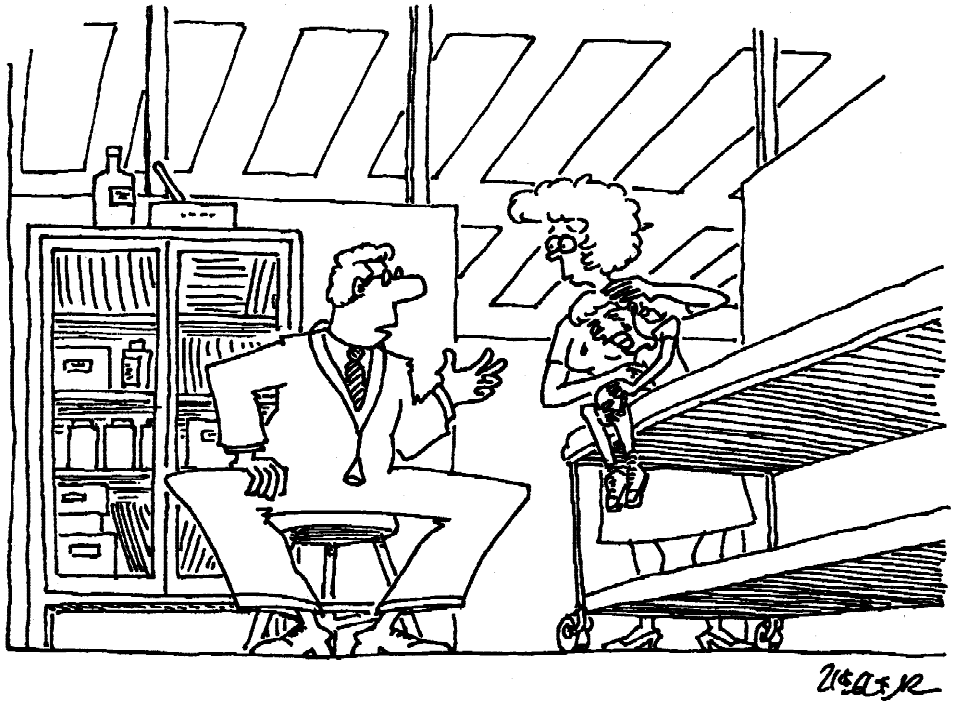

"Sorry, but I don't do stitches anymore. All stitches are now handled by Local 405 over at Bellevue."

Collective Protest Actions by Licensed Health Professionals

PAUL J. REITEMEIER

Public opinion polls consistently reveal that U.S. society wants three basic characteristics in its healthcare system: (1) convenient access to skilled professionals and quality services for everyone, including primary care and specialty personnel and services especially for the very seriously ill; (2) personal affordability at both levels of service; and (3) happy health professionals. Meeting these three goals simultaneously has proved to be quite challenging. The goal of universal access to basic and specialty services pulls against the goal of affordability. Health professionals caught in the middle of this struggle find that their satisfaction with work conditions suffers as a result. If truth is the first casualty of war, worker and consumer happiness appears to be the first casualty of substantive healthcare reform in the United States.

In this essay, I provide a brief overview of several key features of modern healthcare organizations and their systems of service delivery and financing, which contribute to some licensed health professionals feeling the need to engage in collective protest actions, including work slowdown or stoppage, and several types of strikes (e.g., refusal to perform out-of-contract work, informational picketing, coordinated sickness call-ins, refusals to report to work). When work-related tensions caused by unsatisfactory working conditions and unresponsive management become unbearable, some health professionals have objected by withholding their services as a form of protest against management's refusal to concede to certain demands. These demands typically focus either on aspects of patient care, or on professional compensation arrangements, or both. Public reaction to strikes by health professionals is strongly opinionated and divided. Protest supporters emphasize the need to ensure quality healthcare services and work environments that maximize patient welfare, whereas critics object to patients being placed at risk through the intentional withholding of essential health services. The moral question of interest is whether collective protest actions, especially strikes, are ever ethically defensible. If they are not, what alternative protest methods are both effective and ethically defensible? And if they are not defensible, is it mostly owing to the nature of healthcare as an essential service, or to the nature of the life-preserving need for these services by persons who are seriously ill, or to some other factors?

Organizational Changes

From an organizational point of view, the structure of healthcare delivery and finance has changed dramatically over the last 30 years. Clinical practice styles

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have seen a marked operational and philosophical shift from that of a service orientation to one of commercial business. This has been accompanied by a serious blurring of the nature of providing licensed healthcare services from a profession into a commerce. In the 1970s, three-fourths of medical and surgical residency graduates in the United States were trained as specialists who referred patients to and from other specialists for consultation and treatment. Financing arrangements were primarily retrospective fee-for-service compensation to individual practitioners and freestanding group practices. In the 1990s, by contrast, nearly one-half of the 20,000 annual medical school graduates now train to deliver primary care under prospective capitation reimbursement and are employed in the service of large corporate organizations. Within these large corporations, physicians typically represent less than 10% of the total employees. Their role has changed from the undisputed singular power leader to that of an institutionally embedded team player, and with that change has come a myriad of challenges to their professional self-image and sense of ethical accountability.

Corporate management language now reflects a new professional hierarchy and orientation. Patients have become "clients" and "stakeholders," and corrective changes to internal structural and operational processes increasingly focus on systems rather than individual decisionmakers. This is represented by new organizational operation systems such as Continuous Quality Improvement, Distinction Through Quality, many of which capture their new orientation with the adage, "People do not fail—systems do." Health professionals' behavior now responds more to external oversight and explicit regulation and sanctions by nonlicensed (or licensed but nonpracticing) professional managers than the traditional—and confidential—peer assessment. This is important for it introduces a significant third party into the previously private provider-patient dialectic. The acute care hospital is no longer the central facility in the new healthcare organization, nor is it the site where most clinical services are delivered or where most revenues are generated. Local and regional associations of clinical professionals are increasingly fractious and openly competitive with each other for securing an increased and stable market share of insured persons' healthcare contracts.

One of the most ethically alarming changes is that organizational allegiance is beginning to replace patient advocacy and technical competency as the primary markers of professional success within healthcare organizations. In assessing professionals' skills for the new healthcare marketplace, behavioral measures have taken on increased importance in both undergraduate curriculums and patient satisfaction surveys, and expectations of continuous self-education have also increased. As corporate healthcare organizations grow larger and purchase ever-greater portions of the healthcare industry, including pharmacies, long-term care facilities, health promotion initiatives, and hospice programs, distinctive corporate cultures and ethos slowly emerge. Organizational "fit" and "adaptability" (including agreement to variable compensation structures) are joining completion of accredited training programs and personal recommendations as the criteria for evaluating new professional employees. Corporate leadership in healthcare, however, often consists of directors whose backgrounds and goals are rooted in business concerns, not patient care. This is perhaps most succinctly captured by the timeworn administrative caution, "No (profit) margin, no (patient care) mission."

When this period of dramatic organizational change stabilizes—or at least slows to a predictable rate of change—the final outcomes for both employees and patients will require decades to mature before durable operational stability can return to the healthcare industry. During the interim period of metamorphosis and uncertainty, health professionals' collective protest actions, including strikes, can be expected to increase for two reasons. First, significant organizational changes heighten employees' personal uncertainty concerning their role in the organization, and this often leads to professional hesitancy and political skepticism concerning the functional value of loyalty. These reactions create psychological attitudes conducive to forming and joining others to struggle together toward resolving personal uncertainty. Second, the growth and restructuring of large healthcare organizations frequently displaces hundreds, sometimes thousands, of workers, causing those who remain to reexamine the stability of their own relationship and the depth of commitment to their employer and coworkers. Employees at all levels quickly learn that large-scale institutional change generates a momentum that is difficult to resist or even to redirect. Organized, collective protest actions may be viewed by employees as the only tangible effort they can effectively expend in reaction to large shifts in organization philosophy and priority setting.

Health professionals' personal moral ethos and accountability may need to change in response to the altered economic arrangements and the increased bureaucratic control of large-scale patient care operations.[1,2] The professional's self-image must shift from that of autonomous and authoritative leader to one of subservient team member whose personal goals and objectives are routinely subordinated to organizational objectives. Indeed, some have suggested that organizational changes in healthcare during the last quarter of the twentieth century reflect a larger social evolution into a new age in which the very roles and functions of health professionals are fundamentally being changed. Historian Rosemary Stevens has predicted that the current organizational changes will engender a reexamination of the very nature and meaning of the medical profession and of professionalism, will reflect shifts in the public's basic assumptions about health, illness, and roles of service providers, and, perhaps most interesting to bioethicists, will require a new ethical reference frame in which to assess these changes.[3] Bioethicist and nursing professor Mila Aroskar has echoed this concern, arguing that although

> traditional nursing values were imperfectly realized in fee-for-service medicine in which medical goals of cure often dominated nursing goals of care, [these values] are even more under siege . . . in the emerging healthcare systems under the broad rubric of managed care.[4]

Health professionals entering the job market today will not share the same working experience as did their predecessors even 20 years ago, roughly one half of a professional career. The new organizational changes are having profound effects on professional autonomy and accountability in virtually every aspect of patient care.

Changing Healthcare Needs and Services

In addition to organizational changes and the accompanying operational challenges to health professionals' character, patient illnesses and treatment modal-

ities also have changed, although more slowly. Since the 1940s, two important shifts have occurred in the nature of most patients' healthcare needs. First, the types of illness that occupy physicians' professional time have changed. There has been a comparative decrease in acute, infectious processes generally and an increase in need for treating chronic illness and disability, especially among elderly patients. More recently, pandemics of drug abuse and interpersonal violence also have emerged, becoming the leading causes of death among some age cohorts.[5] Medical treatment itself also has changed, with much greater emphasis being placed now on behavioral and cognitive aspects of diagnosis and treatment and the open acceptance of alternative forms of healing, including the creation of an Office of Alternative Medicine at the National Institutes of Health.

Second, patients themselves have shifted from being passive recipients to active consumers of professional services. They are better informed, more articulate, and bolder in stating their treatment preferences than a few decades ago, and medical consumerism is a popular focus for both public activism and the media. Media reports on breaking medical news items often highlight differences of opinion among clinical experts. Clinicians themselves increasingly inform patients of the wide availability of self-educational resources in brochures and on the Internet. An increased division of health professional labor and the slow emergence of more egalitarian partnerships between licensed professionals and their patients are diffusing authority in healthcare from single physicians to all members of the healthcare team, with the patient nominally and often in fact at the top of the hierarchy. These changes place the professional's clinical diagnostic and treatment decisions under additional stress, and the result can produce significant variability in treatment decisions for patients with similarly presenting complaints. These differences are due in part to the range of information sources utilized and partially to the need to accommodate multiple and sometimes divergent interests among the affected parties. Traditional reimbursement rules, however, require standardization and reproducibility across treatment incidences.[6] These changes in illness prevalence, identification and preferences for treatment options, and patient roles point to a need for reconceptualizing the nature of healthcare services. Moreover, the substantive components of providers' individual and collective integrity as clinicians may need to be examined and recast in light of these new roles and relationships. Attempts to retain previous professional autonomy when negotiating with patients for mutually acceptable treatment plans may or may not prove to be the ethically most important objective. But until a new conceptualization of their roles and responsibilities is clearly and widely understood by providers and patients alike, it should not be surprising that preserving or enhancing traditional professional autonomy is the most often cited reason for collective protest actions by licensed health professionals.

Evaluating the Ethics of Collective Protest Actions by Licensed Health Professionals

Constructing an appropriate reference frame for evaluating morally any collective protest action by health professionals is complex and difficult. It is complex because the evaluation objectives selected dictate which empirical features get emphasized and which get set aside. It is difficult because not all observers will

select the same evaluation objectives or agree on the relative importance of their various features. These considerations include (1) identifying ethically acceptable methods of protest and conflict resolution within private, corporate, public, and academic organizations; (2) philosophical conceptions of justice concerning access, financing, and distribution of essential services; (3) the rights of patients to publicly funded resources and services; (4) protections for licensed professionals against restrictions of trade and supporting the freedom to practice; and (5) the appropriate role of government in constraining costs through price controls while simultaneously increasing provider costs through regulatory oversight for safety and efficacy.

Once ethical evaluation objectives have been selected, a starting point is then needed to begin the analysis. Whereas philosophers typically conduct a straightforward logical analysis using well-known ethical theories, health professionals are decidedly not philosophers. Thomasma has noted that striking healthcare workers of the past often did not deduce their reasons for or justification of strike actions from any particular ethical theory but acted instead from an emotional base that was drawn from their "fundamental value commitments to the good of patients."[7] Similarly, Linn reported finding an absence of principled reasoning altogether among one group of striking physicians,[8] and Zawacki has raised serious doubts whether professional duties or oaths have significant meaning or importance compared to other motives, especially economic ones, when healthcare professionals were considering strike actions.[9]

Without a generally accepted theory-based starting point for justifying strike actions under all possible circumstances, the pragmatic rules of ethical conduct must be sensitive to the local conditions of what has become a rapidly evolving medical marketplace. Additionally, the public must be able to understand the protesters' motives in order to judge the rightness or wrongness of particular protest actions. Therefore, two important features of the protest must be accurately portrayed. First, the precise nature of the protesters–management tensions must be made transparent. Second, because of the wide variability in local conditions including available economic resources, patients' demographic characteristics, provider competition, and organizational commitment to serving the common public good, it is not reasonable to presume that a single set of ethical rules will be adequate for ethically governing all possible protest actions under all possible conditions. Thus, to be defensible, the most that probably can be said is that adherence to a few basic ethical principles is required for any protest action that impacts patient care, and the public must be convinced that these principles have been faithfully observed.

Ethical Requirements for Industrial Actions

Twenty years ago, Norman Daniels argued that for a health professional strike to succeed on ethical grounds, it had to meet four conditions:[10] (1) the strike action could itself entail no serious increased risk of loss of life; (2) significant strike goals must include (but are not limited to) improved patient care; (3) alternative avenues must have been pursued in good faith; and (4) a clear target must exist against which the strike action is aimed and which controls sufficient force to grant the legitimate goals of the strike. The ethical basis for these requirements can be found in Kant's second formulation of the categorical imperative: always treat other persons as having individual moral worth and

dignity and never treat them merely as a means to one's own ends. Striking workers are sometimes criticized for using patients as a means to serving the workers' own ends. Although that is, admittedly, a necessary element for a strike action to be ultimately successful, it becomes ethically problematic when such use fails to properly regard the patients' moral worth and dignity. In such cases, it is a serious breach of moral duty, regardless of the motivations of the strikers or the desperateness of their employment situation.

To meet Daniels's first condition, several preparatory steps are required. First, the timing of the strike must be announced in advance so that the public's need for making alternative arrangements can be anticipated. Second, striking workers who provide essential healthcare services must maintain the standard of care during the strike. The precise details needed in this regard are often contentious, but in healthcare they typically include emergency and critical care services, including emergency surgery and selected clinical laboratory services.

Daniels's second condition—that the strike aim at improving patient care—must remain primary in any strike action or one of the character-defining aspects of health professionals will have been lost, perhaps permanently. Strike actions are explicitly designed to exert financial and political pressure on management to make concessions to the strikers' demands. These pressures, however, arrive circuitously because the strike's immediate effects are on those inconvenienced or harmed by the loss of striking workers' services, and those effects are neither financial nor political but essential for healthy and safe living—for example, loss of medical treatment, fire or police protection, garbage removal, mail delivery, public education, or rail or airline transportation. Consumers and their representatives put political pressure on management to do whatever is necessary to return the protesting workers to their regular work functions. If patient welfare is placed at risk through the withholding of health professionals' services for purposes that do not include enhancement of patient welfare, the very status of healthcare workers as professionals may be lost. Daniels's third condition, pursuing alternative avenues of conflict resolution, must continue during the strike action by both management and the protesters' leadership.

The Changing Face of Healthcare Leadership

Most individual health professionals are neither greedy nor opportunistic with respect to their expectations of compensation. Moreover, health professionals' strikes in the past have been rare and traditionally have put patient concerns well ahead of the professionals' own economic or other personal interests. However, the practice of healthcare, like many other professional practices, is shifting toward large-scale organizations. Individual health professionals no longer have the organizational, administrative, or economic autonomy they enjoyed in the past and, consequently, their bargaining positions are comparatively weaker. Managed care leaders have demonstrated that they can alter physician practice styles and thus reduce use of resources, but the measures they use to do so often engender a professional-organizational conflict.[11] Money is more tightly controlled; insurance, goods, and services are in stiff competition; and more extensive managed care and prospective capitation is acceler-

ating. To assuage health professionals' concerns about the loss of patient-care focus in understanding and addressing these issues, some physicians find they must decrease their clinical roles and accept administrative functions to ensure the presence of the "clinical point of view" in making difficult trade-offs and compromises that both continue the mission of patient care and ensure financial solvency. At the same time, groups of self-employed practitioners are increasingly assuming financial risk in order to preserve a reasonable and ethically responsible level of professional autonomy.

The recent appearance of multistate healthcare organizations that control billions of dollars, cover millions of lives, and employ thousands of people may tempt us to view healthcare as a powerful but unwieldy industry, a brutish, undisciplined, commodity-producing player in the capitalist free market. Adopting such a view, however, also requires that we change our traditional view of healthcare practice from that of a vocation to one of a business and to reconceptualize the healing arts from a social service to a market-controlled exchange of commodities for cash. The commodification of health services, goods, education, and insurance products "solves" the access to services problem by placing their just distribution squarely in the market of free trade and exchange. If that is what the public truly desires to happen, the Federal Trade Commission presumably could attach restrictions to the procedural rules for forming and operating health system conglomerates and to regulate healthcare like any other industry. But healthcare as an industry is too vulnerable and responsive to extra-market influences to behave like a traditional corporate entity. Although some have suggested that systemic healthcare reform is unalterably headed in precisely this direction, the ethical advisability of such a shift remains an open question. Health professionals (and indirectly their patients) now face social, political, and economic choices that will have enormous influence on their professional ethics, but for which their previous experiences may not have prepared them to know how to choose well.

Restrictions on professional autonomy in the United States notwithstanding, financial earning differences within the healthcare maelstrom are legend. The average annual income for the more than 700,000 physicians has reached $200,000, approximately 5.5 times the average patient's income, with low-end physicians earning about half that much and high-end earners receiving several multiples of it. Nearly two million nurses now earn an average of $35,000 for full-time work, roughly equivalent to the average two-income U.S. household, and range upward to more than twice that amount. The received view is that health professionals are hardworking and the vast majority compassionately serve those who are ill. But the business of healthcare is simply too big and financially too lucrative to be completely free of unscrupulous professionals whose economic self-interests direct their thinking and actions. In February, 1999, the Inspector General of the Health and Human Services Department reported that recent efforts to fight fraud and overbilling by health professionals had reduced the erroneous payment rate in Medicare by one-half (from 14% to 7.1%), producing a savings in only one year of *eight billion dollars*.[12] In 1997, six strikes of one and two days were called by the 7,500-member California Nurses Association and a seventh strike was averted at the last moment. In New York, the state nurses association members struck for over ten days to protest switching from 12- to 8-hour shifts, losing some of their disability coverage, increased parking costs, and reduction in tuition assistance.[13]

On the healthcare consumer side, however, the annual outlay by patients and their employers for health insurance premiums, copay charges, deductibles, and over-the-counter medical products total more than food, clothing, housing, and transportation.[14] On a national scale, more than one trillion dollars is spent annually on all aspects of healthcare yet 41 million Americans, roughly 18% of the population under 65 years of age (including 11 million children) lack any health insurance at all but are not eligible for the social assistance programs that are reserved for the desperately poor.[15] An additional 31 million are underinsured and face out-of-pocket costs upward of 10% of their after-tax income if they were to become seriously ill.[16] Thus, whereas health professionals are very well paid, and their patients are very deeply challenged to afford healthcare services, some health professionals have found it necessary to withhold services as a protest action against what they perceive as unacceptable working conditions.

A Health Professional's Duties to Patients and Duties to Self

A distinction concerning striking health professionals' different duties to their patients and the public often is overlooked. It is inaccurate to say that emergency medical transport workers, physicians, or nurses directly harm patients by withholding professional services during a strike action. Rather, these professionals either fail to rescue patients with an existing illness (which the health professional did not cause) or they fail to diminish or prevent foreseeable future harm from occurring (e.g., intentionally not treating a patient with suspicious chest pain). During a strike action, the risk to the public is that of increasing existing harm more than otherwise would be the case, not the risk of suffering an initial harm that otherwise would not occur. This is an important distinction because the three moral duties of not harming, removing harm, and preventing harm in the general case have different degrees of obligation. Moreover, these three obligations are further complicated by the comparative degrees of risk and severity of the harms involved under different circumstances.

If the risk and severity of a given harm are both moderate, say a knife wound to the arm, then the duty to refrain from causing that harm to another person is the most obligatory, whereas the duty to repair the harm already done (by someone else) is comparatively less obligatory, and the duty to diminish or prevent the harm from occurring in the future is least weighty of all. Part of the reason for this turns on the socially embedded roles that individuals have voluntarily assumed for themselves by accepting work assignments in society. The duty to not stab another person maliciously is equally shared by all persons regardless of their social role. The duty to remove the harm of a stab wound falls exclusively to those with appropriate medical training and positional responsibility, such as those working in a medical emergency department. The duty to prevent future stab wounds from occurring falls most centrally on those responsible for public safety, including lawmakers and enforcement personnel.

However, if a mix of different harms and their accompanying variable risks are included in a matrix of possible and actual duties, the situation becomes much more complicated. If the risk and severity of harm are both significant, the duty to prevent that harm from occurring in the near future may outweigh the duty to remove an already existing but less severe harm. Thus, the duty of

preventing future harm of a cardiac arrest by thoroughly evaluating and protectively admitting to the hospital a patient with symptomatic chest pain and shortness of breath may be more compulsory morally than the duty of removing existing low back pain. In both cases, health professionals who withhold professional services do not harm patients; they only fail to prevent predictable future harm from occurring, or fail to relieve patients of existing harms, which is not the same thing from a moral point of view.

It is clear from these distinctions that in the healthcare environment the duty to refrain from engaging in a collective protest action, including strikes, falls differently on workers with different professional foci and responsibility. For example, emergency and critical care professionals focus primarily on diminishing or removing significant harm that presently exists and secondarily on preventing potential future harm from occurring. Clinical office professionals focus both on evaluating and diminishing existing harm and on preventing future harm, but the severity of the harm ranges from significant to trivial. Clinical laboratory professionals provide important assistance to patient care providers in both removing existing harm and preventing potential future harm. An emergent care center that lacks the support services of a clinical laboratory will be significantly hampered in its ability to provide appropriate diagnostic and interventional services to remove or diminish harm to patients. Thus, clinical laboratory health professionals' moral duties regarding strike actions are more closely aligned with those in emergency and critical care than with those in clinical offices. Finally, health professionals who provide only administrative services do not work to remove or prevent harm to patients but instead increase the efficiency of the institution's bureaucratic, regulatory, and financial functions so that the direct care providers can focus on removing and preventing harm. These considerations suggest that different health professionals have varying moral obligations regarding individual participation in a strike action.

Suppose that there is a strike by a subgroup of health professionals at a particular hospital. Suppose the workers' reasons for striking primarily concern patient care in some long-neglected areas such as staffing needs, and that the strikers believe that current patients are at risk of substandard, even dangerous, conditions as a result. Finally, suppose that all previous good-faith attempts at negotiating a resolution to the issues have failed and that the strike was previously announced before being called. What are the strikers' duties to patients and the public? What are nonstriking health professionals' duties to the striking workers?

Avoiding "Them-Us" Versus "Us-Us" Mindsets during Strike Action

The provision of essential medical services such as emergency and critical care (including adequate lab services), although specialized and highly skilled, often can be provided by select other health professionals within recognizable limits. For example, if nurses are engaged in the strike action, nurses employed in the emergency, critical care, or surgical operating areas can have some of their nursing work adequately approximated by physicians from other care areas, within certain skill limits, for at least a limited period of time. Similarly, if resident physicians are on strike, some of their professional services can be provided by knowledgeable nurses or physicians working in administration,

on a temporary basis. The focus in these substitution situations is to minimize the risk of avoidable harm to patients without employing external professionals in an effort to break the strike. It is to attempt to maintain a minimum standard of quality services to patients who are unavoidably under hospital care, while granting to the striking workers a reasonable show of solidarity and support for their strike demands.

By substituting health professionals from other clinical areas to cover the hospital's essential services, patient welfare may be minimally safeguarded, at least temporarily. If the nonessential service workers are honoring and enhancing the effectiveness of the strike action by voluntarily refusing to cross picket lines, they are not directly withholding their professional services from patients. Rather, their refusal to work is properly construed as respecting an ethical obligation of solidarity with professional coworkers whose legitimate protests are deemed of sufficient moment to warrant such recognition. This is where significant political pressure on hospital or health plan management arises. If essential services are provided in a way that both maintains a minimum standard of care quality and reflects a broad base of worker solidarity, then the health professionals cannot be accused of failing to adequately remove or diminish existing harm to patients. It will not, however, be an optimal or permanent working arrangement and all workers' frustrations, therefore, will be heightened. Management cannot fail to notice such changes, as will the local media, and the combination of internal and external pressures likely will catalyze focused efforts toward strike resolution.

It is of some interest to note that the American Medical Association, the largest body of licensed physicians in the United States, reversed its long-standing opposition to unionization among physicians in June 1999. This move was not without controversy, however. The House of Delegates petition arose from a grassroots-level concern about practice constraints under managed care organizations' directives and incentive practices. The AMA leadership unsuccessfully opposed the position reversal. Unionization does not logically entail collective strike action, however. The AMA's final position statement stipulates in its first section that, "Collective action should not be conducted in a manner that jeopardizes the health and interests of patients," and later in section 3, specifically addresses strikes as follows.

> Strikes reduce access to care, eliminate or delay necessary care, and interfere with continuity of care. Each of these consequences is contrary to the physician's ethic. Physicians should refrain from the use of the strike as a bargaining tactic.[17]

Recognizing that strike actions only follow from long-standing conflicts between large groups of workers and management, the ethical objective for resolution is finding a compromise to the positions of the parties in conflict while preserving the ethical integrity of each.[18]

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