract, it refers to "regular and recurrent assignment of employees to duties substantially different from

Chapter 6

The CIR: Labor union or professional association

those stated in their job specifications." (HHC Contract, 1980-1981, p. 28) In order to document out-of-title work at Kings County, the delegate distributed 3 x 5 cards to the residents. They were asked to write a brief note about the nature of the out-of-title work, sign it, and have another person, such as a nurse cosign it. "They just feel such a sense of helplessness and hopelessness. What . . . good is it going to do us? So we'll all report it, so what? I'll have to do the same thing tomorrow night also." (Interview, Kings County delegate) This statement typifies reactions to the grievance procedure. Additionally, there is frustration with this mechanism because it is very time consuming. The same delegate described a grievance that had been filed over a year before the interview. He had just learned that although the case was about to go to arbitration, the housestaff officers in question were no longer required to perform the out-of-title task that had been in question. Keeping in mind that housestaff officers train at a hospital for an average of three years, the delay can make the grievance mechanism impractical.

At Bronx Lebanon, the delegates also complained about the nature of the grievance procedure. Although out-of-title work was a significant problem, the process of documenting these grievances was also problematic. One delegate claimed he knew of no grievances being filed for the previous two years. Part of

Chapter 6

The CIR: Labor union or professional association

the explanation was that the committee to which the grievance is appealed, was stacked against housestaff due to its composition.

At Montefiore, one delegate maintained that "glaring infractions" are the only ones that housestaff grieve. For example, in the Montefiore contract housestaff officers are entitled to free prescription drugs, which they were not getting. Another grievance involved on-call schedules. The delegates explained that since the committee was biased in favor of administration, the grievances that were brought were usually the ones that were thought to have a good chance of being won. However, because the process is so tedious, problems are often handled informally, within one's department.

Among the sample of fifty-seven, six (11%) had filed grievances. Three of them filed as part of the previously mentioned change in the psychiatrists' on-call schedules at Bellevue. Another involved a housestaff officer who was not allowed to pass through an X-ray door; another case was a resident who learned that he was being set up for a disciplinary action; and finally another was a grievance against an attending, who, according to the resident, intervened inappropriately in a situation involving her and a resident working under her. Except for one grievance they were all resolved informally. The other grievance was still pending.

Chapter 6

The CIR: Labor union or professional association

Consequently, although grievances were considered effective and appropriate as methods to address problems in the workplace, they were rarely utilized by the housestaff.

However, a "latent function" of the grievance process was that it became a legitimate channel for residents to deal with the administration. According to a former CIR president, this has had great significance for the nature of CIR and housestaff labor relations. Previously, the CIR lawyers filed the grievances; more recently, the housestaff have done it themselves. They were becoming "politicized." "You learn to play ball; you learn to play off one thing against the other; to give away something to get something - that's part of politics." (Interview, Larry Boxt)

The former Executive Director of CIR agreed that "grievances get you in touch with management; they work solutions out; they give you a track record with management." (Interview, Ed Gluckmann) On the other hand, he found that the function of grievances for the union had changed, and perhaps not to its benefit:

In the past, one of the things we always thought was important was servicing people, which meant you got out there and you serviced them. Part of servicing them was to find grievances and to pursue them. This now has been converted into - you do grievances to organize people concept and they're two different things One is people paying for a service and they should get the service. And that in and of itself will lead to other organizing because of the base developed and there'll be credibility and there'll be success pattern and people will look to it and say, this is something I

Chapter 6

The CIR: Labor union or professional association

want. That's how it helps. You don't go into a hospital and say: "I'm going to take this grievance because it'll help me organize something." Organize for what? They are already under contract. You service them well, you be there, you help them and they will respond. (Ibid)

Apparently, the perceived change was from processing grievances, because that is how the contract gets enforced and "wrongs" are redressed, to filing grievances as a focal point around which to organize housestaff. This perspective on the role of the grievance procedure in the union typified some of the changes that had taken place in the CIR over the years. This will be discussed in later sections.

Other union tactics that the CIR engaged in included job actions, providing testimony at Joint Commission on Accreditation of Hospital surveys, press conferences, strikes, and use of contract negotiations to include patient care provisions. The respondents were asked their opinions as to the effectiveness and appropriateness of these tactics and if they had participated. The responses are stratified by type of hospital.

Table 6c Housestaff by type of hospital on CIR tactics

	<u>Housestaff sample on CIR tactics</u>								
	<u>Effective</u>			<u>Appropriate</u>			<u>Participtd.</u>		
	<u>Tot</u>	<u>Mun</u>	<u>Vol</u>	<u>Tot</u>	<u>Mun</u>	<u>Vol</u>	<u>Tot</u>	<u>Mun</u>	<u>Vol</u>
Job actions	49%	48	50	67	59	75	35	34	36
JCAH surveys	37	38	36	79	86	72	0	0	0
Press confs.	46	52	39	72	79	64	5	3	7
Strikes	60	59	61	58	55	61	21	14	29
Pat. care in contract	58	62	54	90	90	89	33	21	45

Chapter 6

The CIR: Labor union or professional association

Except for strikes, effectiveness and appropriateness are not correlated. What may work best in achieving goals may not be regarded as appropriate for housestaff officers and what may be considered appropriate may not successfully attain the desired results. For example, the least effective tactic, according to the sample, i.e., giving testimony at JCAH hearings, was considered appropriate for housestaff. Similarly, one of the presumably more effective tactics, striking, is considered least appropriate of the tactics. It is important to note, before discussing the tactics in detail, that the sample did not feel overwhelmingly that any tactic was very effective, although most were considered appropriate for residents. Most of the sample had not participated in any of these actions at the time of the interview (although the subsequent 1981 strike involved all four hospitals).

Job actions

A traditional union tactic is the job action. In one form, it slows down the work process by meticulously "going by the book." Job actions at various CIR hospitals were usually directed at the reimbursement process, in order to affect the hospital economically. For example, slowing down or not doing paperwork, especially not signing insurance forms, was intended to slow down the reimbursement process. In other cases groups of

Chapter 6

The CIR: Labor union or professional association

housestaff have engaged in job actions with limited ends. For example, all the pediatricians at a particular hospital refused to go on a new schedule in order to be returned to their old schedules. Some job actions were intended to ward off a strike.

One of the problems with actions such as not signing insurance forms or charts is that the culpable individuals were easily identified and vulnerable to the threats of the administration or departmental chairmen. Because recommendations of chairmen are considered significant to a resident's career, these threats could be an effective deterrent. Job actions were often haphazardly executed and difficult to organize. In the case of not signing forms, several delegates claimed that the administrators would have another physician sign so that the hospital would not lose funds. Another delegate, at a municipal hospital, pointed out that nonsigning actions don't work because:

. . . it takes a long time before it costs the city any money. . . . It's just very difficult, this double bind that we're in, which is that the hospitals, the less money they have, the worse their patient care is. And so, if the administrators were competent and if the system responded quickly, then they would see nonsigning for what it was and they would try to avoid it. But they're so incompetent and the system is so slow that it doesn't do anything except make them lose money and then they wake up to it some time later and they don't even have the money to give you what you need. (Interview, Bellevue delegate)

Apparently, the "system" is so complex and diffuse, a traditional labor strategy, such as a job action, was regarded as

Chapter 6

The CIR: Labor union or professional association

ineffective. In addition, 30% of the sample had no idea of the purpose of a nonsigning action. Consequently, although job actions can be effective in certain circumstances, the other strategies were required to bring pressure to bear on administrations for changes in patient care and housestaff working conditions. These tactics would have to continue to preserve the legitimacy of unionized doctors for both the public and the housestaff themselves. Two such strategies were giving testimony at JCAH hearings and holding press conferences.

JCAH hearings and press conferences

The Joint Commission on Accreditation of Hospitals periodically visits every hospital that desires accreditation in order to be eligible for Medicare, Medicaid and Blue Cross reimbursement. According to the contracts with the CIR, each hospital must notify the CIR of the date of the inspection so that interested housestaff officers could give testimony concerning deficiencies in patient care in the hospital. As a legitimate whistle blowing strategy, it demonstrated that doctors were willing to take time to document inadequacies and report them to an agency that was empowered to compel the hospital to make changes. One CIR leader referred to it as "blackmail." Most of the sample felt it was an appropriate tactic, although not very effective. The Executive Director claimed it did

Chapter 6

The CIR: Labor union or professional association

sometimes result in corrections, although it was not clear if the CIR testimony or just luck led to the change. He felt that, as with other tactics, it involved CIR members in the union and patient care, making them visible in a positive way.

Press conferences performed a similar function. Housestaff have called press conferences to publicly expose unsatisfactory hospital conditions. They tend to dramatize conditions that cause the delivery of patient care to be problematic. In one case, facing the threat of various HHC hospital closings, CIR members refuted HHC's claim that there were excess hospital beds, asserting instead that several HHC hospitals were overcrowded (New York Times, 2/18/80). At another press conference a group of residents at Metropolitan, a hospital slated for closing, charged:

"They (HHC) are not closing it officially, they are closing it subtly, and they are bleeding us to death."
. . . The doctors cited more than a dozen examples of what they called "institutional and governmental malpractice" as a result of budget cuts, including a "critical shortage of nurses" and a lack of supplies and medication. (New York Times, 6/30/79)

Finally, in a very dramatic and daring news conference, the headline read "Physicians at Metropolitan Lay 2 Deaths to Staff Cuts." (New York Times, 11/19/79) Here the claim was made that the cuts in staff, particularly nurses, had resulted in two patients' deaths because the required care was not available.

Chapter 6

The CIR: Labor union or professional association

Of the housestaff sample, 46% felt press conferences were effective, 72% felt they were appropriate and 5% had participated. It appears that the municipal hospitals have chosen this tactic more frequently than the voluntaries. Although the impact of this strategy in accomplishing its goals was unclear, from the union point of view it organized housestaff around patient care issues. It enabled the resident to view union activity as legitimate by appealing to his professional responsibility to seek quality patient care. Additionally, it publicly legitimized the physician as whistle blower. He was not seen as a wealthy individual, exclusively interested in self aggrandizement, but rather as a person willing to put himself on the line to improve conditions for the patients that he served.

Finally, the press conference was the vehicle by which a strike was announced to the public. Here the issues became tricky. On the one hand, the physicians were telling the public that they planned to withhold their services, a seemingly self serving action. What they had to do to legitimize it was to present the issues in such a way as to redefine their action as altruistic. In almost all the CIR strikes, they were able to make the case that what appeared to be an action that hurt patients, was in fact an attempt to better their situation on a larger, more permanent scale. "Patient care" was the banner of all the major strikes. However, before discussing the strike, as

Chapter 6

The CIR: Labor union or professional association

a tactic, the notion of patient care requires examination.

Patient care

The propaganda and mystique of the time had posited the aviator as a special kind of man - superior in talent, nerve, physique, and intellect. (Hopkins, 1971: 51)

This description of airline pilots could also be applied to physicians and other professionals in our society. Because of their education and responsible positions, they are prestigious individuals, with considerable credibility. Our society respects them and what they have to say. From the beginning, CIR was regarded as a credible source because physicians were on the frontlines in the hospital.

If CIR comes out and says "look, the patients are dying" there is a credibility factor simply because they are physicians. . . . (Interview, Montefiore Family Practice resident)

CIR, a union representing a group of professionals, has opted to utilize this credibility factor to focus on the "product," patient care.

Almost from the beginning there was as much concern with patient care issues as there was with matters of self aggrandizement. (Interview, Murray Gordon, initial CIR attorney)

Chapter 6

The CIR: Labor union or professional association

The definition of "patient care" has never been clearly defined, but it appears to include two separate, but related dimensions. On the one hand, it is presented, as in the above quote, as a concern that is in opposition to self interest. An assumption here is that the issues surrounding patient care and the issues involving the betterment of the resident's situation are in conflict or mutually exclusive. In 1979, when the CIR was considering organizing attendings, a resident said the difference between attendings and residents is:

The central theme for attendings is his money and his behind. . . . We take care of people, not money.
(Statement made at House of Delegates meeting,
12/11/79)

Some residents in the sample seemed to separate the membership from the leadership in terms of their commitment to the patient care philosophy:

I would say that the majority of the housestaff are really not interested in most of the actions of the CIR. All they want is a decent wage, decent hours, and peace and quiet. . . . I don't think they (the leadership) live in the real world. They're not going to change the patient care situation in New York City. The only thing that will change it is money. They don't have it. (Interview, Kings County resident)

I think the CIR should mainly be interested in the economic well being of its own members - that's first - and then secondarily, working conditions. . . . I think it's sort of a copout for the union and I think again it comes from . . . the role conflict that they have: they want to be good New Dealers and good friends to the Third World and I just don't think it's right.
(Interview, Bellevue resident)

Chapter 6

The CIR: Labor union or professional association

On the other hand:

I think things can always be dichotomized into the more political patient care side of things, and individual benefit and job demands side of things. . . . I do not have any interest in support of salary raises; I do not care who they are. (Interview, Kings County resident)

One example, in which patient care did seem to be in opposition to self interest was the Patient Care Trust Fund, implemented in the 1980 CIR contract with the HHC. This fund, originally in the amount of \$200,000, was offered by the CIR, to be taken from housestaff wages. It was to be administered by the CIR for equipment that housestaff deemed necessary for their hospitals. Two-thirds of the housestaff sample agreed with this approach. Eighteen per cent felt it was not appropriate for housestaff to give up money, but rather it was the role of the city to finance hospital equipment.

The other definition of patient care focuses on working conditions which simultaneously affect residents and patients. Rather than viewing "patient care" as something that may be in opposition to improving the resident's situation, it is conceptualized as concurrently affecting the lot of the resident and that of the patient.

I think people would be very happy if we could improve conditions they work under, which for years has been misnamed patient care and has become so widely accepted under that rubric that it's hard to get people to understand another term. To the public, we should have said we're trying to improve care which, in fact, we are trying to do. That's something they can understand from their point of view. But to the members we should

Chapter 6

The CIR: Labor union or professional association

have said, we're trying to get you out of the messenger business. We're trying to get you out of the business of working all night and having your patients die because there's no one there - having surgical patients brought down without enemas so that they have to be evacuated before they go into the O.R. or sent back. So you don't have to wait three days for tests. . . . housestaff would be delighted with all of that. (Interview, Ed Gluckmann, former CIR Executive Director)

Thus, "patient care" is defined in terms of working conditions. The argument is that if working conditions are improved, in all probability the patient's care will be improved. When the housestaff sample was questioned as to what their priorities for the next contract would be, patient care was chosen as their first priority (35%), followed by reduced hours (26%), salary increase (18%), job security (5%), and benefits (2%). When first and second priorities are combined and stratified by hospital the results are the following:

<u>Table 6d Priorities for next labor contract by hospital*</u>						
<u>Priority</u>	<u>Total</u>	<u>Bellevue</u>	<u>Kings Cty</u>	<u>Montefiore</u>	<u>Bronx</u>	<u>Leb</u>
			<u>Salary</u>			
First	18%	23	19	27		0
Second	33	46	44	13		31
Total	51	69	63	40		31
			<u>Hours</u>			
First	26	23	19	47		15
Second	14	23	19	13		0
Total	40	46	38	60		15

*~~Respondents~~ respondents answered this question by numbering priorities on a card. Some did not follow instructions and checked, rather than numbered, their choices. Thus, the percentages do not always add up to 100%.

Chapter 6

The CIR: Labor union or professional association

<u>Priority</u>	<u>Total</u>	<u>Bellevue</u>	<u>Kings Cty</u> <u>Benefits</u>	<u>Montefiore</u>	<u>Bronx Leb</u>
First	2	0	0	0	8
Second	21	15	13	27	31
Total	23	15	13	27	39
			<u>Job security</u>		
First	5	0	6	0	15
Second	5	15	0	0	8
Total	10	15	6	0	23
			<u>Patient care</u>		
First	35	38	38	27	38
Second	16	8	6	40	8
Total	51	46	44	67	46

When first and second priorities are totaled, salary ties with patient care for first place, followed by hours, benefits, and job security. There are some significant differences among the hospitals, as well. Patient care and hours are particularly important to Montefiore housestaff. Salary is more significant for municipal housestaff, whereas benefits are higher priority for voluntary hospital residents. Job security plays a more important role for Bronx Lebanon housestaff, who may feel more vulnerable as foreign medical graduates.

Hours is an example of a working condition that can impact on both the resident and the patient. It has been an issue that has permeated CIR negotiations for many years. The case is made that a resident's ability to function effectively is impaired by working long hours. As discussed in the previous chapter, on July 1, 1989 hospitals in New York State must implement

Chapter 6

The CIR: Labor union or professional association

guidelines that limit residents' hours to 36 hour shifts and 80 hour work weeks. In addition residents' schedules would require an 8 hour break between shifts and at least one day off a week. Emergency room doctors' shifts would be limited to 12 hours. This decrease in residents' hours, although initially designed to improve patient care, was also considered a critical change in housestaff training. By reducing hours, additional staff would be necessary as well.

Of those residents who mentioned patient care as a priority, 81% mentioned the hiring of ancillary staff as necessary. Forty-seven percent mentioned lab services, 40% cited equipment and 37% said patient amenities. The argument is made that ancillary staff, lab services, and equipment all clearly allow the resident to concentrate on diagnosing and treating in a more efficient and up to date manner. By eliminating out-of-title work and, by speeding up the "doctoring process," the length of stay of the patient can be shortened, thus decreasing hospital costs. Patient amenities, such as blankets, slippers, and pillows have less of an impact on the physician, although a cold patient may have a longer recovery.

On a larger scale CIR has protested cuts and closings of hospitals which, it was argued, would have an impact on patient care, as well as affect housestaff positions. The January, 1979 one day walkout was a reaction to proposed cuts, possibly up to

Chapter 6

The CIR: Labor union or professional association-

50% of the municipal hospital system. Arguing that the cuts were unplanned and haphazard in serving the health needs of New York City, they asserted that what was required was a "rational health care plan", as well as patient care in their contract.

In sum, patient care, the dominant philosophy of CIR, enables a trade union to embrace professional and social concerns. Thus it legitimates the notion of a union for both the public and the medical profession. In doing so it also sanctions union tactics which otherwise would be condemned as self serving and unprofessional.

Strikes

The strike is the ultimate weapon of a labor union. As mentioned before, it was considered by the sample to be the most effective tactic (60%). Although it was cited as the least appropriate tactic for the CIR, 58% did claim it was appropriate for housestaff to strike. The issue of the propriety of striking for housestaff, and professionals, is central in organizing residents in labor unions. In comparing tactics, the sample found that the most appropriate tactics were the most unobtrusive and least confrontational. In order of most appropriate to least appropriate:

Chapter 6

The CIR: Labor union or professional association

Table 6e Housestaff Sample on Appropriateness of CIR's Tactics

1. Patient care in contract	90%
2. Grievances	86
3. JCAH testimony	79
4. Press conferences	72
5. Job actions	67
6. Strikes	58

In addition to the notion of strikes as unprofessional ("We are not the Teamsters"), housestaff were also somewhat fearful of the possible consequences of such actions. Their future positions as physicians could be at risk. They were concerned that negative letters would be put in their files or that they would be denied recommendations for fellowships for other positions. As discussed in the previous chapter, residents in subspecialties were made to feel privileged to have attained their positions and unlikely to threaten their future careers with participation in union activities.

A resident at Bellevue explained why he believed his hospital did not get involved in union activities:

. . . this hospital is basically a very prestigious housestaff program, at least in medicine, and therefore, people are upwardly mobile and they know that basically they're going off into good positions. And they really don't want to have the boat rocked because they know in three years they're going to be out. So I think people here basically believe that doctors shouldn't strike and a lot of the *raison d'etre* for a union is lost in that regard. . . . I know last time when there was a job action at other hospitals. . . the word . . . went out that anybody in our department that is involved in that is going to feel the iron fist of the chief of the department. I don't

Chapter 6

The CIR: Labor union or professional association

know if that actually was true or not but everybody believed it because I don't think people really wanted to go off. . . Because people really don't want their futures jeopardized and they know they're basically hanging out with a good crowd here. (Interview, rheumatology resident)

The reality of striking is that, in addition to the perceived professional risks, it is illegal. The CIR contracts prohibit it and, in the case of the municipal hospitals, the strikers are subject to the Taylor law which covers municipal employees. If the Taylor law is invoked the CIR can be fined; they can lose the right to dues deduction, i.e., the HHC is not required to automatically deduct CIR dues from the housestaff paycheck; they can invoke a "two for one deduction" which means every housestaff officer loses two days pay for every day on strike; there can be individual fines for contempt of a strike injunction.

Finally, the dilemma for residents is that they are leaving their patients. One aspect of the residency that housestaff find desirable is the responsibility they have for patient care. They frequently have the responsibility, especially at the municipal hospitals for most of the care of their patients. Feeling personally obligated to their patients, they do not want to compromise care by withholding services. When the sample was asked under what conditions they would strike, 60% of the responses referred to patient coverage. One delegate put it this

Chapter 6

The CIR: Labor union or professional association

way:

When anybody strikes the people that get hurt the most are consumers. When the transit workers go on strike, people have to schlepp to work; when the garbage men go on strike, the trash piles up in the street which is a health hazard. If the doctors go on strike, and if they were to have as an effective a strike as a strike ought to be, which means that nobody comes in and nobody works, people would die. We can't. We can't allow patients to suffer. It's against our oath, for one thing, but even more than that, no human being can stand by and watch another human being suffer like that. . . . So we could never have, as far as that goes, a 100% effective strike. (Interview, Kings County delegate)

Another delegate cited the need for a skeleton crew which would provide minimal coverage by housestaff in case of emergency:

It covers the vulnerable flank of the accusation that you've abandoned the patients. It's possible to provide skeleton coverage and yet still have the economic impact of withdrawal of labor. (Interview, Montefiore delegate)

According to Ed Gluckmann, the former Executive Director, "the psychological and political problem of housestaff is how do you not provide and provide care at the same time? How do you go on strike and still not go on strike?" (interview)

Thus, the premise for most housestaff officers is that their patients are their personal responsibility, not that of the institution in which they work (although the institutions and insuring agencies are increasingly defining the rules under which physicians work). They fear that if a patient dies because of

Chapter 6

The CIR: Labor union or professional association

lack of care, the responsibility will be theirs and the public will perceive it as such.**

In spite of this dilemma, 79% of the respondents said they would strike in the future if they agreed with the issues. When asked if the rest of the housestaff in their hospital would also be willing to strike, 40% said yes and 20% said some would strike. In general the respondents felt they were more pro-strike than their counterparts in the hospital. Perhaps this judgement error was due to the nature of the interview, which focused on the respondent's relationship to the CIR, and thus, inadvertently encouraged positive responses to CIR among some respondents; or the respondents may have misjudged their peers because of their lack of contact with most of the housestaff in their hospitals.

In March, 1981 there was a strike of the municipal hospitals, as well as Bronx Lebanon and Montefiore. Bellevue, as expected, did not participate. Here, the respondents read the situation correctly. The Bellevue housestaff felt, more often than the other housestaffs, that the residents in their hospital would not participate and they were correct. The strike will be

**According to Mizrahi's study of residents (1984), all residents, at some point, had either made a mistake or witnessed one, which had a negative effect on a patient. However, they developed a perspective that emphasized the unique character of their position and as such, denied that they could be accountable to any outsider.

Chapter 6

The CIR: Labor union or professional association

discussed in more detail in the next chapter.

The issues that are acceptable for housestaff as strike issues are patient care issues only (12%), patient care and economic issues (60%), and economic issues only (5%). Of the remaining respondents, 2% did not know and 21% opposed striking for any reason. Thus, for the majority of the housestaff, the central concern is not whether striking is a moral or ethical act, but how to go about doing it. How is a strike orchestrated that hurts the hospital enough to compel them to meet demands and simultaneously not threaten patient care in any catastrophic way?

When the delegates were interviewed after the 1981 strike, there was some sense of disillusionment. Among the reasons given for the strike's failure was a lack of organization, both prior to and during the strike. Another position was that administrators did not really have the commitment to patient care and therefore, were willing to hold out even though quality patient care was not being provided to those who needed it.

We're not U.S. Steel and we do not produce something that somebody sells and if they don't make money, they're in trouble. We take care of people that nobody particularly cares about anyway. And if we can convince enough people to care about them and can motivate enough interest that they get better care, great. But if we kill people trying to do it, that's really bad. (Interview, Bellevue delegate)

It's (striking) not a tactic to use. Not in a hospital setting by physicians. Because it's totally ineffective. The hospital will either hire outside help or they're let the patient suffer before they'll give in to what you want. As I said, they're business

Chapter 6

The CIR: Labor union or professional association

oriented, not patient oriented. (Interview, Bronx Lebanon delegate)

(For a strike to be effective) it has to significantly affect the function of the hospital either financially or politically or public relations wise. (Interview, Montefiore delegate)

Thus, striking is judged as a very risky tactic because, unlike unions whose workers deal in a profit making product, CIR's members are dealing in an intangible product, health care. Thus, the patients will feel the immediate effects of withdrawal of labor while the hospital continues to function at a minimal level. The problem for the union is to strike so that the ongoing operation of the hospital is upset, without endangering patient care. If patient care is significantly affected, the press and the public are more likely to lose their sympathy for the residents.

It is unclear at what point the administrations feel compelled to respond to a strike. However, administrations have responded to strikes, such as the one in 1975. One factor that appears to be crucial is the supportive network that has been created among other hospital workers and the press. If CIR can use its credibility to convince the public of the justice of their cause, the chance of winning increases. In the case of the 1979 one day walkout by municipal housestaff, success was measured in terms of the involvement and support of the housestaff and co-workers. According to one analysis in the

Chapter 6

The CIR: Labor union or professional association

CIR's newsletter, "the strike of the 17th informed the public of our philosophy, mobilized support and established credibility, as well as protesting the cuts and giveaways." (Stephen K. Heier. "On Not Signing," CIR News, vol. 8, #1, January 1979, p. 4)

In summary, the patient care philosophy presented the striking physician as the altruistic professional, willing to take risks in order to serve the cause of quality care for patients on the institutional level. Professional concerns were also expressed by the routinized whistleblowing that occurs at JCAH hearings and press conferences.

CIR as social advocate

Once CIR established itself as a union with a genuine commitment to health care, especially for the indigent, it was approached by various organizations. Because of the dual identification, representing both labor interests as a union and health care interests as a professional organization, CIR was contacted for support on a variety of issues.

However, before discussing its contribution and relationships with other groups, it is important to note how CIR dealt with a population of its own that was experiencing discrimination, foreign medical graduates.

Chapter 6

The CIR: Labor union or professional association

The CIR and FMG's

According to a leader of the 1975 strike, who himself was a FMG, a review of 220 publications since 1972 compiled by the CIR-FMG Committee, demonstrated that there was a "well orchestrated attack" on FMG's almost on a weekly basis. (Interview, 6/18/75)

More and more in order to justify their expulsion and curb their future influx, the FMG has been viciously painted in the medical and general press as a large homogeneous group, poorly trained, speaking no English, and delivering poor medical care. ("FMG's Begin to Mobilize," CIR Bulletin, May, 1975, p. 3)

Thus, there were a variety of covert and overt forms of discrimination that FMG's encountered in this country. Since they make up approximately 40% of the CIR's membership, it became clear that CIR had to service them as a group with somewhat unique problems.

Over the years, CIR assumed a number of roles with regard to the FMG's: 1) Legally, they published handbooks, held conferences and disseminated information to help clarify the FMG's legal position with regard to the various changes in the law concerning their visa status, rights, and permitted length of stay. They also provided legal representation in cases involving discrimination, threats of deportation, and general immigration problems (in 1970, CIRLS, the CIR legal service, was involved in 15 immigration cases out of a total of 66 cases) (notes from CIR Trustee meeting, 5/13/80). 2) CIR represented FMG's in larger forums where policy was being decided. For example, at an AMA

Chapter 6

The CIR: Labor union or professional association

Convention in 1974 a proposition requesting the State Department to re-evaluate the "open door policy" for FMG's and encourage "repatriation" to the country of origin was being discussed. CIR housestaff officers, "appalled at the idea," managed to get it tabled and referred to committee. (CIR Bulletin, January-February, 1974, p. 5) Unfortunately for the FMG's, at the AMA Convention the following year, the only issue on which housestaff were defeated was a resolution which would have permitted the dissemination of a housestaff report on FMG's "which concluded that FMG's needed support, not penalties and discrimination." (CIR Bulletin, January, 1975, p. 4) Similarly, FMG's were represented by CIR at the State Department and the Educational Commission on Foreign Medical Graduates (ECFMG) in order to improve their situation in the United States. In 1975, for example, they took credit for delaying the implementation of immigration policy changes for one year.

3) CIR has protested overt discrimination against FMG's, e.g, when medical magazines ran want ads which specified "American grads only," CIR wrote letters of protest.

FMG participation in CIR

What has been somewhat problematic is the lack of FMG involvement in CIR. Although at various points throughout CIR's history, FMG's have made up 40-50% of the membership, they were

Chapter 6

The CIR: Labor union or professional association

poorly represented among the leadership of CIR. However, although there are no official statistics, it is generally agreed that FMG's were active in CIR actions, especially strikes. Additionally, in the late 1970's and early 80's, there was a dramatic increase in organizing among the "FMG hospitals." What remains unclear are the factors that determine these various levels of involvement by FMG's.

Among the reasons given for lack of involvement, especially in the daily operation of CIR are, that in addition to the problems inherent in being a member of another cultural group, such as language, differing values, laws, working conditions, and finding a place to live, the FMG is often older than the American graduate and supporting a family. Perhaps, as some housestaff officers have suggested, this contributes to their "vulnerability." Furthermore, CIR itself is a typically bureaucratic organization with its rules, forms etc., that may appear confusing and intimidating. Thus, from the point of view of the FMG, CIR may not give the appearance of being an organization in which they would feel comfortable participating.

From the point of view of CIR, and its leaders, there were a variety of perspectives that must be dealt with. Some housestaff officers felt removed from the FMG and his/her problems:

That's a group that I feel that I don't have that much commonality of interest with . . . I'm not especially interested myself (in FMG's) in terms of what I regard as my responsibility as a doctor and as a housestaff

Chapter 6

The CIR: Labor union or professional association

officer for patient care. (Interview, Bellevue delegate)

Other tend to view FMG's as indistinguishable from housestaff officers in general, who, therefore, do not require special attention: "making them separate, it's like saying. . . what about the role of Jews, the Irish, in the CIR." (Interview, Kings County delegate) Similarly, some see the issue of FMG involvement as part of the general issue of housestaff involvement in CIR. Finally, for some, FMG participation is not problematic. At Bronx Lebanon, one CIR representative claimed "they are the CIR here." (Interview, delegate) The other delegate described the assimilation process this way:

I think that the immigration syndrome has a natural history. You come here very scared, and then you work hard, and then you become more interested in this thing and then you finally become Americanized. (Interview, Bronx Lebanon delegate)

Implied in this statement was an assumption that FMG's go through a process that eventually resulted in them being like their American counterparts, who may or may not choose to be active. What seems to be the underlying factor in accounting for these various perspectives was the hospital in which one trained, i.e., as the proportion of foreign born FMG's in a hospital increases, so does the awareness of FMG's as a group with special needs. At Bellevue, where FMG's constituted 39% of

Chapter 6

The CIR: Labor union or professional association

the sample, but were all American born, 46% of the sample did not know if CIR represented the needs of FMG's. Similarly, at Montefiore, where the only FMG in the sample was American born, 2/3 of the respondents had no idea if FMG's interests were represented by CIR. On the other hand, at Kings County, where 82% of the sample were FMG's (44% U.S. born and 38% foreign born) 31% were ignorant of CIR's role with respect to FMG's and at Bronx Lebanon, where only one respondent was not an FMG, only one respondent was unaware of CIR's involvement with FMG problems. The complete results to the question of whether CIR represented FMG concerns was the following:

Table 6f Housestaff Sample on CIR as Representative of FMG's

	<u>Total</u>	<u>Bell</u>	<u>KC</u>	<u>Mont.</u>	<u>Brx Leb</u>
Yes	39%	23	50	27	54
No	23	31	19	7	39
DK	39	46	31	67	8

At a hospital like Bellevue, where FMG's constitute a small minority, confined to a few specialties, they were likely to be isolated from the graduates of American medical schools, and thus their concerns and problems were unknown to others (although the Bellevue sample did not tap the foreign born FMG population at Bellevue, according to 1979 data they constituted 18% of the housestaff, concentrated in the pediatrics, pathology, anesthesiology, and rehabilitative medicine departments). FMG's, in that type of situation, may have been more fearful and

Chapter 6

The CIR: Labor union or professional association

intimidated. On the other hand, in a hospital like Bronx Lebanon, where the FMG's were in the majority, they could more easily overcome their problems of adjustment and unite as a group. The former Executive Director, Ed Gluckmann, in discussing why they were successful in organizing "FMG hospitals," said:

you have some ingredients there, potential issues, people that have the ability to do mindset as a collective - unsympathetic Americans treating everyone else in a denigrating way. It leads to a set of circumstances that can lead to organizing. (Interview)

Another factor to be taken into account in the activism of FMG's is their own socialization in their native countries. According to a former CIR leader, active both in organizing Bronx Lebanon in 1973 and in the 1975 strike, political socialization in Argentina was part of everyday life:

We are 300% more involved in politics in this country. Politics is our way of life. It is more important than anything else. If you are a medical student, a sociology student, engineer, architect etc. you are active. To go to the student center is like going to the classroom every day. To me CIR activity was a continuation. (Interview)

What became apparent, is that all the FMG's formed a distinctive group within CIR and were recognized as such by the union. The foreign born FMG's had additional problems, as discussed previously, of discrimination, cultural adjustment, and

Chapter 6

The CIR: Labor union or professional association

threats of deportation.

The history of CIR includes an ongoing awareness of the FMG group with sporadic attempts to stimulate their involvement in the organization. The union has taken responsibility for an "affirmative action program," wherein "it's the responsibility of the union to overcome these factors (that deter FMG's from being involved), not the responsibility of the individual." (Interview, Jonathan House, former CIR President) However, what seemed to have been occurring was FMG activism at the local hospital level, but an unwillingness to become active on an ongoing basis, especially by foreign born FMG's:

We have FMG Committees that get chaired by the Rosenthals^{***} and . . . what have you, but it doesn't need that kind of flavor. . . It needs a Dr. Shah, A Dr. this, a Dr. that who are going to come forward and make it work. . . . The FMG's who've had a leading role in a lot of what CIR's been building on and doing, should come forward and claim the prizes. . . "I want this, I want that." But they've got to put in the time; they've got to ask for the resources - make a commitment. (Interview, Ed Gluckmann, former Executive Director)

Nevertheless, as late as 1981, an active FMG member felt compelled to send a letter to the CIR Executive Committee, in which he expressed his concern:

^{***}This is a reference to Sheldon Rosenthal, an active CIR member, who chaired a FMG Committee, but was not a foreign born FMG.

Chapter 6

The CIR: Labor union or professional association

(a) In the city strike (1981) though FMG's were almost a majority among the residents, they were ill-represented on the strike committee. The danger here is clear. (b) A perusal of the CIR's house organization will not produce a photograph or article illustrating FMG's CIR activities or few articles designed to address their specialties. The remedy is obvious. (c) There is little evidence in CIR general literature that the CIR is proud to have their doctors as members and is concerned with their participation in the union's governance. (Letter to Executive Committee, 5/5/81)

What emerges is a situation where a "minority" group is almost the majority. For a variety of reasons FMG activism in the CIR exists in situations where they are visible in the context of the housestaff group. Consequently, if they are the majority of a specialty within a hospital, or of the hospital itself, they are more likely to be active. On the other hand, if they are isolated they are more vulnerable and thus, unlikely to be active. They have maintained a history of participation in strikes and organizing efforts, but not at the ongoing organizational level.

While CIR continues to focus efforts on integrating FMG's into the organization, CIR has become involved in supporting the efforts of various health related groups, including patients' rights and the delivery of health care.

Rights of patients

Chapter 6

The CIR: Labor union or professional association

The Committee for Abortion Rights and Against Sterilization Abuse (CARASA) came to CIR on several occasions to request support for positions on legislation e.g., allowing minors free access to abortion. In general, CIR supported the work of CARASA, by backing their general philosophy and, temporarily, renting them cheap office space at CIR headquarters. When the respondents in the survey were asked about CIR's endorsement of abortion groups, about 2/3 agreed with CIR's position, 28% disagreed, and the remainder took no position. Although CIR justified their position in terms of patients' rights, some members could not reconcile this position with their own religious or personal beliefs.

Due to the emotional and personal nature of this issue, CIR's support could be interpreted as a gesture supporting the rights of patients as a health issue or as an example of CIR's liberal politics.

The delivery of health care in NYC

CIR, from its inception, voiced a commitment to the delivery of quality health care to the poor. A large proportion of the CIR housestaff served the poor, either in the HHC hospitals, or in the voluntaries located in the poorer neighborhoods of NYC. Thus, CIR, often in alliance with union or community groups, participated in various campaigns to prevent cutbacks in

Chapter 6

The CIR: Labor union or professional association

municipal hospital services. Among the groups CIR was involved with were the Citywide Coalition to Save our Hospitals, the Health Coalition Against Cutbacks and Layoffs, the Community Coalition to Save Metropolitan Hospital, and the Coalition for a Rational Health Policy. Among their activities was support and participation in protests, testimony at hearings on closings and cutbacks, and strategy meetings with various community and union groups. Hoffman, in her study of twenty-two insurgent professional groups, found upon examining CIR, that as CIR focused away from issues emanating from work within the hospital, CIR deflected their strategies away from

contract oriented strategies, to . . . job actions, expose tactics, coalition building, political mobilization and health planning advocacy. (Hoffman, 1981: 440)

CIR specifically took a position in 1979 against hospital closings and cutbacks until the city developed a "rational health plan." Of the survey sample, 65% agreed, 26% disagreed and 9% took no position.

However, although the sample agreed with this position, there was ambivalence about joining community groups to achieve health care goals. When asked about aligning with community groups, 46% favored it, 44% were against it, and 9% didn't know. Those who favored alignment felt they could work together on patient care issues. However, the membership did not appear to view the community's role in the delivery of health care as

Chapter 6

The CIR: Labor union or professional association

significant or necessary. When asked to rate the major problems with medicine today, out of six categories, "community education" was rated first or second by 18% of the sample and "lack of public involvement" by 4%. When asked to check off what changes in medicine were needed, although "attack on societal problems, such as racism, sexism, poverty, environment" was checked by 69% of the sample, the best method for accomplishing this was unclear. There was no consensus on government involvement (30% to increase, 28% to decrease) and 25% felt community control was necessary.

There clearly was ambivalence about the role of the patient as embodied by the community. Some residents expressed views in terms of their own identity as upwardly mobile middle class professionals who, consequently, did not find they had much in common with the patients and communities in which they worked:

As I get older I get a little more selfish and I'm entitled to be selfish and I'm in favor of those groups that are interested or help me in achieving my lifestyle in my professional and personal satisfaction. . . . What they (CIR) have to say is true but I'm disappointed with the fact that they have to say it and it just makes me aware of the sort of basic conflicts that are going on between the haves and the have-nots and I'm obviously one of the haves and I'd like to continue to have and it's perfectly obvious that the have-nots would like to have also and they're only going to get it from the haves - it emphasizes that unfortunate conflict that's occurring. (Interview, Bellevue, 4th year resident)

It is difficult to determine the typicality of this

Chapter 6

The CIR: Labor union or professional association

perspective, which considers patients' and residents' interests to be in opposition to each other. However, when questioned about instituting national health insurance in this country, 30% were against it. Although there are a variety of reasons one could hold this position, it is probably safe to conclude that most of these respondents viewed national health insurance as a gain for the "have nots" and a loss for the "haves."

Nevertheless, the CIR did participate quite actively during the years of the proposed cutbacks and closings with other groups committed to the same goals.

Delivery of health care in general

The CIR has had a commitment to issues surrounding the delivery of health care in the U.S. The National Health Service contacted CIR to use it as a forum to present its program to residents. The New York Public Interest Research Group (NYPIRG) approached CIR for endorsements of legislation that would better enable the patient/public's interests to be represented. The Physicians's Statement of Practice Bill was a consumer bill designed to compel physicians to disclose fees, hours etc. NYPIRG also supported a bill to change the structure of the HHC by substituting several mayoral appointments with Community or Medical Board appointments. CIR endorsed both bills.

Chapter 6

The CIR: Labor union or professional association

On the conservative side, the Coalition for Fair Malpractice Rates was leased space by CIR. Although among the members of this group there were "not many you would want to have a drink with" (Jonathan House, CIR president, CIR meeting), the CIR felt their cause was legitimate.

Thus, the CIR became a political entity in NYC health politics.

CIR and other unions

CIR has been approached by unions, ranging from the Coal Miners and United Farm Workers to non-professional hospital workers (1199 and DC 37) to nurses (New York State Nurses Association and the Nurses Network) to other housestaff unions (San Francisco Interns and Residents Association-SFIRA). The requests have included support for a strike, medical aid during a strike or similar action, financial aid, office space (use of an office on a part-time basis), or formation of an alliance for bargaining purposes.

In general, the CIR's House of Delegates responded positively to the requests of other unions. When the union in questions seemed "close to home" with respect to the nature of the work of the union's membership, CIR was more inclined to support their efforts. For example, when DC 37 or 1199 were having a strike, CIR supported it and urged its housestaff to

Chapter 6

The CIR: Labor union or professional association

avoid doing non-emergency work and walk picket lines, rather than cross them. It was clear that the leadership of CIR felt a loyalty to workers in their institutions or, in any case expressed a fear that patient care was threatened by their absence and therefore, the housestaff should support the strike. Here the membership and the leadership parted ways. As discussed in the chapter on the work situation, 26% of the sample agreed that CIR should align with non-professional workers, 63% disagreed, and the remainder was undecided. Of those who endorsed a relationship with non-professional workers, it was for mutual goals in the work setting, such as patient care. However, the more typical responses, cited in Chapter 5, indicated skepticism regarding the appropriateness of such a relationship and the lack of identification with the labor movement.

As a group of young professional people, it (CIR) is an anomaly. Its characteristics, types of people, their lengths of stay as employees in a particular setting, the parallel goals in getting an education and end point of all this trade unionism is to become an entrepreneur and make more money than 99.9% of labor will ever make puts them in a totally different box. (Interview, Ed Gluckmann, former CIR Executive Director)

This "entrepreneurial" self image was instrumental in precluding housestaff from accepting the notion of an industrial health workers union in which they could be members. As long as they were a distinct professional group in control of their work

Chapter 6

The CIR: Labor union or professional association

they foresaw no need for unionizing in conjunction with other "workers." Others, like former CIR president Jonathan House, anticipated a situation in which physicians increasingly became employees of institutions such as hospital or health care corporations; they also are increasingly subject to others dictating the conditions of work: hospital stays are a function of Diagnostic Related Groupings (DRG's) i.e, the government through Medicare and Medicaid, as well as private insurance companies, have become more involved with areas such as length of hospitalization, in order to trim costs of health care delivery. Thus, whether physicians eventually seek out unions or other organizations to represent their interests remains to be seen.

As previously mentioned, the housestaff sample felt the closest affinity with the nurses and could envision aligning with them for similar goals in the work setting, such as patient care. The leadership supported nurses' requests, through the NYSNA, to back demonstrations at City Hall regarding the need for more nurses, and strikes. When nurses struck at Maimonides Hospital, in 1980, the housestaff refused to do their work. According to the survey, 2/3 of the housestaff approved of CIR's support for non-CIR hospital worker strikes.

At one point, the CIR found itself in the midst of a split between various nurses' groups that wished to represent the hospital nurses. 1199 came to CIR in April, 1980 asking their

Chapter 6

The CIR: Labor union or professional association

support in a bid to represent nurses at the voluntary hospitals (as opposed to NYSNA). CIR did support 1199 on the grounds that NYSNA had a poor grievance procedure and was more concerned about the "professional nurse" and less about good patient care.

In October, 1980 the NYSNA called a strike in the HHC hospitals, using the slogan "no contract, no work." According to nurses in attendance at a CIR meeting, NYSNA had organized and mobilized a strike with the intention of staying out 8 to 9 hours but it "turned into a monster they couldn't control." Nurses came out in force and wanted to stay out until their demands were met. CIR permitted a splinter group of nurses to use the CIR's office facilities and advised the housestaff not to do the nurses' work. When the issue was raised as to how much input the CIR should have into this new group, it was decided to support nurses in a "tender way," i.e., not take over their union but offer help where it was needed. It was agreed that it was important to help nurses since they were dealing with the same working conditions as residents. However, as one housestaff officer pointed out, it was a "utopian vision of health workers united in a union." Thus, the notion of CIR 's involvement in organizing health workers, other than doctors was regarded as inappropriate at that time.

Interestingly, at this time, CIR was approached by the San Francisco Interns and Residents Association (SFIRA) for a loan.

Chapter 6

The CIR: Labor union or professional association

SFIRA was planning to strike for patient care i.e., hours, out-of

title work, but they lacked the backup of a lawyer as well as funds for other organizing activities. After they won their strike CIR did help them, but not without some hesitation on the part of many of the residents. There was a sense that SFIRA's heart was in the right place, but they didn't have the same kind of "mind-set" (Executive Committee discussion) that CIR did about what a housestaff union is, i.e., they didn't require dues; they didn't have a plan as to how to organize. This raised the more general issues of what CIR's role should be with respect to organizing other housestaff and how limited resources should be spent. One delegate, expressing concern about CIR's support of SFIRA, argued that this was an "abstraction" (Metropolitan delegate, House of Delegates meeting, 10/14/80) when nurses at their own hospitals were fighting for the same working conditions as the residents. Although there was not a groundswell on the part of the nurses or the residents to combine forces, the involvement of CIR in the nurses' strike did provide some exposure for the residents to note some similarities in their positions.

Summary

Chapter 6

The CIR: Labor union or professional association

The criteria that underlie CIR's identification and affiliation with other unions appear to select as well as discard certain elements from both the trade union model and the professional association model.

On the one hand, CIR could not exclusively be a trade union, identified with goals of self-aggrandizement and autocratic government, exclusively adopting the format of a trade union, i.e., negotiating contracts, implementing job actions and strikes. On the other hand, the professional association model, which assumed control over the profession, was based to some extent on its collectivity or service orientation. Thus, as a society we grant the physician control over the profession because we believe that their concerns as physicians to be altruistic. As this altruism was questioned, CIR sought to reestablish it through its notion of patient care.

CIR itself questioned the service orientation of all other health workers, including attending physicians. This was demonstrated by their unwillingness to affiliate with other health workers, except perhaps for nurses, as well as their skepticism about attendings' interest in organizing a union modeled after CIR. They maintained that theirs was an exclusive claim to patient care. Non-professional workers did not work with patients so their interest was perceived as self aggrandizement. Although nurses might have had some interest in

Chapter 6

The CIR: Labor union or professional association

patient care, they did not have the expertise that physicians had with regard to what the patient care needs might be. Finally, the perception was that attendings had become cynical and lost their ideals and perhaps were not willing to make the commitment that patient care demanded. The implication was that they had already become part of the "system" and could not assume the responsibility and risks that a dedication to patient care required.

CIR and political organizations

Although CIR tried to remain apolitical, e.g., by taking a position that it did not endorse political candidates, it was approached by several groups for support due to assumptions about CIR's political preferences. Essentially, CIR, through its "patient care" and "defense of the public hospital" stances, came to be identified as a group that defended the underdog, i.e., poor and minority groups. Thus, groups such as the Downtown Welfare Advocates Center and the NAACP successfully approached the CIR for aid. The welfare organization requested support for a demonstration which CIR gave, in the form of a bus (House of Delegates meeting, 2/20/79) The NAACP came to CIR several times in order to gather support for an investigation by the federal government regarding the enforcement of Title VI Civil Rights legislation in order to stop cutbacks and closings of hospitals

Chapter 6

The CIR: Labor union or professional association

that served minority groups.

On the wider political scene, CIR entered into discussions involving Nicaragua, Vieques (a small island off the coast of Puerto Rico), El Salvador, and South Africa. Some requests were specifically medical in nature, e.g., requests for medical supplies and aid in Nicaragua; request for medical support during a demonstration against U.S. intervention in El Salvador; or a request for a letter of support against the "deprivation of medical neutrality" (House of Delegates, 11/18/80) to the El Salvadorean Medical Association when doctors were hampered in their ability to deliver medical care. Others were not quite so clear.

There was consensus, in 1981, on a motion to remove CIR's money from their Citibank account due to the bank's dealings with South Africa, but the question of Vieques provoked a discussion on the general issue of taking positions. Vieques is a small island whose occupation by the Navy raised some environmental and human rights issues. CIR was asked to join governmental bodies such as the New York City Council and New York State Legislature in supporting resolutions to remove the Navy from Vieques. For most of the delegates this was somewhat remote from the everyday issues that concern a resident and they were ambivalent in their dealings with it. The CIR president, Jonathan House, expressed the issue in terms of the nature of the CIR itself. His view

Chapter 6

The CIR: Labor union or professional association

was that issues such as sterilization guidelines and FMG laws were clearly within their purview; also, CIR as a democratic organization should permit any member to discuss anything.

However, the issue to be considered was: what was the significance of a CIR endorsement, both in terms of the cause in question and CIR itself. He recommended against endorsing a leaflet on Vieques because the endorsement would have minimal impact for Vieques, yet result in organizational problems for CIR. Ultimately, no clear policy was formulated but guidelines were developed, e.g., a speaker had to be sponsored by a CIR delegate at a meeting in order to speak. Nevertheless, the issue continued to resurface, such as in 1981, when a motion was passed supporting the resignation of Jeanne Kirkpatrick as U.S. ambassador to the U.S. due to her actions regarding South Africa. Although the motion was passed there was some discomfort about endorsing matters that appeared to be removed from the issues significant to CIR.

The issue of political involvement has had an impact on CIR's reputation with its membership, as well as other groups. Not unexpectedly, CIR leaders have often been involved in other political activities. For the sample interviewed, college activism was the norm and most of the leadership had participated in demonstrations on issues such as the Vietnam War, Kent State, civil rights, anti-poverty, and free speech. In the early

Chapter 6

The CIR: Labor union or professional association

1970's, some of the leadership, especially from Montefiore Hospital, were overtly left wing in their political beliefs. Some were members of the Progressive Labor Party, some communist. In the June, 1976 House of Delegates election of officers, the issue of political position played a significant role. One delegate felt it was significant enough to have prevented her from being elected as a CIR officer, thus prompting her to write a position paper on "redbaiting," which was attached to the following month's minutes.

At the other extreme were those whose political consciousness revolves around their own status:

I think CIR's purpose is the betterment of conditions for residents and that's all they should do. I think purely enlightened self interest, just basically selfishness should be the guiding philosophy of the CIR. Their efforts in any other direction are bound to be so little and so fruitless that it would be pointless; it would just give us all a bad name.
(Interview, Kings County resident)

I think they are mired in a 1930's view of labor - structure and function of labor unions and I think that they aspire to be blue collar and I don't think . . . it's very appropriate for health professionals. . . . When I hear them I get the feeling that what they think is very noble is like the "wobblies" they would like to be involved in John Lewis, George Meany kind of things and things are different now. (Interview, Bellevue resident)

A similar view was expressed to an informant, by a leader of a major New York City union, describing the CIR leadership as:

irresponsible. They're only there for a short time. They can't control their radical wing who want to

Chapter 6

The CIR: Labor union or professional association

socialize the world from here. (1977)

However, even among outsiders there was no consensus on the nature and direction of CIR's leadership. Ed Rothschild, who had witnessed CIR's development from his perspective as a member, as well as a HHC negotiator said:

I think the CIR has gone through leadership that are a mixed bag but tend to have more social conscience or are less concerned with what other people say about them; they're not as threatened; some people would say they're a little crazy but I don't happen to believe that. I've been impressed by their presidents and the quality of their leadership. I've fought with them; I've disagreed with them both as management and in terms of strategy, saying "you're off base." But I'm not impressed that they're a bunch of crazy kids. They know exactly what they're doing; they got trouble with their own troops; it is not a unified solid group. (Interview, 1979)

In summary, the political nature of CIR provoked controversy because the political views of the membership, which as a group, may have been more middle class and self-involved, differed from that of the leadership, which was more oriented to social change. Thus, both among the membership and among other groups, CIR's stances and actions may have generated some skepticism about their role as serious trade union leaders.

Thus, the CIR, as a trade union, found itself grappling with a mixture of traditional labor issues in combination with professional concerns. The central question is whether the trade union model could successfully achieve professional goals, which

Chapter 6

The CIR: Labor union or professional association

here are represented by the concept of patient care. Can contracts, grievances, job actions, and strikes effect the changes in the delivery of health care that CIR has advocated? It appears that CIR has somewhat effectively achieved the more limited union goals, such as wages, benefits, and vacations. However, if the union model is impractical for professional goals, what alternatives could be implemented?

Before attempting to consider these issues, the 1981 strike requires examination. The goal of that strike was patient care, through contract guarantees for equipment and staffing. This strike should provide some insight into the issue of whether a trade union can successfully negotiate a traditionally non-union issue.

Chapter 7
The 1981 Strike

Preparing for negotiations

CIR's defeat in obtaining any patient care provisions in the 1978-1980 municipal contract became a springboard for negotiations for the subsequent contract:

The central issue of this year's negotiations will be patient care. This follows from policy set by housestaff negotiating committees and the House of Delegates over the past two years of bargaining. It also parallels a national trend, dramatically illustrated in Boston and San Francisco this summer by housestaff actions over patient care. (CIR News, August/September, 1980, vol. 9, #2, p. 1)

Thus, the CIR began preparations for negotiations with renewed determination to obtain patient care standards in the contract. Their proposed demands, recommended by a City-Wide Bargaining Committee of CIR, were arrived at through consideration of demands not won in the previous contract, as well as the needs of the current municipal residents, as ascertained through discussions at the House of Delegates and a housestaff questionnaire. These demands included:

1. Wages: up to 15% increases in each of two contract years in order to achieve parity with housestaff in voluntary hospitals affiliated with HHC hospitals;
2. Hours/scheduling: limit on-call duty to one night in four;
3. Specific demands regarding housestaff working conditions, e.g., clean on-call rooms, adequate parking facilities, adequate

Chapter 7
The 1981 Strike

security, and meal allowances.

4. Patient care demands based on the questionnaires, regarding staffing and equipment for ancillary services. (Memorandum: To: House of Delegates; From: City-Wide Bargaining Committee; August 19, 1980; Subject: Proposed Demands -Attached to CIR Minutes of the House of Delegates Meeting, August 19, 1980)

Furthermore, "local" demands, such as security, that uniquely applied to each hospital were to be considered.

The context of the strike

In addition to the settlement of the previous contract with the city, CIR was in the midst of several "identity crises" that affected their goals and strategies with regard to the upcoming HHC contract negotiations. CIR had organized a number of voluntary hospitals between November, 1979 and May, 1980. In the fall of 1980, USPD's first local, Flower Fifth Avenue Hospital, won its organizing strike. At about the same time, CIR withdrew from its national organization, the Physicians National Housestaff Association (PNHA), the result of a disagreement about the nature of housestaff unionism. PNHA was a national organization of residents that encouraged and aided housestaff groups to organize and form unions. CIR's position was that all PNHA members be union locals with contractual agreements at their hospitals, preferably with patient care as a provision. The

Chapter 7 The 1981 Strike

incident that provoked CIR's leaders to recommend withdrawal from PNHA to its House of Delegates was PNHA's decision to appeal to the Supreme Court the National Labor Relations Board Cedars-Sinai decision. (This was the decision that overturned the NLRB's original ruling, thereby defining housestaff as students, not protected by the NLRA.) The CIR Executive Committee opposed this strategy, since it would be costly, unlikely to succeed, and might affect other actions designed to regain their coverage under the Act.

On the national scene local housestaff unions were organizing and succeeding in struggles for patient care. In June, 1980, after a seven day strike, the housestaff at Boston City Hospital "won what we consider to be one of the most progressive house officer contracts in the country." (Boston House Officers' Association Report to the CIR News, March 13, 1981, vol. 10, # 4, p. 4) Among their gains were:

significant advances in ancillary services, including guarantees for medical record runners, round-the-clock translator service, input into improving the messenger and transportation service, prompt EKG services and adequate ward clerk coverage, extended coverage in nursery blood drawing, and continued guarantees in hematology lab and IV services. (ibid)

The assumption was that, once implemented, these provisions would significantly decrease the amount of out-of-title work that residents do, thus freeing them for other activities, e.g., rest,

Chapter 7

The 1981 Strike

"doctoring," discussions with patients etc., thereby improving quality of care. There was also a provision for a patient care fund to be administered by the housestaff for equipment and supplies.

In October, 1980, the San Francisco Interns and Residents Association (SFIRA), representing residents at San Francisco General Hospital, engaged in a four day strike over patient care demands. They won on issues of staffing, out-of-title work and meeting JCAH standards for clinical practice, staffing, and the physical plant. According to the SFIRA president, Mona Safaty, "the real breakthrough is that they had to put staffing in a contract as a negotiable issue." (Ibid, p. 5)

These two successes were considered to be milestones for housestaff unionism. Both had achieved patient care language in their contracts by requiring minimum staffing levels. Thus, the housestaff could file grievances if these levels were not maintained. Both had demonstrated that striking could be a successful tactic to achieve these gains.

On the local front CIR was having some success in negotiating contracts at the voluntary hospitals. In the spring of 1980, Catholic Medical Center (CMC), of Queens and Brooklyn, settled a contract which included agency shop, upgrading on-call rooms, formation of a six person committee to monitor the situation regarding labs, staff, and equipment, and participation

Chapter 7 The 1981 Strike

in the Voluntary Hospitals House Benefits Plan (VHBP), a CIR administered benefits package. At Bergen Pines Hospital, a contract was settled in November, 1980 in which housestaff won the highest salary for residents in New Jersey. At Wyckoff Heights Hospital, in Brooklyn, housestaff won demands for the VHBP, as well as guarantees for maintenance of equipment and 24 hour test availability.

Nevertheless, at the municipal hospitals CIR experienced a number of setbacks, although there were some significant legal victories. The "Pat Hart arbitration" compelled the HHC to maintain nursing staff levels in a situation where a housestaff officer was doing a significant amount of out-of-title work. An arbitration in favor of CIR regarding free meals for municipal housestaff was also considered a victory. However, on a larger scale there was a sense that the viability of the HHC system was being threatened, both on the level of housestaff positions and its ability to provide quality patient care. Budget cuts and closings were encountered at all the city hospitals, but were felt most acutely, according to the housestaff, at Metropolitan where there had been a hiring freeze, and Sydenham, which was scheduled to close or be converted to some other purpose, e.g., a drug and alcohol rehabilitation center. Although housestaff did not "rally" to the Sydenham cause by engaging in any organized effort to prevent the closing, CIR officially opposed it as part

Chapter 7
The 1981 Strike

of its general stance against closings and cutbacks. As one CIR contract administrator said: "to us it only means five residents but it means a lot of health care to the people of Harlem."

(House of Delegates meeting, 5/20/80)

These deteriorating conditions in the municipal hospitals were experienced on a daily basis by the housestaff, resulting in a general feeling of demoralization. In response to the CIR questionnaire, distributed to obtain information on specific working conditions in the municipal hospitals, as well as through observations by delegates, the conditions reported at various hospitals included:

- out-of-title work (the Bellevue delegate described it was a "way of life," taking up 50% of an intern's time)

- security problems (housestaff had been attacked)

- poor living conditions, e.g., cockroaches, unchanged bed linens, no phone in on-call rooms

- lack of air conditioning (resulting in two operating rooms being shut down at Harlem Hospital)

- housestaff being told to report to work when calling in sick

- lack of support personnel, especially at night

- lack of functioning equipment, delays in obtaining lab reports etc.

At a September, 1980 meeting of the Executive Committee,

Chapter 7 The 1981 Strike

after discussion of the positions of the housestaff at the various municipal hospitals, there appeared to be consensus that they were "solid" regarding patient care, except for Bellevue. Among the voluntary hospitals, there was more variation. At one voluntary hospital "patient care" was cited as a means to a financial end, i.e., the housestaff were less committed to patient care, per se, and therefore, willing to concede those demands in exchange for salary increases. At others, such as Montefiore, there was a clear commitment to patient care. (notes)

The differences between the municipal and voluntary housestaff have roots in the nature of the population served, the responsibility for patient care by housestaff, and their working conditions. Few would disagree that, in general, working conditions for housestaff were worse at the municipal hospitals. When the housestaff sample was asked which hospital they would recommend to a friend for an appendectomy, 69% of the Montefiore sample and 82% of the Bronx Lebanon sample said their own hospital, whereas none of the municipal hospital respondents cited their hospitals. The Kings County sample predominantly referred to the poor physical conditions, whereas the Bellevue sample cited a variety of reasons, including poor auxiliary care.

The municipal patient population tends to be poorer, sicker, and more likely to be suffering from social problems that compound illness and treatment, such as drug addiction, teenage

Chapter 7 The 1981 Strike

pregnancy, alcoholism. (Forty-four per cent of the Kings County sample reported that the patients they liked least were those whose condition was the result of self-abuse, such as drug addicts and alcoholics.) Finally, municipal housestaff were more likely to have responsibility for patient care and thus, were compelled to be on the "frontlines" on a daily basis. Some opted for this setting in order to be exposed to the diversity and seriousness of illness found more often in the municipal hospitals (about one-quarter of the municipal housestaff sample opted to train there for the clinical opportunities versus one resident from the voluntaries). Others had a social commitment to treat those who were most needy. This experience as a resident may have resulted in an ongoing commitment to indigent patients or frustration with the situation, leading to a desire to work in a different type of setting, e.g., three Kings County residents in the sample expected, when in practice, to treat patients of all social classes, except the poor.

In spite of these differences, at that point, the CIR was attempting to obtain uniform language, for both voluntary and municipal hospitals, on certain issues such as out-of-title work. Negotiators were also proposing that each voluntary buy the identical benefits package, the Voluntary Housestaff Benefits Plan.

Negotiations with the HHC began in the fall of 1980 and by

Chapter 7

The 1981 Strike

November the HHC had agreed to a two year contract; a non-discrimination clause including physical disability, sexual orientation and affectional preference; a salary increase of 8% in each of two years, with a \$1500 living out allowance; and a non-pensionable cash payment. The notable areas of disagreement were night duty (CIR asked for one night in four) and staffing levels, about which the HHC refused to negotiate. One CIR negotiator asserted that the HHC refused to discuss "everything that improves patient care and ourselves." (House of Delegates meeting, 11/18/80) Their patient care demands revolved around the issues of hours and staffing (maintenance of minimum staffing levels of nurses, escorts, technicians, nurses aides and ward clerks). Non-patient care demands that the HHC had not responded to were maternity leave and the conditions in on-call rooms. There were no demands that could be classified as strictly patient care, in the sense that they would not improve the lot of the resident as well as that of the patient. For example, a demand for slippers or gowns or other patient "amenities" was not included.

By the following month discussions on tactics resulted in the negotiating committee requesting the delegates to survey their housestaffs on the possibility of a strike. At the January meeting it was reported that the HHC had refused every fourth night (on duty), maternity leave, and patient care (staffing and

Chapter 7

The 1981 Strike

equipment standards). As it became clearer that the HHC was adamant about not negotiating the patient care issues (viewing them as inappropriate areas of bargaining), CIR delegates began to move in the direction of militant action. A resolution was passed to poll the housestaff members on a March strike. To determine if the housestaff supported the delegates on a militant action, the poll included the options of no action, a job action, or a strike. The degree of militancy among the membership was an unknown, but as one delegate described it there was a sense that the housestaff were the "silent, not satisfied majority." (Kings County delegate, House of Delegates meeting)

Among the voluntaries, bargaining continued at various stages. Among the hospitals that had signed contracts were Brooklyn Cumberland, Maimonides, Catholic Medical Center, Kingsbrook Jewish, and Staten Island Hospitals. They settled without any patient care provisions. Although CIR encouraged each housestaff to include patient care demands, each hospital housestaff was independent, and therefore, entitled to prioritize its demands. As previously mentioned, the commitment to patient care demands was not visible at these voluntaries, either because the need was not as great, or the housestaff was not as committed to changing the conditions.

Due to a financial crisis at Wyckoff Heights Hospital, negotiations were suspended. After several months of attempts to

Chapter 7

The 1981 Strike

negotiate at Montefiore, during which the residents found the administration uncooperative and unwilling to give any power to CIR, such as the Voluntary Housestaff Benefits Plan, Montefiore delegates described negotiations as a "flop." The administration refused to discuss every fourth night, out-of-title work, and any patient care demands. In addition the administration wanted givebacks such as elimination of due process and the Standards and Grievance Committee. The housestaff, at a local meeting, were angered, interpreting these demands as, in effect, withdrawal of union recognition. Many Montefiore residents were militant, the PGY 3's and 4's feeling confident about their positions and the interns being quite angry. A strike was clearly a possibility if an issue could be found that everyone could rally around. (Surgeons were not as committed to demands such as every fourth night.) At a House of Delegates meeting a CIR staff member suggested that since staffing was a problem at Montefiore, and was acknowledged as such by the housestaff, patient care might be the issue that could unite the housestaff.

At Bronx Lebanon the issues were similar to those at Montefiore and the leadership there was watching the developments at Montefiore.

In the meantime, the CIR at Methodist held a successful eight day strike in January. Methodist was a "captive nation" hospital i.e., the housestaff had been CIR members until the

Chapter 7
The 1981 Strike

strike of 1976. However, the lack of security in the hospital and inadequate living quarters prompted the housestaff to take action to organize again. When the administration refused to negotiate the housestaff achieved their goals through a strike that had widespread support by the housestaff and the press. The administration negotiated on the seventh day, granting CIR recognition and agreeing to their demands.

Preparing for the strike

At the February meeting of the House of Delegates, results of the first municipal housestaff strike poll indicated wide variations among hospitals. The results of the initial poll were the following:

Table 7a. First Municipal Housestaff Strike Poll

<u>Hospital</u>	<u>Total</u>		<u>A*</u>		<u>B*</u>		<u>Other</u>	
	<u>Housestaff</u>	<u>Votes</u>	<u>#</u>	<u>%</u>	<u>#</u>	<u>%</u>	<u>#</u>	<u>%</u>
Bellevue	295	95	41	43	48	51	6	6
Bronx Municipal	446	198	86	43	108	54	4	2
Coney Island	128	45	12	27	33	73	0	0
Harlem	262	158	10	6	148	94	0	0
Kings County	397	223	73	33	148	66	3	1
Lincoln	213	95	22	23	71	75	1	1
Metropolitan	232	70	18	26	52	74	0	0
Totals	1973	884	262	30	608	69	14	2

(*A = Accept a contract without enforceable patient care [staffing] provisions; B = Strike - starting March 17 unless HHC agrees to enforceable patient care [staffing] provisions)

Thus, although approximately 70% of the voting housestaff voted to strike, 56% of the housestaff had not participated in this

Chapter 7

The 1981 Strike

poll. Bellevue, which had a particularly poor turnout, was working on a holiday schedule; the psychiatry department dominated the yes vote. Lincoln and Bronx Municipal were adamantly in favor of a total strike, opposing any skeleton or weekend coverage. Harlem's vote was the strongest, with 60% voting and 93% of that group favoring the strike. Kings County reported the largest turnout for any CIR vote.

Based on these results, the ten delegates present and the CIR President considered the options. Other than a total strike they considered a job action, which they referred to as working to achieve "high class medical standards." At some hospitals the housestaff were reported to be angry about the patient care situation; they wanted to strike and win. There was also an awareness of their relationship to the media ("our most powerful weapon") and the importance of winning the media over and thus, the public. Despite the ambiguous poll results, the consensus among the delegates was that only a strike could result in HHC management, as well as the general public, taking notice of the issues.

The delegates, however, had to weigh the potential Taylor law penalties for public employee strikes. These included heavy fines for the union (up to \$50 - 75,000 per day), and individual fines for members, criminal penalties, jail, and loss of dues checkoff for up to six months. A strike would also jeopardize

Chapter 7

The 1981 Strike

CIR's union recognition by the city. Jonathan House, the CIR President, identifying himself as a "full time union bureaucrat," (notes) was compelled to have the House of Delegates consider options, since the potential aftermath of striking could be the dissolution of the union. The CIR lawyer asserted that a judge would look more favorably toward limited actions such as sickouts, rule book slowdowns etc. Nevertheless, CIR's official position was that "the housestaff present felt that the city was provoking a strike because of its inability or unwillingness to address patient care matters with CIR in a constructive and enforceable format." (Minutes, House of Delegates meeting, 2/17/81, p. 3) A motion was passed to strike on March 17. Delegates were instructed to return to their memberships with the voting results, form departmental strike committees, and attend weekly meetings at CIR to organize for the strike.

Although the poll results were ambiguous, and the potential strike consequences severe, the delegates pressed forward for a strike of 2,000 residents. Several factors resulted in that decision. The 1979 one day walkout was still fresh in the minds of many delegates, who had participated or recalled its media success: "We can't lose if we go out for patient care; last time it helped build a movement." (Jonathan House) Secondly, there was an almost contagious belief in the justice of their cause and the necessity for them, as "hero-like" figures to fight for it:

Chapter 7

The 1981 Strike

We are young, sexy doctors who tell the truth
and work hard for our patients. (ibid)

I don't think we can lose a strike in the
eyes of the public. (Bronx Municipal
delegate)

Thus, eight CIR leaders set the wheels in motion for an unprecedented strike in the New York City municipal hospital system.

Housestaff leaders continued to meet with their housestaffs to determine support for the strike as well as discuss how to handle the strike at their hospitals. A few hospitals conducted informal follow up polls. At Bellevue, pediatrics housestaff claimed to have taken a poll in which they overwhelmingly decided to strike. This apparently was a response to a reduction in the Pediatric Intensive Care Unit. Although psychiatry residents originally voted to strike due to poor physical conditions in their building, they were swayed by the majority's decision not to strike.

When the housestaff sample was surveyed for this study, during the period from May, 1980 to February, 1981, there was strong support for striking, in general, if they agreed with the issues. (Bellevue: 69%, Kings County: 88%, Montefiore: 73%, and Bronx Lebanon: 85%) However, the actual ballots revealed varying scenarios. Bellevue's support for the 1981 strike came

Chapter 7

The 1981 Strike

only from the pediatrics, psychiatry, and dermatology departments, which probably could not have sustained a strike at the hospital without support from some of the larger departments, such as medicine, obstetrics-gynecology, and surgery. At Kings County 2/3 of the voting housestaff favored the strike. At Montefiore and Bronx Lebanon, whose housestaffs joined the municipal strike, there was strong support: at Montefiore, several votes were taken and the results ranged from 85% in favor to a minimum of 2/3 at each ballot; at Bronx Lebanon the vote was between 90 and 95%.

Thus, as the CIR came to terms with the varying degrees of strength at each hospital, it became clear that Bellevue would be the weak link. In addition, the strike support of the pediatrics department was diminished when the chairman met with the residents and reassured them that their particular grievance was being addressed. The House of Delegates considered adopting the "Bellevue plan," which would exclude Bellevue housestaff from participating in the strike as part of a strategy to keep one municipal hospital open during the strike. This strategy would accomplish several objectives: since the housestaff there felt the hospital was relatively well-staffed, they would not be asked to strike for objectives that they felt they already had; it could alleviate residents' concern for patients at other hospitals - all ambulances would be instructed to go to Bellevue;

Chapter 7
The 1981 Strike

the result might be a more complete walkout at the other hospitals; finally, it would "make everybody look great" (delegate at Strike meeting, 2/24/81).

Evidently, the strike leadership recognized Bellevue's status as the "jewel" of the system and thus assumed the media's presence there in the event of the strike. Although support was weak at Coney Island Hospital as well, it was not considered a cause for concern. Those that argued against the Bellevue plan claimed it would reenforce the elitism of Bellevue and eliminate the possibility of Bellevue striking. As one delegate at the meeting put it: "If Bellevue walked out we would have the city by the balls." (ibid) The Bellevue housestaff continued to discuss the strike, but, according to their delegate, they were "frightened of a strike in the current political climate. Although rightness is on our side, the law is on their side." (House of Delegates Emergency meeting, 3/3/81, notes)

This delegate also felt that, in addition to the fear of doing something illegal, there were ethical issues that affected Bellevue differently than the other hospitals:

I think that we feel. . . that we are doctors of last resort. And I think that it is a very difficult issue for the doctors of last resort to refuse to take care of the patients. I think, unlike a lot of other city hospitals, we don't have full time attending staff. There would have been nobody here if the housestaff weren't here. It's not a matter of there would have been fewer people or a skeleton crew; there would have been nobody here. And I think people really objected to that. (Interview)

Chapter 7

The 1981 Strike

At Bellevue "residual responsibility," i.e., total responsibility for the well being of patients, appeared to be an institutional phenomenon among the housestaff. The notion that the administration could assume the responsibility for patients by hiring temporary staff, or through other means, was not considered to be an option. Although a majority of the Bellevue respondents in the survey claimed they would join a strike, in reality this was not a viable option for most of the housestaff at Bellevue.

At other municipal hospitals, there was also a perception that they were necessary, to some extent, to provide patient care. At Jacobi, it was argued that a skeleton crew was required to get housestaff support. Similarly, at Kings County, the feeling was that a total strike would result in patient deaths, due to insufficient competent attendings. At Metropolitan, Lincoln and Harlem Hospitals, the housestaff defined the situation in terms of the need to win the strike: people had already died because of the very conditions they were protesting and now they had to commit to a total action. In other words their commitment to patients had to be on a grander scale to achieve their ends.

Another factor in Bellevue's non-participation was the working conditions themselves. One of the benefits of being a

Chapter 7

The 1981 Strike

housestaff officer at the flagship municipal hospital seemed to have been less out-of-title work. When the sample was questioned on the quantity of out-of-title work, 69% of the Bellevue housestaff reported rarely or never doing messenger work or transporting patients (versus 47% and 49% for the total sample). In tasks that were out-of-title, but more directly related to patient care, 39% said they rarely or never drew blood (compared to 25% for the sample) and 46% said they rarely or never started IV's or did transfusions (compared to 23% for the sample). The psychiatric housestaff felt they had the worst working conditions since they were housed in the old wing of Bellevue and consequently, voted to strike in the first ballot. What seems to be apparent is that, although various factors entered into Bellevue's lack of participation, conditions were simply not as bad at Bellevue as they seemed to be at other hospitals.

At Montefiore, housestaff were angered by the administration's response to them. At a housestaff meeting the consensus was that:

the administration's gratuitous dismissal of housestaff contract demands, their refusal to acknowledge that any of these demands were negotiable, their repeatedly stating that "there will be no changes made" - all constitute a challenge to the existence of the housestaff union. (Montefiore CIR Negotiations Update, vol. V, #3, 2/3/81, p. 1)

Frustrated by their "inability to deliver optimal care

Chapter 7

The 1981 Strike

despite working 100 plus hours per week" the housestaff made plans for an "educational and organizing campaign." (ibid, p. 2) At the March Emergency House of Delegates meeting, Montefiore announced its intention to strike with the municipal housestaff.

At the same meeting, the Bronx Lebanon delegate reported that after its administration had said no to most demands, their housestaff, at a meeting attended by over 50% of the residents, had voted unanimously to join the March 17 strike.

Strike issues

The issues surrounding the strike included the substantive issues of why the strike was taking place, the legal issues, especially those posed by the Taylor Law and the issues that dealt with the structure of the strike, e.g., should it be a total walkout or a "skeleton" strike? These concerns were discussed and decided upon at both the union level and the local level, at individual hospitals.

The Taylor Law

As discussed previously, the potential impact of invoking the Taylor law included financial penalties to individuals and the union, and jail sentences. If maximum penalties were to be imposed, the CIR would be out of business, either through financial ruin or HHC's withdrawal of CIR recognition.

Chapter 7

The 1981 Strike

Following the House of Delegates' decision to strike, the leadership had to convince residents that violating the law and suffering the consequences were worth it. In a handout distributed on the second day of the strike, to non-striking house officers, CIR argued the following;

FEAR OF TAYLOR LAW PENALTIES: Those who go on strike will probably be fined for their action. THERE IS NO OTHER PENALTY WHICH CAN BE LEVIED AGAINST AN INDIVIDUAL WHO IS NOT A UNION OFFICER. Ironically enough, the City has in past confrontations taken attendance the way it handles patient care so some non-strikers may lose pay anyway. The real issue is whether the temporary loss of pay is outweighed by the chance to make a lasting contribution to better patient care. Clearly the overwhelming majority of your colleagues feel that it is. (Handout: "To all house staff officers who have not yet joined the strike.")

Other deterrents to striking

The imposition of Taylor Law penalties was a real threat. Other legal issues surrounding the strike included the fear by foreign medical graduates (about 40% of CIR members) that they would be denied a visa if they struck. Although this was illegal, intimidation had an impact on FMG's and others as well. At Kings County, a CIR delegate reported that the HHC came around during the strike with their "Goon Squad," taking pictures and using a movie camera with "CBS" written on it, although their executive director had assured them there would be no photographer. (Delegate interview) Bellevue housestaff in

Chapter 7

The 1981 Strike

medicine and surgery were intimidated; they feared loss of their fellowships if they participated. At Bronx Lebanon, the surgery department was told by their chairman they "were screwed for the rest of their lives" if they struck. The obstetrics department did go out at first, but came back when their director used the "loyalty approach." (Delegate interview) At Montefiore the anesthesia housestaff, which was composed largely of FMG's in a hospital dominated by American graduates, were fearful of striking. In the radiology department, and especially in the surgery department, the chairmen were characterized as "autocratic," using their positions to threaten the careers of residents who struck.

The CIR attempted to counter these threats with handouts explaining that if the housestaff acted in unity the department heads would be rendered powerless. Their jobs were not in jeopardy since they had already been rehired for the next year; the CIR received a statement from the American Board of Internal Medicine condemning any attempts to deny access to medical board exams, except for medical incompetence. Other boards had taken similar positions.

Other issues relevant to the decision to strike

However, the decision by each housestaff officer to participate or not in the strike was influenced by factors other

Chapter 7 The 1981 Strike

than intimidation or loss of pay. Some felt that striking was "morally wrong." (Bellevue delegate interview) Others, for example, surgeons in general, and those at Montefiore were portrayed as

not traditionally . . . sympathetic to patient care goals of the union; (Montefiore delegate interview) there's a different group of people there. . . they're pyramiding, they have to do more ass kissing; they're different types; there aren't as many radicals there." (Montefiore delegate interview)

Both delegates described the difference between surgeons and other specialists in terms of their recruitment and the structure of their training: they compete to be assigned cases; they have a close relationship with their mentors; they lack a patient care orientation. Surgeons are generally perceived as different: "domineering and arrogant, aggressive, full of energy, and mainly concerned with his or her own prestige." (Bruhn and Parsons, 1964, 200)

The radiology department at Montefiore was also described as unsympathetic to patient care goals because of a lack of direct patient care responsibility. In fact, strike participation (which will be discussed later) was often related to departmental affiliation. Similar observations have been made concerning physicians in radical patient care settings, such as free neighborhood health centers and clinics, i.e., their specialties were in primary care such as family practitioners, internists,

Chapter 7 The 1981 Strike

pediatricians and gynecologists. (Resnick, 1976)

Strike demands

"Because the Health and Hospitals Corporation (HHC) does not meet its own standards, we are asking for enforceable patient care language in our contract." (Handout to residents at voluntary hospitals, 2/23/81) "They (CIR) demanded guaranteed minimum staffing levels for nurses, aides, technicians and other support personnel and an end to what they called chronic shortages of lifesaving medical equipment." (New York Times, 3/18/81, p. A1) These were the issues that CIR put forth for its membership and the public. However, as previously discussed, conditions that housestaff encountered on a daily basis, as well as the acceptability of those conditions, varied by hospital, department, and other factors. Consequently, what might have been considered intolerable in one institution or department, might be tolerable in another. Two residents in the same hospital might have different perceptions of the conditions there due to their differing experiences. Thus, when delegates were questioned on the significant strike issues, their answers differed somewhat, according to the particular situation at their institution. At Bronx Lebanon, the issue was "patient care;" at Kings County: "improving the hospital, that was the bottom line" (Delegate interview); at Montefiore one delegate focused on the

Chapter 7

The 1981 Strike

patient care issues, i.e., "working conditions, out-of-title work, physical plant" (Delegate interview) while the other saw these issues as the ones that precipitated discussion of a strike, but the sticking point was:

really the unwillingness of the administration to yield on any significant point. In other words, all along they had refused to even discuss anything and then when they discussed it, they finally said no. So that we were given a package that we had to take it or leave it. And if we didn't take it, we were on strike. So it was the intransigence getting people upset and patient care. (Delegate interview)

Although Bellevue did not strike, a delegate speculated that they would consider striking if the conditions in their own department were very poor, e.g., a 12 bed coronary care unit was changed to a 2 bed unit or if they were understaffed.

Planning for the strike

The issues that dominated the planning of the strike were:

1. Integration of Bellevue into the strike plans as it became clear that the housestaff was not striking.
2. Extent of the strike: should the strike be a total strike, in which 100% of the housestaff are expected to walk out, or should the housestaff continue to take some responsibility for patient care, i.e., hold a "skeleton" strike, in which housestaff provide minimal coverage, particularly in emergencies. For some residents these were difficult decisions to make. Some were

Chapter 7

The 1981 Strike

adamant that the strike be total in order to win. "We have no obligation to be good guys - people have been suffering and dying without care." (Metropolitan delegate, House of Delegates Emergency meeting, 3/31/81) Lincoln, Metropolitan, and Harlem hospitals favored a total strike, arguing that the public, the media, and the HHC would not misconstrue what was happening.

However, there was a significant group of housestaff that was reluctant to go on strike for fear of retaliation or due to a belief that their obligation was not to leave patients. As previously discussed Bellevue housestaff argued that there would be no attendings to take care of patients. At other hospitals so many of their admissions were on an emergency basis, the housestaff could not envision a scenario in which those patients could be adequately cared for without their presence, e.g., at Kings County there were 1,000 visits daily in the emergency room. Thus, in order to win support from residents who otherwise would not strike at all, a skeleton strike appeared to be a reasonable alternative. Initially the strategy was to give notice of the strike to the administrations of HHC, Bronx Lebanon, and Montefiore; following would be an attempt to empty the hospitals of all but emergency admissions. Thus, housestaff would be required to only treat emergencies and could then return to the picket lines. Additionally if a partial rather than total, strike was called, CIR's legal counsel argued that a judge might

Chapter 7

The 1981 Strike

look more favorably upon the action and Taylor law penalties would be minimized or avoided. However, as discussions progressed at the hospitals a more militant stance, i.e., a total strike, was called for at Lincoln, Harlem, and Metropolitan Hospitals. Their housestaffs felt this stance was imperative in order to be clear that this was a strike, not a job action and to win as quickly as possible. Jacobi and Kings County Hospitals continued to opt for skeleton coverage, to alleviate the fear that people would die if there was a total walkout and to get the support of housestaff who would otherwise not participate. A total strike was chosen as the official position of the CIR, although the degree of participation varied considerably from hospital to hospital.

The "Bellevue plan," i.e., CIR's plan to keep Bellevue open in order to provide patient care in the HHC system, during the strike, was a public relations strategy. Since it was apparent that support was minimal for a strike at Bellevue, CIR was attempting to shift the focus from questioning the residents as to their lack of participation, to keeping Bellevue open as a positive organizational decision: "In Manhattan, because it is the only municipal hospital with close to adequate staffing, we will leave Bellevue open but eliminate all elective admission." (CIR News, Special Edition, Vol. 10, #4, March 13, 1981)

Although some delegates objected to the plan, fearing any

Chapter 7 The 1981 Strike

possibility of Bellevue joining the strike was being thwarted, the decision to proceed with the plan.

HHC actions

During the months of February and March, the HHC took a number of legal actions to hinder the strike. At the March 3 emergency House of Delegates meeting, two weeks prior to the strike, several of these actions were discussed.

The city removed Jonathan House, CIR's President, (whose position was financed by the city) from its payroll "on the grounds that he is organizing, planning, directing or participating in a strike or job action against the City."

(Minutes, Emergency House of Delegates meeting, 3/3/81, p. 3)

The HHC claimed House's removal would be permanent.

Secondly, the HHC had been granted a temporary restraining order (TRO) against any strike or job action related activity, pending a hearing on a motion for a preliminary injunction, to be held on March 6. The penalties included a criminal contempt citation, fines ranging from \$100 to \$1,000 per day, loss of dues checkoff, jailing and individual fines for the leaders. Although the CIR lawyers were not surprised by the TRO itself, asserting that TRO's were quite common as tactics to frighten employees, they did consider the timing to be unusual. Ordinarily, TRO's arrive at the "11th hour," not two weeks in advance of a strike.

Thirdly, the HHC had petitioned for "scope and impasse."

Chapter 7
The 1981 Strike

"Scope" refers to the demands considered "bargainable." Demands are categorized as permissive, i.e., they can be discussed but neither side can force the other side to discuss it or take it to the impasse stage; illegal, i.e., cannot be discussed; or mandatory, i.e., must be discussed and can be taken to impasse. The HHC asked that patient care demands regarding equipment and staffing be declared permissive but not mandatory, using the rationale that they are the prerogative of management, not housestaff. The CIR, as in the past, contested this.*

"Impasse" is an arbitration procedure in which one side declares that nothing further can be achieved by bargaining and requests that negotiations be taken over by neutral arbitrators. Although CIR opposed the HHC's petition on impasse, the city proceeded to set up an impasse panel, asking for CIR's input. CIR's opposition to impasse was based on a belief that "the HHC

*Clearly, "management prerogative" was an issue for the voluntaries, as well. At Montefiore, one of the significant issues was the housestaff demand to transfer their health and benefits plan to a CIR administered plan. According to an article in the CIR News:

The Chief hospital representative refused to provide the costs of the Hospital's program and strenuously opposed a switch to the 'CIR sponsored plan because such a move would strengthen the housestaff union (*italics theirs*). "We are willing to increase the benefits to bring them up to those offered at competitive hospitals, but we are unwilling to give the benefits to the downtown CIR." (Allen Abramson, Montefiore's Deputy Director for Human Resources, quoted in the CIR News, January, 1981, v. 10, #1, p. 5)

Chapter 7
The 1981 Strike

has created a false impasse by refusing to negotiate in good faith." (House of Delegates meeting, Minutes, 3/3/81, p. 3)

With the strike close at hand, housestaff leaders continued to meet with local housestaffs and take votes to determine the strength of the walkout at their hospitals. Among the factors that affected support for the strike were one's specialty, PGY level, and the degree of support for the strike in the hospital. As previously discussed, residents were sometimes fearful of repercussions and were confronted individually, or in groups, with threats to their careers. Others were demoralized because certain departments, regarded as key, were not participating.

Clearly, the decision to strike was a painful one for many of the housestaff. In a newspaper interview a resident described his daily concerns in the hospital this way:

It gets to the point that I was uncomfortable coming to work each day. I felt as if I was abusing patients. I felt as if I was privy to something that was wrong, and I was not doing anything about it. (Interview in New York Times, 3/26/81, "3 City Physicians Explain the Strike")

Yet, in spite of a consensus among housestaff that conditions were poor and patients were suffering, the decision to strike at a time in one's career when "a lot of your future depends on not appearing too aggressive, too intelligent, too assertive, or too political" (resident interview in New York Times, 3/29/81, "Doctors on Strike Give In to Reality") was

Chapter 7

The 1981 Strike

difficult.

Thus, on the night before the strike, faced with a situation of threats, varying conditions of demoralization, as well as varying levels of support from the community, co-workers, and attendings staff, the CIR was set to strike on March 17, 1981.

The strike

Participation

On March 17 the following HHC hospitals were struck by the CIR: Coney Island, Kings County, Metropolitan, Harlem, Lincoln, and Bronx Municipal (Jacobi). Bellevue did not strike, but maintained an informational picket line, handing out leaflets, for a few days. The HHC hospitals were joined by Montefiore and Bronx Lebanon Hospitals, the following day. The strike lasted seven days at the municipal hospitals and eight days at the voluntaries.

Every evening representatives from each hospital met to assess the day's activities and plan for the next day. Reports of housestaff participation were given, including breakdowns by department. Since the housestaff was also required to sign in at the HHC hospitals, the HHC was able to assess what proportion of housestaff were on strike. (North Central Bronx [NCB], Montefiore's affiliate, was included in the HHC's analysis, although technically the housestaff were employees of Montefiore,

Chapter 7

The 1981 Strike

not of HHC.) According to the HHC data, total participation ranged from 54% on the first day up to 65% on the remaining days. Both housestaff reports and the HHC data agreed that Harlem Hospital's strike participation was the greatest (on the evening of Day 2 it reached a high of 90%). Similarly, Lincoln and NCB had "substantial" strike activity. There was also consensus that Coney Island Hospital's housestaff participation was poor. However, there was some ambiguity concerning the remaining hospitals: Metropolitan, Kings County, and Bronx Municipal. The HHC report mentioned Bronx Municipal and Kings County as having low levels of "no shows," i.e., minimal strike participation. According to the housestaff reports, Bronx Municipal started off slowly, but gathered strength day by day. Additionally, the HHC statistics may have been somewhat inaccurate as, according to one resident's report, when the Executive Director at Kings County took attendance the attendings reported that all housestaff were in house. At Kings County, although strike activity varied significantly by department, overall there was moderate support for the strike. The HHC reports did not specifically mention Metropolitan's participation, but according to the housestaff, there were up to 2/3 of the housestaff out of the hospital.

To some extent, the striking strength of the various housestaffs could have been predicted, based on their composition and past performance. Although this research did not delve into

Chapter 7

The 1981 Strike

the makeup of the housestaffs of the hospitals, other than those at the four sample hospitals, a preliminary examination of all the hospitals was necessary in order to select the sample hospitals.

After talking to various CIR staff members, one can see distinct characterizations emerge from some of the hospitals. For example, Harlem Hospitals's housestaff was portrayed as the "pride of black medicine." They were known as community advocates with a well-organized local association. Their commitment to the community they served, plus deteriorating working conditions, prompted their vigorous support of the strike.

At Coney Island there was a very different depiction of the housestaff and its relationship to the hospital. Coney Island Hospital was unlike most municipal hospitals; it served a middle class, insured population; its conditions were better than in most city hospitals; attendings in the area would have preferred that it become a community hospital. Therefore, except for a few activists, the housestaff were less likely to identify with the issues raised by CIR. Consequently, their participation was low.

At the voluntaries, participation varied as well: at Montefiore, according to the delegates, about 200 of the 375 housestaff officers did not work and of those 200, 100 to 150 picketed; at Bronx Lebanon, of 176 housestaff officers there were

Chapter 7

The 1981 Strike

110 striking residents at the outset and 80 pursued it to the end.

Some patterns emerged across hospitals by specialty. As could be predicted from previous discussions, surgeons did not participate in the strike, except at Metropolitan and Harlem Hospitals. On the other hand, medicine and psychiatry residents did strike at most of the hospitals. All hospitals reported that medicine residents demonstrated strong participation in the strike. At Bronx Municipal, however, the medicine residents, under pressure from their chairman, provided only weak support for the strike and, by the sixth day, were the only ones that were all in the hospital. At Montefiore, the social medicine department reported 93% participation. Although pediatrics and obstetrics-gynecology were supportive of the strike, their participation was the most variable. At most hospitals these residents started out with strong participation, but at hospitals such as Lincoln and Metropolitan they returned to work, in greater numbers than other departments. At Harlem Hospital, where the general support for the strike was strong, all the departments walked out, and except for surgery, where there was a split at the end, they remained out. The smaller departments, like radiology, orthopedic surgery, neurology, pathology, and anesthesiology varied, but tended to be less supportive overall. This variation is not surprising, the nature of a housestaff

Chapter 7

The 1981 Strike

strike being such that much of the dynamics depended on each department. Departments would meet together and vote whether to strike. They would often strike or return to the hospital as a unit, so that a small department, with a few residents, would feel more isolated and vulnerable in such a situation. In addition, some of the smaller departments, such as pathology and radiology were less sympathetic to the goals of the strike since they were not directly involved with patient care. Although their work might have been slowed down by inadequate staff and equipment, they generally did not witness the impact on the quality of care the patients received. Thus, the risks and loss of money involved in striking outweighed the gains.

Support for the strike

The Press

An important factor for a strike's success is the support of other groups, both within the hospital and the community. One of the great surprises of the 1975 strike was the support from the press, the AMA, and other groups. This support was credited with bolstering the efforts of the strikers, as well as pressuring the League of Voluntary Hospitals to negotiate a contract.

As the following discussion illustrates, what support existed for the 1981 strike was weak at best. The three daily newspapers opposed the strike. The New York Post and the Daily

Chapter 7 The 1981 Strike

News viewed the residents as students who were stepping out of line:

The fledgling physicians, it seems, aren't content to work and learn in the hospitals, they want to run them. ("Rebellion in the Ranks," Daily News, March 14, 1981) The interns and residents should concentrate on getting themselves the best possible medical education they can in the three years that they are in the city's municipal hospital system - not to play the role of trade unionists. ("An Indefensible Strike," New York Post, March 18, 1981)

The New York Times agreed that CIR's charges of unnecessary deaths in the city hospitals required investigation, but striking was inappropriate for the residents. ("Needless Deaths and a Needless Strike," New York Times, March 19, 1981)

Thus, without the support of the press, the necessity of support from community and co-workers took on greater significance.

Attendings - It was crucial for the CIR to be effective in communicating the goals of the strike to the other hospital workers since their critical demand centered on staffing levels. The support that the strikers received from them was uneven and not necessarily effective. The Doctors Council, representing the HHC attendings, had just concluded a contract with the HHC. Thus, although the "Doctors Council supports the commitment of CIR to improve patient care in the municipal hospital system

Chapter 7

The 1981 Strike

. . . our collective bargaining agreement . . . contractually and legally constrains us from any strike activity." (Letter to Doctors Council membership, March 14, 1981, from Barry Liebowitz, President). On the other hand, the United Doctors of Harlem Hospital, representing the attending physicians at that hospital, issued a press statement concerning the "irresponsible and damaging statement by Mr. Stanley Brezenhoff (sic), President of the Health and Hospitals Corporation, that the municipal hospitals can provide adequate patient care without housestaff physicians." They supported the CIR's demands and criticized the HHC for not decreasing the hospital work load during the strike. They also pledged to provide "necessary patient care" during the strike, provided that the HHC reduce the work load. (Press statement, March 16, 1981, by Dr. Edward B. Heaton, President, United Doctors of Harlem; Subject: Strike by the Committee of Interns and Residents).

Reports from other hospitals reflected the attendings' ambivalence about the strike. Although they often agreed that the problem of delivering quality patient care was real, they objected to the strike strategy: it meant more work for them and they opposed it on philosophical grounds, asserting it was not professional to strike. Finally, as a Kings County delegate reported, some felt that the strike could backfire if it resulted in the closing of the hospital or a reduction by the city in

Chapter 7
The 1981 Strike

hospital funding for the subsequent year.

At Kings County the Chief of Medicine, Dr. Wilson, found himself in a Catch 22 position. According to the Kings County delegate:

He did not want to have the people from this neighborhood he is black himself, and he feels that black and other underprivileged minorities have gotten the short end of the stick when it comes to health care. So he did not like striking because this deprived them actually of essential services. Though nobody was endangered, many people were inconvenienced.
(Interview)

At Montefiore, delegates reported the attendings' response as "very negative." A few attendings walked the picket lines and one was threatened with firing (a former CIR member). At Bronx Lebanon, although the overall response was "indifferent" the medicine attendings were reported to be "very, very supportive" whereas the obstetrics attendings were "absolutely vehement" (against) and the pediatrics attendings were "midline."
(Interview, Bronx Lebanon delegate).

Nurses

Nurses, in the HHC, were themselves in a somewhat transitional stage. In the fall of 1980 the New York State Nurses Association (NYSNA) had called a strike, and then, after a short time, called it off. At that point a splinter group of nurses, the Nurses' Network, was formed in an attempt to represent the more activist nurses. They were supported at the time by CIR. Nurses Network supported the CIR strike. They were

Chapter 7 The 1981 Strike

in agreement with the demands, asserting that the HHC's contention that "staffing is not a negotiable item is sidestepping the issue." (Letter to CIR, for Nurses' Network, n.d.)

Reports of support by individual nurses at the hospitals varied. One delegate at Kings County, felt that the nurses' job action didn't work so, although they supported the action and the demands, they were not too optimistic that the CIR would be successful. At Montefiore, nurses were reported to be increasingly supportive, to the point of considering a sickout, although it never occurred.

Co-workers

The consensus among the other hospital workers' unions was opposition to the strike. According to House's report, the second day of the strike, the leaders opposed the demand setting minimum staffing levels, contending that it would open a Pandora's box among their members; if CIR was perceived as setting standards for staffing levels, then why shouldn't all hospital workers have a say on this issue? This demand did not conform to the traditional demands that focused on working conditions.

Although the CIR demands were not always clear to the other hospital workers, there was some sympathy to the strike. At

Chapter 7 The 1981 Strike

Bronx Lebanon and Montefiore some workers walked the picket line during their lunch hour. At Kings County a delegate reported that they were "very strongly supportive," wearing CIR buttons. Although ambulance drivers were asked to take patients to other hospitals in the catchment area, they chose not to get involved.

Community

Unlike the press, whose view was that striking housestaff were "out of line," spokespersons from the community expressed support for CIR's action. Perhaps, since the municipal hospitals were the only places where the communities sought medical care, they had experienced the conditions that CIR focused on. The issue then was whether a strike action could be supported and could this method of solving the problem, i.e., through contractual guarantees, be condoned? In general, community support came in the form of written statements promoting the goals of the housestaff action. Although the Bellevue housestaff did not join the strike, the Community Board stated that they supported the CIR's demand "for better patient care and not money issues." The Black United Front, a Brooklyn based group, asserted that "since more than an overwhelming majority of those who use the municipal hospitals are black and Latino residents of the city, we see the issue of qualitative patient care as having a direct relationship upon the lives of our people." (Undated

Chapter 7 The 1981 Strike

press release) They stated that they were considering joining the picket lines.

Although efforts were made at some other hospitals to gather community support, the response was minimal. At Kings County the housestaff planned a Sunday rally so that housestaff could speak at various churches to explain their position and request support for the rally later in the day. However, community members did not show up, which demoralized the housestaff. At Bronx Lebanon there was very little support, except for individuals coming to the picket lines to express their support for the strike. One delegate maintained that because the community was "uneducated and illiterate" the hospital was allowed to continue as it was, i.e., there was no community pressure to improve hospital conditions. At Montefiore, although the community center did allow CIR to use their facilities for mass meetings, other kinds of support were not forthcoming.

Conclusion of the strike

On the fifth day of the strike, March 21, CIR held a meeting open to all CIR housestaff, at Harlem Hospital, with approximately 700 housestaff officers in attendance. The purpose of the meeting was to discuss and vote on a new HHC offer.

Jonathan House prefaced the presentation of the offer by explaining that the HHC was steadfast in its resolve not to give

Chapter 7

The 1981 Strike

contractual guarantees on staffing levels. According to House, it did not want to deal with conflicting union demands on this issue, nor did the other unions want to get into this issue. Additionally, Mayor Koch was aware that the strike was weakening at some hospitals and was prepared to "take the hit" rather than give in. The repercussions, financially, to the union could be devastating. In addition, the HHC could go to court to deny certification of the union. Thus, House recommended accepting the proposed settlement: "I think they have a gun to our head and though we can wound them . . . we will hurt more than we can stand." The proposal was the following:

1. Patient care committees would be set up as sub-committees of the Medical Boards to review and make recommendations concerning staffing and equipment, which would be passed on to the HHC President.

2. A mechanism to report problems regarding equipment and staffing would be instituted.

3. Emergency room rotations would be limited to 16 hours, except at Metropolitan where 12 hour shifts would be the goal. This last proposal was regarded as the significant change.

The discussion around this proposal and the CIR's options was animated and lengthy (4 hours). The consensus was that the gains of the offered contract were minimal. However, the membership was anxious to end the strike and many of them could

Chapter 7

The 1981 Strike

not see the value of staying out any longer. Others were incensed by the HHC's response to the CIR. In essence, their contention was that they were striking in a sincere effort to improve the health care system for the poor people of New York and the HHC was insensitive to the issue of patient care. For some it was a significant affront to their pride and, as one negotiator phrased it, to their "manhood." "I prefer no contract at all than to sell out to this shit." (Negotiator from Harlem Hospital) Others, in agreement with House, and fearing for the very existence of CIR, were ready to concede defeat and fight the battle on other fronts.

A controversial tactic that had emerged spontaneously was reporting to the press various atrocities that had occurred in the hospitals, resulting presumably from a lack of functioning equipment or adequate staff. One case, reported by a Coney Island Hospital surgical resident, involved a patient admitted with a condition, hemorrhagic pancreatitis, that ordinarily would have resulted in admission to the intensive care unit (ICU), but, due to insufficient beds, was not. When he suffered cardiac arrest the necessary equipment was either malfunctioning or missing and the patient died. Three other cases of death or brain death were reported by residents at Lincoln Hospital. All three cases were attributed to insufficient staff to monitor equipment or perform emergency procedures or to malfunctioning

Chapter 7

The 1981 Strike

equipment. Hospital administrators maintained that nothing irregular had occurred, but the New York City Medical Examiner was called in to review the cases. In the Coney Island case, his conclusion was that the patient neither had hemorrhagic pancreatitis, nor that he died of cardiac arrest, but rather that complications of the liver and pneumonia associated with alcoholism were the causes of death.

Although, upon independent examination, CIR's claims were not always substantiated, CIR did succeed in attracting the attention of the press, the public, and the hospital administrations. The resident at Lincoln Hospital who came forward was threatened with being fired. The Executive Director at Lincoln Hospital, who originally supported the residents, reversed his position. The HHC President, Stanley Brezenoff, was concerned that this tactic might threaten reimbursement. The residents expressed some concern about divulging the names of the patients, but as a strategy, they regarded it as their "ace in the hole." It was discussed as both a means to escalate the strike and as an alternate method to striking to gain minimum standards. Some felt it was their obligation to do so, since they were in the best position to report these incidents. Thus, sporadic attempts at institutionalizing this tactic would continue.

The negative impact that the strike had on individual

Chapter 7

The 1981 Strike

housestaff officers was another paramount issue. For some, especially FMG's, their paycheck was the total family income and they could ill afford to lose it. FMG's, as was the case in the past, were made to feel particularly vulnerable. Several residents reported HHC personnel videotaping the strikers. There were reports at every hospital of threats to individual housestaff officers. The HHC President had warned the striking residents that they were risking loss of one year's certification which would result in repeating one year of residency. The CIR advised housestaff not to go into their hospitals alone, but in groups, to reduce intimidation. By the March 21 meeting, support for the strike was weakening at some hospitals (Coney Island residents had returned to work). Thus the leadership had to assess their strength and determine what support remained should the strike continue. Many of the more vocal residents in attendance at the meeting were personally committed to "going down fighting."

Consequently, when the representatives caucused and voted, by hospital, they did so with conflicting pressures regarding continuation of the strike. Although there was consensus on not ratifying HHC's proposal, there was disagreement on their assessment of the strike's strength, as well as its possible outcomes. Representatives from Montefiore called on the HHC residents to continue. The Executive Director, Martin Cherkasky,

Chapter 7

The 1981 Strike

had threatened that he would break the union if they struck. In the midst of their own strike, they perceived a need for the HHC housestaff to strike as well. Others were concerned for the very existence of CIR. However, one Harlem Hospital resident, who appeared to reflect the views of others, expressed the belief that because they struck initially for their patients, the "poor working class minority," they should not be considering the issue in terms of money.

The three options chosen to vote on were:

1. continue the strike;
2. support the strike if others stay out, i.e., although one might favor ending the strike, he would stay out if the majority of his housestaff were in favor of striking;
3. end the strike.

The initial vote, taken by hospital, was the following: Harlem Hospital voted to stay out; Lincoln voted to go back; Jacobi and Kings County voted to remain out until Monday (2 more days); and Metropolitan voted to stay out one or two more days. After more discussion, the final decision was that all the hospitals would try to keep their memberships out until Monday.

On Monday night a meeting was scheduled at the CIR office to assess the strike. At that meeting it was clear that the only hospitals that could continue were Harlem and possibly Jacobi. Although the residents tried to reconcile their desire not to end

Chapter 7

The 1981 Strike

the strike without some concrete gains, it quickly became apparent that there were no options.

Defeat

They attributed their loss to naivete about union operations; they felt that the preparation and ongoing support necessary for a successful strike was absent. Residents, inexperienced in trade union politics, were not adequately prepared for the possible consequences of their actions, e.g., the potential duration of the strike, the threats etc. Some asserted that CIR should have worked from the "top down" in order to compel residents not to cross picket lines. The unclear division of labor, both from the CIR office and at local housestaffs was also cited. Although vowing to continue the "struggle" they agreed to return to work the next day, while continuing to support both Montefiore and Bronx Lebanon, where strikes were still in progress.

At Montefiore, the next day, the eighth day of the strike, the housestaff opted to return to work the following day. At least half the housestaff had already gone in after being threatened with loss of their jobs. After various last minute attempts to meet with the Executive Director failed, the housestaff decided to go in as a group the following morning.

At Bronx Lebanon, a similar situation occurred. Residents gradually returned to work and ultimately the threats, both to

Chapter 7
The 1981 Strike

individual residents, as well as to continued recognition of CIR ended the strike.

Strike aftermath

Financial - HHC: According to the HHC's figures, the census during the eight day strike was down by 6,000 patient days from the pre-strike average, costing the HHC \$1.95 million in loss of income. Outpatient visits declined by 11,600 at a cost of \$.5 million, and emergency room visits declined at a loss of \$.25 million. Thus, immediate revenue loss was estimated at \$2.7 million. The total estimated cost over the long range was an additional \$10 million or more over the weeks to follow the strike. (Memo: To: Mayor Edward Koch and Robert Wagner, Jr., Deputy Mayor for Policy; From: Stanley Brezenoff, President, HHC, 4/2/81)

CIR: The immediate financial cost to the CIR was \$15,000, to cost of the strike itself. In addition, the membership decreased by 450 at Montefiore and 175 at Bronx Lebanon, after loss of CIR recognition, resulting in a dues loss of \$125,000. A \$175,000 fine was imposed on the union for criminal contempt of the injunction and violating the Taylor Law and individual Taylor Law deductions were also taken.

The contract: The contract with the HHC was finalized on May 6. "The settlement is essentially the same package CIR had

Chapter 7

The 1981 Strike

accepted on economic items prior to the March strike over patient care, conforming with the standard Municipal Coalition Economic Agreement." (CIR News, June, 1981, Vol. 10, #6, p. 1) There were no agreements on any of the issues that were at the heart of the strike, such as out-of-title work, staffing, emergency room rotations, on-call schedules, and hours. Apparently, HHC's offer, presented at the March 21 meeting, was no longer discussed. However, in a report to Mayor Koch, regarding the strike's impact, HHC President, Stanley Brezenoff stated that he had "written to the Executive Directors and Medical Board Presidents of all our hospitals asking them to set up Patient Care Committees, or similar mechanisms, to report regularly on patient care issues and make realistic recommendations for action on staffing and resource allocation." (President's Report: To Mayor Koch and Deputy Mayor Wagner, from Stanley Brezenoff. Subject: Impact of CIR Strike on Municipal Hospitals. 4/2/81) However, the contract had no such provision, but merely extended in a sideletter, an agreement reached in 1975 between the CIR and the HHC regarding the right of either party to request a meeting to discuss staffing, patient care facilities, patient admission policies, and housestaff training "in order to clarify and promote the mutual interest." (Collective Bargaining Agreement between the City of New York, Health and Hospitals Corporation and the Committee of Interns and Residents). There were no

Chapter 7

The 1981 Strike

structural changes in the mechanism for dealing with staffing and equipment standards.

The housestaff: According to one delegate at Kings County, the housestaff perceived the strike as "fair" in the sense that it was an appropriate response to the situation in the hospitals. Beyond that it seemed to create an awareness of the issues in the residents' daily work. For example, a resident who initially opposed the strike, but did participate, reported an incident to the Kings County delegate concerning a machine which had insufficient power to revive a patient. Her reaction was to want to strike all over again. Others were motivated to continue the work begun by the strike, by monitoring patient care conditions. At Kings County, a group of residents established a system of recording out-of-title work, as well as incidents where it was believed patients died unnecessarily. A CIR committee was formed to establish a system for recording deficiencies in staffing, including the recording of equipment and staffing deficiencies, as set forth by JCAH standards, on patients' charts. In addition, a six month study of "how doctors spend their time in non-doctor work" (House of Delegates Minutes, 9/15/81, p. 2), as well as a more detailed study of conditions at Harlem Hospital, was initiated.

At Bronx Lebanon Hospital, residents felt that they went out for the right reasons, but that striking was a "futile effort."

Chapter 7

The 1981 Strike

(Interview, Bronx Lebanon delegate) At Montefiore, where the housestaff unsuccessfully attempted to regain CIR recognition from the administration, the strike also had a demoralizing effect:

I think the housestaff is in a period of mourning for the loss of strike goals, loss of union recognition. Housestaff are depressed, withdrawn, generally not participating anywhere near the levels that they were during or immediately before the strike. I think that with conditions such as they are at the hospital it's just a matter of time before there's a creative resolution to the mourning process and people realize that these problems are permanent and are going to require concerted, collective action. (Interview, Montefiore delegate)

To me, there were many positive aspects in terms of what people learned; . . . people saw what kind of oppression there could be from that institution. (Interview, Montefiore delegate)

In retrospect, the leadership had misgivings about the strike, some feeling that it never should have happened - or that there should have been more extensive preparation and organization. The question that remains is why did the 1975 strike succeed and the 1981 strike fail? Perhaps an analysis of the union itself will reveal the factors that resulted in the dynamics and failure of the strike.

Strike analysis

Patient care had always been at the forefront of CIR's philosophy. However, they were unable to mesh the patient care

Chapter 7

The 1981 Strike

goal with union tactics. Although it is difficult to determine a reason for this failure, perhaps a combination of factors contributed to their "profound defeat." (Interview, Jonathan House)

In analyzing the dynamics of the 1981 strike, comparisons to the more successful 1975 strike will be made in order to comprehend the conditions under which a housestaff strike is more likely to be successful.

The nature of the membership

Unlike other unions, CIR's members are transient, because the status of resident is also transient. Their perspective, as union members, was relatively short range, an average of three years. Consequently, their concerns were for current conditions, not future ones. Since they had just emerged from medical school training, where they were exposed to up-to-date methods, drugs, and technologies, their expectations were to implement what they had learned. What they encountered, especially in the municipal hospitals, did not meet their expectations. Not only were there gaps in equipment but staff shortages, resulting in residents doing out-of-title work; they encountered inefficiency and they were exhausted from working long hours.

The CIR was the organization that represented them in their hospitals, although most housestaff had little or no experience

Chapter 7

The 1981 Strike

as union members. Grievances did not appeal to many because they were time consuming, singled one out, and often did not apply to the issues of concern. A strike, although risky, appealed to housestaff, because they could take a stand, as a group, on issues that concerned them on a daily basis.

Jonathan House, as CIR President, was a leader in the 1979 one day walkout and attempted to apply that experience to the 1981 strike. The 1979 action was intended to bring publicity to the conditions in the municipal hospitals. It was planned as a finite action with a public relations goal. In 1981 the goal was to implement staffing and equipment levels through the grievance process. Initially, housestaff were to strike until this goal was achieved. Thus, much preparation was required to ready the membership for a strike that could be prolonged and serious in its consequences, as well as to persuade other groups such as the community, hospital workers, political groups, such as the NAACP, to support the strike. Although there were flyers and other attempts at communication with these groups, it was not clear what kind of support would be most helpful. Ed Gluckmann, the Executive Director, who had been through several CIR strikes since 1975, put it this way:

It's nice on the picket line - lots of people from the community came up and said, "oh, I support you." It was very helpful when I was on the Bronx picket line. . . that's one type of support. Another type of support is that forty community groups go into the

Chapter 7

The 1981 Strike

administrator's office and beat him up, in a way, not physically - "What are you doing to get the doctors back in" . . . At Montefiore the attendings would come out and make speeches at the rallies - "I support you all the way - that's why I'm working 80 hours a week." That isn't support for a strike. . . (they should) say to the administration: "I want you to sit down and work out a contract with these people, we'll give you three days and then we're pulling our patients out - we're pulling us out." (Interview)

The transiency of the membership did not permit them to have a historical perspective about the union. More than half of the respondents in the survey had no knowledge about previous strikes. About 2/3 of the sample had no knowledge of the 1979 strike, although 18% did participate in it. Thus, of those who had experience, it was with a one day action, whose goal was to bring about a greater awareness of municipal hospital conditions. Essentially, it was a media event. Gluckmann felt that the CIR President was among those who "rolemodeled" after the 1979 experience. In contrast, the 1981 strike, in order to succeed, required full-scale preparation on all levels, so that when it actually took place the issues, as defined by CIR, were clear to everyone:

That wasn't what we were into. . . . This was a strike that had to be absolutely devastating and crushing. It required every alliance possible. It demanded almost 85% of 90% turnout. It required a kind of public relations that destroyed from the beginning. And it required the kind of singleness of purpose from the whole staff. (Interview)

Chapter 7

The 1981 Strike

House admitted that the coordinated planning necessary to "build" for a successful strike was lacking. In addition, he faulted the failure to properly educate the membership about their options and the significance of striking. Other than the 1979 walkout, the group actions the housestaff had experienced were student demonstrations against the Vietnam War, nuclear power etc., where the most serious repercussion was missed classes. Although there were attempts to allay their fears, housestaff were made to feel vulnerable in a variety of ways.

It was difficult to conceptualize them as a unified group of workers. They did not qualify as a collectivity in the sense that other union workers do. They were divided in many different ways, e.g., hospital, department, FMG status, and PGY level, so that even a goal as noble as "patient care" could not unify them. Some had very little contact with patients; others felt the conditions were not that bad; others did not think this was the union's business; some were too fearful to participate; some were too close to the end of their residency to feel anything but "burnout." In different terms, their relationship to the "means of production" was a variable. They did not have the same mindset, nor were they all subject to the identical set of conditions.

Finally, their commitment to the personal care of "their" patients made it impossible to have a "devastating and crushing"

Chapter 7

The 1981 Strike

strike. Here was another difference between the 1975 and 1981 strikes. In 1975 the residents were part of the voluntary hospital system, where they had less direct responsibility for patients, because the patients were often the responsibility of their private physicians. At the municipal hospitals, housestaff generally have more direct responsibility for patient care. Even in the small sample interviewed for this study, the municipal housestaff claimed more responsibility than the voluntary housestaff, especially at Montefiore Hospital. Thus, even if they could deal with the threats, they had difficulty not feeling that they were abandoning their patients. (Those residents in specialties that were not patient oriented, eg., radiology did not experience this dilemma; however, they did not strike because patient care issues did not impact directly on their daily work situation; also, they were more inclined to be seeking a hospital based position after their residency, which they might feel would be threatened by striking).

During the 1976 strike, an incident occurred at Einstein that illustrated this belief among housestaff, and perhaps among the general public as well. A man and woman came out of the hospital, yelling at the picketers. Apparently, a close relative had just died at the hospital. Although a physician was not immediately available, and the patient presumably would have died anyway (a resident was taken off the picket line to see her),

Chapter 7

The 1981 Strike

they felt that her last minutes would have been more pleasant if a doctor had been at her side immediately. The man yelled: "if you want to strike, take off your white jackets." The picketers were dumbfounded; they seemed embarrassed and had difficulty responding, although they knew other doctors were inside. Thus, the issue that pervades all housestaff strikes is the predicament residents find themselves in when they attempt to shift their concerns for individual patients to a larger, more macroscopic picture of patient care concerns on an institutional level, to be dealt with through organizational efforts. To many, leaving patients (by striking), in order to help them in the long range, is not sensible. The more militant housestaff analyzed the problems of delivery of health care as institutional issues. Thus, they were less likely to experience the guilt that resulted from framing patient care problems as a consequence of the "doctor-patient relationship" model. That model focuses on health care as the responsibility of the physician and the patient, with less emphasis on economic, political, and social context.

Consequently, although there were housestaff, especially among the leaders, who were committed to the strike for the improvement of municipal hospital conditions, as the strike became prolonged, support diminished. The 1975 strike ended more quickly (four days) so that the housestaff were less likely to

Chapter 7

The 1981 Strike

experience the guilt that would return them to their hospitals.

Another difference between the scenario of 1975 and that of 1981 was the reorganization that had taken place at central CIR in the intervening years. It is necessary to examine that reorganization to understand the failure of the 1981 strike.

The CIR as a complex organization

In many ways the CIR resembled a bureaucratic structure, with rules and regulations, a division of labor, and administrative staff. However, some of the taken-for-granted aspects of bureaucracy were vague and undefined. The CIR, as it grew, hired staff with various specific responsibilities, such as community relations, patient care, contract administration, and organizing. Yet the staff found itself in a position where it was unclear how, and under what conditions, they should utilize their expertise. The Executive Director, Gluckmann, was their superior, but was subordinate to the President and the House of Delegates. The President had stated that this was to be a strike organized by housestaff. Gluckmann felt that the leadership did not want his input and when he attempted to get involved they were not interested. In 1975, with only a few staff members at their disposal, CIR hired a public relations firm, accepted help from the national housestaff organization, PNHA, and depended somewhat on the legal staff for direction. The 1981 strike was to be "built from the ground up." House, in his own analysis of

Chapter 7

The 1981 Strike

the strike's failure, cited tactical mistakes resulting from overextending the staff and leadership. (Jonathan House, "The City Strike: Summing Up," CIR News, vol. 10, #5, April-May, 1981, p.3)

Historically, this notion of separating the staff from the membership may have been rooted in the relationship the CIR had with their lawyers, especially Murray Gordon, prior to hiring in-house counsel. Gordon, who perceived himself as the founding father of CIR, played a significant role from its inception. However, his well-meaning but paternalistic attitude was not acceptable to physicians, trained to be independent thinkers. It became clear that the leadership did not want to establish a similar relationship with the CIR staff during the strike. Perhaps, this resistance to being restrained by lawyers and the traditional boundaries of collective bargaining, encouraged the leadership to pose contractual demands outside of the usual wages, hours, and conditions of work. The relationship between the lawyers and the CIR leadership was one in which the lawyers were sometimes consulted for their opinions, but essentially they requested direction and instructions from the leadership. Although, as Gordon put it, "no union can really be dealing in a union modality with the quality of the product or the service of the employer," CIR attempted to do just that by focusing on patient care demands that were not appropriate, according to the

Chapter 7

The 1981 Strike

traditional rules of collective bargaining.

Additionally, the focus on grievable minimum standards of equipment and staffing in the CIR contract, was offensive to other unions, and a challenge to the administration's notion of "management prerogative." The CIR was not acting as one union of workers in an organization of several unions of workers, but rather put itself in a more elite position, paralleling the position of the individual physician in relation to nurses, non-professional workers, technicians etc. Historically, this relationship had been called into question in 1975, when Leon Davis, of 1199, objected to the demand eliminating out-of-title work. His claim was that by refusing to do out-of-title work, residents were saying that they were above such work, but others were not. In 1975, the CIR dropped this demand and focused on hours. The 1981 CIR demand to include staffing and equipment standards in their contract was offensive to other unions, whose workers would be directly affected.

When the Committee of Interns and Residents struck seven municipal hospitals and two private voluntary hospitals in March, many of the city's labor leaders believed that the 2,000 young doctors were either naive or a little crazy. . . . At no time did the doctors, . . . demand higher salaries or any of the other things that striking workers usually want. . . . As a consequence, few of the city's labor unions showed any sympathy, much less support, for a strike that they regarded as misguided and even self-destructive. (Ronald Sullivan. "For Doctors Union, Striking is a Matter of Life and Death," New York Times, May 10, 1981, p. 8E)

Chapter 7

The 1981 Strike

The CIR's relationships with other municipal unions had accomplished little in the way of undoing their reputation as a left wing radical group. Their actions from the late sixties and early seventies were still in the minds of many of the labor leaders. In 1969 the housestaff, attendings, and hospital workers, represented by 1199, engaged in an action to close Jacobi Hospital, to protest the city's job freeze. It failed when the Medical Board succumbed to pressure by the Department of Hospitals. The housestaff followed and then 1199, who could not succeed independently. The consequence was layoffs of the hospital workers, which resulted in more work for those left behind.

Local 1199 concluded that doctors were not to be relied upon politically. The union had always considered the city and the medical school their adversaries. Doctors as a group had never particularly figured in their concept of the battle for income and job security. "We had no position on docs," (Abe) Dimmer (1199 leader) mused. "But this was an unusual bunch of them. We thought it would be worth a try. Sort of a united front. We got burned. Now we know what we knew to begin with: our strength is ourselves, our rank and file. It won't happen again." (Mullan, 1976: 83)

Housestaff had continued to be involved in actions considered to be "left wing." In 1970 Lincoln Hospital's pediatric housestaff formed the "Lincoln Collective," whose goal was to run the pediatric department without a hierarchy and

Chapter 7

The 1981 Strike

increase service to the community, e.g., by staffing community clinics. The Collective supported a takeover of Lincoln Hospital by a group of young Puerto Ricans, the Young Lords.

What became increasingly clear was that hospital workers defined their interests as distinctly different from professionals whose stay at the hospital was short-lived and whose future prospects were significantly different from their own.

Thus, the leadership's lack of experience in trade union politics, as well as perceived differences between physicians and hospital workers, became problematic in rallying the support of other unions.

Not only were the demands of the 1981 strike perceived as offensive to other unions, but also as clearly threatening to HHC's "management prerogative." House claimed that CIR mistakenly believed the HHC could

come up with staffing language that would not set a city-wide precedent. However, the City felt that if it negotiated even very weak language a precedent would have been set and they would then have to negotiate on the "two man patrol car," on manning levels on the fire trucks, etc.

In fact, the city saw the staffing and equipment language as overthrowing the whole of municipal labor relations. (Jonathan House, "The City Strike, Summing Up," CIR News, April-May 1981, Vol. 10, #5, p. 3)

Again, their perceived elite status, prevented them from identifying with other unions or predicting the effect of their

Chapter 7

The 1981 Strike

demands on other unions and on their relationship to the city. In effect, if the city had negotiated staffing levels, the feeling was it would open up a "Pandora's Box" on this issue.**

Interestingly, in a 1979 interview with Ed Rothschild, a man with a unique perspective, having been both an original CIR member and a HHC vice-president, the issue of infringing on management prerogative was predicted. He noted that the Patient Care Fund was the first step for CIR to get its foot in management's door. CIR had succeeded in having some control over resource allocation. He expressed the management point of view on patient care standards in the CIR contract as follows:

. . . if you say . . . the standards are adequate supplies or nursing staff, how can you not support that in the contract? Well the answer is if you can't provide it, you don't have the resources, then you have to be crazy to put it in there and then let somebody take you to court and say you've got to do it.
(Interview)

**However, this was not the first time that the city had dealt with professional union demands that did not meet traditional criteria for labor contracts. The United Federation of Teachers (UFT) had been bargaining for years around issues such as student-teacher ratios, provision of special services in the schools, and the hiring of teachers aides or paraprofessionals to assume the less demanding duties of the teachers. Although these changes did not interfere with the domain of other unions (the UFT actively organized the paraprofessionals), they did acknowledge that teachers were, and should not have been, doing out-of-title work, and that teachers were credible sources for recommending change on issues such as class size. (Taft, 1974.)

Chapter 7

The 1981 Strike

Thus, the potential for victory may have been overestimated by their failure to put their demands in the context of other unions, and thus, anticipate the city's position. In the case of the 1975 strike, hours evolved as the central issue, an issue that conformed to traditional management-labor negotiations, although challenging the medical hierarchy. The 1975 strike may have cost the voluntaries some money, since reduction in housestaff hours required hiring additional staff to compensate, but it did not infringe on management control. The blow was taken by the chiefs of service, who had determined hours as a condition of training, not employment. Thus, 1975 was a hallmark year, bringing housestaff closer to being defined as employees, rather than students.

Union democracy

Another issue that may have been intrinsic to the failure of the strike was an aspect that CIR was most proud of: democracy in the union. There was a strong feeling that, unlike many other unions, CIR responded to, and was directed by, the membership. The structure was "bottom up," not "top down." Yet, as Jonathan House pointed out, the implementation of union democracy became a significant structural problem:

. . . because we've grown and things are complex and difficult. . . and because of other problems of getting people involved, and the shortage of time of . . .

Chapter 7

The 1981 Strike

residents, certain kinds of decisions, power, whatever you want to call it, tends to get central. . . . To the extent that we're successful in making people care about the union, and to the extent that the union starts doing more and more, and has to do it rapidly, fast, there are more decisions that have to be made that someone might care about, it actually becomes, in a sense, more of a weakness. (Interview)

Consequently, although decisions involving the strike's beginning, implementation, and conclusion were made "democratically," through votes and discussions, it was those individual housestaff officers and the local organizations at each hospital who were active, strong, vocal, and pro strike, that dominated. For example, at the Harlem Hospital meeting, which was open to all strike participants, House, believing there were no other options, presented and recommended the HHC's final offer. As the meeting progressed, it became clear that the mood of defeat was overturned by some vocal pro strike residents, who dominated the meeting and convinced others to continue. The less vocal participants were, to some extent, intimidated into "going along" with the more militant leaders, although mobilizing their housestaffs was problematic. Thus, the strike could not be uniformly strong because of the differences among hospitals.

Several residents at the subsequent night's meeting questioned how representative they were of their housestaffs, e.g., there were few FMG's at the meeting, yet they accounted for 40% of the housestaff, and whether the militancy of the

Chapter 7

The 1981 Strike

housestaff was pervasive. One housestaff officer characterized the situation as being out of control. It was decided that the next night's meeting would be both small and more equitably representative, by having departmental representatives from each hospital attend. (Interestingly, the 1975 strike ended when the House of Delegates voted to accept the League's offer; the membership did not have the opportunity to directly participate in the decision. This method was probably chosen so that once an acceptable offer was made the strike could come to a rapid conclusion. The 1975 strike differed from 1981 in that it was the first multi-hospital housestaff strike. Strike leaders and lawyers feared that if the strike were prolonged, housestaff would return to work and the chance of patient deaths, which might be attributed to the strike, would increase. Thus, the House of Delegates voted to end the strike. Although the same fear existed in 1981, there was more extensive involvement by non-delegates and it was assumed more of the rank-and-file would be involved in the decision making.)

CIR as defender of the underclass

Finally, the CIR, in defining its role as patient care advocate, had gone beyond the traditional labor-management parameters, and engaged itself in a class struggle:

Chapter 7

The 1981 Strike

. . . they took up the cause of minorities and the poor, who said they were being denied the kind of medical care which government and society had promised. (Ronald Sullivan, "For Doctors Union Striking is a Matter of life and Death," New York Times, 5/10/81, Ideas and Trends, p. 8E)

Their traditional professional concern for their clients, their altruism, was converted into the framework of union politics. Having autonomy in their individual work situations was not sufficient to address the more global problems of their patient population. In their desire to control the conditions of work, through the CIR, they overstepped the traditional trade union boundaries. Unions do not typically address the product or the service delivered. Management, with the support of others such as the press, would not allow this.

The trade union framework was unable to address the issues of the service delivered to the clients. It was hampered because residents are students whose futures depend on faculty's recommendations. The perceived risks include more than losing a job, but more importantly a career involving many years of education, a great financial investment, and a great commitment.

Summary

In summary, although in both 1975 and 1981, a group of transient professionals in training made the commitment to strike in order to secure a contractual demand that would benefit both patients and residents, one attempt succeeded and the other

Chapter 7

The 1981 Strike

failed. In the first case, the residents were voluntary hospital employees, who settled on an issue arrived at through a consensus of housestaff leaders and lawyers, as well as hospital worker union leaders. Thus, a limit on hours satisfied the issues of patient care, housestaff working conditions, and simultaneously did not infringe on the domain of other hospital workers or management. The legitimacy of the residents' demands and the strike as a mechanism to achieve them was recognized.

In 1981, the issues of equipment and staffing levels, clearly focusing on patient care, did not satisfy traditional union definitions of proper areas of bargaining, while infringing on both the domains of management and other trade unions. Thus, by virtue of the demands alone, the stage was set for a difficult and long strike.

Two other factors that contributed to the failure of the strike were limitations due to the nature of the membership and the implementation of the strike. Residents, as "segments" distinguish themselves in terms of their relationship to their work, to other housestaff officers, and their vision of the residency and its relationship to their futures. When inadequate staff and equipment interfere with doing one's job well, patient care becomes a salient issue. If there is a commitment to serving patients, as with the socially active residents, and patient care is perceived as compromised, it becomes a salient

Chapter 7

The 1981 Strike

issue. However, if the hospital where one is training, or the program in which one is training, is perceived as selective or elite the issue of patient care becomes secondary. The phrase "don't rock the boat" surfaced in interviews numerous times. The residency, due to its transiency and its perceived role as the point of entry into the medical profession, resulted in vulnerability among those anticipating elite positions. Thus, among those residents there was an unwillingness to risk their future careers, especially when the potential gains from a strike were both uncertain and to many inappropriate.

Prestigious teaching hospitals which were never organized by CIR, or those that could not sustain CIR membership after the 1976 strike and became "captive nation" hospitals, also bred elitism among their housestaff. CIR staff described one of the "latent functions" of CIR as providing a standard, especially with regard to salary, so that other hospital administrations could thwart any notion of unionizing among the housestaff by keeping up with CIR salary schedules.

Conversely, prior to the 1981 strike the movement to organize hospitals whose housestaff was predominantly foreign trained, focused on the group at the bottom of the housestaff hierarchy. Thus, elitism was not an issue: FMG's did not expect to compete with American graduates for the most prestigious positions. In addition, they were less vulnerable to threats of

Chapter 7

The 1981 Strike

deportation when they virtually were the entire housestaff than when they were in the minority. Thus, Bronx Lebanon was an active strike participant, opting to join a HHC strike.

Finally, the management of the strike itself was, for a variety of reasons, inadequate to be successful. The planning was not sufficient to prepare the housestaff for the possibilities of a prolonged strike. On a psychological level the guilt that the housestaff experienced by refusing to treat patients presented difficulties, especially in light of the editorials criticizing the strike and their motives. They were swayed by threats to their careers. The staff was not always available to intervene, nor was their presence always desired, although it might have spurred on the strikers.

In addition, the decentralization of the strike aimed at satisfying various factions, resulted in unplanned tactics that may have had an adverse effect on their cause. For example long planning discussions about whether to engage in a total strike or a skeleton strike were resolved by allowing each hospital to choose their own strategy. CIR could not compel anyone to strike. At the same time, hospitals engaged in tactics which the CIR had not officially sanctioned, e.g., giving out the stories of patients who had needlessly suffered or died, due to inadequate equipment or staff. This may have hurt the cause of the strike, especially when they were investigated and declared

Chapter 7

The 1981 Strike

without basis.

As previously discussed, CIR's openness to its membership may have resulted in decision making by vigorous groups that dominated discussion. The decision to pursue the strike was made by a handful of delegates, with unclear support from the rank-and-file; the decision to continue the strike at the large housestaff meeting at Harlem Hospital was dominated by the more radical contingent from Harlem, whose dedication to the strike and their community probably shamed others into voting along with them. House himself admitted that his leadership should have been stronger.

Thus, CIR was not prepared, due to problems of staffing, inexperience, conflicts within the union, and the strain on the residents themselves, to sustain a prolonged strike. Although many residents believed in the justice of their cause, a housestaff strike in the municipal hospital system could not be won at that time.

Chapter 8 Conclusion

Patient Care

The history of the CIR demonstrates that self-interest was the motivation for forming and joining the CIR. In 1957 residents were disgruntled: their meager stipends were going to be taxed further so they sought out a lawyer to plead their case. Typically when hospital units joined CIR their own self interest was the motivating force. In addition to economic issues of wages and benefits, issues such as hospital security and the condition of on-call rooms motivated housestaff to organize. The unwillingness of administrators to respond to grievances by residents also served as a catalyst for unionization. Their sense of dignity as physicians was undermined and they were primed for a struggle.

It was at this juncture, when housestaff encountered an intransigent administration, that the CIR harnessed dissatisfaction and organized, often for a strike. For example in January, 1981 the housestaff of Methodist Hospital, a non-CIR voluntary hospital in Brooklyn, staged a week long strike. The impetus was a series of physical attacks on housestaff in the hospital. When the administration did not respond to their requests for increased security, they called in CIR. In the 1981 municipal strike, the housestaff of a voluntary hospital, Montefiore, joined because the administration was not responsive to any of their contractual demands.

Chapter 8 Conclusion

Although self-interest had been the motivating factor for housestaff to organize and join CIR, it has not been sufficient to sustain the union. Residents, whose prospects for future financial and social rewards in this society are considered certain, have been called upon to defend a union whose purpose appears to be enhancement of the material existence of its members. CIR has had to justify itself throughout its history to skeptical residents, as well as to legitimate its existence and programs to the wider community. This "community" included co-workers and their unions, hospital administrators, medical educators, leaders in the hospitals' catchment areas, the NLRB, and the media. They were obligated to legitimate the claim that they as professionals had the requisite expertise to identify necessary changes. As Hoffman has claimed "as political actors, knowledge was viewed as elitist and self-serving." (Hoffman, 1989: 204) The ideology of patient care reconciled two seemingly opposing notions, unionism and professionalism.

However, the meaning of patient care has varied with circumstances. CIR's empirical definition of patient care issues has included limitations on housestaff hours, as well as set standards on staffing levels and equipment. The 1975 strike in the voluntary sector was successful because long working hours were perceived as detrimental to the welfare of patients as well as of the striking residents. With the aid of a concerted public

Chapter 8 Conclusion

relations effort, CIR was able to overcome doubts concerning their altruism and obtain the support of groups as diverse as the AMA, union leaders, community leaders, and the media. The result was a contractually agreed upon change in night duty to a maximum of one night in three. Although members of the medical establishment protested this change as negating a long standing tradition that maintained long hours as a prerequisite for good training, residents were now conceptualized as employees whose well-being was directly related to the care of patients. Residents, through concerted action, had succeeded in gaining some measure of control over the conditions of their work; in a strike regarded as a landmark in the history of housestaff unionism, the credibility of housestaff as altruistic professionals was confirmed.

As a first step, the 1975 strike succeeded in reducing hours on night call to one in three. Subsequent attempts by CIR to further reduce hours failed despite apparent consensus on this issue. It was not until 1984, when the daughter of a prominent journalist died while under the care of residents at New York Hospital (a non-CIR hospital), that this issue was put forth for extensive scrutiny, resulting in comprehensive changes in residents' hours in New York State.

The 1981 CIR strike in the municipal hospitals failed, due to CIR's inability to persuade others that a seemingly nebulous

Chapter 8

Conclusion

issue, standards for equipment and staffing, was indeed critical to residents as workers, as well as to the delivery of quality care. The housestaff's perspective was that contractually agreed upon standards would improve their ability to deliver care with a greater degree of speed, accuracy, and sophistication. It would relieve them from duties, which although not intrinsic to their role as housestaff officers, were deemed necessary for the care of the patient. Thus, by not performing the more unpleasant and time-consuming scutwork, their time could be utilized for the more pleasant and pertinent tasks of "doctoring," including talking to patients and their families, keeping up with medical literature, and sleeping. From the perspective of the patients, their stay would be more comfortable, and perhaps, shorter. Perhaps, the hospital would be a less impersonal and mysterious place. In the more severe cases, as residents asserted with their "horror stories" in 1981 and their "Registry of Abuse" in the 1970's, lives could be saved.

When they asked for contractual standards on equipment and staffing, residents were perceived as meddling in administrative affairs by attempting to enhance their power in areas that were not considered within their domain. These issues were not interpreted as labor issues by other unions, nor as medical care issues by the media. Community leaders were not sufficiently educated or satisfied that these issues were of immediate

Chapter 8 Conclusion

concern, especially when a strike resulted in care being curtailed.

Finally, the validity of the union model to effect change in the hospital sector was called into question. In addition to the implicit and explicit threats that intimidated career conscious housestaff, the viability of the union itself was at risk. The need for a union to sustain the very continuity that an organization of transient housestaff requires superseded the rather revolutionary goals that CIR had posed. The conflict that emerged between the more radical housestaff and the other activists revolved around a union that, although committed to patient care, had been most successful in achieving goals around economic issues and housestaff rights.

Perhaps the 1979 one day job action was more easily construed as an acceptable altruistic act. The goal, although broad in nature (a rational plan for budget cuts), was more vital to a public experiencing its direct impact through reduced services and the closing of Sydenham Hospital. In addition, the action was designed to focus attention on an issue that captured the support of the various "publics" and was confined to one day. This action more closely resembled a student demonstration and was more acceptable, as such. Housestaff were assuming some risk to themselves by not reporting to work, and the action itself had no self-serving end.

Chapter 8

Conclusion

In sum, support for actions in the name of patient care was dependent on CIR's ability to demonstrate a clear relationship between the goals and their impact on the quality of care delivered in the hospitals. The actions themselves were more acceptable if they minimally disrupted the daily delivery of care, appeared to have a high probability of succeeding, and did not appear to be motivated by self-interest.

CIR Origins and Dynamics Demonstrate the Heterogeneity of the Medical Profession

The evidence presented here supports those (see Bucher and Strauss for theoretical discussion and Miller for empirical example), who have argued against considering the profession of medicine as a monolithic group possessing a series of identifiable "traits," among them altruism or service orientation (see Carr-Saunders, Goode). The argument that the medical profession is better understood as a cluster of separate coalitions of sub-groups within the profession is further validated by the residents in this sample.

In the case of CIR, the union attempted to preserve its professional self-image by emphasizing its altruistic goals. However there has been a range of commitment to this ideology among the housestaff, often reflecting the resident's membership in particular segments of medicine. It has become apparent that the CIR housestaff do not have a collective mindset. Changes in

Chapter 8 Conclusion

the medical profession itself have engendered a more heterogeneous work force. As medicine became more specialized, residents were further separated by their specialties; as the residency became more extended, residents no longer postponed family life; as hospitals required more residents than American medical schools could supply, foreign medical graduates entered residency programs. Other social changes that further diversified the resident population were the student movement of the sixties which produced a more politically active physician, to lead the residents of the seventies, and the women's movement which, with concurrent societal changes, contributed to a larger female housestaff population. Finally the housestaff population divided itself using criteria of hospital reputation, i.e., although not universally agreed upon, hospitals could be categorized from high status to low status. These factors, in conjunction with the existing, but extended framework of PGY levels, resulted in a diverse housestaff population with a variety of agendas, goals, political perspectives, and perceptions of the residency and thus, the union and its philosophies. For example, specialty has a direct relationship to commitment to the patient care ideology. According to a chief resident in neurology at Kings County, all the housestaff

want is a decent wage, decent hours, and peace and quiet. . . . CIR's purpose is the betterment of conditions for residents and that's all that they

Chapter 8

Conclusion

should do. I think purely enlightened self interest, just basically selfishness should be the guiding philosophy of the CIR. . . . It's (patient care) a money problem, a municipal planning problem, . . . a social problem. It's beyond the capabilities of these people (CIR leadership) and they should not get involved. (Interview)

This fourth year resident also characterized members of his specialty as less interested in helping patients than those in other specialties and as possessing an elitist view of the world because the "brain is a bit more complicated than anything else."

Representing the other end of the spectrum was a resident in family practice (PGY 2) at Montefiore:

I think they (CIR) have raised a number of issues as it relates to the city hospitals and have articulated some of the problems with the closing down of city hospitals that have not been brought to the forefront as much as they should have been. I think the CIR was one of the groups that really articulated that most acutely for the public. . . . And the only ones that can really do that adequately is the CIR because they're the doctor in the front line trenches. . . . If CIR comes out and says "look the patients are dying" there is a certain credibility factor simply because they are physicians despite the newspapers calling us students, student-doctors. (Interview)

Comparing family practice specialists to their colleagues, he characterized them as more patient care oriented and humanistic, less egocentric, less interested in making money and more accepting of the limitations of medicine.

Thus, although the data are limited with regard to the effect of variables such as specialty, the evidence strongly suggests their significance with respect to the union. Residents

Chapter 8

Conclusion

in specialties, such as the medical specialties, that are characterized by more patient interaction, less hierarchy among housestaff, less prestige in the medical hierarchy, and a less rewarding financial future, tend to be the residents that are more supportive of the patient care ideology and CIR's role in promoting it. Conversely, those housestaff officers who are in the surgical and more "technical" specialties (e.g., radiology and anesthesiology) and therefore, have more limited contact with patients; responsibilities confined to discrete procedures; more promising futures; and whose specialties are considered less prestigious, tend to be less patient-care-oriented. As a group, the respondents in medicine and pediatrics were more likely to find their workload and out-of-title work responsibilities as frustrating than their surgical counterparts. Similarly, while the pediatric residents reported frequent out-of-title responsibilities, medical and surgical residents reported about the same amount, yet surgical housestaff officers rarely reported workload or out-of-title work as frustrating problems. Thus, the greater the prestige of one's specialty with the implied promise of a lucrative future, the more likely residents in that specialty perceive participation in actions directed at change as inappropriate regardless of their working conditions. In addition, these specialties are also the ones that limit the physician's interaction with the patient and thus, may limit his

Chapter 8 Conclusion

identification with the plight of the patient and thus, the patient care ideology.

The hospital in which a resident trains plays a similar role. The obvious distinction of voluntary versus municipal hospital is not the key variable here. Bellevue (a municipal hospital considered to be superb training hospital) and Bronx Lebanon Hospitals (a voluntary hospital with many of the ills attributed to municipal hospitals) do not subscribe to the traditional stereotypes. Rather the key variable is the reputation of the hospital and the subsequent status of the resident as a physician. CIR's history clearly illustrates its limited effectiveness in unionizing the elite hospital housestaff. Either they never joined or were members for only a brief period. After NLRB's withdrawal of its protection for housestaff, the more prestigious hospitals such as Mt. Sinai withdrew from CIR. Bellevue, whose residents are members by virtue of their status as municipal hospital employees, never participated in any of CIR's actions. The dilemma here is similar to that of the prestigious specialties. Residents opted to train in these hospitals often because of their reputations. Therefore, to be critical of the care delivered there threatens their reputations and thus, their own futures.

In addition to segments based on one's position with respect to medical training are those segments based on demographic

Chapter 8 Conclusion

variables. An issue generated by the 1975 strike demand for a reduction of hours was why, when long hours had traditionally been part of a rigorous training program, did housestaff find them objectionable in 1975. Changes had occurred in the demographic composition of the housestaff population, resulting in a group of residents more likely to be married, female, and a parent with different needs than their predecessors:

By the time you reach housestaff level you may have jeopardized your family for your training and a lot of us felt there comes a point where your family obligations and social obligations should be treated equally with your medical obligations. There's a feeling even across the country today that we would rather extend training by one year and do away with night call completely and have a normal work schedule, so we could fulfill our family and social commitments as well. The day is past when the physician thinks only about one thing. There are other areas as well: physician-politicians, physician-musicians, a friend. (Interview with Elmhurst Hospital delegate, May, 1975)

The increase in the years of training coupled with changes in the demographic characteristics of the resident and in the medical field itself, exacerbated the strains of the role of the resident. By extending the years of the residency it became more difficult to accept arduous working conditions. When FMG's, female, and married residents became more prevalent their particular needs of legal counsel, part-time residencies, child care and parental leave demanded attention. Although in recent years, due to changes in legislation, the number of FMG's training in the U.S. has declined, at the time of the data

Chapter 8 Conclusion

collection they accounted for approximately one-fifth of the housestaff in the nation. The number of women residents between 1970 and 1986 increased by 304% and whereas in 1977 women were present in only one-third of all specialties, by 1982 they were represented in all specialties. Thus, during the time of the data collection women residents were in the midst of increasing and expanding their role in medicine. As previously discussed, women to a much greater degree than men experience conflict due to pressures of career and family. In addition there was the financial strain of supporting a family in the metropolitan area for all those residents in that position. Thus, the single-minded, unquestioning devotion to career was increasingly untenable for various segments of the housestaff population. Consequently, housestaff were more receptive to the alternatives that CIR offered. The patient care ideology allowed them to retain a professional self image, yet improve their conditions of work.

In sum, although the members disagreed as to the validity of patient care ideology, it did allow CIR to assume a role with which professionals are more comfortable, that of watchdog. No one could dispute that action in the name of patient care was acceptable, if not admirable. Whatever its meaning to different segments of the population, the goal of patient care defined their actions as altruistic, rather than self-serving, to the

Chapter 8 Conclusion

public, the press, and the residents themselves. It encouraged belief in the mystique of the physician, a mystique under attack when physicians were accused of operating "Medicaid mills," engaging in unnecessary surgery, cheating on exams, price fixing and lacking in compassion.

More recently, as CIR continues to press for contractual guarantees for patient care items, such as 24 hour availability of x-rays, charts, labs, and libraries, it also is exploring other avenues leading to change. Lobbying governmental agencies and testifying before investigative committees on issues concerning health care delivery, housestaff conditions, and related issues has become a more favored strategy. Significantly, CIR was well prepared to testify in the aforementioned hearings in New York regarding the implementation of regulations on residents' maximum hours. The data that CIR had accumulated for collective bargaining contributed to the final outcomes of these hearings. Here the profession of medicine had failed to intervene; CIR, in its effort to restrict hours had met with some success in 1975 by striking the hospital administrations. However, when Sidney Zion's daughter died unexpectedly in a prestigious hospital, a governmental agency was charged with the resulting investigation and recommendations.

In sum, although CIR is accused of being an organization whose true goals are to improve the power and welfare of its

Chapter 8 Conclusion

members, its members do continue to bring to the forefront issues where "greed, irrationality, and social irresponsibility" produce an untenable situation in the delivery of health care, and thus openly challenges the status quo.

Implications for the medical profession

The CIR had begun to have an impact on the medical profession in a variety of ways. In sum, it asserted that the medical profession had not responded to the needs of its members or its clients. CIR defined issues such as resident hours as labor, rather than educational or professional issues, thus making the claim that the profession could not or would not question its past practice and therefore, the issue had to be addressed in another arena. The CIR's rejection of the NLRB definition of residents as students has had profound implications for residents' claim to have input on their own training conditions, which are labeled as working conditions.

Secondly, the CIR questioned both the medical profession and the bureaucracy in which it is housed, the hospital, regarding its commitment to a service orientation. Witnessing, for a number of years, daily violations of the medical profession's commitment to serve to the best of its ability, the CIR functioned as a watchdog in its pursuit of "patient care." Housestaff officers themselves, unable to provide optimal care,

Chapter 8 Conclusion

focused on their working conditions as the cause. Through a variety of strategies, detailed in previous chapters, the CIR called attention to deficiencies in the delivery of health care. However, a caution is necessary here. These whistleblowing strategies, such as exposing hospital conditions at JCAH hearings and at press conferences, were often implemented as bargaining chips, e.g., if contract negotiations were at a standstill, CIR leaders might have called a press conference.

Thirdly, the CIR confronted the issue of autonomy. Residents were never truly autonomous in that they were still training under the aegis of other physicians in the hospital. The one year internship, which eventually developed into a longer term residency, was regarded as the practical extension of a medical education. The status of student was appropriate. Both as apprentices in the management of patient care and as students in an educational institution, residents did not pursue control over their own work or larger issues of hospital policy. Autonomy over the delivery of health care was anticipated when one was in practice, on an individual level, and on the level of the profession at large, through organizations like the AMA.

However, several changes occurred in subsequent years that made their position of powerlessness less defensible. Two-thirds of the respondents in this study claimed to be responsible for the management of their patients' care and approximately the same

Chapter 8

Conclusion

percentage did not perceive a need for more autonomy in their work. However, the majority (84%) did agree that housestaff as a group should have more control over a variety of matters including hospital policy on budget, priorities, housestaff education, working conditions, patient admission criteria, and emergency room policy. Being given control, and thus the responsibility, over the work without the authority to control the conditions of work resulted in a frustrating situation. Although administrators agreed that the issues raised by the housestaff had merit, they disputed their validity as contractual issues. As Freidson noted (1986, 169), as in other organizations resource allocation is the issue over which basic conflicts occur.

The consensus among housestaff on the need for greater control may have stemmed from a number of changes in the nature of the residency and the resident.

As technology and advances in the delivery of health care became more complex, the nature of the residency became more stressful. Developments in diagnostic testing, treatments, procedures, and drugs increased the factors to be considered in caring for patients. Paperwork, which may appear redundant or without purpose at times, became a significant part of the resident's responsibilities.

Chapter 8

Conclusion

Moreover, the doctor-patient relationship itself was in a state of flux. The increase in long term illnesses as well as in those conditions that are "recidivist" in nature, such as alcoholism and drug abuse, increased the social distance between patients and physicians. A result of people living longer is an increase in the prevalence of long term medical conditions such as cancer and heart disease. These conditions require monitoring, but there are no cures. Thus, residents who measure success in terms of accurate diagnosis and treatment increasingly encounter patients whose treatment is directed at maintenance rather than cure. The added pressure of the ensuing long term doctor-patient relationship strained residents' ability to maintain a stance of "affective neutrality." (Parsons, 1951)

Respondents in this sample also expressed frustration with these patients whose symptoms were treatable, but whose conditions required non-medical intervention such as job training, counseling, or nursing home care. Sometimes they expressed feelings of being compromised by patients who used medical services as a temporary stopgap measure and did not follow up on treatment, thereby returning with the same or worsened condition. Confronted with multiple demands on their time, such patients were viewed as wasteful of medical resources.

An additional source of frustration expressed by many of the residents was their inability to practice state of the art

Chapter 8

Conclusion

medicine due to the deficiencies in technology and medications in their hospitals. While rotating between hospitals residents observed the variations in the extent of these deficiencies in the voluntary and municipal hospitals.

Although these factors affected health care workers other than the residents, their frustration was exacerbated by norms prevalent in the housestaff subculture:^{*} the norm to be thorough and detailed in their work, which they learned in medical school; the norm to be responsible for their patients' care and welfare; and the norm to treat patients in an efficient manner due to the extensive workload.

Increasingly, segments of the resident population experienced discontent. On the individual level, the AMA has labeled housestaff officers as a group "at risk" for impairment. It has been documented elsewhere that "the often grueling stresses of residency education may harden cynical detachment and precipitate depressive episodes, drug abuse, and suicidal thinking. . . . The strikingly higher suicide rate of younger

^{*}In a study of housestaff at a non-union hospital, Mizrahi found that these techniques of blaming the system, the disease, or the patients were implemented to rationalize mistakes that they or their colleagues had made in treating patients. She concluded that their response to the norms of thoroughness and efficiency was a strategy of "getting rid of patients," in order to minimize the probability of making a mistake. (Mizrahi, 1984, 1986) Perhaps a union like CIR enables housestaff to focus on the environment that perpetuates these conditions, rather than the patients who are also its victims.

Chapter 8 Conclusion

women physicians poses a significant problem for the profession."
(Weinstein, 1983)

On the level of housestaff as a group, as previously mentioned, the majority of the respondents in this study agreed that they should have more autonomy. Their strategy for coping with their discontent varied to some extent by their membership in various subgroups of the housestaff population. Residents in elite hospitals or elite specialties or subspecialties claimed to have no options. They asserted that, having obtained positions in a very competitive system, they were members of an elite group. For them it was important not to "rock the boat" in order to protect their positions. Consequently, they maintained a negative or neutral position with regard to agitating for change. Their discontent manifested itself as "burnout" or alienation. Their solution was to get through the residency, learn as much as possible, and avoid involvement in the more complicated issues of health care delivery; change was seen as at best unlikely, perhaps unnecessary, and at worst risky. Therefore, survival was the goal; cynicism seemed to be the only strategy.

In spite of this attitude it is important to note that some members of elite hospitals were interested in change through union membership. When the CIR organized voluntary hospitals, prior to the Cedars-Sinai decision, residents at hospitals such as Mt. Sinai, Long Island Jewish and Montefiore Hospitals did opt

Chapter 8 Conclusion

to join. Clearly, the legality of being covered by the NLRA as employees was significant for their membership.

At the other end of the spectrum were the segments that were subject to the greatest abuse (interns and FMG's), experienced the greatest anonymity in their training programs (medical specialists), trained in less prestigious hospitals and less prestigious departments, did not aspire to selective fellowships or positions, or had a political commitment to change such as family practitioners; they were most likely to favor the union model to represent them. They not only were experiencing the most difficult working conditions but also had the least to lose by "rocking the boat."

The employee status seemed more appropriate to both the resident's perception of his role in the hospital and as a mechanism to effect change. It served the needs of the various segments of CIR: those who wanted an improved existence for themselves as housestaff officers welcomed improved wages and benefits; those who perceived their resident status to be potentially at risk, such as FMG's, had an organization to protect them; those who identified themselves as "professionals" and were averse to joining a labor union could identify with the "professional" goals of the CIR related to patient care; similarly, those with a political commitment to change in the health care system could relate to the patient care philosophy.

Chapter 8

Conclusion

Thus, the changes among the segments of the housestaff population, dissatisfaction with working conditions, as well as the belief held by many active residents, that they uniquely understood and were committed to improving patient care conditions led to the CIR's vision to fill a perceived void of leadership on behalf of the clients of the health care system. They rejected the medical establishment, the hospital management, the existing hospital labor unions, and community groups' ability to effect the changes they saw as necessary. To invoke Alford's model, neither the "professional monopolists" nor the "corporate rationalizers" nor any other group interested in the hospital had the commitment to the changes CIR proposed. As transient members of their hospitals and neophyte members of the medical profession their perspective was fresher and more critical than those who were entrenched in their positions in the health care system. CIR both defined what changes were required and became the agent to effect those changes. By demanding contractual guarantees on issues of staffing and equipment, they sought a measure of control of the health care system in New York. From another perspective, they sought to restore that element of their professional status, control of the work situation, through a labor union, an organization in which professionals historically had no interest. The CIR appealed to successive cohorts of residents because it went beyond the traditional parameters of a

Chapter 8 Conclusion

labor union in order to grapple with the problems of the resident in the contemporary hospital. However, the more radical residents were encumbered in their efforts to effect change because CIR could not threaten its own existence to further the "cause." For example, in the 1981 strike, Harlem Hospital residents were willing to put their careers, as well as the union itself, at risk to achieve the goals of the strike. Similarly, the conservative members of CIR found the leadership and their goals to be too radical.

In evaluating how successful CIR has been in meshing its roles, the economic successes are most evident. By utilizing traditional labor strategies and traditional areas of negotiation, salaries and benefits for housestaff advanced at a rate that most housestaff found acceptable. At hospitals where housestaff were not unionized, salaries were kept competitive with CIR salaries. From the beginning the HHC, as well as voluntary hospital administrations, found CIR's wage demands acceptable.

However, salary and fringe benefits were issues that emerged from the residents' role as employees. Their union activities had minimal impact on their student or "residency" roles except for the issue of hours, which had consequences for both roles. Whereas long hours once were acceptable as a rite of passage, they became unacceptable in most instances. Long hours once

Chapter 8 Conclusion

meant working for long periods of time without sleep, doing whatever was necessary to insure a level of patient care. Concurrently, residents, although at the bottom of the hierarchy, were considered to be esteemed members of the medical profession, entitled to respect by patients, faculty, and administrators. This difficult period in residents' lives lasted a year or two and they were ready to be accepted as card carrying members of the medical profession. The demanding aspects of the residency were ameliorated by its short duration and by the esteem granted to residents by significant others in the work situation.

In more recent years, due to the explosion of medical knowledge, technology, and bureaucratic requirements, long hours were increasingly filled with out-of-title tasks and paperwork. A perceived loss of autonomy and prestige that appeared to extend beyond the residency, left the resident feeling alienated.**

** It has been asserted that the medical profession is facing "deprofessionalization" resulting from the loss of autonomy. This phenomenon is attributed to factors such as the proliferation of large health care corporations, increased governmental regulations, competition from other occupational groups seeking to provide health care, the proliferation of professional health care administrators, the increase in lawsuits, and the self-help movement which, through mechanisms such as home diagnosis tests and over-the-counter drugs, decreases the necessity of physician intervention. (Reed and Evans, 12/11/87) CIR's encounters with health care administrators whose priorities seem to be financial have solidified CIR's own commitment to what it regards as health care priorities. In 1983, when Jersey City Medical Center filed for bankruptcy CIR argued against a solution that encompassed employment of an outside for-profit management corporation, fearing that health care for the poor would lose significance.

Chapter 8 Conclusion

One sentiment expressed by respondents in this study was regret that unionization was required in order to provide the minimum amenities for housestaff; it was perceived as a reflection of the deprofessionalization of housestaff.

It . . . has taken us from the level of being a professional to . . . a union member like everyone else." (Interview, Kings County resident)

For some, the hospital administration violated an unwritten contract to care about the needs of its housestaff:

The hospital as such expects you to do your job right. At the same time I feel that they have a moral obligation toward any other personal problems that you have outside in terms of giving counseling, in terms of giving advice, in terms of giving support. Unless it happens, any of the employees, not only the housestaff. . . can't serve his duties right to their satisfaction. . . . All the minorities just do their work. (Interview, Bronx Lebanon resident)

Thus, residents expected to be treated with respect. If they did not warrant waiter service as was customary in the 1950's, then they expected some basic concern about their welfare. Without it, they were less inclined to reciprocate with loyalty to the institution and more likely to seek protection elsewhere, through the CIR.

From the start CIR was committed to dealing with health care issues that surfaced in residents' work situations. CIR was a "committee." Although its successes, utilizing union strategies, had been greatest in the economic areas, it had always emphasized its allegiance to patient care. What became clear was that union

Chapter 8

Conclusion

strategies of negotiation of contracts, grievance of contract violations, and striking were frequently unsuccessful in achieving patient care goals. The one notable exception was the establishment of the Patient Care Fund as an ongoing feature of the municipal contract. Although the funding was provided by a cut in salary increases for housestaff, it granted housestaff the authority to determine what equipment would be purchased through the Fund. (By 1987, the money provided by the HHC for the Fund was increased from the original \$200,000 to \$800,000.) However, CIR has not been successful in obtaining contractually mandated levels of equipment and staffing; perhaps even if this were realized the victory would more likely be symbolic than real: the layers of bureaucratic red tape would likely prolong the grievance process to the extent that the situation originally in question could easily change in the interim due to other factors.

The CIR, a labor union of resident physicians, with diverse segments, a transient membership, representing trainees in one of the most prestigious professions, focuses attention on the strains within the medical profession and the role of the physician in response to these strains. In the past the transiency and limited nature of the residency aided in the resident's ability to endure its conditions. The resident looked forward to the one-to-one doctor-patient relationship practiced

Chapter 8

Conclusion

in a solo fee-for-service environment. However, this model no longer represents the trend in delivery of health care.

Residents are aware of this and in the 1981 sample, only one-fourth of the respondents envisioned their futures in independent practice. As hospital employees they have been exposed to the limitations physicians encounter in delivering health care.

Confronting tasks such as out-of-title work and excessive paperwork were not only tiresome and time consuming, but also detracted from their availability to perform as professionals. Their objection to long hours was in terms of how those hours were utilized. The profession of medicine, however, did not come to their defense. Long hours were a tradition and although, it appeared that more recently residents worked these hours to fulfill bureaucratic, rather than educational needs, the medical profession did not interfere with the hospitals. The labor union, by utilizing this opportunity to define hours as a working condition and therefore, within its domain was able to call attention to this issue and confront it through the hospital administration.

Thus, although CIR is technically a labor union, due to its nature as a heterogeneous professional union in the framework of educational and bureaucratic domains it must play the role of a chameleon, changing its strategies and modifying its goals to suit varying and often conflicting needs of its members, its

Chapter 8

Conclusion

potential allies, and its adversaries. What remains to be seen in the future is what direction it will take. Will it opt to represent physicians under the umbrella of "salaried doctors," (USPD is still affiliated with CIR) thereby asserting that the interests of residents and employed attendings are not in conflict; will it opt to join with other hospital workers, seeing its interests best represented in an industrial union; will it focus on other issues surrounding the resident experience such as the stresses of residency. As with the issues dealt with thus far, it appears that CIR's leadership will continue to reflect the nature of the membership and the leadership, as well as the restraints of the workplace.

Epilogue: 1981-1989

Although formal data collection ceased in June, 1981, a brief overview of the past eight years may be of interest. As of December, 1989, CIR represents approximately 4,800 housestaff, with a \$2 million budget and twenty-four staff members.

CIR's defeat by the HHC was difficult, but not insurmountable. CIR continued to pursue patient care goals in contracts, but the focus in negotiations was the Patient Care Fund, which increased with each contract. Out-of-title work was confronted through grievances, including one that resulted in increased staffing at Harlem Hospital, as well as a retroactive payment of \$238,000 to ten former housestaff officers.

Contractual gains for the membership included changes in coverage pools and maternity benefits that one CIR staff member described as "exemplary."

The most significant shift in strategy was less utilization of confrontational tactics, such as strikes to more involvement with the governmental agencies that have the authority and resources to implement changes in the delivery of health care. Although the longest strike in CIR's history occurred in 1985, it was a strike for survival: Interfaith Hospital's (formerly Brooklyn Jewish and St. John's Episcopal) administration had withdrawn CIR recognition. CIR won this strike, but lost recognition at Maimonides, Staten Island, and Brooklyn Caledonia (formerly Brooklyn Cumberland). However, as in the past, CIR

Epilogue: 1981-1989

pursued and welcomed new members. The housestaffs at Children's Hospital National Medical Center, and D.C. General, both in Washington, D.C., joined CIR.

CIR also affirmed its claim as a valid source of information by testifying at various hearings on issues including emergency care and nuclear accidents, a hospital closing, FMG licensure, legislation on drug abuse testing in the workplace, and as previously discussed, testimony to the Bell Committee on Hours Reduction. (The new regulations resulted in the hiring of an additional 140 housestaff officers.) The current Executive Director serves on the New York State Council for Graduate Medical Education and the New York State AIDS Task Force.

On the national level, CIR held an organizing conference on which eventually resulted in the creation of the National Federation of Housestaff Organizations (NFHO). Unlike its predecessor PNHA, NFHO's membership units are housestaff organizations with collective bargaining agreements, rather than a conglomerate of organizations, associations, and individuals. Its governance structure is modeled on the Congress consisting of a Senate in which all members have an equal vote and a House in which the membership of the organization dictates the number of votes. Consequently, CIR effectively has veto power, but can be overridden by a majority of the Senate.

Political activity focused on a wide range of issues

Epilogue: 1981-1989

including strike support for legal aid attorneys, apartheid, excess hospital beds, and the homeless.

In sum, CIR's goals have remained constant, while their strategies have become more cooperative than confrontational.

Appendix - Resident Interview Schedule

Interview schedule for CIR members

Training and working conditions

1. Specialty : _____
2. PGY level: _____
3. Have you trained as a hso in other hospitals?
 - a. Yes : Name of hospital(s): _____
 - b. No
4. Did you or will you rotate through other hospitals in this PGY year?
 - a. Yes - Name(s) of hospitals: _____
Amount of time in each hospital : _____
 - b. No
5. Is _____ Hospital your first choice for your residency?
 - a. Yes
 - b. No, What was your first choice? _____
6. Why did you choose this hospital?

Probe: _____

 - _____ salary
 - _____ prestige of hospital in the medical profession
 - _____ prestige of hospital in the community
 - _____ clinical opportunities
 - _____ research opportunities
 - _____ geographic setting
 - _____ located in the area where you intend to practice or want to live
 - _____ knew residents who were happy with the program
 - _____ quality of house officers
 - _____ quality of teaching
 - _____ patient mix
 - _____ spouse had job or other personal commitment to the area
 - _____ experience at this hospital as a student
 - _____ experience at a similar hospital as a student
 - _____ other: _____
7. Is there a pyramid system in your training program (ie, fewer positions at each level)?
 - a. Yes
 - b. No

Probe: If Yes, could you describe how it works?

Probe: Are any provisions made for residents who are not chosen for the next level of the pyramid?
8. Do you approve of the pyramid system for training housestaff?
 - a. Yes
 - b. no

Probe: Why?

Interview

9. Who assumes responsibility for a patient in this hospital? ie, admits, diagnoses, treats, discharges?

10. In this year of your residency how often, on the average, do you do each of the following?

<u>Several times</u>	<u>Once</u>	<u>Every few</u>	<u>Every few</u>	<u>Rarely</u>
<u>a day</u>	<u>a day</u>	<u>days</u>	<u>weeks</u>	<u>or never</u>

- a. take admission history
- b. do admission physical exam
- c. write progress notes
- d. start IV's
- e. request consultations
- f. talk over case with attendings
- g. talk with patient's family about diagnosis, prognosis, progress, etc.
- h. write orders on patients

11. Which of these things should hso's do more often?

12. Which of these things should other personnel in the hospital be responsible for?

13. Are there any other things that you do that you feel other personnel should be responsible for?

14. If you had a friend who required an appendectomy, which hospital in the metropolitan area would you recommend? _____

15. (If hospital other than one in which hso is training): How about _____ Hosp?

16. What do you find most rewarding about working here?

17. What do you find most frustrating about working here?

18. Do you find that you have too much paperwork to do?
a. Yes b. No

19. Are there any forms in particular that you find especially bothersome or unnecessary?

20. What kind of paperwork is routinely neglected? Why?
a. not enough time
b. other personnel should fill out the forms
c. not completing forms puts pressure on the hospital to deal with complaints, ie it is a tactic
d. other

Interview

21. What kind of medical problems do you like best?
22. What kind of medical problems do you like least?
23. What kind of patients do you like best re social characteristics?
24. What kind of patients do you like least re social characteristics?
25. How many patients per hour do you see now?
New patients Pats on return visit Doesn't apply
a. clinic
b. ER
c. inpatients
26. As far as you know, how many patients per hour do physicians in your specialty in private practice see in their offices?
a. New patients _____
b. Patients on return visit _____
27. About how many hours a week do you work? _____
28. Do you feel, for a hso, this is:
a. too much b. too little c. appropriate
29. How many hours a week should a resident in your specialty work? _____
30. Could you tell me if you agree or disagree with the following statements about the long hours that residents often work?
a. The hours are necessary in order to be trained properly for their specialty es.
b. Long hours build stamina for working long hours when one is in practice.
c. Residents are needed by the hospital to assume patient care responsibilities.
d. Long hours are traditional for residents.
e. Residents working long hours are a source of cheap labor for the hospital.
f. Other
31. How many nights a week do you work? _____
32. Concerning tests ordered for patients, are there tests that you order routinely for every patient?
a. Yes b. No
33. If yes, is this hospital or departmental policy?
A. Yes b. No
34. As compared with your colleagues, do you order more or less tests?
a. More b. Less c. About the same
35. Do you order more or less tests than when you first started your training as a resident?
a. More b. Less c. About the same

Interview

36. How often do you experience difficulty working with? (Card A)

37. How often do you get: (Daily, weekly, monthly, every few months, never)

- a. formal written evaluations
- b. formal oral evaluations
- c. informal feedback

From whom?

38. How helpful to your clinical skills are these evaluations?

Would you say very helpful, somewhat helpful, of little use

- a. formal written evaluations
- b. formal oral evaluations
- c. informal feedback

39. How fair do you feel these evaluations are?

very fair moderately fair somewhat unfair very unfair

- a. formal written evaluations
- b. formal oral evaluations
- c. informal feedback

40. With reference to the following how often do you participate in?

daily or more few times a week once a week once a month never

- a. "grand rounds, consulting rounds or similar teaching sessions at which both attending staff and he are present
- b. lectures or conferences by attending staff
- c. informal talks with he about patients
- d. informal talks with attending staff about patients
- e. journal clubs

Probe: Are these things available?

41. Would you prefer more or less of these things?

42. How do you feel about the following aspects of your training? (Card B)

*42.

43. The National Labor Relations Board has contended that he are students rather than employees. In light of your role as a housestaff officer, how do you feel about that decision?

- a. Agree
- b. Disagree
- c. No opinion

44. Would you rate: (Card C)

44a. Overall, do you feel that at _____ Hospital you can practice up to date medicine.

Yes No

44b. _____

Interview

45. With reference to other housestaff officers at this hospital, would you say :

All Most Few None

- a. They are open and free about exchanging medical information.
- b. They are willing to help out a fellow resident who has a lot of work to do.
- c. They get along socially.
- d. They tend to be elitists.

46. With reference to the administrators at this hospital, would you say

All Most Few One None

- a. Are available to talk to him
- b. attempt to monitor his problems and needs
- c. show only a superficial concern for his problems
- d. if at all possible, attempt to meet his demands and solve his problems
- e. know your name
- f. know their names

47. Have you ever had occasion to take some action about some problem you had as a hso?

- a. Yes b. No
- If yes, what did you do and what was the outcome?

48. Are there any other problems that make it difficult to do one's work as a hso?

49. If in voluntary hospital, what percentage of the municipal hospitals do you think are equal to or better than this hospital for:

- a. residents : _____%
- b. Patients: _____%

If in municipal hospital: what percentage of the 100 voluntaries do you think are equal to or better than this hospital for:

- a. residents: _____%
- b. patients: _____%

50. At this hospital approximately what percentage of the income is derived from:

- a. Blue Cross _____%
- b. Medicaid _____%
- c. Medicare _____%
- d. Private insurance _____%
- e. Other _____%
- f. Don't know

51. Number the following in order of importance to the hospital administration.

- ____ Inpatient care
- ____ Outpatient care
- ____ Education
- ____ Research

Interview

52. Is there a community board here?
a. Yes b. No c. Don't know
53. If yes, has it been able to implement any changes in this hospital?
a. Yes, describe briefly:
b. No, why not?
c. Don't know
54. Give an example of an issue on which a community group's input would be appropriate.
55. Give an example of an issue on which a community group's input would be inappropriate.
56. Are you familiar with the actions of the Lincoln Collective and its approach to the delivery of health care?
a. Yes
b. No, (interviewer briefly describes team approach, lack of hierarchy among staff, community input)
57. Do you think the Collective's approach to the delivery of health care is a useful one?
a. Yes b. No
Why or why not?
58. Do you plan to continue your training at this hospital?
a. Yes b. No c. This is my last year of training.
59. Why or why not?
60. Would you recommend your program to someone interested in:
a. generalist practice: Y N DK
b. specialist practice: Y N DK
c. academic medicine Y N DK
d. administrative medicine or public health: Y N DK

Interview

CIR and unionization

61. How active are you in the CIR?

Card D

61A. How long have you been a CIR member? _____

62. In the past the CIR has been involved in a variety of actions. For the following how effective do you think these actions are; are these actions appropriate for housestaff officers, ; did you participate in any of these actions?

Card E

63. At your hospital, in what ways are you better off because of CIR?

Probe: a. wages

b. hours

c. benefits

d. protection from arbitrary actions of hospital

e. improves communication with administrator and/ or attendings

f. patient care standards

g. better working conditions

h. other: _____

64. At your hospital, in what ways are you worse off because of CIR ?

Probe: a. takes time away from training

b. makes relationships with administrators and/or attendings uncomfortable

c. results in threats of "retaliation" for union activity from administrators, chiefs etc.

d. other: _____

65. How adequately does the CIR leadership (Executive Comm. of central CIR) represent the memberships' needs and wishes? Would you say:

a. extremely well

d. not too well

b. moderately well

e. poorly

c. OK

f. don't know

66. What specifically do you like about the leadership?

67. What specific complaints do you have about the leadership?

68. In the future, do you intend to be more or less active in the union?

a. more

c. same

b. less

d. doesn't apply

Why:

69. Have you ever filed a grievance?

a. Yes

b. No

70. If yes, what was the issue involved? How was it resolved?

Interview

71. If no: under what conditions would you file a grievance?

Probe: for what contract violations?

72. In the past few years, the CIR has led 3 strikes. Could you tell me approximately when they were, what hospitals were involved, what the issues were and outcomes were,?

-Did you approve of them?

- If appropriate, did you participate in any of them?

1975:

1976:

1979:

73. There's a lot of controversy about doctors leaving patients to strike. What is your position on that?

Probe: striking is OK if patients are being cared for

striking is OK if the issues concern patient care

striking is OK under any circumstances - economic issues, refusal of other side to bargain etc.

leaving patients to strike is unethical, under any conditions

housestaff should provide emergency coverage for patients during a strike.

74. Would you strike in the future if you agreed with the issues?

a. Yes b. No c. don't know

75. Do you think the housestaff in this hospital would be willing to strike?

a. Yes b. No c. don't know

76. Do you think all hospitals with housestaff should belong to the CIR?

a. Yes b. No c. don't know

Why or why not?

77. Why do you think some hospitals are not CIR members?

Probe: a. satisfactory working conditions

b. fear of reprisals

c. ignorance about the CIR (don't know it exists or what it does)

d. dislike of union tactics

e. Other : _____

78. For the next contract number, in order of importance, which of the following represent your main interest.

Card F

79. How much of a financial compromise would you be willing to make for improving patient care?

Interview

80. In general, what activities do you think the CIR should stress in the future?

Probe: more benefits for members
working more for patient care
organizing non- CIR hospitals
other:

81. In 1976, the CIR supported a strike by 1199 by refusing to admit non-emergency patients and refusing to do the work of the strikers. A local housestaff has recently taken the same position with regard to a nurses' strike (Maimonides).

What is your position on this type of action?

- a. Strongly approve
- b. Approve
- c. Don't know
- d. Disapprove
- e. Strongly disapprove

82. Do you think it is beneficial for the CIR to align itself with any of the following groups? For what purpose? eg, recently the CIR helped a group of attendings at Flower Fifth Avenue Hospital to organize and lent their name to the group.

- a. Nurses (State Nursing Assn)
- b. DC 37
- c. 1199
- d. AMA
- e. Community groups

83. The CIR has taken stands on various issues in the past. What is your position on the following? Do you strongly agree, agree, strongly disagree, disagree, no position.

- a. The CIR will not officially endorse a political candidate. SA A D SD DK
- b. The CIR supports groups that favor a woman's right to an abortion. SA A D SD DK
- c. The CIR opposes any cutbacks or closings of municipal hospitals. SA A D SD DK
- d. The CIR went on record against the Bakke decision. SA A D SD DK

84. Are you familiar with the most recent CIR contract for your hospital?

- a. Yes
- b. No

85. If yes, what do you think is the best aspect of the contract?

86. Is there any demand that the housestaff wanted and did not get into the contract?

- a. Yes: What was it?
- b. No
- c. Don't know

87. How do you feel about the statement that "unionization poses a threat to a physician's autonomy"? Do you strongly agree, agree, disagree, strongly disagree, don't have an opinion. SA A D SD DK

88. Do you feel that as a nso you should have more autonomy in your work situation?

- a. Yes
- b. No
- c. No opinion

Describe briefly:

Interview

89. Do you feel, that as a group, housestaff should have more control in the decision making process in your hospital?

- a. Yes b. No c. No opinion**

Can you give an example?

90. Do you feel the CIR is responsive to your problems as a resident?

- a. Yes b. No c. Don't know, no opinion**

91. In the past, CIR members have refused to sign Medicaid and Medicare reimbursement forms.

a. What do you think is the purpose of this action?

b. What impact does it have on:

1. Patients:

2. Hospitals:

3. Housestaff demands:

92. How do you learn about the activities of the CIR?

Probe: bulletins and other mailings

delegates - through meetings or informally

word of mouth

other:

Interview

93. Why did you choose _____ as a specialty?

Probe: Intellectual challenge
opportunity to help patients
money
hours

94. Do you plan to go into a sub-specialty?

a. Yes b. No

If yes, which one and why?

95. Describe the type of person that goes into _____ (specialty).

Would you say that he/she is more, less, or the same as other specialties with regard to:

- a. conscientious M L S
b. possesses the intellectual qualities necessary for being good doctors M L S
c. egocentric M L S
d. ambitious M L S
e. wants to make a lot of money M L S
f. other:

96. What kind of practice do you plan to go into when you complete your training?

Card C Circle as many as apply.

97. Where do you plan to practice? _____

98. What do you think will be the social characteristics of your patients?

a. Social class	b. Ethnicity	c. doesn't apply
1. Mostly poor	1. mostly black	
2. mostly lower middle class	2. mostly hispanic	
3. mostly upper middle class	3. mostly Jewish	
4. mostly upper class	4. mostly Italian	
5. mix	5. mostly Chinese	
	6. mostly Irish	
	7. mix	
	8. other: _____	

99. Approximately, in 1980 dollars, what do you expect your annual income at the financial peak of your career? \$ _____

100. Has your experience as an intern or resident in any way affected your career goals?

a. Yes b. No
If yes, in what way?

101. Has your experience in the CIR in any way affected your career goals?

a. Yes b. No
If yes, in what way?

102. Much has been said about the need for more monitoring of physician behavior. From your experience, do you think the following have been effective in doing this?

- a. tissue review committees yes, no don't know
b. mortality review conferences
c. medical record committees
d. PSRO's

Interview

103. The New York City hospital crisis is very much in the forefront of the news lately. How do you explain this crisis?

- Probe:** a. is there really a deficit?
b. mismanagement
c. increasing costs
d. lack of cost controls
e. attack on public hospitals
f. other:

104. Do you agree with proposals to close or reduce services at hospitals such as Metropolitan and Sydenham?

- a. Agree b. Disagree c. don't know

105. Why do you think these hospitals were chosen to be closed?

- Probe:** a. They duplicate services of other hospitals in those communities.
b. Compared to other hospitals, they are the most expensive per patient to operate.
c. It is an attack on the poor minorities in NYC
d. It was expected that the least resistance to closing would be at these hospitals.
e. Other:

106. Do you think some form of national health insurance is inevitable in this country?

- a. Yes b. No c. Don't know

107. If a national health insurance plan were to be implemented, what do you think its impact would be on the following:

- a. quality of patient care: better worse dk
b. cost of health care delivery : increase decrease dk
c. improve preventive care : yes no dk
d. interfere with physician's professional freedom: yes no dk
e. crowd medical facilities : yes no dk
f. interfere with doctor-patient relationship: yes, no dk,
g. increase availability of health care to everyone: yes no dk
h. other:

108. Do you favor national health insurance?

- a. Yes b. No c. can't say

109. Number, in order of importance, the major problems you think are facing the medical profession today.

Card H

110. What changes do you think are needed to solve some of these problems? Check as many as apply.

Card I

Interview

Background

111. Age _____
112. Sex F M
113. Marital status: a. single, living alone.
b. single, living with roommate(s)
c. single, living with main sexual partner
d. divorced, living alone
e. divorced, living with roommate(s)
f. divorced, living with main sexual partner
g. widowed, living alone
h. widowed, living with roommate(s)
i. widowed, living with main sexual partner
j. married
114. Number of children: _____
115. Ethnicity: _____
116. Place of birth : _____
117. Religion: _____
118. Parents' occupation: Mother: _____ Father: _____
119. Undergraduate school: _____ Year graduated: _____
120. Medical school: _____ Year graduated: _____
121. Foreign medical graduate: a. Yes b. No
122. What's your political affiliation? a. Republican b. Democrat c. Liberal
d. Socialist Workers e. Other _____
f. None
123. During the period you were growing up were your parents:
a. liberal c. conservative e. apolitical
b. moderate d. radical left f. don't know
124. When you were in college did you participate in any of the following: If yes,
what were they?
a. clubs
b. demonstrations
c. marches
d. strikes
e. held political office
f. other: _____
125. When you were in medical school did you participate in any of the following:
If yes, what were they?
a. clubs
b. demonstrations
c. marches
d. strikes
e. held political office
f. other: _____
126. Have you been active in any of the following?
a. feminist groups or activities
b. civil groups or activities
c. anti-war groups or activities
d. anti draft groups or activities
e. anti-nuclear groups or activities
f. giving medical aid to some group other than in the course of your training
g. other: _____

Interview

- 127. Have you been a member of any other groups such as:**
- a. Medical related:**
 - b. Political:**
 - c. AMA: a. yes b. no**
 - d. If no, do you intend to join the AMA at some point ?**
 - a. Yes b. No: Why not?**
 - e. Do you belong to a local medical society?**
 - a. Yes b. No**
 - f. If no, do you intend to join a medical society when you are in practice?**
 - a. Yes b. No**
 - g. Are there any other groups that you are considering joining now or in the future?**
 - a. Yes: _____**
 - b. No**

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