Milbank Memorial Fund Quarterly/*Health and Society, Vol. 56, No. 4, 1978*

Intern and Resident Organizations in the United States: 1934–1977

ROBERT G. HARMON

School of Public Health and Community Medicine,
University of Washington, Seattle

ON MARCH 17, 1975, the Committee of Interns and Residents (CIR)* of New York City waged a 4-day strike against 21 hospitals, eventually winning elimination of every-other-night call schedules. One year later, on March 19, 1976, the National Labor Relations Board (NLRB) ruled that house staff in private hospitals are "primarily students," not employees, and not entitled to collective bargaining rights under the National Labor Relations Act (NLRA) (National Labor Relations Board, 1976).

These two key events focused international attention on issues that had been affecting interns and residents for decades. Adverse working conditions, low pay, and uneven educational standards had led house staff to organize and seek correction of grievances long before the CIR strike. The issues and dynamics of the house-staff organizing movement provide a fascinating look at postgraduate medical education and urban hospital working conditions in the United States over the past four decades.

**Editor's Note:* A key to the acronyms used in this paper appears on p. 502. A key to the varying usage of "house staff" appears in *Webster's New Third International Dictionary* (1971). The term is printed as two words and hyphenated when used as a compound adjective to modify another noun. The Editor recognizes, however, that "housestaff" appears elsewhere with seeming frequency and favor.

0026-3745-78-5604-0500-30/$01.00/0

History of the House-Staff Organizing Movement

Early Activism Era: 1934–1941

Our story begins in New York City in the days of the Depression, the New Deal, and the 2-year internship. Dissatisfied with no salaries, lack of teaching rounds, and often dangerous working conditions such as ambulance riding, 66 intern representatives from 26 hospitals met in April, 1934, and formed the Interne Council of Greater New York (Aims and Achievements, 1940). By January, 1935, the organization was publishing a four-page newsletter, *The Interne,* sent to over 1000 interns in New York City. An early accomplishment occurred in November, 1935, when the New York Board of Estimate awarded salaries of $15.00 per month to city hospital interns.

In May, 1936, the organization reconstituted itself as the Interne Council of America (ICA), with headquarters in New York City. *The Interne* soon became a monthly journal with a circulation of 7000 and a life-span that would extend into the early 1950s. Membership dues were $1.00 annually.

Initial achievements included successful lobbying for the inclusion of interns under the New York State Workmen's Compensation Law and upgrading of medical libraries in many hospitals (Silagy, 1939). The ICA supported national health insurance and was outspokenly critical of the American Medical Association (AMA) for its opposition. Critics of the ICA linked the "pay-for-internes" movement to "the forces of Communism, political expediency, trade unionism, and idealism. . ." (A Vicious Attack on Internes, 1938). The ICA did not refute the trade union analogy, but said: "Because two things are similar, it by no means follows that they are identical" (Is The Council a Union?, 1939). Indeed, by 1940 the ICA was calling for "binding contracts" for all interns (Internes Need Contracts, 1940).

The ICA was plagued by the problems that are now familiar to those who have attempted to recruit and retain house staff in a national organization—lack of funds, difficulty in maintaining affiliations with distant chapters, rapid turnover of leadership and membership, and lack of time for organizational matters due to arduous work schedules. Membership figures tended to outrun dues income. In 1939, a membership of 3000 was claimed, while dues were

Key to Acronyms

AAMC	Association of American Medical Colleges
AFL-CIO	American Federation of Labor-Congress of Industrial Organizations
AFPD	American Federation of Physicians and Dentists
AFSCME	American Federation of State, County, and Municipal Employees
AHA	American Hospital Association
AIMS	Association of Internes and Medical Students
ANA	American Nurses Association
AMA	American Medical Association
AMS	Association of Medical Students
AMSA	American Medical Student Association
CIR	Committee of Interns and Residents (New York City)
ECFMG	Educational Commission for Foreign Medical Graduates
FMG	Foreign Medical Graduate
GAP	Goals and Priorities
HOA	House Officers Association
ICA	Interne Council of America
IRA	Intern-Resident Association
IRBS	Intern-Resident Business Session (AMA)
IUS	International Union of Students
JAMA	Journal of the AMA
JCAH	Joint Commission on Accreditation of Hospitals
LCGME	Liaison Committee for Graduate Medical Education
NARI	National Association of Residents and Interns
NASW	National Association of Social Workers
NBME	National Board of Medical Examiners
NEA	National Education Association
NLRA	National Labor Relations Act
NLRB	National Labor Relations Board
NPC	National Physicians Council
NTEU	National Treasury Employees Union
PNHA	Physicians National Housestaff Association
RPS	Resident Physician Section (AMA)
SAMA	Student American Medical Association
SEIU	Service Employees International Union
SHO	Student Health Organization
UAP	Union of American Physicians

collected for only 739 (Treasurer's Report, ICA, 1939). Affiliated chapters outside New York City were claimed only in New Jersey and Baltimore, yet intern councils did exist at Cook County (Chicago) and Boston City Hospitals.

Concurrently, activist medical students in the Eastern United States had organized the Association of Medical Students (AMS). This organization was founded in the spring of 1937 at the fourth annual Eastern Medical Students Conference attended by 361 delegates from 32 medical schools. This group grew to a membership of 2400 with up to 20 chapters. Its publication, *Journal of the Association of Medical Students,* eventually reached over 20,000 students. The activities of the AMS included curriculum reform, information exchange at the annual Christmas vacation convention, and local social programs.

In December, 1941, the ICA and AMS merged into the Association of Internes and Medical Students (AIMS) "to avoid duplication of effort and to achieve greater strength." *The Interne* became the official publication, and the first president was a medical student. Provision was made for dual medical student and intern officers to serve as secretary and editor. Spirits were high as the new organization faced the biggest issues of the day—civil preparedness and World War II.

War and Post-War Era: 1942–1951

Both the ICA and AMS had testified before Congress in March, 1941, in favor of the Murray Bill (doctor draft). Soon AIMS was actively supporting the war effort. In 1944, AIMS submitted Congressional testimony concerning wartime draft deferment of medical students. It urged that medical schools abandon their long-standing, restrictive, discriminatory admissions policies "against Negroes, Jews, Catholics, Italians, and women. . ." (Perry and Ely, 1947).

The end of World War II permitted AIMS to regain lost momentum and again hold its popular conventions. The most critical post-war issue for house staff was adequate postgraduate training for military veteran doctors. Technological advances, especially in drugs and surgery, led to a growing interest in specialization. Good residency positions, however, were scarce, and AIMS responded by publishing the popular book, *Study Guide and*

Bibliography on Postwar Medicine. Other issues receiving attention included limitation of routine laboratory and clerical chores, reasonable working and on-call hours, more clinical conferences, better housing, better food, a minimum intern salary of $1200, elimination of discriminatory practices in medicine and medical education, and international cooperation (Perry and Ely, 1947). This last area would prove to be the Achilles heel of AIMS.

By 1946, AIMS had 14 chapters; its 1947 convention in Chicago attracted 307 delegates and observers from 63 medical schools and hospitals. *The Interne* was doing well and had become primarily an educational journal containing clinical review articles. The organization had achieved prominence and respectability. An impressive list of medical leaders served the ICA, AMS, or AIMS in varying capacities, including Drs. Arthur Sackler, Henry Sigerist, Leslie Falk, Jeremiah Stamler, Karl Menninger, Milton Roemer, Bernard Lown, Quentin Young, and many others.

By 1948, there were 8000 interns in the U.S. earning an average monthly wage of $60. Some were still serving 2-year assignments. About 12,000 residencies were approved by the AMA, but there was a need for another 10,000. Salaries ranged from $0 to $375 per month (Baker, 1948). AIMS was faced with a growing trend among its members of pursuing specialty training; this implied not rocking the boat, especially for interns. Medical students began to play an even more active role in the organization.

In June, 1948, AIMS began its demise. In an atmosphere of post-World War II anti-Communism, the AMA Convention authorized an investigation of AIMS on the basis that it "advocates the overthrow of the United States government by force and violence . . . favors strikes upsetting to proper medical education," exhibits "Communistic tendencies," and has "Communistic affiliations." AIMS vigorously denied the charges and offered its cooperation in the investigation (AIMS National Committee on Academic Freedom, 1950).

Nearly 2 years later, the AMA Council on Medical Education and Hospitals released its report, drawing two main conclusions: "the National Association has a reputation of being a left-wing organization," and, in the Council's eyes, "this reputation would appear to be justified." Three pieces of evidence were listed: 1) from December, 1947, to December, 1949, AIMS was affiliated with the International Union of Students (IUS); 2) a Communist publication

in April, 1938, had urged medical students to join the AIMS; and 3) "the Association has welcomed papers by officers of the American Medical Association, by prominent leaders in medicine and medical education, and by members of the medical profession who are known to be affiliated with organizations and institutions that have been cited as communist fronts or which have been declared subversive by the Department of Justice." AIMS met with the AMA to defend itself, saying that the IUS affiliation accusation was "guilt by association," that nothing subversive had been shown, and that the "left-wing" reputation was hearsay perpetuated by unsubstantiated editorials in the *Journal of the American Medical Association (JAMA)* (AIMS National Committee on Academic Freedom, 1950).

On April 21, 1950, the AMA sent a letter from its president to every intern in the U.S. urging them to "read the enclosed article with interest." The article, highly critical of AIMS for alleged Communistic tendencies, was from *Medical Economics* and entitled "Leftist Minority Woos Future Doctors."

The reason for such actions may never be fully known. At the time, the AMA and AIMS were locked in an ideological battle over elimination of racial discrimination in medicine, adequate salaries for interns, and national health insurance. AIMS favored, and the AMA opposed, all three. The political climate of McCarthyism was probably also a factor.

AIMS had limited membership and financial resources with which to fight back. Dues at the time were $2 per year. Apathy and shrinking membership left AIMS vulnerable to competition. In December, 1950, the Student American Medical Association (SAMA) was established by the AMA at a Constitutional Convention attended by representatives from 47 medical schools (Fagel, 1972). Although the organizations were structurally separate, the AMA began providing significant financial and technical assistance to SAMA. Within 2 years, AIMS and its journal, *The Interne,* were dead.

Hiatus Period: 1952–1957

House-staff organizing at the national level was to be dormant for nearly 2 decades. Even New York City interns and residents were quiet during the mid-1950s. Perhaps the return to normalcy was too tempting, although the issues didn't disappear.

In 1956 SAMA began publishing an improved journal, *The New Physician,* which is still active. By 1957, New York City municipal hospital interns were receiving $71 per month and residents $105 per month. The city employees voted to join Social Security, creating the possibility of large deductions from the meager paychecks of house staff (Interns and Residents More than Double Stipends, 1960). The stage was set for action.

Local Organizing Era: 1958–1970

House-staff leaders in New York City retained an attorney, Murray Gordon, and in March, 1958, established the Committee of Interns and Residents (CIR). Pay raises of $30 per month for interns and $20 per month for residents were promptly won. The CIR soon became involved in educational and quality-of-care issues. It strongly supported the movement to obtain medical school affiliations for the city hospitals and reportedly "helped to pave the way for the necessary reorganization" (It Paid These House Officers to Organize, 1966). The CIR soon had paycheck withholding of $13 annual dues and a membership of over 1000 in the municipal hospitals. By 1966 the CIR had negotiated contracts and was beginning to attract membership from private hospitals. Meanwhile, organizing assistance was being given to house staff in Boston and elsewhere.

In 1961 the National Association of Residents and Interns (NARI) was founded. Based in New York City, it was primarily involved in selling insurance and other benefits to its members. By 1965 it claimed 9800 members, but had no local chapters (Paxton, 1965).

Spontaneous local organizing flourished outside New York City. The Intern-Resident Association (IRA) of Los Angeles County General Hospital grew increasingly militant and in May, 1965, staged a "heal-in," refusing to discharge patients. The issue was supposedly inadequate pay, and the job action resulted in pay increases from $3600 to $4440 for interns. In May, 1967, the Boston City Hospital House Officers Association (HOA) held a 3-day heal-in, forcing a pay increase from $3600 to $6600 for interns and $6600 to $10,000 for residents. The chief of the Harvard surgical service was sympathetic, saying: "It is time we faced the fact that these highly trained young doctors are carrying 80% of the work load in the

hospital. They should be granted their maximum request, which really represents only a minimum demand for a professional person." Opponents of the action said patients were being used unfairly (Boston Interns Stage "Heal-in," 1967). Another heal-in occurred at the Washington, D.C., Veterans Administration Hospital in January, 1968, where 48 hours of no discharges won a pay hike (Heal-in: A New Tactic, 1968).

The magnitude and speed of these salary increases would appear remarkable at first glance. One must realize, however, that Medicare and Medicaid were enacted in 1965. The result was an infusion of badly needed money to public hospitals, which had been chronically underfunded and understaffed despite heavy utilization by the aged and poor. This new cash flow made meeting house-staff demands much easier.

While house-staff salaries were approaching a living wage, a different movement was organizing. Social activism, perhaps spawned by the campus unrest of the 1960s, hit the medical schools with full force. Student Health Organizations (SHOs) were founded in 1965 and attracted considerable interest from multidisciplinary health science students. Emphasizing summer community health projects, civil rights, opposition to the Vietnam War, curriculum reform newsletters, and annual conventions, SHO channeled its energy into idealistic programs. The 1968 SHO Convention in Detroit attracted 600 health students from 40 states (McGarvey, Mullan, and Sharfstein, 1968). Because of its diversity and local focus, SHO was unable to jell into a national body. Although a "National Service Center" was authorized for Chicago, the organization gradually fragmented and faltered as leadership moved on to house-staff positions. Several key SHO organizers, however, were elected to SAMA offices in the spring of 1968. The impact on SAMA was dramatic, with an immediate change in its priorities toward community projects.

The social activism ferment was soon felt in some of the nation's more neglected and underfunded public hospitals. House staff began to expose inadequate patient care and working conditions to the media and the public. The crescendo of job actions that began over salary issues in the mid-1960s would soon focus on patient care issues and culminate in 1975—the year of the strike.

In December, 1969, the IRA of Los Angeles County Hospital sued the county over the issues of patient overcrowding, excessive

patient loads for house officers, and staff shortages (Charles, 1970). The situation was gradually improved through continuous house-staff pressure. In February, 1970, 60 interns at San Francisco General Hospital organized and demanded improvements in social services, laboratory and X-ray coverage, pharmacy hours, and out-patient services (Bottone, 1970). Satisfaction was slow in coming, and only through a 4-day strike in January, 1971, did the interns win some of their desired changes (Interns Stage Four-Day Strike, 1971). In May, 1970, the house-staff association of D.C. General Hospital won permission to put its patient care grievances before the Joint Commission on Accreditation of Hospitals (JCAH) (House Staff Still Pressing for Changes, 1970). This action gained improved funding for the hospital, but conditions continued to show no change and house staff eventually staged a 12-hour strike on December 4, 1970. Their grievances were silenced by a pay raise of nearly $2000 per year (House Staff Gains $165, 1971).

Meanwhile, in July, 1970, a group of interns and residents committed to community medicine and community control of health care joined the staff at Lincoln Hospital in New York's South Bronx. Called "The Collective," the group attempted to reform and improve emergency and clinic services, build bridges with radical community groups, and work medically outside of the hospital on a part-time basis. The program eventually faltered due to inadequate community support, formal hospital opposition, and discouragement among the house staff (Mullan, 1976). Its members gradually left Lincoln.

The missing element in many of these local efforts was backup and continuity from an established organization. The issues such as hours and job actions were becoming complex. Some strong local groups like the CIR had already obtained union recognition and hospital contracts through collective bargaining. A "ripple" effect was already occurring, and house-staff gains were ripe for nationwide dissemination. It had been 20 years since the demise of AIMS, and sentiment was growing for a national house-staff organization.

National Organizing Era: 1971–1974

Leaders of SAMA supported the concept of a national house staff organization as early as 1969. In 1970, a plan was submitted by past SAMA president, Dr. David Kindig, to then SAMA president, Ed

Martin, calling for a national conference. Funding of $33,000 was obtained under contract to the Health Services and Mental Health Administration, U.S. Department of Health, Education, and Welfare, by the Department of Social Medicine, Montefiore Hospital and Medical Center, Bronx, New York (U.S. Department of Health, Education, and Welfare, 1971).

The conference was held in St. Louis, March 18–21, 1971, and attracted 181 registered house staff from 120 hospitals in 31 states. Participants adopted progressive positions on a broad spectrum of health care and house-staff issues, including community participation in health policy, patients' rights, women's rights, foreign medical graduates' rights, and a model contract for house staff. The contract called for a minimum wage equal to the Bureau of Labor Statistics figure for an intermediate budget for a family of four ($9000 for interns) plus adequate fringe benefits and decent working conditions. The conference also authorized a coordinating committee to communicate with local house-staff associations and plan another conference in 6 to 12 months (Restless House Officers Move Toward Community of Action, 1971).

Concurrently, in 1971, a journal survey of 1527 interns, residents, and fellows showed 70% reporting the existence of a local house staff association. Chief accomplishments were reported as improved stipends, improved fringe benefits, and better communication with the administration. Only a small minority listed better working conditions or patient care standards as an accomplishment (Will House Staff Associations Become More Than Unions?, 1971). An earlier survey in 1970 found that 60% of responding teaching hospitals reported the existence of a formal house-staff organization, but less than one-half of these had written bylaws. The major areas of house-staff interest at that time were stipends, which 67% of hospitals mentioned, and education, which 29% mentioned (Association of American Medical Colleges, 1975b).

Within this framework, the coordinating committee of the national house-staff conference reported a lack of enthusiasm and financial support for a national organization. It obtained outside funding from HEW and the Veterans Administration to hold an educational conference at which organizing was prohibited. The event occurred in Atlanta, March 3–5, 1972, and was attended by 284 registered house staff from over 40 states. Participants again discussed multiple health issues, but much of the interest was focused

on after-hour "rump" sessions where a spontaneous national organizing movement was active, separate from the coordinating committee. Led by the Mayo Clinic Fellows Association, the movement soon had a petition signed by leaders of 50 house-staff associations representing over 10,000 house staff, pledging to hold a constitutional convention within 6 months. An interim constitution was adopted, establishing the National House Staff Coalition and its 11-member executive committee (House Staff Declares Independence, 1972). The Coalition accepted substantial administrative, technical, and financial assistance from SAMA.

The AMA watched this national movement with interest and concern. For decades it had done little to attract membership among younger, salaried physicians. Since its own aging membership was then barely half of all practicing U.S. doctors, a decision was apparently made to actively recruit house staff. In June, 1972, the AMA established and funded the Intern-Resident Business Session (IRBS), which permitted six house-staff members to be officers, including one voting representative out of approximately 240 in the AMA House of Delegates. The first IRBS Chairman, Dr. John Mather, was the past chairman of the Atlanta Housestaff Conference Coordinating Committee.

On October 3–5, 1972, the National House Staff Coalition held its constitutional convention attended by 113 representatives of 7000 interns and residents (Frishauf, 1972). A constitution and bylaws were adopted, establishing the Physicians National Housestaff Association (PNHA). Annual dues of $2 per member were set, and a 16-member National Council, composed of 4 officers, 4 minority representatives, and 8 regional representatives, was empowered to run the organization between national assemblies. Assistance from SAMA was again accepted.

Early PNHA objectives included the implementation of medical care as a human right and the promotion of adequate educational, working, and living conditions for all health providers. Observers questioned whether the underfunded organization could rally support for progressive causes and still balance the interests of 33 different affiliated associations, large and small, some of which were not even assessing dues. Asked what was the first priority of PNHA, newly-elected president Dr. Rex Greene said, "Survival" (Frishauf, 1972). Another priority was sending organizing and technical assistance to a multitude of weak local associations which

wanted to negotiate contracts with their hospitals. Murray Gordon, the CIR attorney, was retained for this purpose, and contracts from New York, Chicago, and Los Angeles were widely disseminated. This key move magnified a "ripple" effect into a "wave" of negotiated (or easily granted) changes in house-staff salaries and working conditions.

Foreign medical graduate (FMG) house-staff members were active in PNHA from the start. An FMG was elected vice-president after coauthoring the first draft of the constitution. FMGs were later instrumental in obtaining a house-staff seat on the Educational Commission for Foreign Medical Graduates (ECFMG) and advocating successfully for better educational conditions and fair treatment for FMGs. This was felt to be critical at a time when about one-third (32.7%) of the 56,244 interns and residents in the United States were FMGs ... physicians who were faced with predominantly service assignments, often in non-university affiliated hospitals (American Medical Association, 1976). In addition, a racial minority caucus began to work for improved recruitment and retention of minority house staff.

By 1973, an AAMC teaching-hospital survey reported that 9% of the institutions had collectively bargained contracts with house staff, and an additional 10% reported requests for collective bargaining recognition by house-staff groups. The house-staff union concept was spreading, with the CIR and Cook County Hospital Resident-Intern Association already recognized as bargaining agents, and the Los Angeles County Hospital IRA and University of Michigan IRA winning union status in 1973 (New Tactic for House Staffs, 1973). The latter group persevered through 3 years of state labor board and court proceedings, including $40,000 in legal fees, to win its case. The recognized unions promptly won attractive contracts with guaranteed improvements in patient care conditions plus hefty hikes in salary and fringe benefits (House Officers Sign Landmark Contract, 1974). Those groups without bargaining status benefited from the trend. A journal survey of house-staff salaries in 1973 revealed a median of $9590 for interns and $11,060 for residents, compared to $3810 and $4870 respectively in 1965–66, representing increases of 152% and 127%. A majority of house staff responding attributed these increases to house-staff association pressure (Agresta, 1973).

Despite early successes and enthusiasm for house-staff unions, a strong undercurrent of resistance was building among hospitals and

medical schools. An early indication of this occurred in Pennsylvania in 1972 when the State Labor Relations Board ruled house officers to be students, not employees, and ineligible for collective bargaining rights (Philadelphia House Staff, 1972). With this roadblock, house-staff associations in Philadelphia floundered, impaired in their ability to obtain paycheck withholding of dues, to negotiate contracts, and to survive from year to year.

A key issue in 1973 was "due process," or the right to a fair hearing in grievance matters. Five residents at Duke University Medical Center had been suspended for violating a ban on moonlighting (outside jobs). The five residents were eventually reinstated after the PNHA carried out a nationwide publicity campaign to secure due process (Frishauf, 1973). This example opened a Pandora's box, as house staff from across the country began to contact the PNHA for assistance in cases of arbitrary sanction or dismissal where their due process rights guaranteed by the 14th Amendment to the U.S. Constitution had been violated. The debate over moonlighting was to continue. One thing was certain: informal surveys repeatedly showed that one-third to one-half of the residents seemed intent on moonlighting, regardless of official policies.

The right of the house staff to obtain independent state medical licensure appeared in jeopardy when the Committee on Goals and Priorities (GAP) of the National Board of Medical Examiners (NBME) issued a report urging that house staff not be licensed until certified by specialty. The concept was immediately opposed by house staff as restrictive. Proponents claimed it would clarify the uncertainty over specialty standards. The issue remains unresolved.

Another issue that emerged in 1973 and 1974 was the relationship of house-staff associations to the AMA. In December, 1973, a slate of PNHA candidates was elected to office in the AMA IRBS. This situation was to continue until November, 1975, when the two house-staff groups went their separate ways. The AMA meanwhile was moving with unusual speed to open the door for house-staff membership and participation. Several AMA committees and councils designated voting house-staff seats. Joint PNHA-IRBS seats were obtained on the National Board of Medical Examiners (NBME), Liaison Committee for Graduate Medical Education (LCGME), and other bodies. A landmark was passed during this period of AMA-PNHA detente when in December, 1974, the AMA House of Delegates approved a set of guidelines for house-staff

employment contracts (Gordon, 1976). This endorsement of collective bargaining and employee status delighted house staff but angered many hospital administrators and medical school deans.

Meanwhile, a key event in labor history had occurred. On August 25, 1974, Public Law 93-360 had been enacted, amending the National Labor Relations Act (NLRA) to extend collective bargaining rights to employees of private, voluntary, nonprofit hospitals. These institutions now braced themselves for the type of labor organizing by hospital employees and house staff previously seen only in public hospitals where permitted by state or local law.

The PNHA Convention in 1974 counted 28 affiliated chapters and about 5000 members. The organization had been sharing headquarters with SAMA in Rolling Meadows, Illinois. It decided to move to Washington, D.C., where it accepted technical and financial assistance from the American Federation of State, County, and Municipal Employees (AFSCME) and joined the Coalition of American Public Employees (CAPE), composed of AFSCME, the American Nurses Association (ANA), the National Education Association (NEA), the National Association of Social Workers (NASW), and the National Treasury Employees Union (NTEU). The PNHA also hired an executive director with a background in organized labor, Steve Diamond. The stage was set for unionization.

The Year of the Strike: 1975

Many observers had assumed that house-staff grievances would be appeased by a living wage, which by 1974–75 was up to $10,692 for interns and $12,128 for postgraduate year (PGY)-3 residents (AAMC, 1975b). Few expected the torrent of job actions in 1975 over the issues of excessive hours and poor working conditions. A prelude to 1975 occurred on November 25, 1974, when the Howard University House Officers Association (HOA) struck Freedman's Hospital for 12 days over multiple grievances. The HOA won a commitment from the hospital to upgrade laboratory services, to provide better nursing coverage, and to improve house-staff fringe benefits such as malpractice insurance coverage (Housestaff Win Patient Care Improvements, 1975). This settlement represented yet another house-staff venture into the sensitive area of management rights and decision-making.

On March 17, 1975, the biggest job action by physicians in U.S. history took place. The CIR struck 15 voluntary hospitals and six affiliated public hospitals over the issues of excessive hours and out-of-title work (menial tasks commonly called "scut" work). House-staff support was strong, with over half the 3000 interns and residents joining picket lines. Critics said house-staff members were soft, shirking their traditional duties, and interested only in time off for moonlighting. Many doctors feared that, at best, union tactics were "unprofessional" and, at worst, the strike was unethical.

Supporters included the AMA and two out of three New York daily newspapers. They agreed that work weeks of up to 110 hours and shifts of up to 50 hours were not in the patient's or the doctor's best interests. A frequently quoted bit of evidence was a 1971 study which demonstrated, not surprisingly, that sleep-deprived interns were significantly less able to recognize potentially life-threatening electrocardiogram arrhythmias than rested control subjects (Friedman, Bigger, and Kornfeld, 1971). The CIR pointed out that interns, with the longest hours of all, were not eligible for licensure and therefore couldn't moonlight. It claimed the strike was justified ethically if it benefited the general population in the long run. The hospitals failed to gain public support, primarily because they refused the CIR proposal for binding arbitration, saying such a process was inappropriate on matters concerning medical education (Applebaum, 1975).

On March 20, 1975, the strike ended with the signing of a 2-year contract. It stipulated that hospital standing committees, composed of equal numbers of house-staff and medical executive board members plus an additional member chosen by the committee from the executive board, would be set up to formulate standards and guidelines for patient care operations, including call schedules. It also mandated that, as of July 1, 1976, no house officer "shall be required to perform on-call duty more frequently than one night in three, except where so provided by a majority vote of the standing committee. Other provisions included a ban on repeated out-of-title work, a provision stipulating that house officers can be fired only "for cause," a new salary schedule ranging from $15,000 to $22,500 (settled before the strike), and a pledge that the hospitals' training programs would meet the AMA's *Essentials of Approved Internships and Residencies* (Coste, 1975).

Within weeks, the Joint Council of Interns and Residents of Los Angeles County struck on May 8, 1975. Two hospitals, Los Angeles County and Harbor General, settled after only 3 hours, but the Martin Luther King Hospital house staff struck for 7 days. Over 30 striking doctors were fired, then rehired, during their dispute. The eventual agreement awarded a 10.5% salary increase to house staff, who turned back half of this into a $1.1 million patient care fund. The unprecedented fund, administered by a house-staff-controlled committee, was used to purchase needed equipment and hire additional allied health staff.

The next major confrontation occurred at Chicago's Cook County Hospital where 500 House Staff Association members struck on October 27, 1975, for better working and patient care conditions, claiming that the hospital administration had failed to bargain in good faith. The hospital claimed that the association was breaking a pledge to go through fact-finding arbitration prior to any job action. House-staff leaders chose to reject a temporary restraining order from a county court against their strike and continued the action for 18 days. House staff did continue to negotiate and agreed to court mediation. After a settlement was reached, the judge unexpectedly sentenced seven house-staff leaders to 10 days in jail each and fined their union $10,000. Six immediately served their sentences. Some observers predicted a chilling effect on house-staff union organizing.

The Cook County settlement was another landmark, calling for a committee of five house staff and five attending staff to oversee implementation of patient care improvements including adequate numbers of Spanish language interpreters, more intravenous teams, faster processing of lab and X-ray requests, and a maximum workweek of 80 hours (one night in four).

Meanwhile, in October, 1975, the PNHA met in Washington, D.C., and formally changed its structure to a registered labor organization. The media reported the event as a major change in organized medicine. The vote was unanimous, but some of the 26 local affiliates were concerned about meeting strict payment requirements to the national organization of $6 annual dues per member. Membership at this time was approximately 9000. Critics said the unionization move was unprofessional and would alienate some house staff, although a 1975 survey by the AMA showed that

between 70% and 90% of the interns and residents felt house staff "should be allowed to bargain collectively" (American Medical Association, 1975). Supporters felt it would strengthen PNHA finances and organizing. It was also announced that PNHA had earlier that year contracted with the publication, *Hospital Physician,* as its official journal.

The first sign of reaction occurred in November, 1975, when through a combination of PNHA apathy and AMA organizing, the AMA IRBS elected officers more in tune with AMA policy. This was simultaneous with a major new AMA program that included outright endorsement of collective bargaining for house staff and attending physicians plus the establishment of a new "Department of Negotiations" designed to function "above" the level of a union. The stage was set for competition to organize the nation's 62,000 interns and residents.

Legal Struggle Era: 1976–?

An AAMC hospital survey in 1975 reported that 71% of the hospitals had house-staff associations (up from 60% in 1970), 12% had house-staff contracts in force, and 9% had received requests from house staff for collective bargaining recognition. Public hospitals were much more likely to have house-staff associations and contracts than private hospitals (AAMC, 1975b).

This was the situation as at least a dozen local house-staff associations sought to hold National Labor Relations Board (NLRB) union recognition elections at private hospitals. At issue was the old "student vs employee" status. Case after case went through lengthy, expensive, regional NLRB hearings only to be referred to NLRB headquarters in Washington, D.C., for a final decision.

The hospitals and the AAMC argued that:

1. Interns and residents are not employees or integral parts of the hospital work force, but students preparing to join it.

2. Patient care is for the benefit of the student (house officer) rather than a service that the student renders for the benefit of the hospital.

3. House staff is not experienced enough for the independent practice of medicine.

4. Long hours are necessary for house staff to be exposed to a wide range of experience.

5. House staff does not receive salary for work, but rather, stipends for training.

6. The equality of bargaining power is incompatible with the student-teacher relationship (AAMC, 1975a).

The local associations and the PNHA countered that:

1. Student status is contrary to the legislative history of the 1974 hospital amendments to the NLRA in which the PNHA had testified for employee status, with a favorable reception.

2. House staffs have collectively bargained in a responsible manner in city and state hospitals for years, with a positive rather than a negative effect on patient care.

3. Patient care activities account for well over 70% of house-staff time, as verified by numerous studies (AAMC, 1968; AAMC, 1969; Institute of Medicine, 1976);

4. If house-staff programs were cancelled, the cost of providing care by full-time physicians would be *more* than before, especially in light of the long hours worked at low wages (Freymann and Springer, 1973);

5. Hospitals fund the bulk (often over 70%) of house-staff training programs out of patient care revenues (Institute of Medicine, 1974).

6. Their revenues are generated by house staff acting as employees.

7. House staff members are considered to be employees by the Internal Revenue Service and therefore ineligible for the Section 117 $3600 fellowship income exclusion.

8. House staff members are often fully licensed for independent practice by their state, able to prescribe a full range of medications, including narcotics, without co-signature.

The cases before the NLRB included Cedars-Sinai Housestaff Association, Los Angeles; St. Christopher's Hospital Housestaff Association, Philadelphia; Wayne State University House Officer Association, Detroit; St. Clare's Hospital and Health Center—CIR, New York City; and University of Chicago Hospitals and Clinics Housestaff Association, Chicago. On March 19, 1976, the NLRB handed down its decision. By a 4-1 vote it ruled: "Interns, residents, and fellows, although they possess certain employee characteristics, are primarily students," and therefore "are not 'employees' within the meaning" of the NLRB (National Labor Relations Board, 1976).

Hospitals and medical schools praised the decision while house staff denounced it and dug in for a long battle to attempt a reversal. An early appeal back to NLRB was turned down, as expected. The Joint Council of Interns and Residents of Los Angeles County struck for 3 days in April, 1976, to preserve their contract and patient care fund. The PNHA Convention in May, 1976, raised membership dues to $25 and tightened its constitution to require full dues payment by all locals. Membership was listed as 8500.

An unexpected boost for house staff occurred in April, 1976, when the Massachusetts Labor Relations Commission ruled that the 40 members of the Cambridge Hospital House Officers Association were employees, not students. The Commission said it had taken the NLRB decision into account but found it "inapplicable" (Massachusetts Labor Board Counters NLRB, 1976).

In June, 1976, the AMA replaced the IRBS with a new Resident Physician Section (RPS), urging all state medical associations to set up similar house-staff groups to send representatives to AMA conventions. AMA house-staff membership at the time was 8000,

with dues of $35 annually. The AMA, meanwhile, was supporting the house-staff employee position.

Also, in June, 1976, the legal issue of state versus federal authority over house-staff collective bargaining became more complicated. The New York State Labor Relations Board relinquished its authority over CIR bargaining, with the League of Voluntary Hospitals (a private hospital organization), in force since 1970, saying its authority had been pre-empted by the NLRB decision. The CIR took the case to the New York State Supreme Court and meanwhile struck in protest on October 5, 1976, at three of 21 private hospitals. On October 14, the Supreme Court ordered the Labor Board to reassert jurisdiction. In spite of this favorable decision, the CIR lost several affiliated local house-staff groups and over 1000 members due to local contract changes during the confusion. The NLRB then challenged the N.Y. State Labor Board's jurisdiction. This led U.S. District Court Judge Charles Stewart to rule that the NLRA did not apply, and the state could exercise authority over house-staff negotiations (U.S. District Court, 1977). Prior to this time, on December 9, 1976, the Massachusetts State Labor Commission had ruled that members of the Worcester City Hospital Housestaff Association were employees and eligible for bargaining.

In late 1976, Rep. Frank Thompson (D-N.J.) had sponsored H.R. 15842, which in 1977 became H.R. 2222. This bill would amend the NLRA to explicitly define interns and residents as professional employees, thereby nullifying the NLRB "student" decision. Congressional hearings held in March, 1977, attracted extensive testimony both pro and con. Those in favor included the PNHA, CIR, AMA, American Medical Student Association (AMSA—formerly SAMA), the AAMC's Organization of Student Representatives, ANA, and the NEA. Those opposed included the AAMC, American Hospital Association (AHA), American College of Physicians, American Council of Medical Staffs, Congress of County Medical Societies, American Osteopathic Hospital Association, Association of American Universities, and the National Right to Work Committee (U.S. Congress, 1977).

Supporters emphasized the employee rather than student status of house staff for the purposes of voting residence, worker's compensation, veteran's reemployment rights, and federal income tax payment. They noted the extensive constructive experience of state and local governments in collectively bargaining with house staff, es-

pecially in locations such as Ann Arbor, Michigan, and Los Angeles, California. Opponents maintained that the fundamental nature of the relationship between teaching hospitals and house staff is educational rather than economic. They feared that the application of an "industrial" model would disrupt education, that the NLRB would become the final arbiter of educational affairs, and that Congress would be undermining the NLRB (U.S. Congress, 1978).

Extensive lobbying on H.R. 2222 occurred, with both sides organizing large-scale letter-writing campaigns. In July, 1977, Senators Donald Riegle (D-MI.) and Alan Cranston (D-CA.) introduced an identical bill (S-1884). Opinion was mixed about the future fate of the legislation.

On March 3, 1977, the PNHA filed suit in U.S. District Court, Washington, D.C., to overturn the 1976 NLRB decision, claiming that the ruling violated the intent of Congress. A lengthy, expensive, court battle was expected.

The PNHA convention in April, 1977, revealed about 6000 members and 20 local affiliates. For the first time, the president of the CIR was elected PNHA president. The organization rededicated itself to the long legal battle ahead for employee status. It also announced arrangements for regional staff to be shared by local affiliates and the national office. A foundation, Project HELP, was established to carry out educational and research programs. In June, 1977, the AMA RPS met and reported 10 state-wide resident physician sections and 10,450 house-staff AMA members for 1976. Relationships between the RPS and the AMA were observed to be cordial—a sharp contrast to 1974 when intern and resident representatives had walked out of the AMA House of Delegates over the issue of autonomy of the house-staff section. Matters had now progressed to a point where a house-staff candidate for the AMA Board of Trustees lost by only 10 votes (Tough Talk and Little Action, 1977).

In late June, 1977, the Nebraska Supreme Court upheld by a 6–1 vote an earlier decision of the Nebraska Court of Industrial Relations that house-staff members are employees and eligible for collective bargaining with the University of Nebraska. The court cited eight cases in three states—New York, Michigan, and Massachusetts—where state courts had also rejected the NLRB position. The State Supreme Court rejected, however, a separate bargaining unit for house staff. This left interns and residents bargaining with

other professional employees, pending further legal action (Nebraska High Court, 1977).

In September, 1977, the Second U.S. Circuit Court of Appeals ruled that the NLRB, not the New York State Labor Relations Board, had jurisdiction over house-staff labor relations in private institutions. This reversed an earlier lower-court ruling (NLRB has Jurisdiction over Housestaff, 1977). An appeal to the U.S. Supreme Court was planned by the CIR.

The NLRB itself had undergone changes in 1977. Member John Fanning, the lone dissenter in the "student" decision of 1976, had now become chairman. Additional new appointees of the five-member board by a Democratic administration raised the possibility of a different attitude toward collective bargaining by house staff.

Thus, 1977 ended with intern and resident organizations facing uncertainty over collective bargaining. The confrontations and job actions of 1975 had now cooled down to a plateau period of court proceedings and uneasy normalcy. Senior residents were becoming increasingly concerned about finding a suitable private practice site in competition with large numbers of specialist colleagues. Foreign medical graduate physicians were facing new difficulties in obtaining U.S. residencies because of strict standards imposed by the Health Professions Educational Assistance Act of 1976 (P.L. 94-484). Most local house-staff associations were busy consolidating the gains of the early and mid-1970s and enjoying relatively good relations with hospitals and medical schools. Disagreements were being taken to hospital committees or the courts, a more time-consuming but less disruptive situation than 2 years earlier.

Discussion

The issues leading interns and residents to organize have been remarkably constant over the past 40 years: inadequate pay and fringe benefits, poor working conditions, and uneven standards of patient care and training. Methods of achieving reform have also changed little—collective negotiation and occasional job actions. A major trend recently, however, has been the formalization of this

process. House-staff associations locally and nationally have found that viability depends on an explicit membership structure, regular dues income, staff support, newsletters, affiliations with stronger organizations, and, most important, negotiated contracts. Only through these mechanisms have intern and resident organizations been able to survive. Otherwise, the old problems of transiency, time constraints, and poor funding have resulted in neglect of implementation of gains achieved.

The house-staff choice of unionization as a formal process has disturbed some health professional leaders. One has pointed out that for a house officer to don another hat, that of striking union member, in addition to those of student, teacher, administrator, investigator, physician, and employee, may be a regrettable complexity that will further erode public confidence in physicians (Hunter, 1976). Others have seriously questioned the ethics and morality of physician strikes (Rosner, 1975).

Supporters of house-staff strikes have pointed out that the actions were a last resort to obtain necessary social change, that patients needing care "here and now" were provided for, and that the long-range improvement in health-care delivery justified short-term disruption of services (Dobkin, 1975, and Veatch, 1976). Binding arbitration as an alternative to health-care strikes has the support of some health professional union leaders. The concept is currently being written into some contracts and deserves further attention to prevent future dilemmas.

Although they were the first physicians to formally unionize and strike in the United States, house-staff members were not the first health professionals to do so. The American Nurses Association (ANA) has endorsed collective bargaining since 1946 and, as of 1977, had around 100,000 members under contracts. Collective bargaining had also been pursued by other organizations such as the American Society of Hospital Pharmacists (ASHP) and the American Society of Medical Technologists (ASMT) (Pointer and Cannedy, 1972). Physician unions emerged in the early 1970s, including the American Federation of Physicians and Dentists (AFPD), the Union of American Physicians (UAP), and the National Physicians Council (NPC) of the Service Employees International Union (SEIU) affiliated with the AFL-CIO. These were effectively countered by the AMA, which in 1975 endorsed collective bargaining and strikes, and set up a Department of Negotiations to

formally enter itself into the jurisdiction competition. Hospital and health workers had been unionized since the late 1950s by District 1199 (National Union of Hospital and Health Care Employees), SEIU, and AFSCME. Health professionals had sometimes been unionized into these groups when broad bargaining units were mandated.

Physicians, however, were not eager to risk a drop in professional status by joining unions where they could be outvoted by other workers. They generally preferred a unique "professional" approach to "collective negotiations" rather than traditional unionized collective bargaining. This usually meant, like the nurses, that their professional association had to deal directly with collective bargaining issues.

Beyond the borders of the United States, unionization of interns and residents was becoming quite active. Collective bargaining rights were won and effectively used in the 1970s by house staff in the United Kingdom, Australia, and certain Canadian provinces including Quebec, Ontario, and British Columbia. House-staff goals and tactics—better working conditions through job actions—were similar to those in the U.S. Unlike the U.S., in these countries house staff was not assigned student status. An anomaly developed in England as overtime pay was successfully negotiated by house staff. Junior (house staff) doctors began to receive better pay than some junior consultants (faculty). This result vividly demonstrated the effectiveness of collective action.

House staff in the U.S., while still struggling with student status, was ill-prepared to look ahead to the next big issue. A major unresolved question concerns to which bargaining *unit* interns and residents will ultimately belong. Will they have their own unit (as does the CIR)? Will they be placed with all salaried physicians (as has happened in some state universities)? Will they be lumped with many different categories of health professionals? Registered nurses in 1975 won an independent unit in NLRB proceedings, and it is possible that house staff will be assigned to either its own or an all-doctor unit in the future. If employee bargaining rights are ever achieved from the NLRB, it is possible that major jurisdiction competition could occur for affiliation of house staff associations. An intern or resident might ultimately vote in a union representation election for either an independent local association, the PNHA, the state medical association, the AFPD, or the NPC-SEIU-AFL-CIO.

Reform of postgraduate medical education was of interest to intern and resident organizations, but saw limited progress until contracts were negotiated. The rights and obligations of house staff and clinical departments had long been spelled out only vaguely in the AMA's *Essentials of Accredited Residencies*. Enforcement was not particularly strong until house staff spoke up in an organized manner. The key issue of excessive hours was neglected until contractual guarantees were won in New York, Chicago, and Los Angeles. Deans and department chairmen often considered the training program to be non-negotiable. However, the considerable overlap between training and service often led to items, such as on-call schedules and allied personnel support, appearing in the negotiations and ultimate contract. House-staff voting seats on important hospital committees were frequently granted to improve communication and help solve problems.

Conclusions

What have intern and resident organizations accomplished in the past 4 decades? Although it is difficult to ascribe specific achievements to such a diverse movement, the following generalizations are offered. House-staff associations were probably a major force behind improved salary and fringe benefits for interns and residents. From no salary in 1934 to a living wage in 1977 may have occurred spontaneously, but one has to believe that collective action played a major role. Better hospital funding through Medicare and Medicaid was no doubt a significant factor. This economic success may, however, be creating new problems. With salaries and training costs increasing and hours decreasing, cost-effectiveness of house staff may be eroded to such an extent that replacement by salaried physicians, nurse practitioners, or physician assistants becomes attractive. The national-average starting annual salary for physician

assistants in 1977 was about $14,000. Some hospitals have already begun substituting these professionals for surgical interns. How much the idea will catch on remains to be seen.

Shorter hours and better working conditions were certainly an accomplishment. One need only examine the contracts negotiated by house-staff associations to see major improvements in call schedules, ancillary services, and staff support. The old 120-hour workweek has gradually given way to a more reasonable schedule, but not without confrontations, such as the 1975 New York Strike.

House-staff associations were also successful in publicizing the plight of underfunded, understaffed, large, urban, public hospitals. Reforms were often short-term or token, but few other professional employee groups were as successful in directing public attention to the massive problems of these institutions. Ironically, by exposing these defects, house staff may have been hastening the demise of public hospitals. Closures, cutbacks in beds and staff, conversion to chronic care facilities, and take-over by the private sector have been the fate of a significant number of public hospitals lately. Hence, house-staff members have generated cutbacks in their own jobs. New residencies are being created, but these are often more closely supervised and lack the old autonomy and massive exposure to very sick patients. Whether house-staff activism actually improved patient care is difficult to judge. In certain places, like Los Angeles County Hospital, it *seemed* to stimulate reforms. One fact cannot be denied—house staff *tried* to improve the system.

Intern and resident organizations were responsible in part for persuading organized medicine and medical education to listen to its younger colleagues. Voting seats on key councils and committees of professional associations, policy-making bodies, hospitals, and medical schools were not granted until organized pressure was generated. The response to a more youthful viewpoint has been generally good. A major question now is whether succeeding groups of house staff will continue to provide input into such mundane matters as hospital governance. If apathy sets in, previous gains and contractual guarantees could slip, and history might repeat itself.

House-staff associations are also responsible in part for persuading organized medicine to support collective bargaining and open negotiations. For better or worse, the malpractice insurance crisis of 1975 opened the eyes of practicing doctors to the importance of collective negotiations and job actions. Although the concept is

still embryonic in the private medical sector, an increase in activity may occur. In 1977, a group of 80 doctors from a prepaid health plan in Washington, D.C., requested an NLRB election for a collective bargaining unit. Such activities would probably have been considered preposterous in the 1960s.

Finally, it is doubtful that house-staff associations have had much effect on the social orientation of doctors. The leadership of such organizations has often come from activist and even extreme left backgrounds, but such ideology has usually given way to the pragmatic necessities of survival in a teaching hospital environment. Collective bargaining did result in doctors dealing and collaborating with other hospital unions and professional associations. Such communication undoubtedly left some house-staff leaders with an improved understanding of the concerns of their co-workers. Negotiations also educated house staff about the concerns of hospital and medical school administrators. Such experience may prove valuable in the future careers of house-staff leaders, but only time will tell. Most house officers still remain committed to getting through their training and setting up a practice. Residency is a period of such rapid transition and heavy workload that many have little time for involvement. Any organizational success is, therefore, a tribute to the forward-thinking young physicians who have worked hard to keep intern and resident organizations alive all these years. Credit is also due to the older medical leaders who have seen fit to negotiate and deal with them in a fair and reasonable manner.

What does the future hold for intern and resident organizations? They will undoubtedly survive at the local level and perhaps at the national level, also. If one judges from history, the issues will not disappear. If collective bargaining rights are guaranteed by law, the associations will probably become more organized, powerful, and perhaps independent of the House of Medicine. If these rights are not guaranteed, the current situation of loose organization and periodic influence will persist. The collective bargaining model utilized will differ from the traditional trade union model in that so-called "professional" concerns will continue to come up in negotiations. As with teachers, nurses, and airline pilots, doctors will persist in seeking a strong voice in decision-making through negotiated contracts. This is inevitable as institutions in our society continue to become larger and more complex.

References

Agresta, N. M. 1973. House Officers are Headed for a Prosperity Plateau. *Medical Economics* 50 (May 14): 244.

Aims and Achievements. 1940. *The Interne* 6 (1): 14–17.

AIMS National Committee on Academic Freedom: The AMA and AIMS. 1950. *The Interne* 16 (4): 84–89.

American Medical Association. 1975. *Opinion of AMA Members—1975.* p. 213. Chicago, Ill.: AMA Center for Health Services.

———. 1976. *Directory of Accredited Residencies, 1975–76.* p. 22. Chicago, Ill.: American Medical Association.

Applebaum, A. L. 1975. Meaning of the N.Y. Strike. *Hospitals* 49 (April 16): 17a–d.

Association of American Medical Colleges. 1968. *Program Cost Allocation in Seven Medical Centers—a Pilot Study,* p. 30. Washington, D.C.: Association of American Medical Colleges.

———. 1969. *Program Cost Estimating in a Teaching Hospital—a Pilot Study.* Chapter 6. Washington, D.C.: Association of American Medical Colleges.

———. 1975a. *Brief of Association of American Medical Colleges as Amicus Curiae. NLRB cases No. 4-RC-11363, 7-RC-12639* (April 14). Washington, D.C.: Association of American Medical Colleges.

———. 1975b. Council of Teaching Hospitals. *COTH Survey of Teaching Hospitals—1975.* pp. 2, 58–62. Washington, D.C. Association of American Medical Colleges.

Baker, R. 1948. No Pay for Interns, No Room for Residents: the $64 Poser. *Medical Economics* 25 (February): 113–120.

Boston Interns Stage "Heal-in" to Force Pay Hike. 1967. *Medical World News* 8 (June 9): 11–12.

Bottone, A. 1970. San Francisco—Anatomy of a Non-strike. *The New Physician* 19 (October): 833–6.

Charles, A. F. 1970. Los Angeles Lawyers and Doctors Sue County for Better Health Care. *The New Physician* 19 (October): 823–6.

Coste, C. 1975. What the Strikers Won. *The New Physician* 24 (May): 33.

Dobkin, J. 1975. Housestaff Strike—Immoral or Inevitable? *New York State Journal of Medicine* 75 (September): 1784–6.

Fagel, B. 1972. The Evolution of SAMA. *The New Physician* 21 (1): 7.

Freymann, J. G., and Springer, J. K. 1973. Cost of Hospital-Based Education: Hartford (Conn.) Hospital. *Hospitals* 47 (March 1): 65.

Friedman, R. C., Bigger, J. T., and Kornfeld, D. S. 1971. Intern and Sleep Loss. *The New England Journal of Medicine* 285 (July 22): 201–3.

Frishauf, P. 1972. Survival: First Priority for Housestaff Association. *The New Physician* 21 (December): 714–719.

———. 1973. Thou Shalt Not Moonlight. *The New Physician* 22 (November): 694–701.

Gordon, M. 1976. Hospital Housestaff Collective Bargaining. *Employee Relations Law Journal* 1 (Winter): 418–38.

Heal-in: A New Tactic for Higher House Staff Pay. 1968. *Medical Economics* 45 (March 4): 160.

House Officers Sign Landmark Contract with Medical Center: Ann Arbor, Michigan. 1974. *Modern Hospital* 122 (January): 23.

House Staff Declare Independence. 1972. *Medical World News* 13 (March 24): 19.

House Staff Gains $165 for Each Hour of Walkout—DC General Hospital, Washington, D.C. 1971. *Hospitals* 45 (January 1): 96.

House Staff Still Pressing for Changes at DC General. 1970. *Hospitals* 44 (May 16): 118.

Housestaff Win Patient Care Improvements: Freedman's Hospital, Washington, D.C. 1975. *The New Physician* 24 (February): 17.

Hunter, T. H. 1976. How Many Hats Can a House Officer Wear? *The New England Journal of Medicine* 294 (March 11): 608–9.

Institute of Medicine. 1974. *Costs of Education in the Health Professions.* Washington, D.C.: National Academy of Sciences.

———. 1976. *Medicare-Medicaid Reimbursement Policies—Final Report.* Chapter 4 (Graduate Medical Education), p. 12. Washington, D.C.: National Academy of Sciences.

Internes Need Contracts. 1940. *The Interne* 6 (9): 274–286.

Interns and Residents More Than Double Stipends in Two Years in New York City. 1960. *Medical Economics* 37 (August 15): 46.

Interns Stage Four-day Strike at San Francisco Hospital. 1971. *Hospitals* 45 (February 16): 128.

Is the Council a Union? 1939. *The Interne* 5 (5): 141–3.

It Paid These House Officers to Organize. 1966. *Hospital Physician* 2 (April): 78–83.

Massachusetts Labor Board Counters NLRB, Declares That Housestaff are Employees. 1976. *Hospital Physician* 12 (June): 50.

McGarvey, M. R., Mullan, F., and Sharfstein, S. S. 1968. A Study in Medical Action—the Student Health Organizations. *The New England Journal of Medicine* 279 (July 11): 74–80.

Mullan, F. 1976. *White Coat, Clenched Fist.* p. 205. New York: Macmillan.

National Labor Relations Board. 1976. *Cedars-Sinai Medical Center (Employer) and Cedars-Sinai Housestaff Association (Petitioner).* Report No. 57, Case 31-RC-2983, pp. 3, 223. Washington, D.C.: National Labor Relations Board.

Nebraska High Court Says Housestaff Are Employees. 1977. *The New Physician* 26 (September): 19.

New Tactic for House Staffs: Bargain for Better Patient Care. 1973. *Medical World News* 14 (September 7): 20–1.

NLRB has Jurisdiction over Housestaff, Says Court. 1977. *Health Manpower Report* 6 (21): 2.

Paxton, H. T. 1965. National Voice for House Officers? *Hospital Physician* 1 (November): 83–84.

Perry, T., and Ely, D. 1947. AIMS: Past, Present, and Future. *The Interne* 13 (5): 126–177.

Philadelphia House Staff: "Students Not Employees." 1972. *Medical World News* 13 (January 28): 53–4.

Pointer, D. D., and Cannedy, L. L. 1972. Organization of Professionals. *Hospitals* 46 (March 16): 70–72.

Restless House Officers Move Toward Community of Action. 1971. *Hospital Physician* 7 (June): 59.

Rosner, F. 1975. Immorality of the New York Physicians Strike. *New York State Journal of Medicine* 75 (September): 1782–3.

Silagy, J. 1939. Five Years of Progress. *The Interne* 5 (7): 197–199.

Tough Talk and Little Action at AMA Annual Meeting; SBS, RPS Focus Inward. 1977. *The New Physician* 25 (August): 10–13.

Treasurer's Report. Interne Council of America. 1939. *The Interne* 5 (1): 5–6.

U.S. Congress (95th). 1977. Hospital Housestaff as Professional Employees. *Hearings Before the Subcommittee on Labor-Management Relations of the Committee on Education and Labor—House of Representatives. HR 2222.* No. 89-7780. Washington, D.C.: U.S. Government Printing Office.

———. 1978. Coverage of Medical Housestaff Under the National Labor Relations Act. *Report from the Committee on Education and Labor—House of Representatives. HR 2222.* No. 95-980. Washington, D.C.: U.S. Government Printing Office.

U.S. Department of Health, Education, and Welfare. 1971. *Proceedings and Recommendations of the First National House Staff Conference.* DHEW Publication No. (HSM) 72-9, pp. 14–17. Washington, D.C.: U.S. Government Printing Office.

U.S. District Court. 1977. Southern District of New York. 76 Civ. 5119, pp. 32–33, January 31.

Veatch, R. M. 1976. The Ethics of Physician Strikes. *Hospital Physician* 12 (January): 28–37.

A Vicious Attack on Internes. 1938. *The Interne* 4 (1): 6–30.

Will House Staff Associations Become More Than Unions? 1971. *Hospital Physician* 7 (June): 59.

The author would like to thank Fitzhugh Mullan, Arthur Bushel, and Peter Frishauf for their assistance in reviewing this manuscript, and Cindy Della Monica for its preparation.

Address correspondence to: Robert G. Harmon, M.D., M.P.H., Department of Health Services, School of Public Health and Community Medicine, University of Washington, 340 "U" District Building, 1107 N.E. 45th, Seattle, Washington 98105.