

## DOCTORS AND UNIONS

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### ABSTRACT

This is a study of the unionization of physicians. This article will examine the factors that have affected the medical profession encouraging doctors to do something that was unheard of fifty years ago—to unionize. This article describes the societal changes that have encouraged doctor unionization, analyzes the legal overlay, examines the extent of doctor unionization, and makes a number of projections about the future.

A half century ago doctors had nearly total control over the management of their profession. They typically worked in solo private practice. This involved either maintaining a separate office and staff or associating with a medical building for purposes of convenience and referral. Doctors had relationships with hospitals, to whom they sent patients. They also worked with private insurance companies for administration of patient claims. But doctors were essentially independent operators, working as general practitioners and, less often, as specialists.

There was little regulation by government. The financial rewards and respect for the medical profession were at the highest levels. These were justified, as one practitioner put it, by the “. . . long years of training, hours of service, risk of exposure to disease, shortened earning life-span, attenuated freedom and family life, and devotion to professional self-advancement. . .” [1]. This situation no longer exists.

## THE CHANGING NATURE OF THE PROFESSION

In the mid-1960s, under Presidents Kennedy and Johnson, an agenda for social change through the establishment of government programs was adopted. The “war on poverty” was declared, and the “Great Society” was envisioned. Accompanying the rising expectation levels were laws designed to expand and improve the health-care system. These laws imposed greater control over physicians’ treatment decisions and the fees they charged for services. The two biggest government programs created were Medicare and Medicaid. Others were established to empower the public in making health-care decisions, increase medical school enrollments, combat life-threatening diseases, and upgrade the technological infrastructure.

President Nixon sponsored legislation in 1973 to promote prepaid care through health maintenance organizations (HMOs). The idea was to focus on “preventative care” to head off medical problems before they start, or to identify them before serious damage was done to a person’s health. Organizations rather than individuals would produce this result. Patients would be managed. Application of the economic concepts of division of labor and economies of scale would keep costs down.

Costs, however, continued to rise at a rapid pace. As a result, during the 1980s, further significant changes took place in the institutional structure of health care [1]. Many small hospitals were closed. Contracts were established between nonprofit hospitals and private managers, and more health-care facilities came under a for-profit corporate style of operation, which became known as “managed care.” The idea was to provide more efficiency, to achieve cost containment while improving services. This market approach, with its supposed benefits of competition, met with favor from the Reagan Administration. Medical practice continued to evolve from cottage industry to corporatism.

By the 1990s the transformation to HMOs featuring managed care came to full flower. Several large companies operating on a for-profit basis achieved industry dominance, including Aetna, PacifiCare Health Systems, Inc., Humana, United Health Group (formerly United HealthCare Corp.), Wellpoint Health Networks, and Foundation Health Systems. There was also growth among nonprofit HMOs, such as Kaiser Permanente, the nation’s largest, although many nonprofit HMOs converted to profit status. HMOs have become a powerful political force in America, especially through the American Association of Health Plans, a Washington, D.C. lobby group that acts on their behalf. HMOs typically use a *protective* basis for the payment of fees (fixed-fee schedules) versus the system of *retrospective* payment employed by older insurers such as Blue Cross/Blue Shield. In these retrospective payment systems, bills are submitted and payment is made for all reasonable and actual costs. These two systems have very different impacts on medical costs and doctors’ charges.

Although a sizable number of doctors remain self-employed, either solo or in a group, the trend has been toward more doctors becoming salaried employees. This is illustrated in Table 1. The number of employee doctors has risen because of the high cost of maintaining independent practices, especially for clerical and administrative service and malpractice insurance. When doctors work for someone else, it is typically for a federal, state, or county clinic, nonprofit hospital, or private medical group [2].

### THE CHANGING ROLE OF THE AMERICAN MEDICAL ASSOCIATION

By way of further background, the role of the American Medical Association (AMA) should be noted. Operating as a kind of guild, the AMA has traditionally provided scientific, professional, and educational support to doctors. It was initially opposed to unionization of doctors and refused to recognize such organizations. Over the years, however, membership in the AMA has dropped from nearly 100 percent to about 50 percent of active physicians. When membership declines became apparent, in about the mid-1970s, the AMA's stance shifted somewhat, in that it began to teach bargaining methods to doctors, especially in dealing with HMOs and large insurers over fees and wages.

The AMA determined in 1984 that because salaried physicians engaged in bona fide employer-employee relationships, they should be able to engage in collective bargaining. In 1999 the AMA established its own labor organization, which is discussed below. At the root of the AMA's action is the dominance of and problems associated with HMOs.

Table 1. Physicians' Sources of Employment

Type	1983 (%)	1994 (%)	1999 (%)
Self-employed solo practice	40.5	29.3	25.6
Self-employed group practice	35.3	28.4	36.2
Employee	24.2	42.3	36.1
Other <sup>a</sup>			2.1

<sup>a</sup>The data for 1999 include categories listed as "independent contractor" (1.6%) and "not reported" (1.5%).

**Sources:** *Journal of the American Medical Association*, 1996, 276(7), p. 557; American Medical Association, *Physician Socioeconomic Statistics, 1999-2000*, p. 125; and Tom Abate, "Doctors Examine Union Option," *San Francisco Chronicle*, September 3, 1999, p. C1.

A key part of the rationale for HMOs is to cut costs for participating employers by more efficient operation and controlling waste. Doctors, in order to provide complete medical care, have incentives to perform tests. But while doctors may have a tendency to perform too many tests and procedures if left to their own devices, there are claims that HMOs do not allow enough tests to be performed. While HMOs did help restrain rapidly rising medical costs by eliminating unnecessary tests and procedures, once they trimmed the fat they continued to slash so as to maintain rising profits [3].

## REASONS FOR UNIONIZING

### Economics

The rationale for joining a union depends to some extent on whether one is a salaried doctor or in private practice [4]. One of the major frustrations for private practitioners is in collecting fees for work performed, since claims for such work may be denied by managed-care HMOs, based on their policies and rules. Also, HMOs may not approve certain medical procedures, and they place limits on fees for procedures that are performed. A primary motivation for salaried doctors is to raise their compensation levels and, for interns and residents, to reduce the number of hours worked and improve working conditions.

Regarding economic issues, until about ten years ago physician incomes were increasing faster than any group except athletes in professional team sports. Limitations imposed by HMOs have caused doctors' incomes to stagnate. According to the AMA, while doctors' median net income rose from \$108,100 to \$164,000 between 1987 and 1997, when adjusted for inflation their real income advanced to only \$118,100 [5].

During this period in which their real income stagnated, doctors came under increasing pressure from the media, which blamed them for soaring medical costs. Doctors became a lightning rod for criticism, as the press asked, for example: Don't doctors order the expensive equipment that drives up costs? Don't they charge excessive fees to patients or pad expenses to get more money out of insurance companies? Don't they perform unnecessary tests and procedures? Don't they make about five times more income on average than nurses, and is this justified by education, training, skill, responsibility, or other factors?

### Autonomy

A hallmark of the medical profession has been its autonomy, which gives control and self-direction over work. It results from the dominance of physician expertise and its recognition by the public. The traditional autonomy has been eroded, however, as medicine is now subject to formalized and hierarchical controls from outside the profession [6].

The reasons for this loss of control are diverse. One is deprofessionalization. Doctors no longer have a monopoly over access to a defined body of knowledge. Automated retrieval systems featuring computerized algorithms can be used by nonphysicians to assess the symptoms of patients. Also, doctors are more specialized today, making them more dependent on each other as well as on advice and expertise from outside the profession. Doctors are viewed as more fallible by a better-educated and more-knowledgeable public. More duties performed by doctors are being shifted to nurses and other lesser-paid medical practitioners for reasons of efficiency and economy. Under managed care, patients may view themselves as clients of the organizational entity, rather than as patients of the doctors they consult.

There is also, according to Frederic Wolinsky, a kind of proletarianization occurring [6, p. 15]. As the number of intermediaries between patients and doctors increases, physicians become more like other people who work, selling their services rather than being wholly responsible for providing medical care. Doctors can no longer do what they think is best for their patients. They take orders from functionaries who in many cases do not have medical training.

When government agencies and managed care companies impose budgetary restrictions on health operations, the level of medical care deteriorates. This leads to complaints from patients that injure the dignity, prestige, and self-respect of doctors. A reason for looking to unions is that doctors have nowhere else to turn. The AMA has not been sufficiently supportive. A union may be viewed by doctors as the only kind of organization that can provide the power to resist the forces that are taking over physicians' prerogatives and limiting their income.

In short, over the past fifty years several societal and institutional changes have posed threats to the medical profession. The growth of federally sponsored health-care programs, the emphasis on cost control, and the emergence of HMOs has turned more doctors into employees, has threatened their position of economic preeminence, and has cut into their control over patient care. These changed conditions tend to encourage them to take the kind of collective action that is the stock in trade of the labor organization. In the next section we will see that public policy changes have also increased their tendency to organize.

### **THE LEGAL OVERLAY**

The law applicable to physicians' organizing and collective bargaining rights is quite detailed and subject to change. Legal rights depend on whether doctors are in private practice as independent contractors or whether they are working for a private or public employer. The principal laws applicable to physicians working in the private sector are the National Labor Relations Act of 1935 (NLRA), as amended, which provides the right to unionize and bargain collectively to non-supervisory employees; the Sherman Antitrust Act of 1890, which states that

combinations in restraint of trade are illegal; and the Clayton Antitrust Act of 1914, which exempts labor unions from coverage under the Sherman Act.

Decisions of courts and the National Labor Relations Board (NLRB) have interpreted these laws as applied to private physicians and other professional employees. Recently the NLRB ruled that full-time staff physicians employed by an HMO were *managerial* employees in nature because they serve on committees and otherwise carry out employer policies. The implication of this ruling is that these private sector physicians are excluded from coverage under the NLRA, as amended [7]. Another implication here is that reasoning such as that found in the Supreme Court's *Yeshiva* decision applies to private sector doctors, at least to those who work for HMOs [8]. In a more recent decision (*AmeriHealth HMO and UFCW Union, Local 56*), the NLRB ruled that physicians working for this HMO were *independent contractors* and thus not employees within the meaning of the NLRA [9].

If doctors work in the public sector, they are covered by different laws. Those who are employed by a federal institution are covered by the Civil Service Reform Act of 1978, as amended. Those who are employed by state or local government will be covered by the relevant public sector law within that jurisdiction. Most public jurisdictions have enacted laws providing public employees with the right to organize and to bargain collectively over terms and conditions of employment. Most of these jurisdictions also outlaw strikes by public employees, particularly when the strike would have an adverse impact on public health and safety. Presumably, a doctor's strike would have such adverse impact on health and safety and therefore would be illegal or closely monitored [10].

### **Who is Eligible for Collective Bargaining?**

Table 2 refers to the percentages of U.S. doctors that are employees in various categories. As shown in Table 1, the majority of doctors are self-employed, and these persons are not included in Table 2. There are approximately 640,000 doctors in the United States. According to the AMA about 108,000 employed postresident physicians are eligible for unionization [11].

### **Residents and Interns**

Under a 1999 decision by the NLRB, about 40,000 to 50,000 more interns and residents became eligible for unionization [12]. As a result of this decision, we would estimate that about one-fourth of American doctors can currently be organized by unions in a conventional sense for purposes of collective bargaining.

*Boston Medical Center* is the NLRB decision that allows bargaining rights for interns and residents [12]. It overruled two earlier decisions that had held that interns, residents, and fellows were primarily students and therefore not "employees" within the meaning of the NLRA [13]. *Boston Medical Center* is expected to significantly increase the density of union membership among the

Table 2. Employment of U.S. Physicians by Category, 1999

	Percentage <sup>a</sup>
Postresidents employed by medical schools and universities	27
Hospitals	24
State and local governments	10
HMOs	7
Ambulatory sites	5
Other employees	26

<sup>a</sup>Percentages do not add to 100 because of rounding.

**Source:** American Medical Association, cited in Ted Fourkas "AMA's 'Union' Won't Do Much, But the Campbell Bill . . ." *Sacramento Medicine*, September 1999, p. 16.

16,500 students who graduate each year from U.S. medical schools [14]. Approximately 90 percent of the graduates immediately enter a residency program at a medical institution. The first year of residency is known as an internship. Residencies commonly last for a total of three years, and if a doctor goes on for further training in a specialty s/he is known as a fellow. Interns, residents, and fellows as a group are commonly known as "house staff."

*Boston Medical Center* focused largely on the NLRB's interpretation of "employee" in the NLRA. Section 2 (12) of the law defines a professional employee as "any employee engaged in work . . . requiring knowledge of an advanced type in a field of science or learning customarily acquired by a prolonged course of specialized intellectual instruction and study in an institution of higher learning or a hospital. . . ." The board found that this language, literally read, embraces house staff. It also noted that these doctors were not really students because they made about 80 percent of medical decisions on their own, and up to 80 percent of their time involved direct patient care [12].

Many house staff employees work long hours under difficult conditions. New York is the only state that limits such work hours (to 24-hour shifts and 80-hour workweeks) [15]. *Boston Medical Center* affects only house staff working in private hospitals [12]. Most of those who work in public-sector hospitals had already been permitted to join unions under various state laws. There are about 100,000 total house staff doctors working in private and public facilities.

### **Doctors in Private Practice**

As *Boston Medical Center* illustrates, labor law applies only to people involved in an employee-employer relationship. Nonemployees, as well as managers, are not covered. This has had an impact on the organization of doctors into unions for purposes of representation for two main reasons: 1) Many doctors are self-employed independent contractors, who are private practitioners rather than employees (see Tables 1 and 2), and 2) even if they are employees, doctors may be viewed as managers because they typically supervise their own work as well as that of others. Regarding the latter point, the U.S. Supreme Court, in the *Yeshiva* case, prohibited professors at private universities from collective bargaining [8]. The Court determined that university faculty members act as managers when they sit on committees responsible for setting organizational guidelines and policies that have a direct effect on organizational governance. *Yeshiva* appears also to have application to the medical profession. Many doctors working for HMOs sit on committees and make independent decisions.

Physicians in private or group practice cannot organize for purposes of conventional collective bargaining for two reasons. First, a private physician practice is considered a business by the Internal Revenue Service, and the protection of the NLRA does not extend to owners and operators of private businesses. Second, the Sherman Antitrust Act prohibits such doctors from organizing for bargaining purposes. When a group of doctors in Delaware joined a union to negotiate a managed-care contract, the U.S. Department of Justice filed an antitrust suit charging the doctors with restraint of trade. An exception is the state of Texas, which in 1999 passed a law allowing independent doctors to bargain collectively with health insurers [16]. Although collective bargaining is not generally permitted, there have been several lawsuits filed by groups of private doctors against managed-care companies regarding unfair contract terms, delayed payments, and deceptive business practices [17].

### **Potential New Public Policy**

A bill in Congress, called the Quality Health-Care Coalition Act, would exempt private physicians, pharmacists, and other health-care professionals from antitrust laws so they could collectively bargain with managed-care companies. Sponsored by Representatives Tom Campbell (R-Calif.) and John Conyers (D-Mich.), the bill is supported by the AMA, American Federation of State, County and Municipal Employees (AFSCME), and the Union of American Physicians and Dentists (UAPD). It does not create doctors' unions or give doctors the right to strike, but it allows the right to bargain for quality medical care, such as eliminating restrictions on patient access to certain diagnostic and therapeutic techniques. The bill would allow doctors three years to band together when negotiating with insurance providers, with the legislation expiring at that time if not renewed by Congress.



Arguing in favor the bill, UAPD President Robert L. Weinmann, M.D., said:

Insurers have enormous market power and bargaining leverage which dwarfs that of individual or small group practices. Doctors are presented contracts on a take-it-or-leave-it basis, strong-armed into signing contracts which may violate professional and ethical standards. Medical sweatshops have been created as a result of the unbridled power that the insurance industry wields over how and what kind of medical care is to be provided [18].

The bill is opposed by insurance companies with backing from big business. Leading the charge to defeat the bill are the American Association of Health Plans and the Blue Cross & Blue Shield Association. The main theme being emphasized by opponents is that if the bill were to pass health-care costs would undoubtedly rise. In May 2000, the opposition was able to exert political pressure against taking a vote on the bill [19].

#### *Independent Practice Associations*

Another possibility for collective action by doctors is through an Independent Practice Association (IPA). Found in several states, these are umbrella corporations that typically include a few hundred to a few thousand doctors in private practice. The IPA negotiates with insurance providers on the rates the doctors get for treating HMO patients. IPAs are vulnerable to charges of price fixing in violation of antitrust law. For this reason they are usually kept small to avoid legal challenge. An interesting twist is that unions can also establish IPAs. The UAPD did so in 1994. The advantage is that unlike private practice doctors acting together, these same doctors under a union umbrella may be able to take advantage of labor unions' exemption from antitrust violations under the Clayton Act.

## **THE DOCTORS' UNIONS**

Historically, the first doctors' union was the Committee on Interns and Residents, formed in New York City in 1957. Largest of the doctors' unions, in 1999 it had about 9,000 members and was affiliated with the 1.3 million member Service Employees International Union (SEIU) [20]. The second largest union of doctors is the UAPD. Founded in 1972 in the San Francisco Bay Area by Dr. Sanford Marcus, the UAPD had 6,000 members in 2000, all of whom were postresidency physicians. It became affiliated with the American Federation of State, County, and Municipal Employees (AFSCME) and its 1.3 members in 1997. Another early union, called the District Council, was founded by Barry Liebowitz in 1959 in New York City. It has maintained a steady membership of about 3,000 doctors over the years.

Table 3 shows that those doctors who have affiliated themselves with the mainstream union movement are concentrated in four unions: SEIU, AFSCME,

Table 3. Membership in Unions by Doctors, 2000

Union	Members
Service Employees International Union	20,000
American Federation of State, County and Municipal Employees	10,500
American Federation of Teachers	9,500
Office and Professional Employees International Union	9,300 <sup>a</sup>

<sup>a</sup>Figure includes 400 members of the Puerto Rican College of Physicians.

**Source:** Authors' survey of organizations, by telephone interviews in 2000.

American Federation of Teachers (AFT), and Office and Professional Employees International Union. Other large national unions have sought to organize doctors, including the International Association of Machinists and the United Food and Commercial Workers, but did not report any members. Altogether, there were about 50,000 doctors who were union members in 2000, up from 25,000 in 1996. This doubling of membership in just a few years reflects the increased desire of doctors for representation. It is a case of mutual attraction. Unions are attracted because doctors, as highly skilled, needed employees, are potentially a powerful bargaining group that could provide a base for further unionization in health care. And doctors are attracted by the union's ability to deal effectively with bureaucratic organizations.

This anticipated growth has prompted the AMA to enter the field. In June 1999 the AMA's House of Delegates voted to form a union of doctors called the Physicians for Responsible Negotiations (PRN). It was created because of complaints that insurance companies prevent doctors from providing the best care, overload them with paperwork, and drive down their pay. The PRN renounces strikes and does not actively recruit doctors. It supplies expertise that doctors need to establish bargaining groups and assists them in negotiations.

### What Do Unions Do to Represent Doctors?

For salaried physicians, as well as other employees, unions negotiate collective bargaining agreements on wages, hours, and working conditions. After a negotiated contract is in place, the union enforces its terms through the grievance procedure, which typically culminates in arbitration by an outside neutral if the parties cannot come to terms on an amicable settlement of the grievance.

When it comes to doctors in private practice, however, the negotiation process is more varied. Instead of a single agreement to be negotiated and enforced for all members of the unit, the bargaining is often done with several managed-care companies and other health-care providers and facilities. Unions also go to bat for individual doctors or groups of doctors about matters such as patient care, charge reimbursement, doctors' privileges at facilities, malpractice issues, legal advice, legislative initiatives, and discipline against physicians. A union permits doctors to turn to a single source of expertise for a variety of problems, and the cost of this service is typically far less than it would be if an individual attorney or consultants were used. If a problem is common to individual physicians, a union can provide greater clout by taking collective action on their behalf.

### STRIKES

The strike is an especially difficult issue for doctors who are sworn to the Hippocratic oath, and most physicians are opposed to the idea of withholding their labor to exert pressure at the bargaining table. Unions and strikes do not have to go together, although they usually do. Ironically, some doctors urge that because strikes are unethical and cannot be used, unions are required to provide the organizational solidarity necessary to achieve objectives. Other doctors are not unequivocally opposed to striking and would do so if conditions became sufficiently untenable and a strike were a last resort. Even those doctors would not engage in a full-fledged work stoppage, so that adequate medical care would be on hand in emergency situations.

There have been a few job actions by doctors over the years. Although technically not a strike, members of the Nevada Physicians Union in 1973 and 1974 undertook action called a "white-in," where they refused to fill out necessary paperwork but otherwise provided basic medical care.

The biggest strike by private-practice doctors occurred in California in 1975. As a result of legislative initiatives announced by Governor Jerry Brown, malpractice insurance rates were raised by an average of nearly 500 percent. In protest, anesthesiologists walked out for four weeks in May and a broader range of specialists struck later in 1975. The strikes were individual actions, not organized by a union, although the UAPD became involved in seeking to mediate the dispute and its members later sought to organize a statewide doctors' strike. The dispute was settled when the legislature agreed to reconsider the initiatives causing the insurance premium increases, in consultation with the medical community [1, pp. 19-20]. The legislature eventually agreed to impose a \$250,000 cap on awards for pain and suffering, which reduced malpractice insurance rates significantly.

Another strike occurred in 1978 by a union of doctors in Washington, D.C., against the Group Health Association HMO. At issue were wages and working conditions, and a settlement was worked out with help from the Federal Mediation and Conciliation Service [1, pp. 20-21]. Since the early 1980s there have been a

few strikes by doctors and interns in the New York City area, notably a weeklong walkout by the Committee Interns and Residents in 1981 against seven city-owned and two private hospitals [21]. The committee struck for nine days at Bronx-Lebanon Hospital in 1990, and attending doctors at Woodhull Hospital in Brooklyn struck for a week in 1991 [21].

The AMA is absolutely opposed to physicians' strikes. Although other unions actively organizing doctors would not necessarily strike, none has specifically renounced the idea of withholding labor under certain circumstances. UAPD President Robert Weinmann probably summed up unions' perceptions on the issue when he said, "If you give away your best weapon, you're like a general who says in advance he won't use ground troops" [22, p. 297].

## THE FUTURE

While it is difficult to predict the future, it appears the changes that have taken place to date indicate a prospective surge in unionization of doctors. The print and broadcast media support this idea, for the most part, and it seems that doctors have legitimate grievances against managed-care companies that may be adversely affecting medical care. Certainly the quality of medical care in the United States is not very good given the money spent on it. According to a recent report, Oman spends \$334 per person on health care while the United States spends \$3,724, the most of 191 countries surveyed. Yet, Oman ranks eighth and the United States thirty-seventh for overall fairness and quality of their health-care systems [23].

Much will depend on how successful unions are in improving the economic welfare of doctors. A few big contracts could lead to far more widespread unionization, creating a snowball effect. What impact the AMA will have is unclear. It is doubtful that this organization will transform itself into an active collective bargaining agent, similar to what the National Education Association did back in the 1960s when faced with the representation challenges from the AFT. But with half of the doctors under its tent already, the AMA is poised to help them in their efforts at collective bargaining.

Boding well for the future of unionism in this occupation is the 1999 vote of 800 postresident physicians in Los Angeles County to be represented by UAPD. This is the largest group of doctors to organize in nearly twenty years. The election was prompted by cost cutting by the county health department and layoffs of doctors.

There is also a big and fairly ripe plum that has taken some steps toward organization: Kaiser Permanente. In 1997 Kaiser, the nation's first and largest HMO, signed an agreement with the AFL-CIO pledging to allow organization of its health-care workers. As a *quid pro quo*, the labor federation promised to promote Kaiser to its approximately 14.5 million members as the preferred health plan. SEIU is seeking to sign up Kaiser physicians for a union representation

election. The fact that many employees of Kaiser already have union representation should make this task easier.

The future depends also on the ability of traditional unions and the AMA to overcome the heavy corporate resistance to the passage of H.R. 1304 (the Quality Health-Care Coalition Act). Prospects for passage may not be bright but they are getting better. If passed, the law would provide private doctors with substantial power over managed-care companies. Even if the bill fails, momentum should be sustained by the widespread organization of interns, residents, and fellows at private institutions, pursuant to the landmark *Boston Medical Center* case.

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2. Recently, however, as a result of bankruptcies and further closure of health-care facilities, some doctors who were employees have become employers by taking over the medical group they formerly worked for. Mitchel Benson, "Doctors Seek a New Model in the Ashes of Failed Firm," *Wall Street Journal*, April 19, 2000, p. CA1.
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8. *NLRB v. Yeshiva University*, 444 U.S. 672 (1980).
9. AmeriHealth HMO and UFCW Union, Local 56, 329 NLRB 76 (1999).
10. Paul D. Staudohar, "Reappraisal of the Right to Strike in California," *Journal of Collective Negotiations in the Public Sector*, Vol. 15, No. 2, 1986, pp. 89-97. Twelve states authorize some public employee strikes. Police and firefighters are not allowed to strike, and the same is true for any strike that would adversely impact public safety and health, like a strike by physicians.
11. Data from Ted Fourkas, "AMA's 'Union' Won't Do Much, But the Campbell Bill . . ." *Sacramento Medicine*, September 1999, p. 16.

12. *Boston Medical Center Corporation and House Officers' Association/Committee of Interns and Residents*, 330 NLRB No. 30, case decided November 26, 1999.
13. The earlier cases are *Cedars-Sinai Medical Center*, 223 NLRB 251 (1976), and *St. Clare's Hospital & Health Center*, 229 NLRB 1000 (1977).
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18. Personal interview with Robert L. Weinmann, M.D., by Paul D. Staudohar on June 22, 2000, in Oakland, California.
19. Jim VandeHei, "GOP Cancels Vote to Permit Doctors' Unions," *Wall Street Journal*, May 26, 2000, p. B12.
20. In 1997 SEIU combined its three affiliated doctors' unions into the National Doctors Alliance. The groups are the Committee on Interns and Residents, Union of Salaried Physicians and Dentists; and the Doctors Council.
21. Steven Greenhouse, "Angered by H.M.O.'s Treatment, More Doctors Are Joining Unions," *New York Times*, February 4, 1999, p. A1.
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