Editorial:
What Course for Health Workers

Demands for radical restructuring of the health system are the focus of the health movement which has emerged in the last few years. But for most of the one and a half million unskilled and semi-skilled hospital workers in the country, such demands are irrelevant, a utopian luxury. They have more basic needs that come first, and they are turning to conventional labor unions to solve them.

Hospitals have long been the urban employer of last resort. The newcomers, the discriminated-against, those who are excluded from other jobs are likely to end up as porters, nurses' aides, orderlies, kitchen help, housekeepers, and the like, in the immense and rapidly growing hospital industry. Wages for these jobs, in most of the country, are scandalous; $60 a week is still common. Hours are long, duties dirty and boring, job security non-existent. Anyone who can get out of a hospital into another job does so; turnover rates often approach 90 percent per year.

Throughout the country, the drive to unionize is on. Local 1199 of the Retail, Wholesale and Department Store Workers, the Teamsters, the Service Employees International Union, and the American Federation of State, County and Municipal Employees are organizing hospital workers in a score of cities. And despite a rapidly turning over, demoralized, fragmented work force, despite intense hospital opposition, despite an almost total lack of legislation protecting the rights of hospital workers to organize, unionization is making rapid progress throughout the country. The movement to join unions is the major mass movement taking place among health workers today.

What will be the impact of this mass movement of hospital workers be on the growing movement to reshape the health system? To many politically active health workers and students, a unionization drive seems an ideal opportunity to (radicalize) workers, to gain allies in the struggle to change the health system. Some have hoped that once unionization has been achieved, the union itself would become a major force in changing the health system. For reasons to be discussed below, this seems unlikely, in the short run at least. Nevertheless, health movement activists cannot remain aloof from the unionization drive.

For one thing, unionization and the gains it can bring are rightly the number one priority of most hospital workers. Demands for higher wages, shorter hours, and job security are their most pressing needs. No one can be a friend to the workers who ignores the fastest route to meeting these needs. For another thing, workers do not necessarily lose interest in other issues once their economic demands are met. In fact, it is just as likely to be true that when workers have escaped from the imminent threat of hunger, when they are not afraid that their jobs will disappear from under them tomorrow, that then they are freed to turn their attention to more distant, more far-reaching issues. In any event, the union, by freeing the workers from the fear of arbitrary dismissal from their jobs, can provide the environment in which effective organizing around non-bread and butter issues becomes possible.

This means that, in places where there is no union, health movement activists must wholeheartedly support the drive to unionize. And in places where there already is a union, it is wrong to treat the union in itself as an enemy. Support need not be blind support, of course. Unions can be criticized for their failure to raise non-bread and butter issues, for internal lack of democracy, for their unwillingness to ally themselves with other forces for change in the health system. But in being critical, it is necessary to be careful not to be divisive, not to threaten the union's role as an organization that is able to protect the economic well being of its members.

The potential role of unions in restructuring the overall health system in addition to meeting the immediate needs of the workers cannot be understood without a more general discussion of the relation between health workers and consumers of health care. Some activists have suggested natural grounds for unity between health workers and consumers of health care. Some activists have suggested natural grounds for unity between health workers and consumers of health care. Some activists have suggested natural grounds for unity between health workers and consumers of health care. Some activists have suggested natural grounds for unity between health workers and consumers of health care. Some activists have suggested natural grounds for unity between health workers and consumers of health care. Some activists have suggested natural grounds for unity between health workers and consumers of health care. Some activists have suggested natural grounds for unity between health workers and consumers of health care.
of schools. But the factors forcing service workers and their clients apart seem in the short run at least, more powerful than the unity of skin color and place of residence.

The situation in which health care is delivered in this country almost naturally pits workers against consumers. First, under American capitalism, health, like other social services, takes a low priority. While defense budgets, highway budgets, and the like flourish, health institutions are starved even within the hospitals, high wages for administrators and professionals, expensive research and educational programs, prestigious equipment and fancy new buildings take priority over wages for non-professional employees and health service for the public. When the workers ask for higher wages, shorter hours, better fringe benefits, all of which cost money, the hospitals claim they have only two alternatives. They can raise charges which, in turn, increases health insurance premiums paid by the public and forces the costs of tax-supported programs like Medicaid and Medicare to soar. Or they can cut back on services and lay off workers. As long as health care is not a high priority of this society or even of its health institutions, the needs of hospital workers and hospital consumers are in direct conflict. More for one means less for the other.

The second cause for conflict between hospital workers and the community stems from the nature of hospital work in our health system. Most hospital jobs are dirty, low paid, tedious. The stagnant hierarchy, supported by elaborate credentialing requirements and arrogant professionalism, turns most hospital jobs into "dead end" jobs: a porter or aide is stuck forever as a porter or aide. It is under these conditions that health worker-patient relations deteriorate, that every patient's endless tales of the rudeness and indifference of hospital workers originate.

It is in the context of this tendency of our health system, in our overall political-economic system, to pit worker against client that the role of the union must be examined. Can the unions overcome this worker-consumer antipathy, or will they make it worse? At first glance, their potential to exacerbate the situation dominates our view.

First, unions, by their nature, are organizations of workers. They exclude consumers. They are thus organs for the workers to press aggressively for their own interests, which in our health system are often in conflict with the needs of the public for low cost, high quality hospital care.

Second, unions are a peculiar kind of institution. By law and custom, their role vis à vis management is limited. At contract time, they are the organs of the workers' struggle, trying to force management to give the workers more wages, better working conditions, etc. Once the contract is in effect, however, they become to a significant extent an agent of conciliation. They do administer the contract, trying to make sure that management lives up to the end of the bargain. But in return, the union's role is to supply a disciplined work force. The contract sets up procedures for disciplining workers who threaten an orderly work relationship (whether in a political way or simply through personal tardiness, not knowing their place, etc.). The union contract often forbids wildcat strikes over workplace issues, and the union is legally bound to help quiet things down if the workers do get restless.

The union-management relationship, defined both in Federal and State law and in the contracts themselves, creates roles for union and management, leaving a broad area of management prerogative in which the union must not interfere. In effect, the union and the management have made a deal: The management agrees to be reasonably cooperative in giving the workers improved wages and working conditions and in not being too arbitrary in their dealings with workers. It also agrees to tolerate the union's existence, as the workers representative in these dealings. In return, the union pledges not to tread upon the management's toes in many vital areas of decision-making and to help management maintain a disciplined workforce.

It is not absolutely necessary for a union to accept this framework, of course. The alternative is to refuse formal recognition under the labor laws, to make no long term contracts, to bargain issue by issue. The choice facing a workers' organization is a bitter one. To forego the protection of the labor laws means constant struggle against management and even against the government merely to go on existing. Meanwhile, the organization and its members will lack the elementary protections for their activities which the laws and a contract would provide. In practice, the pressure is very strong for a workers' organization to accept the limitations on it implied by the conventional union-management relationship in order to be able to continue to assure gains for its members.

The need to accept this "arrangement" is particularly pressing for the typical hospital union. These unions are made up of unskilled and therefore easily replaceable, poor and therefore easily starved-out work-
Finally, the necessity of bonding together a large and diverse group of workers to effectively confront a united and powerful institution such as a hospital has encouraged union leaders to try to centralize their power and to squash dissent. Centralized, unquestioned power in the leadership often becomes stagnant, undemocratic bureaucracy. The continuing power of this bureaucracy is dependent on the existing structure of management-worker relationships. Thus, the union leadership often comes to oppose any moves, whether among their own members or from outside the union, which threaten to disrupt those relationships.

For all these reasons, there are tendencies for hospital workers' unions not to become involved in efforts to change the health system and even to try to crush such efforts. Ultimately, however, health workers and consumers do have a common interest in restructuring the health system, and this common interest raises the possibility of common action and even of a positive role for unions in this struggle. Consumers cannot hope for decent, dignified health care if they get it from oppressed, alienated, underpaid workers, from people who do not see themselves as participating in the delivery of health care but only as doing an onerous job. Just as consumers are forced to demand more money for the hospitals in order to get decent health services, they have to demand opportunities for health workers to learn about the function of their jobs, to advance to more complex and interesting and prestigious jobs, to break down the hierarchies that oppress them, and, of course, to be decently paid, decently secure, decently honored. Similarly, for the workers, in the long run, better pay and longer vacations alone will not end their oppression. They need opportunities for advancement, education, an end to the humiliating hierarchies of the present health system. And they need to be able to take pride in their "product," in the services they provide. This would only be possible if those services were something to take pride in—if they were high quality, dignified, and humane for all patients. These are goals which can only be achieved when the health system is no longer run for the power, prestige, and wealth of a handful of doctors and administrators, but rather in the interest of and with the participation of the people who need health care and the people who provide it.

The possibility of this community of interest has been recognized by the new health movement insurgencies which have overflowed union bounds. Groups of radical health workers have come to understand that they cannot depend on hospital unions to uphold the workers end of the health struggle, that they must go outside the union. At the same time, they are beginning to understand that although the union may not take a leading role in their struggle, it is central to it. They have realized that the union can provide space for struggle, that it can protect workers who are involved in struggle. Alternatively, it can narrow that space or even eliminate it entirely, by cooperating with hospital management to smash dissent. And so many radical health workers are realizing that part of their struggle must be within the union itself, to democratize it, to keep it open as an arena for struggle, a point of contact with other workers, to prevent it from itself turning into an open enemy. They have learned that however much they may see the union itself as an obstacle to change in the health system, they cannot isolate themselves from the union members, their fellow-workers, by openly considering the union as their enemy. Increasingly, the struggle to change the health system may have to become a struggle to change the union, as well.

### Hospital Unions: a Long Time Coming

The most massive and dramatic insurgency going on in the health services world today is the headlong rush of the nation's two million hospital workers into unions. Most Americans have forgotten that there was ever anything "new" or "insurgent" about trade unions. Unions by and large have returned, along with the economy, into comfortable middle-aged respectability, if not stodginess. Hospital unions are not intrinsically different from unions in other sectors of the economy. In cities such as New York and San Francisco, where hospitals have been organized for a decade or more, the hospital unions have been unable to escape the aging process that has turned unions in other industries into defenders of the status quo. They have failed to work basic changes in the system of care delivery, and their relationship with the new, less conventional insurgencies in the health world is quite unfriendly. (See article, page 15. In hospitals in most of the country, which are still back in the 1930's in terms of labor relations, unions are a new and cataclysmic phenomenon.)

In the late 1960's a wave of hospital unionization began to sweep the country. Unions working hand in hand with civil rights organizations have turned cities such as Charleston, South Carolina, into battlefields; complete with mass marches through the streets, mass arrests, and national guard. The hospital in-
The impact of unionization on hospital workers is immediate and profound. In New York, for example, wages for unskilled hospital workers surged into unions in 1958. Hospital workers in Baltimore, Pittsburgh and other cities throughout the country were swept with the same dizzying excitement that had New York in an uproar 10 years ago. The public is reacting against some of the events which occurred when this particular union (Local 1199) appears on the scene, for they bear a resemblance to unpopular and illegal activities engaged in by dissidents in other protest movements in our country. But his words were wasted; tens of thousands of hospital workers surged into unions in 1958. Hospital workers in Baltimore, Pittsburgh and other cities throughout the country were swept with the same dizzying excitement that had New York in an uproar 10 years ago.

The effect of unionization on the hospital business other than in the area of labor relations, however, has so far been almost negligible. More than 80 percent of the nation's hospital workers are still ununionized, and the hospital unions remain oriented toward organizing the unorganized and winning bread and butter gains. But as the unions grow and consolidate, it seems clear that they could potentially be a major force helping shape the health care system of the future.

The first forty years of hospital unionization make a pretty short story. The beginnings took place in San Francisco, where a union of hospital employees was organized as early as 1919, but it was not until the 1930's that any substantial gains were made. Service and maintenance workers in three San Francisco hospitals were organized into a union in 1936 and other Bay Area hospitals quickly joined the fold. Three years later, after the passage of a state labor relations law protecting their right to organize, hospital workers in Minneapolis unionized. From 1939 to 1958, except for a few scattered drives in such places as Toledo, New York, and Seattle, unionization made no waves in the hospital field. An American Hospital Association survey taken in 1961 revealed that less than 3 percent of the nation's hospitals had collective bargaining agreements covering their employees.

There were several factors accounting for the failure of unions to gain a foothold in hospitals. The hospital work force was difficult, and the development of a sense of common grievances all but impossible. Even where common cause could be found, the attitude among the more skilled workers that "unions are unprofessional" held sway.

Among the less skilled workers, other factors prevented unity. The low wages of the industry, together with its philanthropic image, led to hospitals being more or less the employer of last resort. The work force was rich in the old, the illiterate, the discriminated against, the disabled, the demoralized. Workers came and went; it was a rare hospital worker who stuck out a job for as long as a year. It was thus hard to develop leadership within the hospital, and hard to maintain a stable membership in a union for even long enough to wage a struggle for recognition.

Another factor inhibiting the growth of unions in hospitals was the exclusion of hospital workers from coverage under the laws protecting bargaining rights of other workers. The 1937 Wagner Act had set up machinery under which workers could force their employer to conduct an election to determine whether the workers wished to be represented by a union. If the union prevailed in the election, the employer was legally bound to recognize it and to bargain in good faith with it. Originally, hospitals were included under the coverage of the law. But in 1947, intensive lobbying by the American Hospital Association (AHA) succeeded in getting an amendment onto the Taft-Hartley law which exempted non-profit hospitals from these provisions. The AHA's principle argument, according to Senator Millard Tydings of Maryland who offered the amendment, was that "this amendment would be very helpful in the hospitals' efforts to serve those who have not the means to pay for hospital services." The charity of the underpaid hospital worker, who in the absence of union protection was forced to donate his hopes for an adequate living standard to the hospital's bank account, was to continue to be the main philanthropic underpinning of the hospitals' charitable acts for the poor. State Labor Relations Acts in a handful of states did cover hospital workers, but this was the exception, not the rule.

The absence of Wagner Act protection for hospital workers not only denied them access to the representation election procedures, but also denied them protection against unfair labor practices. Hospitals were free to fire or intimidate workers for union activities, to misrepresent the facts in the face of a union drive, to offer selective wage increases to "bribe" workers away from the union, and so forth. This freedom proved to be a potent weapon in the hospitals' hands. Although adherence to the labor relations etiquette provided in the law might be in general advisable for public relations reasons even though it was not required, when faced with the im-
ominant threat of successful unionization, no holds were barred. In the words of A. Samuel Cook, the prominent labor relations advisor who (un-successfully) advised Johns Hopkins Hospital how to fight unionization in 1969, "There are times, however, when deviation from some of the provisions of this federal labor code is advisable and in fact essential."

Even state laws protecting the right of hospital workers to organize did not guarantee an end to virulent hospital opposition. In 1969, the Massachusetts Hospital Association advised its members how to respond to unionization efforts under a new state law. "Consider," the Hospital Association handbook said, "whether a proposed action might be an unfair labor practice." After discussing the consequences of such an act, it concluded: "The issue is a matter of balanced risk, and of analyzing the disadvantages of one course of action ... against the disadvantages of alternative courses of action." In other words, it's okay if you can get away with it. "If," the handbook continues, "a recently hired employee is suspected of being a union plant," don't summarily fire him without considering whether "martyring" him might not be counterproductive. Consider first whether he "is still in his probationary period and thus more easily terminated under existing hospital rules." But in any case, if all attempts to isolate the employee from other employees and to otherwise limit his effectiveness fail, "Terminate the individual if necessary as a final step."

In New York, in 1969, Columbia University's College of Physicians and Surgeons responded to Local 1199's attempt to organize its employees by using spies to compile a dossier on its employees. "Dr. [X] is a rabid civil rights advocate and very pro-union ... Mrs. [Y]'s thought concerning Dr. [X] is that he may oversell the union and antagonize people. ... Recently this group of workers signed a petition asking for wages comparable to the Presbyterian Hospital. At this point it is not certain whether Miss [A]'s sympathies lie entirely with the University."

In the face of a fragmented, professionalism-ridden work force, lack of legal protection, and bitter hospital resistance, few unions even tried to unionize hospitals. The few that did, generally failed. But in the early sixties, the picture changed, and unions began to move. For one thing, the whole nature of hospitals had changed since the thirties. Hospitals were no longer poverty-stricken institutions existing primarily for charity care for the poor. Private philanthropy had collapsed, and hospital finance now rested firmly on a base of third party payments. Their financial existence was no longer as hand to mouth as it once had been. Moreover, with most patients insured, increased costs stemming from higher wages and fringe benefits paid to workers could be passed along to the patients, with relatively little financial strain on the hospital. The hospitals could thus relax a bit if a union came around; they might not like it but it no longer threatened financial curtains. The passage of Medicare and Medicaid in the mid-sixties vastly accelerated the improvement in the financial condition of the hospitals. One example of what this meant for union-hospital relations: The day after the last fall's New York State freeze on Medicaid reimbursement rates was overturned by the courts, a high official of New York's League of Voluntary Hospitals told an 1199 vice president, not entirely jokingly, "Ask for the day after tomorrow for anything you want."

Hospital management, as well as hospital finances, underwent a vast change during the forties and fifties. Hospitals had become far more complex, far more technological, far richer. A new breed of more professional administrators developed, trained by newly created schools for hospital administration. Encouraged by the plaudits of the corporate managers who now sat on the Board of Trustees in place of the old individualist philanthropists, Gone were the old, philanthropic organization-oriented managers. Hospital management had entered the twentieth century. And with more modern management came more modern management attitudes: Unionization was still to be fought, but if worse came to worst, unions could be lived with.

If the hospitals were changing, so were the workers. Spurred on by the rising utilization and the growing complexity of hospital services, employment in hospitals has soared (up 34 percent in the last five years alone). The growth occurred within a tight labor market, and was concentrated in the relatively skilled areas of hospital work. Hospital workers, once the most expendable of workers, are now in demand. The workers were a different breed, too. The civil rights movement and the war on poverty had aroused the expectations of the poor and the minority groups that made up the great bulk of unskilled and semiskilled hospital employment, and the civil rights movement had taught the techniques of mass struggle to a generation that had not lived through the unionization drives of the thirties.

Thousands of hospital workers were moved by the words of Dr. Martin Luther King to 1199: "Your campaign to organize all hospital workers, nonprofessionals and professionals alike, is more than a fight for union rights. It is part of the larger fight in our nation against discrimination and exploitation against slums—against all forms of degradation that result from poverty and human misery. It is a fight for human rights and dignity."

Finally, the 1960's saw a great wave of public employee unionization—teachers, office workers, policemen and firemen, etc., and the pressure of these drives influenced the hospitals. For instance, in 1962, President Kennedy issued an executive order which established the right and conditions of collective bargaining for Federal Government employees. In the wake of this order, many Federal hospitals were rapidly unionized. Similar events aided local and state hospitals to unionize in New York City, Mayor Wag-
neer's 1958 executive order gave the go ahead, and a few years later District Council 37 of the American Federation of State, County and Municipal Employees (AFSCME) gained bargaining rights in the Municipal hospitals.

The example of the government hospitals successfully unionizing may have contributed to the momentum of the unionization drive.

As a result of these factors, the early 1960's marked a turning point in hospital unionization. Progress was greatest in the Middle Atlantic, Pacific Coast and north Central states where several states had labor legislation which protected the right of workers in hospitals to unionize.

Most celebrated of the unionization efforts was in New York: Local 1199 of the Retail, Wholesale, and Department Store Union, a small union representing drug store employees, undertook a drive to organize the New York hospitals.

At first their efforts were only partially successful. A 46-day strike against seven hospitals in 1959 failed to win union recognition, although an agreement with the hospitals to improve wages and working conditions was reached. But the fledgling union survived three years without a contract, without recognition, and without dues checkoffs, and in 1962, charging that the hospitals had not lived up to the 1959 agreement, 1199 struck again. This time the impasse was only settled when Governor Rockefeller agreed that in return for an end to the strike, he would press the State Legislature to include non-profit hospitals under the protection of the State Labor Relations Act. Under protection of the law (which they had won in the streets), 1199 organizing proceeded rapidly.

By 1966, the first time it was the union that had the upper hand in bargaining, and by 1969, some 60 percent of the hospital workers in New York City voluntary hospitals were represented by the union. Meanwhile, District Council 37 (AFSCME) had won bargaining rights for most of the city's Municipal hospital workers. (1199 is the bargaining agent for workers on the affiliation payrolls in city hospitals where the private affiliating hospital is organized by 1199. And Local 144 of the Service Employees International Union (SEIU) had signed up the workers in many of the city's proprietary hospitals and nursing homes.

In the wake of the much publicized unionization of New York City hospitals, organizing drives hit such diverse cities as Chicago, Cleveland, Gary, Youngstown, and Detroit. By 1967, AFSCME, 1199, SEIU, and the American Federation of Government Employees (which represented most of the organized workers in Federal hospitals) along with a host of other unions (including the Teamsters, Laborers, Mine Workers, Hotel and Restaurant Workers, and Operating Engineers) represented over 200,000 workers, and almost 8 percent of the nation's hospitals reported to the AHA that all or some of their workers were covered by collective bargaining agreements. New York, Minneapolis and San Francisco still had the bulk of the organized.

In 1969, the dam broke. Local 1199 set up a National Organizing Committee, which set out to organize outside of New York City. First stop, more or less by accident, was Charleston, South Carolina. After an epic 110-day strike, featuring weeks of mass demonstrations led by the Southern Christian Leadership Conference, hundreds of arrests, a threatened closing down of the port of Charleston by the Longshoreman's union, support from unions all over the country, and the occupation of the city by the National Guard, the union was victorious. Although formal recognition was not granted, the hospitals established what was in fact, if not in name, a dues checkoff for the union.

The organizing drive then moved on to Baltimore, where Johns Hopkins Hospital agreed to a representation election (although it was not required by state law) without a fight, hoping to avoid another Charleston. Local 1199E (out-of-New York locals of the 1199 drive were given letters after the 1199) won the right to represent 1400 Johns Hopkins hospital workers by a two-to-one margin.

It is well known that the hospital worker hierarchy features well paid, highly trained, white men at the top; intermediate paid, largely white, women in the middle; and poorly paid, black and brown women at the bottom. The following chart gives the details.

<table>
<thead>
<tr>
<th>Job</th>
<th>% of total Employ-</th>
<th>% of total payroll</th>
<th>pay range ($ per week)</th>
<th>approximate % female</th>
<th>approximate % non-white</th>
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<td>management/supervisory</td>
<td>9</td>
<td>13</td>
<td>200-500</td>
<td>15-20</td>
<td>10-20</td>
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<tr>
<td>academic</td>
<td>2</td>
<td>5</td>
<td>200-400</td>
<td>20</td>
<td>5</td>
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<tr>
<td>interns/residents</td>
<td>6</td>
<td>9</td>
<td>180-250</td>
<td>10</td>
<td>8</td>
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<tr>
<td>staff RN's</td>
<td>21</td>
<td>25</td>
<td>155-170</td>
<td>98</td>
<td>40</td>
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<tr>
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<td>9</td>
<td>135-165</td>
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<td>110-130</td>
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<td>34</td>
<td>24</td>
<td>95-115</td>
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Notes: (1) figures refer to New York University Hospital; (2) figures are for New York City short-term, non-governmental hospitals, spring 1970; (3) figures are for U.S.; (4) figures are for New York City Municipal hospitals.
Other hospitals rapidly fell in line with the prestigious Johns Hopkins, and by early January, membership in Local 1199E was rapidly passing the 6000 mark. In addition to grievance procedures, fringe benefits and the like, Baltimore hospital workers won a contract providing for wage increases of $38 to $42 a week—a lot of money when you are earning $1.80 an hour.

With calls for help pouring in from all over the country, 1199 organizers fanned out to Connecticut, Philadelphia, North Carolina, Harrisburg, Pittsburgh, Ohio. Within weeks, close to ten thousand hospital workers signed union cards. Opposition to unionization had not collapsed, however. In early January, Pittsburgh suffered a hospital strike as Mellon-dominated Presbyterian Hospital and Catholic Mercy Hospital refused to permit a representation election. As in the 1962 New York strike, a temporary peace came when the hospitals agreed to support legislation providing for orderly union-management relations. Meanwhile, the confident 1199 reorganized its National Organizing Committee into the National Union of Hospital and Nursing Home Employees, a division of the Retail, Wholesale and Department Store Workers, AFL-CIO. Other unions, notably AFSCME and the Service Employees, stepped up their drives as well. The spark had ignited a prairie fire, and it appeared that that the long delayed large scale unionization of American hospital workers was underway.—John Ehrenreich

Local 1199: Where is it Leading?

"In the spiritual wasteland [of the labor movement], two unions stand out as nurturers of the old idealism...[One is] Local 1199 of the Drug and Hospital Union, a New York based organization that is combining soul power and union power to bring higher pay and a new sense of group identity to growing numbers of hospital employees across the nation." (A. H. Raskin, New York Times Magazine, March 22, 1970). At a time when the rest of the labor movement is mired in stagnation, 1199 has won a reputation as a special union. It has been a success where older unions have failed. It has organized the unorganized—more than 30,000 hospital workers, mainly black or Puerto Rican, in the New York area in the last ten years, and some 10,000 outside New York in the last year. It's organizing drives have been little less than ideological crusades, fusing civil rights activism and traditional unionism—"soul power and union power" as the union's publicists put it—into a force that has swept thousands of black and Puerto Rican workers into the ranks of the AFL-CIO.

1199 also has a good reputation where it counts for a union: Not only have its organizing drives been successful, but it has succeeded in making great gains for its members, New York hospital workers, who in 1959 earned as little as $28 to $32 for a 44 hour, six-day week, as of July, 1970 earn a minimum $118 for a 40 hour week. They get vacations, sick pay, health insurance, and a pension when they retire. Their rights on the job are protected by orderly grievance procedures.

If success in organizing workers and in winning good contracts were all there were to 1199, the union would not be in the spotlight, it has organized the unorganized—more than 30,000 hospital workers, mainly black or Puerto Rican, in the New York area in the last ten years, and some 10,000 outside New York in the last year. It's organizing drives have been little less than ideological crusades, fusing civil rights activism and traditional unionism—"soul power and union power" as the union's publicists put it—into a force that has swept thousands of black and Puerto Rican workers into the ranks of the AFL-CIO.

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If success in organizing workers and in winning good contracts were all there were to 1199, the union would not be in the spotlight, however. No one writes encomiums to the Teamsters, what makes 1199 a hero to some, a villain to others is its positions on contro-versial social issues. As early as 1965, 1199's Executive Council had come out in opposition to the war in Vietnam, and the union has sent delegations to all the major peace marches. 1199 has supported demands for "community control". When New York's United Federation of Teachers was locked in battle against the Ocean-Hill Brownsville community's demand for community control of schools in 1968, 1199 broke with the rest of the city's labor bureaucracy to support the community. The union has raised money from its members for the defense of the New York Panther 21, accused of a bombing conspiracy. Two of its top officers are members of the Committee to Defend the Panther 21.

With the development of a militant health movement in New York City, however, dissenting voices are heard about 1199. 1199 is a good union, say the dissenting workers, students, and community people, but not all that good. It has won substantial gains for its members, they say, but it has been unable to develop a competent lower level staff to administer and enforce the contract benefits. It has also failed to educate its members in the principles of unionism; no active union life has been developed at the local level. Even the union's positions on the war, community control of schools, etc. come in for criticism: For one thing, the leadership has not translated them into effective, ongoing political education for the rank and file. And for another, on the social issues closest to home—those involving the health system itself—the union is strangely silent. As a result of all these failures, say the dissenters, 1199's members are largely apathetic; they do not participate significantly in union affairs.

1199 has not escaped the forces that have affected other American unions, the critics charge, and it is rapidly coming to reproduce their faults. Worst of all, they charge, the leadership of the union tends to suppress the development of local leadership and rank and file participation—the only force which could counteract stagnation. These charges do not add up merely to a moral condemnation, made from a radical's easy chair, the critics insist. The failure of 1199 to escape the
fate of other unions is already showing up in failures of the union in bread and butter issues.

Hospital unions such as 1199 represent workers in a vital (and underfinanced) public service. They face unique problems both in meeting the needs of their members and in reconciling their immediate welfare with the general public's well-being. This article will examine how 1199, one of the oldest, best-established, and certainly the best known of the hospital unions, has responded to this dual challenge, and what its response implies for the role of unions like 1199 in the movement to reshape the health system.

1199 began its career as a hospital union in 1958, when the Retail Drug Employees Union, Local 1199 of the Retail, Wholesale, and Department Store Union, a union of predominantly white drug stores employees, undertook the task of organizing New York City's voluntary (non-profit) hospitals. 1199 now represents workers in some forty such hospitals. In addition, the union represents hospital workers who work in Municipal hospitals but who are formally employed by voluntary hospitals affiliated with the Municipal institution. Those municipal workers who are on the City payroll are represented by other unions, primarily District Council 37 of the American Federation of State, County, and Municipal Employees. (E.g., Lincoln Hospital, a city hospital, is staffed under an affiliation contract with Albert Einstein College of Medicine. Those Lincoln workers employed by Einstein are 1199'ers; those on the City payroll are members of District Council 37.) Workers in proprietary hospitals are represented primarily by Local 144 of the Service Employees International Union.

About 20,000 of 1199's members are relatively unskilled service and maintenance workers — porters, orderlies, nurses aides, kitchen helpers, housekeepers, etc. These are members of the union's Hospital Division. Another 10,000 members are organized into the union's Guild of Professional, Technical, and Office Employees, which includes lab technicians, X-ray technicians, clerical workers, licensed practical nurses, etc. The union does not represent registered nurses, doctors, or supervisors. In the last few years, the Guild has been the most rapidly growing part of the union, with such groups as psychologists, social workers, and non-medical workers at universities flooding the membership roles. (The union also has a third division, the Drug Division, comprising 6,000 drug store workers.)

Until 1968, 1199 had organized only in New York, Northern New Jersey, and Connecticut. In 1969, however, the union embarked on a national organizing drive. A prolonged and bitter, but ultimately victorious struggle in Charleston, South Carolina, was the kick-off. Since then, Baltimore hospital workers have been almost entirely organized, and active unionization drives are underway in Philadelphia, Pittsburgh, Durham, N. C., Ohio, and a number of other places. In the winter of 1968-70 the union joined the locals in the various cities together to form the National Union of Hospital and Nursing Home Employees, an autonomous division of the Retail, Wholesale and Department Store Union. Locals in the various cities all bear the number 1199, with a letter indicating the city—1199 P in Pittsburgh, 1199 B in Charleston, 1199 F in Baltimore, etc.

1199's structure is formally democratic. The members can theoretically exert their power in several ways. On certain key decisions, the members affected vote directly: authorizing strikes, electing officers, setting dues, approving contracts, etc. Meetings of the members, on a general, divisional, geographic area, or individual hospital basis, must occur, according to the constitution, at least once every two weeks. The members also elect "delegates" (the equivalent of shop stewards in most unions). The delegates serve a double function: they are representatives of the union at the place of work, helping enforce the contract, settle grievances, carry information from the union to the members, etc. And they are the members' representatives to the union, providing the leadership with feedback on their decisions, and attending monthly divisional (i.e., hospital, guild, drug) delegate assemblies where reports from the leadership are heard and where various decisions affecting the members are made.

The officers of 1199 collectively form the Executive Council, which meets weekly and which has control over the union budget and funds; power to call strikes, subject to membership approval; and power "to formulate plans, programs, and policies for the union as a whole." The Executive Council has at its disposal a staff of some forty or fifty people, including the staff of the union publication (the "1199 Drug and Hospital News"), research and educational staff, and a cadre of "organizers" (what are called "business agents" in most unions). The latter are responsible for new organizing drives, for administering existing contracts (handling grievances, helping workers collect benefits from the union health plan, etc.), and for carrying out directives of the Executive Council.

In practice, the Executive Council, and especially its chairman, union president Leon J. Davis, tend to make decisions without significant participation by the rank and file. According to union officers, the strong role of the Executive Council is justified because the council members are elected by the members and hence are, by definition, "responsible" to them. The mechanisms for ensuring this "responsibility" are built into the union constitution. In practice, however, the council monopolizes control over union decision-making through a variety of mechanisms: control over the flow of information to the members; an election procedure that all but guarantees the leadership with its own reelection; effective control over the delegate assemblies by various parliamentary means; and a monopoly on the time, money, and technical skills needed to operate the union.
First, the leadership controls the flow of information to the members. One way in which the union communicates with the members is through the organizers. Organizers are hired (and, with the exception of a handful of them who are elected by their division, can be fired) by President Davis. Their day-to-day information, as well as their entire training in union principles, in relations with the rank and file, in leadership, etc., comes from the union officers — in individual conferences, staff meetings, and special classes for staff members. Through his training, the organizer learns that his role is to convince the members of the correctness of the leadership’s decisions, rather than to provide the members with the information they need to decide for themselves, or to educate the members, or enable the members to participate in union decision-making.

Organizers are under union discipline. Once a decision is made, they are expected to carry it out without question and to defend it to the members they work with. If they cannot maintain this discipline, then according to President Davis they are “finks” and should quit the union.

The leadership also completely controls the union: monthly magazine, and uses it to present its point of view and suppress that of dissidents. For example, in the spring of 1969, workers at the Lincoln Hospital Mental Health Services, primarily 1199 members, occupied the mental health center and took over its operation from management. This action brought the 1199’ers into sharp conflict not only with management, but with the union, which saw the action as a violation of its contract with the center’s management. The 1199 magazine, which has carried lengthy stories on such “experiments” in medical practice as a Montefiore Hospital-run health center and a comprehensive child care program at Brooklyn Jewish Hospital, never even mentioned the novel experiment going on at Lincoln, nor, of course, the union’s controversial role in it.

Eight months later, the union became embroiled in an even more controversial situation at the Gouverneur health center. Again, not a word of the controversy hit the magazine until the battle was over, at which time an article defending the union’s position appeared. The other side to the dispute never got an opportunity to present its position in the magazine.

The second mechanism through which the leadership dominates the union lies in its power to perpetuate itself and to stifle rank and file participation, local leadership, and local initiative. The union’s election procedures all but guarantee that only candidates approved by the present leadership can get nominated, much less elected. To be nominated a candidate must get petitions signed by two percent of the members in each of the union’s three divisions (Hospital, Guild, and Drug). A rank and file member of the Hospital or Guild divisions would find it very difficult to collect the signatures of more than two percent or 125 of the drug division members, who are scattered in small drug stores all over the city. By contrast, the present officers have a staff of paid organizers available to take their nominating petitions around in all divisions. Similarly, election to the union’s top 23 offices requires majorities in each of the three divisions rather than a simple majority of the entire union. Again, this requirement is all but impossible for a rank and file. (The election procedures were not always this forbidding; the most onerous requirements date from a February, 1970, constitutional amendment.) Within the present union structure, the only route to union office is to be the candidate of the present leadership.

In fact, there have been virtually no contested elections in the union’s recent history, whether because of the difficulties in opposing incumbents or because of lack of serious opposition to the leadership. One technician from Kingsbrook Jewish Hospital forlornly seeks a lower level union position year after year, but is always soundly defeated by the leadership’s nominees. In the most recent election, in March 1970, all the other candidates ran unopposed. The only vote possible was “yes” or “no.” Predictably, such figures as President Leon Davis won by a vote of 9294 to 459. (This may very well reflect how most workers feel although it is noteworthy that three quarters of the membership failed to vote at all in the uncontested election.)

Elected leaders of the union do not, in general, come directly up from the ranks. Typically, a rank and file member who is considered a promising leader is offered a non-elective staff job as an organizer. After several years if he has worked out (i.e., is effective in carrying out the orders of the leadership, is able to “deliver” his members as needed, and does not break union discipline), the leadership may select him for inclusion in its slate of nominees for office. He is then certain of election. The trial period as an organizer permits the leadership to weed out any potential officers who would not act as part of the team, or alternately, to “socialize” a dissident, so that he behaves properly. Guild Division director Jesse Olson tells of an organizer who joined the staff as “a redhot radical, ready to make the revolution. . . . It was hard for [the organizer].” He continues, “when he found some of the radical workers calling him an ‘enemy of the working class’.” But, he concluded, this particular organizer had stood up under the attacks and done the union’s bidding. Those who learn what the needs of the union are, i.e. what the “real” needs of workers are, last at the union (and maybe someday will be officers). Those who insist on staying radical get out.

The leadership constantly bemoans its inability to find adequate leadership material in the rank and file, but at the same time sabotages the development of independent local leadership and participation. For example, according to one Guild delegate, when the Guild was first set up as a separate di-
vision, an all day conference was held. The
delegates proposed setting up delegate com-
mittees on education, social affairs, legisla-
tion, etc., to provide a continuing input and
participation from the rank and file. The lead-
ership never followed up on the proposals,
despite the interest. In another case, an ex-
perienced delegate offered to teach a class in
union affairs for delegates, but the officers
refused him, he says, on the grounds that the
union had made arrangements for the Cornell
School of Labor Relations to train union staff-
erers to teach delegates’ classes. In still another
eexample, two Lincoln Mental Health Center
workers talked to union officials about devel-
oping political education courses for mem-
bers, but were turned down, they claim, on
the grounds that “the members wouldn’t be
interested.”

Participation at the individual hospitals is
also frequently discouraged. One delegate
from Jacobi Hospital complains that delegates
are rarely notified of chapter delegate meet-
ings more than one day in advance, and often
are not told at all. And a delegate from Har-
lem Hospital complains: “They never tell us
anything. The only way you can find out
what’s going on in the union is if [union ex-
tecutive vice president] Jesse Olsen happens
to be around and tells you something. . . .
You’ve got to be aggressive [towards the
union] to get anything from the union. That’s
why delegates get disgusted and quit as
delegates.”

Union officials defend their lack of interest
in developing rank and file participation and
leadership. Significant, on-going rank and file
participation in union decision making they
believe to be a utopian “New Left illusion,”
of little practical importance. Strong, able
leadership is what the union needs for sur-
vival and well-being—leadership which will,
they say, be responsible to the members sim-
ply because it is elected and which will lead
the members in struggling for what’s good for
them.

Participation by the rank and file may even
be, in the words of one top union officer,
“divisive.” He explains that any group of
members represent only themselves; the lead-
ership, on the other hand, is elected and so
represents the will of the entire membership.
If a group of members insist on differing with
the leadership, they are breaking “unity” by
thrusting the opinions of a part of the mem-
bership upon an unwilling entire membership
(as embodied in the leadership). The
union’s officers apparently sincerely believe
that they know what is best for the rank and
file, and that this belief is verified by their
repeated reelection.

The makeup of the union’s leadership re-
sects the way in which it is developed and
chosen. The union is over two thirds female
and two thirds black and/or Puerto Rican.
But of the eight top officers of the union (“Pres-
ident, Secretary-Treasurer, Executive Secre-
tary, Financial Secretary, and four Executive
Vice Presidents”), seven are male, seven are
white. Virtually all the top officers originally
came from the old Retail Drug Employees
Union which embarked on organizing hos-
pital workers twelve years ago; only one
comes out of a hospital. The single exception
on all counts, is black Executive Vice Presi-
dent and director of the Hospital Division
Doris Turner, a former hospital dietary work-
er. Even at the level of the fifteen lower union-
wide officers, half are white, and only one is
a woman.

What about the delegate assemblies? “The
delegates are a guarantee that the union will
be responsible to the members,” says Davis.
In practice, they have very little power, how-
ever. At the delegate assemblies, the opinions
of delegates are not welcome. The assemblies
are dreary affairs, poorly attended, with
many of the members filtering out well before
the monthly meeting is over. (On one oc-
casion last fall, the presiding officer at a
hospital division delegate assembly, flustered
because of unexpected opposition over pro-
cedures in choosing a site for the union’s an-
nual Christmas ball, actually instructed union
staff members not to let anyone out of the
room.) At each meeting, the leadership re-
ports on a range of issues, from progress of
organizing drives, or contract negotiations, to
plans for a dance, or progress of the training
and upgrading fund, and problems of the
union hiring hall. The delegates are asked to
approve. There is rarely any significant dis-

cussion.

When there is disagreement, it is put down
rapidly. One technique frequently used is re-
ferring matters to committee. For example, in
December, after the slaying of Black Panther
leaders Fred Hampton and Mark Clark in
Chicago, the Executive Council prepared a
statement protesting the persecution of the
Panthers and demanding an investigation of
their killings. The Guild delegate assembly was
not satisfied, however, and many members
urged that the union get together with other
groups to sponsor a protest demonstration.
The chairman, after a difficult twenty min-
dutes, during which the delegates voted over-
whelmingly to urge such a demonstration,
was able to put off the debate with a promise
to accept the vote as a “recommendation” to
the Executive Council. A month and a half
later, when the Executive Council finally got
around to it, the idea was rejected because
in Davis’s words, “We will not be intimidated
into doing something which is against the will
of the majority of our members.” (In all fair-
ness, the union did print a lengthy article in
its magazine a month later, and did contribute
money to the Panther defense.)

The other major technique the leadership
uses to suppress dissent in the Delegate As-
semblies is parliamentary procedure. The
leadership controls the agenda. It often pre-
sents controversial matters in the form of an
informational report; there is thus nothing for
the delegates to vote upon, and motions on
the subject are out of order. The chairman
will not permit himself to be overruled on a
point of order; "new business" is referred to a traditional agenda item called "good and welfare" which is generally placed as the last item on the agenda. Usually it is never reached because everyone is drifting out by the time the meeting nears an end, and the meeting is promptly adjourned.

There are, thus, great obstacles to effective membership participation in union decision-making, obstacles which the Executive Council maintains while all the time expressing concern over the "apathy" and lack of participation of the membership. The attitudes of many of the old line leaders of the union were expressed by Ted Mitchell, a former drug store porter and hospital division area director for southern Manhattan, at the time of the conflict at Gouverneur Ambulatory Care Center last fall: "They [the dissidents] think the people who built this union don't know a goddamn thing." We built this union, he says, and "I'm not going to let anyone wreck it." Other officers are more paternalistic. Leon Davis told the New York Times' A. H. Raskin about the new multi-million dollar building the union is erecting: "We probably could have rented the space more cheaply, but it is partly psychological for our members. It will give them the feeling: 'You were nobody yesterday, now you've put up your own tall building.'"

1199 presents a great facade of membership participation. There are dances and boat rides, theatre benefits and Christmas parties, peace parades, and conferences of X-ray technicians, college scholarships and a summer camp for children. "1199 has made solid progress toward making unionism a way of life" says the Times' Raskin. It is certainly true that one or two thousand members do participate frequently in the various 1199 activities. But this amounts to only a small fraction of the membership which participates at all, and even they are not active participants in the unions essential policy-making so much as they are actors in a vast recreational therapy program carefully designed and staged by the union's leadership. In fact, the gulf between 1199's leadership and its members, the disparity between the illusion of mass participation and the reality of mass membership apathy, the void between the democratic forms and the bureaucratic substance, grows year by year.

Some union activists question not only the union's internal procedures, but also its relationship with its adversary, the hospitals. "1199 may be good on Vietnam, but when it comes to the hospitals, there's nothing radical about them," says one union member, active in the city health movement. 1199, the dissidents charge, often identifies with hospital interests and is too buddy-buddy with hospital management.

They do not mean that 1199 sells out its members at contract time or is uninterested in administering the contracts. But once you've gotten beyond simple bread and butter issues and on to such work issues as working conditions and control over one's job and to issues of the kind of patient care the hospitals are providing — 1199 is unwilling to challenge hospital management. The union's attitude often comes down to, "What's good for the hospital industry is good for us," say the dissidents.

One example of the attitude of 1199 toward a challenge to hospital management comes from the spring of 1969, when the workers at the Lincoln Hospital Mental Health Services seized control of the center. There had been a long history of bad relations between the union and its Lincoln mental health center members. The workers claim that the union did little for them, especially with respect to grievances about the innovative new careers programs supposedly built into the Lincoln service program. The union, in turn, saw the complainers as loudmouthed opportunists, out for themselves and trying to use the union as their instrument.

When the 1969 mental health center occupation began, the workers called in 1199. The union was at first unwilling to get involved. When it finally did, it urged the workers to give up the action and go back to work. Union Vice President Jesse Olsen told the workers that 1199 had a contract with Einstein which the workers were violating. (Albert Einstein College of Medicine staffs the mental health services at Lincoln under an affiliation contract with the City.) As far as 1199 was concerned, Einstein was the management. The union would gladly fight Einstein over pay, grievances, etc., but, according to Olsen, "If the workers want to challenge who should be management, who should control the center, that is their own affair." 1199 would not help them on that. When negotiations finally began, Olsen says, Einstein wanted 1199 to be there. He argues that Einstein was justified; 1199 had a contract with Einstein. But the workers claim: "The union was like a cop. It tried to pacify us for Einstein rather than helping settle our grievances."

Another example of the unions timidity in confronting hospitals comes from the controversy about hospital costs. In the fall of 1969, 1199 President Davis testified at a State Legislative hearing on Medicaid and hospital costs. The State had shortly before enacted a hospital cost control law to hold down skyrocketing hospital costs. The hospitals blamed the union for the rise in costs, and threatened layoffs and hospital closures. Davis limited his comments to a denunciation of the cost control law as "wage controls" and threatened union action if the law prevented the hospitals from granting their workers a raise in the June negotiations.

Davis could have used the cost issue to make a strong attack on hospital management, while at the same time justifying the workers' continued wage increase demands. After all, the cost crisis is primarily the fault of hospital management, which has misspent patient care funds on high administrative salaries, institutional expansion, expensive research, etc. (See BULLETIN, January, 1970.) There is ample evidence that the wages of
unionized employees made up less than a third of hospital costs, and that they had increased no more (and perhaps less) rapidly than other components of hospital costs. But Davis let hospital management put all the blame for high costs on the workers' pay increases. He refused to challenge the way hospitals are run in this country. Instead he made common cause with hospital representatives and merely asked for a restoration of Medicaid funds to give the hospitals more money.

Davis has even gone so far as to argue that unionization has great advantages for management as well as for workers. During the 1968 round of contract talks with the hospitals, according to insiders, Davis repeatedly pointed out that unionization, through higher wages, organized grievance procedures, etc., improved the quality and quantity of work done. Contented workers are docile workers.

A year later, he repeated this argument to the State legislative hearing on Medicaid, as part of his defense of the union's role in raising hospital costs. The union, he said, has “stabilized” the hospital work force.

The role of 1199, like that of other unions, is to institutionalize struggle between the hospitals and management, to limit it to narrow channels and narrow issues. Statements by hospital management confirm this. Mt. Sinai director David Pomerine told the New York Times earlier this year: "The presence of the union has given minority groups a vehicle for expression so that there is less need for them to be intemperate or irresponsible." And Henry Machover, administrator of New York's Trafalgar Hospital, told Modern Hospital magazine in 1965: "From the hospital's point of view, stability of employment has been improved. ... In certain cases, where difficult-to-pin-down malingering has occurred, the union has been helpful in using employee pressure to correct the matter...." Union Executive Secretary Moe Foner concurred, in the same article: "Administrators can be grateful to the union for what it has accomplished. ... It has set us an orderly method of personnel procedures."

During the recent drive to organize the hospitals in Baltimore, 1199's chief organizer Fred Puch was quoted in the Times as saying: "After it's over ... we must work to build bridges on both sides. A few years from now, we'll be giving testimonials to one another." Sure enough, in New York City, where "it's been over for several years, 1199 President Davis refers to Montefiore's empire builder-director Martin Cherksasky as "a pro," "a thinker," "the best in the business." And in turn, on March 22, 1970, a testimonial dinner, given to benefit a Jewish-Arab friendship organization, honored Leon Davis for "his long leadership in trade union organizing and in the struggle for civil rights and peace." Among the sponsors: Montefiore's Martin Cherksasky, Beth Israel's Ray Trussell, Mt. Sinai's Norman Metzger, and the Executive Director of the League of Voluntary Hospitals and Nursing Homes of New York, Bill Abelow.

Many of 1199's worst characteristics—the tendency to isolate dissenters and prevent the development of local initiative, the inability to deal with issues related to health care save in bread and butter terms, the identification of the union's interests with the hospital industry's interests—came together in the Gouverneur affair in the fall and winter of 1969-70. [See February, 1970, BULLETIN for details.] At Gouverneur, in effect, 1199 cooperated with management to get rid of a small group of radical health workers and to undercut community demands on a hospital.

Gouverneur is a large City-owned outpatient health center on the Lower East Side, affiliated to Beth Israel Medical Center and financed in part by a grant from the Federal Office of Economic Opportunity. At the time of the conflict, Gouverneur was supposed to be controlled jointly by Beth Israel and the Lower East Side Neighborhood Health Council South (LESNHC-S), a community-based body. But Beth Israel's director, Dr. Ray Trussell, had a long history of antagonism to community involvement.

Last fall a small group of 1199 members—workers at Gouverneur and residents of the Lower East Side—got together and decided to work together with the LESNHC-S to demand that Gouverneur should serve the community's needs, not Beth Israel's. They called themselves the Health Revolutionary Unity Movement (HRUM).

One of the first products of this common effort was a request that 1199 plan with the Health Council for a joint community-worker response to threatened layoffs or cutbacks in service resulting from the then pressing Medicaid cutback crisis. Trussell's response was repression. He called in the police to prevent HRUM from meeting and told the LESNHC-S that he would close down Gouverneur altogether "if any group, including the Council [LESNHC-S] causes any trouble." 1199 did nothing to reassure the Gouverneur workers. It rejected out of hand the HRUM-LESNHC-S proposals for joint action, ostensibly on the grounds that LESNHC-S was not "representative of the community". (In fact, as a form to group the core of an effort to mobilize the Lower East Side community in defense of Gouverneur, LESNHC-S was probably ideal. It had been formed by asking all of the community organizations in that area to send representatives. It had members from every segment of the community—black, Puerto Rican, Chinese, white, young and old —and had been active over several years, with significant community support, in struggles involving Gouverneur. But as one 1199 staff member bitterly remarked, "To Davis, an advocate of community control of schools is a community leader, an advocate of community control of hospitals is a self-appointed representative of the community." )

1199's officers were also quite hostile to the HRUM workers, considering their words and actions "divisive," since they represented only a small part of the workers at Gouverneur. In September, the union called a meet-
ing of rank and files from Gouverneur and several other fiscally-pressed hospitals to discuss the union response. At the meeting, the HRUM workers charged that the union was only interested in its members' jobs and not in the welfare of the community. A strike to prevent layoffs was an attack on the community's health, and unacceptable, they said. A few days later, one union vice president told other officers of the union: we have "to isolate those people as much as possible—they have big mouths."

In December 1969, things came to a head. A Gouverneur doctor wrote a letter to LESNHC-S expressing disapproval of Trussell's policies. A month later, he was fired with no explanation. On January 19, more than 100 people, Gouverneur workers, community residents, and outside supporters, marched to Beth Israel to demand that the doctor be reinstated. Trussell's response was to bring in the police. Four people were arrested. The group returned to Gouverneur, sat in for an hour in the director's office, and then scattered to talk to patients and workers at the health center about what had happened.

Nine Gouverneur workers were immediately suspended, and the next day five were fired. Needless to say, the workers picked out for discipline were the leaders of HRUM.

The other Gouverneur workers (i.e., those not in HRUM) were scared and confused. HRUM failed to develop a significant amount of support among the other Gouverneur workers, and so the union was able to play on the workers' fears. It "encouraged" (Davis' words) anti-HRUM workers to let the union know "how they felt." The result was a petition bearing some 160 names (there were 210 Gouverneur workers on the union roles at the time) urging the union not to support the fired workers, and not to take the matter through the grievance procedures in the union contract. The union was happy to agree. Even though it was clear that the workers who had been fired had been selected because they were the political leaders, the union officers argued that "there has been no violation of the contract." that they had "found no reason for the sit-ins and such other actions which a few employees have been engaged in." The union called a meeting of the Gouverneur rank and file to decide whether the union should follow up the grievance. Beth Israel's Trussell announced he would close down Gouverneur. It could have reassured its members that no worker's job would be threatened. It could have used its vast organizational resources to try to build a broad-based community movement supporting Gouverneur workers and users against the threats of layoffs and service cutbacks. It could have aided the efforts of LESNHC-S and HRUM to force Gouverneur to provide the services needed in the community. But it didn't. It let the Gouverneur workers' fears run wild, and it used these fears to excuse its failure to support the fired workers.

The union used one group of members against another group—because, in the end, the union leaders disagreed with HRUM and LESNHC-S politically, just as Dr. Trussell does. The union argues that the HRUM workers isolated themselves and alienated the other workers; for the union to have supported them would have, in turn, alienated the non-HRUM workers from the union. By January this was indeed true. But the union had helped make it true. Right from the beginning, the union had considered HRUM (and the Health Council) divisive and had contributed to their isolation. And the union had never made any attempt to discuss the issues which HRUM and the Health Council raised with its own members. The HRUM-Health Council alliance represented an outstanding attempt by 1199 rank and files to take a leading role in the struggle for both workers' rights and community services. Neither the union nor the Beth Israel management could accept that, and the two together succeeded in smashing HRUM at Gouverneur.

The leadership of 1199 is aware of many of the apparently contradictory elements in its behavior. But to leaders like Leon Davis, the actions of 1199 are quite consistent. "Our basic and primary responsibility is to achieve a degree of power in order to deal with wages, fringe benefits, job security, grievance machinery, and dignity on the job," he wrote in the December 1969 issue of the union magazine. The second priority, Davis continues, is political and other action which supports this struggle: "It is necessary for the union to engage in, and involve its members in activities which relate to, as well as influence the above objectives. This includes, but is not limited to, the involvement of our members in legislative and political action, especially as it directly affects the workers' welfare on the job." (i.e., the union should lobby and demonstrate against Medicaid cutbacks which make the hospitals less able to afford to give their workers raises, for changes in the state unemployment compensation laws, changes in the state labor relations laws, etc.) Third, and
Davis emphasized that it is the lowest priority of the union's major activities, "Our union should concern itself with problems as they affect our members in the community, such as education, housing, health care [!], taxes, and so forth."

Davis elaborates that bread and butter demands are the basis of the unity of the union and the "degree of power" derived with these issues can only be achieved through unity. Anything that threatens that unity is a danger to the entire union. And, says Davis, it is on the union positions on the Panthers, health care issues, community control of hospitals, etc., that there is the most disagreement within the union. If the union were to poll its members to try to take a forthright stand on such controversial issues, it would "tear this union apart." He cannot understand that disagreement need not prevent unity, that in a fully democratic organization, controversy need not necessarily conflict with unity and strength and may even increase them, and that unity without discussion and understanding is not unity at all. Emblazoned across the front of the union's new building is the quote, attributed to Frederick Douglass, "Without struggle, there is no progress." 1199 has understood this slogan with respect to relations between hospital workers and hospitals; it has not understood it with respect to itself. To 1199's leaders, unity, strong centralized leadership, and avoidance of divisive issues seem essential if the union is to fulfill its central role as a labor union: improving the wages, job security, and working conditions of its members. But ironically, it is on the union's performance on bread and butter issues that the union's failure to encourage participation, discussion, action on social issues, etc., has its most immediate impact: Members complain most about the union's lack of competent and dedicated lower level leadership. It's impossible to find your organizer when you want him, they complain, and when the organizer does turn up around, like they not see don't know how to handle your grievance or to pilot you through the union welfare plan, pension plan, and the like. The delegate system, the union's system of rank and file representatives on the "shop" floor, barely functions at all. Many members have no active delegates; many other delegates do nothing more than carry information from leadership to members; and many of the most competent and energetic delegates have quit in disgust. You have to be militant with respect to the union in order to get any help from them on grievances and the like, say members at many hospitals.

Some radical workers add that the union is weakened by its unwillingness to take on the hospital system in a basic way and by its refusal to ally itself with the growing forces for change in the health system. The union's much heralded training and upgrading program, for example, which is supposed to get workers out of dead end jobs and onto "career ladders," has barely gotten off the ground. They're never going to affect more than a handful of workers with the upgrading program, say the health activists, until the entire health system, with its arcane job structure, professionallism, and false hierarchies, is changed basically. But the union's approach to training and upgrading is to sit down at a negotiation table and discuss what the union can get on training and upgrading, with the union's demands always uppermost. It is not the union's job, they say, to change the system. The union's approach is to try to change the system piecemeal, with negotiations.

NYC STRIKE SETTLEMENT

With a strike deadline six hours past, on July 1, New York's 1199 reached agreement with hospital managements on a new contract. The union had threatened to pull out some 25,000 workers in 33 hospitals if its demands were not met. The settlement calls for an $18 or 25 per cent raise (whichever is higher) immediately, $12 or 10 per cent in a year, and cost of living increases if prices go up by more than 6 per cent in the next year. The minimum wage for hospital work will thus go from its current $10 a week to $130 a week in July, 1971. Most of the fringe benefits which the union demanded were also granted.

The gains won were substantial, but the union failed to get hospital agreement on several demands which would have represented major breakthroughs in hospital labor relations. (1) They failed to tie wages either to the cost of living or to Bureau of Labor Statistics standards for a minimum adequate income. At current rates of inflation, the cost of living increments agreed upon will mean nothing; workers will continue to lose close to 6 per cent a year in real income. And the new minimum won by the union is still well below the Bureau of Labor Statistics lower income standard for a family of four ($140 per week). Most hospital workers will still be receiving little more than poverty wages. (2) The union failed to win "establishment of 'career ladders' within each hospital," the key to getting the union's already existing training and upgrading program off the ground. (3) The union also failed to come up with any new protection against the layoffs and speedups which fiscally pressed hospitals have been threatening.

The negotiations took on an atmosphere of high tension as the strike deadline neared. It appeared that the city's hospital system would be crippled, with resulting deaths. Fortunately, a strike turned out not to be necessary. But the union had not looked for alternatives to such drastic action. It had not, for example, tried to mobilize public support to pressure the hospitals to meet its demands. Few people in the city even knew there was a potential problem until one week before the contract expiration date, when the union suddenly threatened a city-wide strike. The union also failed to try a consistent program of job actions short of a strike. The union remains vulnerable to the charge that it was playing with the public safety when it failed to do everything possible to pressure the hospitals before resort to the ultimate weapon, a strike.
table with hospital managers to jointly administer a fund to train people for conventional jobs. No radical restructuring of the health system will come out of that effort, needless to say.

The critics also point out that in the June 1970 contract negotiations, 1199 cast itself in the role of enemy of sick people. They never made any attempt to go to the community, the role of enemy of sick people. They never could identify with. They simply said "we want more." Cut off from potential support, a strike became the only tactic they could use to win their undoubtedly legitimate demands.

1199 has made vast strides for its members on the bread and butter issues, and by so doing has given them a new dignity. No one, seeing the changes in the lives of hospital workers in New York City since 1199 came to town, can argue that the union has not brought fantastic advances for hospital workers. And seeing these things, no one interested in changing the health system can remain aloof when 1199 tries to organize a hospital in New York or other cities. The unionization of hospital workers into 1199 (and in some places into other unions) has been a major achievement, a major bright spot in social progress in the 1960's. But at the same time, no one should be deceived that 1199 has escaped the tendencies which have turned other American unions into conservative, stagnant bureaucracies. It has not gone beyond bread and butter issues and it has not enriched its vision through democratic participation by the membership. 1199 is on the same road as other American unions. We see it now near the beginning of its historical journey. It is bright and shining, and its brightness contrasts with the decay of the older unions. But it remains on the same road, nevertheless, and as it matures, it comes more and more to resemble the unions which, despite their original promise, have failed to become major forces for social change.—John Ehrenreich

Where There is no Union

Over two years ago, in June, 1968, workers in four state mental hospitals in Topeka, Kansas, assumed administrative control of their institutions and ran those hospitals until the police came and made arrests. At that time most hospital doctors and administrators who read of the Kansas takeover saw it as a unique and isolated event. Now, these same men feel less removed from the events in Topeka. Since June 1968 militant workers' actions have occurred in several other institutions including New York's Lincoln Hospital (see April and September, 1969, BULLETINS) and Governor Clinic (see September, 1969 and February, 1970, BULLETINS). Political activity among hospital workers has not yet become widespread, but in several cities around the country hospital workers are beginning to express dissatisfaction about their jobs and to question the quality of service in the hospitals they work in.

Traditionally the only issues discussed by hospital workers and hospital managements have been trade union issues — wages and working conditions. In several places where unions exist or are being organized, workers are now making demands that go beyond traditional trade union issues. Demands for worker and community participation in hospital decision making, the right of workers to form political organizations, an end to racist hiring practices and the oppression of women, meaningful job advancement, and improved quality of health care for the people who use the hospital are issues that ordinary health unions generally stay clear of. The present situation differs from traditional worker struggles in another way. For the first time a coalition is emerging between workers at all levels of the hospital hierarchy. Non-professional workers, technical workers and young house staff are getting together to make demands on the hospital.

The amount of political activity among hospital workers is still small. But young hospital workers are part of a trend toward worker militance that is emerging in other industries as well. In Detroit, young auto workers are refusing to do the unsafe jobs that their fathers had done year after year. Teamsters in California have staged wildcat strikes demanding greater benefits than their union negotiated. And postal worker insurgents have had a well-publicized wildcat confrontation with the Federal government about wages. The activity among hospital workers so far is scattered and on a small scale, but it is impossible to predict what will happen in the future.

Boston: It is difficult to say what single event or chain of events will spur the formation of a worker organization in a hospital. It might be the firing of a particularly well liked worker or a brutalizing event in a hospital emergency room. But one of the essential conditions for stimulating hospital organization is the ability of workers to communicate with other workers. Talking in the locker room or workers lunch room can be a start, but in many locations the genesis of activity has begun with the publication of worker-controlled newspapers. For example, nurses and clerical staff in several Boston hospitals got together and started publishing a newspaper, Pass the Word. Every few weeks a new issue is dis-
tributed to thousands of hospital workers, professional and non-professional, giving them a way to communicate to other workers their criticism of the Boston hospital system and their anger about how the workers in these hospitals are treated.

Articles in the newspaper recount stories of police harassment of patients in emergency rooms, unfair firings of workers, dangerous patient care conditions created by hospital bureaucracy and inefficiency, and unresolved grievances of workers. "Hey, You," an article that appeared in one recent issue of the newspaper, describes the use of different uniforms to distinguish the different members of the hospital hierarchy. Criticizing the use of different uniforms for different types of workers is a simple way of illustrating the stratification and depersonalization of hospital workers and the rigidity of the hospital structure.

Even a minor challenge such as the appearance of a worker newspaper has apparently made the hospital administration feel threatened. Indirect attempts have been made to stop the distribution of the newspaper and to inhibit discussion. At Boston City Hospital, for example, several of the workers involved in putting out the paper were threatened with possible firing by the hospital administration, ostensibly for unsatisfactory work. The workers involved claim the charges are unfounded and that these threats are an attempt to discredit and dismiss the "hard core dissidents."

But these attempts have not been successful. The paper continues to be published. At other hospitals around the country such newspapers have also been put out. For example, in New York there is For the People's Health, in the Staten Island Public Health Service Hospital, The Voice of the Workers, and in Chicago, Outrage.

Chicago: At Wesley Hospital in Chicago worker activity began with an attempt to organize a union. Wesley is a voluntary Methodist hospital located in a ghetto community. Under pressure from the non-professional workers, the hospital was forced to hold a union recognition election but refused to permit the election to be run by the Illinois Labor Relations Department. Instead they ran it themselves and tried to manipulate the election in order to defeat the union. The election ballots were distributed along with the workers' pay checks and were numbered so that the hospital would be able to determine how each worker voted. The hospital also used ministers from the Methodist Church instead of impartial representatives to monitor the election. In the face of this intimidation the union lost the election overwhelmingly. However, the workers filed an unfair labor practices suit against Wesley Hospital with the State Labor Relations Board which ordered a new election. This election resulted in a resounding victory for the union. Though the hospital has challenged the second election, it appears likely that the union will be recognized.

The Chicago newspapers have reported the struggle solely as a fight for a union. But the demands of the non-professional workers at Wesley encompass broader issues than the right to organize a union. Other demands involve extension of the outpatient services so that the hospital will better serve the people who use it. Most of the people who use the outpatient facilities at Wesley are black and brown residents of the surrounding community. The workers have also demanded minority admission to the Wesley Nursing School, which now trains middle class women from Chicago's suburbs.

As the struggle of the workers has grown, support has come from many quarters. Community groups such as the Young Lords have supported the workers' demands. The Young Lords and other community organizations have also joined with the workers to set up their own community-controlled free health clinics with volunteer personnel, and are now demanding that Wesley Hospital donate supplies and personnel to these clinics.

Medical students from Northwestern University and nursing students from Wesley have also participated on the side of the workers and community. By putting pressure on faculty members, and distributing leaflets for the workers so that they would not risk being fired, the students and professionals have made the Wesley administration realize that opposition comes from many levels of the hospital hierarchy. About 30 to 40 nursing and medical students also do volunteer work in the free clinics. The students also helped the workers by leaflet distribution and poll-watching for the union election. The workers responded to the help from the students by offering union membership to all students and house staff. The uniqueness of this offer indicates the kind of trust developed between the workers and the students at Wesley. The hospital responded, however, by expelling one of the most active nursing students seven weeks before her graduation on the grounds that her work had been falling behind because of her political activity. Several medical students were also threatened with expulsion. In spite of this, many students continue their involvement.

Los Angeles: At UCLA Medical Center non-professional workers and a few sympathetic professionals have gotten together around general social issues as well as traditional union issues in a group called the Medical Center Committee (MCC). Since the workers at UCLA are not represented by a union, their first priority has been to act on union issues. The MCC has played the advocate role in negotiating worker grievances and carried on a fight against job discrimination. A typical example is the fight around the job categories "janitor" and "custodian." At UCLA "janitors" sweep the floors, replace light bulbs and move heavy equipment. "Custodians" do exactly the same work but get 10 percent more money. The custodians employed by the hospital are 90 percent white while the janitors...
are 90 percent black. The MCC is pressuring the Medical Center to eliminate the job category of janitor by upgrading all janitors to custodian. To MCC, this battle is a starting point for a challenge of racist practices at all levels of the hospital, from medical school admissions to employment policies.

The MCC has also been waging a campaign to get a day care center for children of employees and patients at the Medical Center. Their main tactic was to sponsor a “baby-in” in the lobby of the hospital. Several weeks in advance of the chosen date the MCC circulated leaflets announcing that they would provide free care for children of employees in the halls of the hospital. The point of the baby-in was to prove to the administration that, with funding from the hospital, a day care center could be run by hospital workers with no difficulty at all. Even though the hospital administration made unauthorized announcements in the name of the MCC cancelling the “baby-in,” 50 children arrived at the hospital and were adequately taken care of and fed by volunteers for the day.

The organizers of the MCC have begun talking about organizing a union so that they can settle grievances and negotiate pay scales with the strength of a contract. They are distrustful of conventional unions, which they feel are often undemocratic, and have decided to organize an independent union of their own.

The Medical Center has already made concessions to the MCC. In the last several months a free speech area was set up for hospital employees. Previously the administration had fired workers for trying to organize political rallies. Though this is not a major victory, it has made the MCC confident that they will be able to force changes within the Medical Center. Since the free speech area has been set up, the MCC has held rallies with speakers from the Black Panther Party and militant Chicano organizations. They have also participated in fund drives and publicity campaigns in support of the Panthers and against police repression.

The MCC is now beginning to make contact with low income groups in the Santa Monica community that uses UCLA Medical Center. They believe that a working alliance with consumer groups will strengthen their hand in the fight against the hospital.—Vicki Cooper

The Lessons of the San Francisco Hospital Strike

As the middle classes flee to the suburbs, often accompanied by industry, American cities sink deeper into poverty year after year. Municipal services — transportation, hospitals, sanitation — deteriorate from crisis to crisis. Municipal hospitals, from New York’s 18-hospital system to Chicago’s Cook County or San Francisco’s General Hospital, are perhaps the most pathetic casualties of the nationwide urban fiscal crisis, but the movement to transform them into adequate community health resources — or at least to rescue them from total decay — is so far just beginning. Hospital workers, long paid at just above welfare levels, tend to put bread and butter demands above patient care issues. Interns and residents are usually more concerned with their education, and the lucrative practice that follows, than they are with improving the hospital facilities they learn in. And the patients, who are in every city overwhelmingly black, brown or aged and in all cases poor, are often too frightened and resentful of “their” municipal hospital to organize and change it.

San Francisco General Hospital (SFGH) could have been different. In March, 1970, the nonprofessional workers, the nurses and the interns all threatened to strike unless their needs, and the hospital’s, were met. The momentum generated by the hospital workers’ strike threats led to a citywide walkout which was greater than anything San Francisco had seen since the San Francisco general strike of 1934. On one day, March 13, 1200 hospital workers walked out, joined by thousands of municipal workers in other services, and supported by thousands more including teachers, clerical workers and transport workers. But, on Monday March 16, the next work day, the citywide strike was over as suddenly as it had begun. At SFGH almost nothing, apparently, had been gained, either for workers or patients. But the lessons taught by the failure of the brief SFGH rebellion will not be forgotten in a hurry by workers and patients in San Francisco. They are just as relevant in Chicago or New York.

San Francisco General Hospital cares for the indigent black, Latin, Chinese, Filipino, American Indian, Samoan, alcoholic and hip populations of San Francisco. Like municipal hospitals across the country, SFGH is underfinanced, hopelessly administered, and lacks accountability to the people it tries to serve. In particular, as in New York City Municipal hospitals, administrative responsibility for SFGH is divided between an inflexible, cost-conscious City bureaucracy and an academically oriented affiliated institution, in this case, the University of California Medical School (U.C.). The main concern of the City bureaucracy, the Mayor and the Board of Supervisors, is to contain and control SFGH’s already meager budget, and to administer the non-physician personnel. U.C., on the other hand, sees SFGH primarily as a site for training interns and residents, and for the research projects of its full-time faculty assigned to SFGH. U.C. has excluded minority group community physicians from practicing in SFGH, encouraged the rapid
rotation of residents through SFGH (with damaging results to continuity of care), and in general neglected community health needs. To both U.C. and the City bureaucracy, patient care is not a priority at SFGH.

Patients hate and fear SFGH, many preferring to forego medical care rather than go to SFGH. As in New York's Municipal hospitals, clinic and emergency waiting times are measured in hours; care is fragmented and episodic. Patients are called by their first names, if they are lucky; otherwise they are often termed "old gomers," "crockers," "alcs," or "grooms" by house staff and U.C. faculty. One U.C. faculty consultant stated (in front of the patient): "The only reason this man shouldn't be thrown out into the street is that he will clutter up the street." It almost goes without saying that SFGH has failed to develop satellite clinics and outreach programs in the surrounding indigent communities.

SFGH's problems stem in large part from its chronic underfinancing, which has been intensified by recent changes in the San Francisco City tax base. In 1967, the California legislature passed the Petris-Knox Act, which markedly shifted the burden of taxation from business to homeowners. With business paying less of San Francisco's tax bill, homeowners were deluged with rapidly rising taxes—some families saw their property taxes rise by 100 percent in one year. Property taxes are inherently grossly inequitable, hitting the lower middle class and middle class far harder than the wealthy: The average family making $1,000 per year pays 13 percent of this income in property taxes; the family earning $4,500 pays five percent in property taxes; yet families with incomes over $15,000 pay only two percent in property taxes. With the lower-middle and middle classes up in arms, San Francisco politicians attempted to control the rapidly growing tax burden by tightening the city budget and starving municipal services, such as SFGH.

The San Francisco situation exemplifies a pattern seen throughout the country: the poverty of the local public sector in the midst of private affluence. Public employees and clients of public services are demanding more pay and better services, while hard-hit lower and middle-class taxpayers are screaming for relief. Local office-holders, unable politically to tax their business buddies, are caught in a squeeze.

The 1970/71 San Francisco City budget promised to be leaner than ever. For the hospital, it meant no new funds for improvements in patient care and inadequate wage increases for the workers. The first result of the 1970/71 budget crackdown was the San Francisco public employee strike. Mayor Alioto, formerly a friend of labor, refused to raise any City employees' salaries more than five percent, despite a six percent increase in the cost of living. The hospital workers' unions (Local 250 of the Service Employees International Union and Local 400 of the American Federation of State, County and Muni-

cipal Employees) demanded ten percent in increases and the lines were drawn for a strike. In addition, SFGH nurses were scheduled to lose their night shift pay differential, a gain which they had won, by striking, four years ago. Hence the California Nursing Association joined the City employees' and hospital workers' unions in strike plans.

The second effect of the budget crackdown was the SFGH interns' strike threat, which had been developing for several months. The 63 interns who had started working at SFGH in July, 1969, were mostly unconcerned, a political people. One typical intern had said of a patient early in the year: "He's just a lousy alcoholic groom. Why should I waste my time with him?" Three months later the same intern, embittered by conditions at SFGH and by the City's hard line on spending, promised to strike for better patient care.

Early in the fall, the interns had drawn up a series of demands involving their own salaries and improvements in patient care (longer pharmacy and clinic hours, more social service, ward clerks, and satellite health facilities). These demands were approved over a three month period by the hospital administration, the Department of Public Health, and the City's Chief Administrative Officer. By December the list of demands landed in Mayor Alioto's office. There—due to the tax and fiscal crisis—it stayed unheeded.

December is a dark month for interns. Long hours and short days exclude them from the light of day. Cold weather brings on an added load of severely ill pneumonias, and holiday binges lead to a steady stream of gastrointestinal bleeding cases. An eternal six months of oppressive intern's work still remains. Restlessness was brewing at SFGH... On December 9 a meeting was called. On December 11 the vote was taken. The interns had decided to stage a heal-in.

Heal-ins have been used in municipal hospitals in other cities to win house staff demands. During a heal-in, house staff admit every needy patient to the hospital, filling it to the overflow point, with patients in the halls and basements. The idea is to focus public attention on the hospital's problems. The trouble with heal-ins, however, is that they tend to hurt the very people who are using them—the interns and workers, by making them do far more work—and they do not put significant economic pressure on the city. For these reasons, support for the planned heal-in was flagging by the time Alioto came to the hospital on January 15 to speak to the interns. The Mayor's message: Your demands are meritorious, but there is no money. Faced on the one side with an unremitting Mayor and on the other by growing enrollments, the heal-in was postponed indefinitely.

Over the next month, however, restlessness reappeared. The workers began to prepare for a strike themselves. The Mayor was granting money for the baseball stadium and for fences around police stations. Final-
The interns' strike was set for March 12; the unions called for a strike vote on March 9. Yet, though the interns' and workers' moves came together in time, they failed to merge in goals or content. Individual hospital workers and nurses could relate to the patient care issues, but the union leadership was concerned strictly with pay. The interns made one attempt to persuade union leadership to merge the interns' and workers' demands into a single package and were rejected outright, on the grounds that the union could not negotiate patient care issues. When it came right down to it, neither the bread-and-butter union chiefs nor the professionally oriented average intern were really interested in such a coalition. During the crisis week in March, the interns' and workers' struggles grew farther apart each day:

March 9: The interns voted to drop their salary demands, most of which had already been granted by the City to buy them off. U.C. faculty at the hospital decided to condemn the interns' strike, though they claimed to back all the demands except that for community/worker control. The unions voted to strike. The rising rebellion at the hospital had been, at least for the near future, effectively squashed. Why? The first reason was the inability of the oppressed groups at the hospital—patients, workers, and interns—to enter into a meaningful coalition. First, community groups representing the patients are suspicious toward interns because of racial and class differences, and the frequent mistreatment of patients by house staff. The interns did not contact community groups until a few days prior to the strike; consequently these groups were practically uninvolved in the goings-on within the hospital. The community was made aware of the situation entirely through the media, which scarcely mentioned the patient-care issues. Thus when the interns belatedly approached community members for support, the community's main concern was for alternative health care during the strike. Community organizations tended to be sympathetic to the interns' demands, but only the militant Welfare Rights Organization agreed to join interns on the picket line. In general, community groups had an enduring disbelief that interns would ever strike for patient-care issues. They turned out to be right. The community is also ambivalent about the workers. In a sense, they are brothers—largely of minority background and in a low economic position. Yet the workers are an identifiable part of the hated hospital, and as such are politically separated from their communities. On their part, hospital employees tend to be distrustful of community control. Many feel (as did New York teachers in the school decentralization battle) that a community board would be harder to deal with in terms of salaries and job security than the public bureaucracy.

March 10: The intern leadership met with Alioto, who promised them a small fraction of their demands. The interns postponed their final strike decision vote. The hospital was already two thirds empty, due to a decree of the City to admit only emergency patients.

March 11: The San Francisco Central Labor Council sanctioned the workers' strike for March 13. The interns, after a heated debate, voted to strike on March 13 if Alioto had not signed a document committing himself to their demands.

March 12: The workers prepared picket signs. Alioto had still made no response to the interns' demands. A rumor began to circulate among the interns that U.C. faculty would refuse to certify any intern who went out on strike, (intern certification is a requirement for receiving a physician's license) and the interns began to have second thoughts about striking. At the final strike vote, the interns voted 29 to 15 against striking. A lengthy press statement was issued attempting to obscure the truth that the interns had given up without gaining anything.

March 13: At 12:01 AM the workers left their jobs and formed picket lines around the hospital. Throughout San Francisco, over 10,000 municipal employees were on strike. At SFGH, the majority of interns, left with an empty hospital, disappeared, probably to the mountains for a weekend of skiing.
the strike finally began, very few interns ever joined the union picket lines.

The second reason for the failure of the SFGH rebellion was that the various elements of the health power structure, in contrast to the oppressed groups, were able to unite into a monolithic body. The local health establishment consists of the San Francisco Medical Society, the voluntary hospitals, the Public Health Department (backed by city government), and the medical school. Sometimes these elements behave independently. However, their quarrels are minor compared with common interests: in this case, to suppress the challenge from below. As the strikers' threats neareded fulfillment, the power structure congealed.

One of their first cooperative moves was to see to it that the SFGH strike would have no economic impact on the city. Potentially, the economic threat posed by the strike was enormous: about one half of SFGH's patients are medically indigent, without any public or private agency to pay for their medical care. These patients, unable to enter the stricken SFGH, would go to private hospitals, and the City would be billed. (Sympathetic doctors in the city had made plans to transport such patients to other hospitals and to facilitate their admission and costly workups.) At the voluntary hospitals' rates of $150-200 per day per patient, the strike would be a costly one. However, the citywide association of private hospitals, in response to the City's request, agreed not to take such patients, thus destroying the strike's effectiveness. The medical society played its part by putting together a plan for the emergency care of displaced patients—to help take the heat off the City and the voluntary hospitals.

The University's primary role was in preventing the interns' strike. This was largely accomplished by the faculty's co-opting the interns' issues, and promising to push for the demands in less disruptive ways. Many of the interns, believing that the faculty would fight their battle, then backed down on the strike. However, the key issue—community-worker control of the hospital—was sold out; the faculty totally opposed such control. Thus, in taking over the interns' fight, U.C. was able to drop the issue which really threatened its own power in the hospital.

The unions also worked with the health power structure by limiting the duration and the intensity of the strike. First, union leadership had refused to work with the interns for improved patient care or structural change at the hospital. Then, after the strike had been in effect for only three days, the union leadership had claimed a satisfactory settlement, and called off the strike without consulting the rank and file. According to some dissenst workers, the union leadership had feared that the strike would get out of their control, and lead to insurgency within the unions.

Thus the SFGH strike brought about a strengthening of the already close-knit ties between the elements of the health power structure. The oppressed groups, however, failed to unify, and their fragmentation contributed to their defeat. Indeed, the very strike tactic itself—a move by workers and interns with immediate bad consequences for the community (no health care)—is a dividing force.

What, then, were the effects of the March crisis at SFGH? Outwardly, the hospital appears 100 percent status quo ante. "Grooms" are still "grooms" and emergency room waiting is as interminable as ever. But certain changes did take place. The final form of the 1970/71 budget, suprisingly enough, contained most of the interns' demands. The SFGH faculty members have challenged U.C. to place more resources at SFGH. Community groups have made proposals for community control. And the City Board of Supervisors has convened a commission to create a hospital board, and to make the hospital autonomous of the City.

In addition, the SFGH crisis has had deep effects on peoples' understanding of the kinds of structural changes which would be necessary to make SFGH a high quality and accountable health institution. Prior to the crisis, many workers and interns felt that SFGH's problems would be solved simply by increased funding. But the crisis exposed the bankruptcy of the dominant forces in SFGH: The City revealed the depths of its indifference to SFGH's financial problems. The University revealed its anti-community posture. And the hospital, in its lack of concern for the hospital workers and patients, thus everyone's confidence in the hospital's reigning parties is weakened. Community people, plus a growing minority of workers, are beginning to talk about the necessity of community and worker control of SFGH.

But, without adequate financing, community control could be an empty slogan. The inadequate financing of SFGH stems from the poverty of the San Francisco City government. The City is unable to extract tax revenues from its potentially most abundant source—corporate business. The result is an impoverished local government, with groups of public employees, clients of public services and taxpayers all scrambling for the meager pickings. This is the great strength of the Establishment: its ability to pit public workers versus public clients (the hospital users, in this case) and to line up both of these groups against the general taxpayers. Were these three groups to recognize their common interests and unite, the change in power relationships would be profound. In the meantime, the more limited struggle for community control of SFGH is serving to raise the issues of democracy and economic justice, and to mobilize large numbers of low-income consumers. —Tom Bodenheimer, M.D.

[Editors' Note: This article is the first in a planned series of reports on major health struggles outside New York City. Tom Bodenheimer is a resident in medicine at San Francisco General Hospital.]