Labor Unions in Medicine

The Intersection of Patient Advocacy and Self-advocacy

Constantine A. Manthous, MD

Background: Labor unions have been a weak force in the medical marketplace.

Objectives: To briefly review the history of physicians' and nurses' labor unions, explore the ethics of unions in medicine, and offer a solution that simultaneously serves patients and professionals.

Research Design: A selective review of the literature.

Results: Labor unions of medical professionals pose an ethical quandary, that is a tension between selfless patient advocacy versus self-advocacy. The primary role of labor unions has been to extract from management benefits for employees. The threat of work actions is the primary tool that labor unions can apply to encourage management to negotiate mutually acceptable conditions of employment. Work actions—namely slow-downs and strikes—may harm patients and may therefore run afoul of professionals' primary duty to the primacy of patients' welfare. An alternative model is offered wherein medical unions align self-centered and patient-centered interests and leverage the Public Good, in the form of public opinion, to encourage good-faith bargaining with management.

Conclusions: As medicine becomes increasingly corporatized, physicians will join nurses in "at-will employment" arrangements whereby self-advocacy and patient advocacy may be impacted. Although labor unions have been a means of counterbalancing unchecked discretion of corporate management, conventional labor unions may run afoul of medical ethical principles. Reconsideration and innovation, to address this ethical dilemma, could provide a solution that aligns both clinicians' and patients' welfare.

Key Words: labor union, collective bargaining, safety, quality, justice

(*Med Care* 2014;52: 387–392)

Although labor unions have been a fixture of many workplaces, <20% of physicians and nurses in the United States are unionized,[1] and unions in other vocations have declined substantially over the past 30 years.[2] In this paper we explore briefly the history of labor unions in the US medicine and grapple with the ethical conundrum posed by the collision of unions' primary weapon, that is strikes, with clinicians' professional obligation to protect patients' interests above their own.[3]

BRIEF HISTORY AND ACCOMPLISHMENTS OF UNIONS IN THE UNITED STATES

Nurses

Owing to historic hierarchies (that are increasingly antiquated), nurses have had a weaker voice for self-advocacy and patient advocacy than physicians. A milestone in health care labor laws was Public Law 93-360 which, in 1974, extended the right to unionize to employees of nonprofit hospitals.[4] Nonetheless, nurses are also more likely to be employed and so subject to national laws that permit and protect labor unions.[5] Far more nurses belong to labor unions; 19.6% compared with only 8.7% of physicians in 2012.[1] Although a detailed history of the far-more-numerous nursing unions and work actions are beyond the scope of this paper, it is worth emphasizing that the history of nursing unions has also been distinguished from that of physicians by the goals and primary concerns of the organizations. Nurses' unions have included patient advocacy as a component, if not the primary focus, of their goals.[5] Moreover, working conditions and nurse:patient ratios that are other primary foci of nursing unions has an impact on both the well-being of nurses and patients—a conflation not generally applicable to physicians (except, arguably, physician-trainees).[6] Nursing unions have most impacted staffing ratios and mandatory overtime.[5]

Physicians

The first physicians' union was initiated in 1934 in New York, and advocated on behalf of trainees' stipends. Recent surveys suggest that <10% of physicians are unionized,[1] and data from 2001 suggest that a substantial proportion were trainees.[6,7] Beyond the ethical issues (see below), antitrust laws have impeded unionization, at least among physicians who are independent contractors (as distinguished from employed physicians).[8] A group affiliated with the American Federation of State, County, and Municipal Employees and the AFL-CIO, the California-based Union of American Physicians and Dentists (UAPD) claims to be the largest union in the United States, but does not provide membership data on its website. The UAPD boasts winning "higher salaries, shorter work weeks, excellent benefits packages, greater job security, more continuing

From the Private practitioner.
The author declares no conflict of interest.
Reprints: Constantine A. Manthous, MD, 4450 Whitney Avenue, Hamden, CT 06518. E-mail: manthous@sbcglobal.net.

ISSN: 0025-7079/14/5205-0387

medical education," but patient advocacy is mentioned only tangentially:

MORE CONTROL—Because regaining control over the quality of care is a top priority for doctors, UAPD has negotiated contracts that give ultimate authority to medical staff.[9]

The Florida-based Federation of Physicians and Dentists similarly provides an impressive list of benefits accrued by unions, including "wages, incentive pay or bonus, overtime and shift premiums, merit pay raises, cost of living increases … " but no mention of patient advocacy or number of physicians represented by the organization.[10]

The history of physicians' collective work actions is greater in other industrialized countries than in the United States.[11] Employed physicians in the United States have staged infrequent, sporadic, small strikes, or work slowdowns, most pertaining to working conditions of resident-trainees,[11] who, with the assistance of the AMA's Physicians for Responsible Negotiation, earned the right to unionize in 2000.[12] Other physician union collective job actions have focused on working conditions, malpractice premiums, and wages,[11] however, we could find no reports of physicians striking on behalf of patients' direct interests.

ETHICAL QUANDARIES POSED BY UNIONS

Although there may be subtle differences between the professional-ethical obligations of physicians and nurses, core principles are shared. Both nurses and physicians are bound to place their patients' interests above their own, to respect patients' autonomy, provide care that they think will be beneficial (beneficence) and not harmful (nonmaleficence) and administer justly.[3] Historically the principle goals of unions have been to advocate for wages and working conditions, that is, for the (selfish) interests of members. Although the well-being and happiness of clinicians—like any other vocation—may enhance performance, thereby indirectly impacting the well-being of patients, the supposition is neither proven nor inherently valid. Conflicts of interest may confound beneficence without physicians' conscious awareness. Bazerman and Tenbrunsel[13] refer to such conflicts as "blind spots"—predicated on unconscious selfish interest. Clinicians' pursuit of selfish needs (wages, working conditions, etc.) should be distinguished from pursuit of patients' welfare, of an institution's welfare, or of the health system more generally. Employed clinicians have a right to join unions, but they must be prepared to accept their chosen union's tools to affect collective bargaining. Job actions, in the form of work slow-downs or strikes, have been the primary "weapon" of unions acting on behalf of constituents' interests, so 2 questions arise: can job actions in medicine be ethical, and if so, under what conditions. And as there are some published reports suggesting patients are harmed as a result,[14,15] clinicians' self-advocacy, using the normal tools of unions, may pose an inherent conflict of interest.

The American Medical Association and American College of Physicians prohibit any actions that could negatively impact patients:

The College opposes joint actions by any physicians that would 1) deny or limit services to patients (including strikes, slowdowns, boycotts, and administrative or other organized actions that would harm patients).[6]

Strikes and other collective action may reduce access to care, eliminate or delay necessary care, and interfere with continuity of care. Each of these consequences raises ethical concerns. Physicians should refrain from the use of the strike as a bargaining tactic. In rare circumstances, individual or grassroots actions, such as brief limitations of personal availability, may be appropriate as a means of calling attention to needed changes in patient care.[16]

A supposition of both major physicians' organizations is that collective work actions cause patient harm. There are scant data to support or refute this premise, and available evidence is mixed.[14,15,17] The absence of abundant studies does not preclude demonstrable patient harm—every strike includes specific variables (who, how long, what activities, vulnerability of an institution to work action, etc.) that are likely to vary considerably, so designing robust studies examining outcomes resulting from health care strikes is untenable. Such would also require the cooperation, to share data reliably. In addition, beyond the impact on patient care, job actions may have an impact on patients' perceptions of their caregivers, undermining trust that is crucial to the clinician-patient relationship.[18,19] Such harm could be substantial, but quite difficult to measures. But unions could have positive effects to counteract any (theoretical) negative effects associated with strikes. A study by Ash and Seago[20] demonstrated a strong association of reduced mortality (by 5.5%) of patients treated in California hospitals with nursing unions. But even after adjusting for multiple confounders, the authors could not rule out the possibility of spurious correlation. Their article raises an interesting possibility; that unions could promote superior patient outcomes (eg, superior staffing, better quality clinicians, clinicians' satisfaction) simply because the possibility of collective action encourages employers to bargain in good faith, thereby serving simultaneously clinicians' selfish interests and selfless professional obligations. Sklar and colleagues also raise a similar putative mechanism whereby physician-trainee unions "risk encouraging members to put their needs above those of their patients … however, if the union can help to create a more equitable, effective institution through the engagement of residents in process improvements and enhanced clinical quality, then it may ultimately create a more professional environment … ."[21] Like other corporate entities, governance in America's health care institutions is problematic. Boards of Directors, nursing councils, and executive physician bodies are in place, but there is little evidence to support that they provide robust checks and balances on hospital executives, to ensure mission-based governance.[22,23]

Most authorities agree that strikes or other work actions that are aimed exclusively to secure benefits only to clinicians are not morally permissible. In a careful exploration of the predicates required for a morally defensible strike by health care professionals, Fiester argues that job actions

should be a last resort AND the impact of the potential harm must be far outweighed by the potential good to patients. She frames these arguments around strikes focused on the malpractice crisis:

Because physician strikes intend harm to patients, challenge the obligations of the physician to her patient, and risk decreasing the public's esteem for the profession, I argue that a walkout over the malpractice crisis cannot be ethically justified as a legitimate political action … [24]

Interestingly, the American College of Physicians offers a similar example, and similar reasoning why a strike would not be justified.[25] But in distinction, Fiester offers a hypothetical example in which the benefits, *to patients*, would warrant a job action with provisos:

Imagine the following case: a strike is organized by hospital physicians to end unsafe practices in a particular institution to demand adequate resources to properly treat patients … serious attempts have been made to secure these changes, and protests have fallen on deaf ears … patients have complained for years about the care they receive there, and they are grateful that physicians have taken up their cause.[24]

By this line of reasoning, collective job actions—because they violate ethical obligations of clinicians and undermine professional legitimacy in the social compact—are permissible only if good-faith efforts have failed to achieve patient-care goals, the potential harm is far outweighed by likely good accruing to patients and patients support the action. These very narrow preconditions are unlikely to apply often (if ever), exclude physicians' self-interests as justifiable grounds for action and assert that clinicians would violate their core ethical principles.

Perhaps the strongest ethical argument against clinicians' job actions is that clinicians can choose a different job where the conditions of practice or employment are more acceptable. The relationship between clinicians and patients is considered asymmetric, or fiduciary, where the clinician has an additional responsibility to act for the well-being of the patient, and never for self-interest at the expense of harming patients. Clinicians join the profession accepting this ascendant principle, and so any action that could harm a patient, violates duty to nonmaleficence; "do no harm."

Paul Neiman[26] offers a more nuanced synthesis, suggesting that nurses are actors in a complex system. When administrators make a decision that negatively impacts their work environment, work actions are the "check and balance" that the system requires for self-regulation:

Nurses' decisions to strike is no different than hospital administrators' decision to increase staffing ratios. In both cases, nurses and hospital administrators play the role assigned to them in the healthcare community … In the competition over how healthcare is provided, members of the healthcare community pressure each other to accept more or less responsibility. Hospital administrators may do this by offering more or less charity care, or by increasing or decreasing staffing ratios. Nurses may do this by engaging in informational picketing or going on strike. It makes no difference whether the goal of the nurses' strike is to increase wages or increase patient safety, just as it makes no difference whether the goal of the hospital administrator is to increase the quality of patient care or increase the profitability of the hospital. These actions are justifiable because they are part of the system set up by the community to meet its healthcare obligations.

In this formulation, strikes *are the systemic check on unjust or medically inappropriate executive decision-mak*ing; and assumes nurses have an appropriate role in governance and autoregulation of health care administration. Neiman avoids, however, that nurses do not take an oath to the health care system; only to their patients. Yet insofar as the system's function—and therefore patients' well-being—depends upon self-regulation, then perhaps a (strained) argument can be made to support the morality of nursing (and more generally, clinicians') strikes.

POTENTIAL SOLUTIONS

In the late 1990s and early 2000s the American Medical Association introduced its Physicians for Responsible Negotiation, intended to unionize physicians but with the strict prohibition of strikes. The group failed to gain members and eventually collapsed.[11] If collective job actions are deemed unethical by medical professional societies, what negotiating "leverage" do clinicians have?

Ultimately, the public served by health care facilities may be the most important ally in seeking repairs of unfair or unsafe health care institutions. The federal government has begun to use precisely this type of leverage, that is, transparency and illumination through public reporting[27–29] to drive hospital safety and quality improvement efforts. Although the government's tools include a promise to pay less to hospitals that fail to perform, the perception of the public—to the extent that patients choose their hospitals—may have also encouraged hospital administrators to respond. In reality, the marketplace for hospitals is not entirely an open/free market. Informed choices are limited by geography, lack of transparency, and stipulations of insurers, just to name a few. Increasing public reporting, however, is one method of improving transparency.

Clinicians' actions on behalf of selfish interests are unlikely to encourage public support for their cause. Doctors are perceived as being well-salaried; so job actions for wages, benefits, and the like will gain little traction. Unions may be the best available remedy but without strikes or job actions, are unlikely to play a major role to advocate for physicians' selfish interests.

Patient advocacy, on the other hand, is very likely to engage the public's interest (and could be a "back-door" into pressing selfish interests if the 2 are tied together).[30,31] Collective action of clinicians on behalf of the quality of care and/or patient safety would resonate with fiduciary and professional responsibilities.[3,22,23] As highlighted above, nurses have demonstrated a much greater interest in pressing employers regarding patient advocacy than physicians (eg, advocating for safer nurse:patient ratios). When "serious attempts have been made to secure these changes, and protests have

fallen on deaf ears,[32]" all methods of reasonable dialogue have been exhausted,[20] and patients remain at risk, clinicians are obliged—at least in theory—to act. But how? The concept of "just cultures" in health care, where polite dissent on behalf of patients is not only tolerated but embraced is relatively new,[33] and in most states employers can fire employees "at will."[34] Continuing to collide with an employer who is immovable entails great risk, that is, unemployment, marginalization, demonization. Whistleblowing may entail even greater risk, that is, ostracism and demonization or a derailed career.[35,36] While an ideal, clinicians should not be expected to risk their own personal well-being for their professional values; there should be some remedy, short of lengthy, time-consuming, expensive, and injurious legal proceedings, for them to pursue clinicians' values (ie, their ethical obligations).[37]

We here propose a new mechanism that deploys several of the concepts discussed above.

Centralized Model—Institutional "Cover" for Patient Advocacy

Although Physicians for Responsible Negotiation (PRN) failed to gain traction among clinicians, the idea—that is, organizational advocacy, especially on behalf of patients, without the threat of strike—is a potentially powerful concept that would not carry negative but only positive "public relations." There is some evidence to suggest that public reporting initiatives focused on hospital outcomes have motivated administrators and staff to improve performance.[38–41] In addition, if health care executives' compensation packages are tied to safety and quality of care,[39] notwithstanding payers' pay-for-performance initiatives that have an impact on the financials, public reporting could be leveraged further on behalf of patient-centered, local clinicians' activism.

Accordingly, we suggest that the AMA, Institute of Healthcare Improvement or other organizations that champion safety and quality might create a group similar to the PRN, whose purpose is to assist physicians and nurses with serious patient advocacy concerns. Here's how it might work. Using Dr Fiester's example above as a concrete example, let us assume nurse understaffing was the issue of concern because there are objective, verifiable standards and both nurses and physicians share a stake. The group of clinicians would first gather evidence regarding patient care concerns, and formulate consensus about what should be requested, and what would be an acceptable administrative response. Interdisciplinary (ie, both nurses and doctors) participation would be most powerful. They would then have the responsibility to approach hospital administrators in a civil and collaborative manner to share concerns and offer suggestions for remedies. If no response, they'd have the professional responsibility to continue to engage, persistently, politely,[32] seeking to convince administrators that they share goals, that is, to provide safe, high-quality care, that serves the institutional interests (both mission and risks that might accrue from mishaps, etc.). Failing to do so, the group might bring its concerns to the proxy negotiating organization (PRN or other) described above. A certain number of certified health care providers might be needed to attest (identities protected) that they share the observations and concerns, and that the due process (above) had been exhausted to seek remedies internally. The negotiating organization would contact hospital administrators to examine the validity/veracity of the claims and offer to mediate. If no response, the group would then notify the hospital's Board of Directors—who have a fiduciary responsibility to serve the public and patients[22,23]—and repeat the process. If still no response, then the advocacy group could simply post, on a public website, the objective description of the problem (eg, "Metropolitan Hospital provides X:1 nursing ratios, whereas both local and national standards of care support Y:1.") Evidence—from local standards and the medical literature—could be posted to support the legitimacy of the complaint/posting. Citizens served by the hospital would be made aware, providing them the opportunity to either "vote with their feet" (when they can) or press at the political (or other levels) for the requested changes. All without a job action or risk to the clinical employees who speak out on behalf of patients.

Decentralized Model—An Alternative: "Selfless," Local Unions

We propose that unions, whose goals are predicated entirely on patients' rights and safety *could* be highly effective, even without the threat of work actions. This construct would require a departure from the historic focus/goals of labor unions. In our proposal, clinicians would:

1. Disavow strikes under any conditions,
2. Not contend for wage issues or work conditions that do not have an impact on the quality of care or patient safety,
3. Work, in good faith, with hospital administrators to remedy deficiencies that are beneath local and/or national standards of care that have substantial impact on patient safety or quality of care.

Although some safety measures involve things (devices, physical plant, medications), most involve people—either more staff or better trained staff, which usually entails financial cost. Arguably the most pernicious employer-employee disagreement that impacts patients is sufficient staff. As labor costs comprise a disproportionately large fraction of overhead expenditures, health care employers have a rational predilection and responsibility to staff at the minimum number necessary to provide appropriate services, that is, to maximize efficiency.[37] The greatest cost savings come from reducing staff and forgoing capital improvements (of big ticket items like physical plant and machinery). So tension between labor, fixated on patient safety and quality of care, and administration which must consider both care and finances is not only natural but a reasonable market force to promote the best balance of quality and efficiency.

The "optics" of this construct are favorable for the employees whose union does not press on behalf of selfish needs. Moreover, advocacy for patients can, in some cases, include positive benefits (improved staffing) that substantially improve work conditions as a secondary, self-serving, effect of patient advocacy. Conversely, it is hard to envision reasonable arguments for employers to oppose patient safety unions. Employers might argue that this form of union would only serve as a slippery slope toward typical unions that press

for wages and benefits. But such would be conjecture; an antiunion reflex, as there would be no evidence to support or refute the claim.

The greatest impediment is initiation. The first few employees who join take great risks if the union fails to take hold (ie, by majority vote of coworkers). The National Labor Relations Board prohibits retaliation against employees who attempt to unionize legally; but at-will employment law strongly favors employers except for the most egregious behavior.[34] Meanwhile subtle forms of retaliation may be deployed in unjust cultures; precisely the situation when such unions would be most theoretically useful (to patients and employees).[37] We emphasize that unions, of any kind, are not required in just cultures where employers work with employees to create transparent accountability and responsiveness to patient-centered concerns.[33] There are no data to indicate how many hospitals have truly just cultures, but there are simultaneously no protections—beyond (career-endangering) whistleblower laws—for clinicians who object when standards of care are violated persistently. Truly just cultures may be an ideal more than a reality; there are simply no data about this issue and so long as tensions of capital and labor remain a fact of life, systems/employees will be vulnerable to injustices.

So why aren't more medical workplaces unionized? First, there is the ethical dilemma posed by strikes by typical unions (obviated by our model). Second, rightly or wrongly, unions have been associated with graft and corruption.[42] Employees must contribute a portion of their salaries in exchange for union management. Employers may oppose unionization because they drive up operating costs; and discourage employees from even considering joining unions. Businesses united recently to block even posting workers' rights in the workplace.[43] Employees may have no idea of their legal rights and may instead fear retaliation in "at-will" employment.[44]

CONCLUSIONS

Health care has become an ever-more complex environment where the perils to patients and health care employees escalate. As more physicians join nurses as employees of health care facilities,[45] health care spending becomes more constrained and resource allocation may come to threaten patients' well-being (and clinicians' work conditions), these labor issues are only likely to become more salient. Clinicians must have a voice both for their selfish but, more important, their selfless concerns. Owing to the ethical dilemmas explored herein, unionization—in the conventional senses—may not be the ideal mechanism for pursuing these goals. Some new approach that serves to check and balance corporate interests while honoring clinical values, may be required.

REFERENCES

1. Hirsch B, Macpherson D. Union membership and coverage database from the current Population Survey. Unionstats.com. Accessed April 1, 2013.
2. Bureau of Labor Statistics. Economic New Release; Union Member Summary. Available at: http://www.bls.gov/news.release/union2.nr0.htm. Accessed April 10, 2012.
3. Medical professionalism in the new millennium: a physician charter. *Ann Intern Med*. 2002;136:243–246.
4. Bond GE, Del Togno-Armanasco V. Public law 93-360. *Nurs Manag*. 1981;12:27–30.
5. Clark PF, Clark DA. Union strategies for improving patient care: the key to nurse unionism. *Labor Studies J*. 2006;31:51–70.
6. American College of Physicians-American Society of Internal Medicine. Physicians and joint negotiations. *Ann Intern Med*. 2001;134: 787–792.
7. Keith SN. Collective bargaining and strikes among physicians. *J Nat Med Assoc*. 1984;76:1117–1121.
8. Turner R. Physicians and unions. Available at: http://www.law.uh.edu/healthlaw/perspectives/Managed/980817Physicians.html. Accessed April 11, 2012.
9. UAPD. All doctors need a union—a union like UAPD. Available at: http://www.uapd.com/all-doctors-need-a-union/. Accessed April 10, 2012.
10. Federation of Physicians and Dentists. Available at: http://www.fpdunion.org/page7.html. Accessed April 11, 2012.
11. Thompson SL, Salmon W. Strikes by physicians: a historical perspective toward an ethical evaluation. *Intern J Health Serv*. 2006; 36:331–354.
12. National Labor Relations Board. Boston Medical Center, 330. NLRB;30:1999.
13. Bazerman ME, Tenbrunsel AE. *Blind Spots: Why We Fail to do What's Right and What to do About it*. New Jersey: Princeton University Press; 2011.
14. James JJ. Impacts of the medical malpractice slowdown in Los Angeles County: January 1976. *Am J Publ Health*. 1979;69:437–443.
15. Gruber J, Kleiner SA. Do strikes kill? Evidence from New York State. *Am Econ J: Econ Policy*. 2012;4:127–157.
16. Opinion 9.025—Advocacy for Change in Law and Policy. AMA Code of Medical Ethics. Available at: http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion9025.page. Accessed April 11, 2012.
17. James JJ. Impacts of the medical malpractice slowdown in Los Angeles County. *Am J Public Health*. 1978;56:500–530.
18. Bessant J, D'Cruz JV. When nurses and teachers strike: public perceptions of 'the betrayal'. *Aust J Adv Nurs*. 1989;6:26–33.
19. Barnoon S, Carmel S, Zalcman T. Perceived health damages during a physicians' strike in Israel. *Health Serv Res*. 1987;22:141–155.
20. Ash M, Seago JA. The effect of registered nurses' unions on heart-attack mortality. *Industrial Labor Rel Rev*. 2004;57:422–442.
21. Sklar D, Chang B, Hoffman BD. Experience with resident unions at one institution and implications for the future of practicing physicians. *Acad Med*. 2011;86:552–554.
22. Goeschel CA, Wachter RM, Pronovost PJ. Responsibility for quality improvement and patient safety: hospital board and medical staff leadership challenges. *Chest*. 2010;138:171–178.
23. Manthous CA. Fiduciary what? *Chest*. 2010;138:10–11.
24. Fiester A. Physicians and strikes: can a walkout over the malpractice crisis be ethically justified? *Am J Bioethics*. 2004;4:W12–W16.
25. American College of Physicians. Physician work stoppages and political demonstrations—economic self-interest or patient advocacy?Where is the line?. Available at: http://www.acponline.org/running_practice/ethics/case_studies/pol_dem.pdf. Accessed April 11, 2012.
26. Neiman P. Nursing strikes: an ethical perspective on the US healthcare community. *Nursing Ethics*. 2011;18:596–605.
27. Hospital care quality information from the consumer perspective. Available at: http://www.hcahpsonline.org/home.aspx. Accessed April 12, 2012.
28. Survey of patients' hospital experiences (HCAHPS). Data.medicare.gov. Available at: https://data.medicare.gov/dataset/Survey-of-Patients-Hospital-Experiences-HCAHPS-/rj76-22dk. Accessed April 12, 2012.
29. HHS. Hospital compare. Available at: http://www.medicare.gov/hospitalcompare/search.html. Accessed March 26, 2014.
30. Goold SD. Collective action by physicians: beyond strikes. *Camb Q Healthc Ethics*. 2000;9:498–503.
31. Daniels N. On the picket line: are doctors' strikes ethical? *Hastings Cent Rep*. 1978;8:24–29.
32. Patterson K, J Grenny, McMillan R, et al. *Crucial Confrontations: Tools for Resolving Broken Promises, Violated Expectations and Bad Behavior*. New York: McGraw-Hill; 2005.

33. Khatri N, Brown GD, Hicks LL. From a blame culture to a just culture in health care. *Health Care Manage Rev*. 2009;34:312–322.
34. Manthous CA, Moncrieff AR. Will my job be safe if I defend my patients? When patient advocacy collides with employment law. *Chest*. 2013;144:1106–1110.
35. Near JP, Dworkin TM, Miceli MP. Explaining the whistle-blowing process: suggestions from power theory and justice theory. *Organ Sci*. 1993;4:393–411.
36. Wilmot S. Nurses and whistleblowing: the ethical issues. *J Adv Nursing*. 2000;32:1051–1057.
37. Manthous CA. Hippocrates as hospital employee. Balancing beneficence and contractual duty. *Am J Crit Care Med*. 2012;21:60–66.
38. Laschober M, Maxfield M, Felt-Lisk S, et al. Hospital response to public reporting of quality indicators. *Health Care Fianc Rev*. 2007;28:61–76.
39. Herrin J, Nicewander D, Ballard DJ. The effect of health care system administrator pay-for-performance on quality of care. *Jt Comm J Qual Patient Saf*. 2008;34:646–654.
40. Hafner JM, Williams SC, Koss RG, et al. The perceived impact of public reporting hospital performance data: interviews with hospital staff. *Int J Qual Health Care*. 2011;23:697–704.
41. Barr JK, Giannotti TE, Sofaer S, et al. Using public reports of patient satisfaction for hospital quality improvement. *Health Serv Res*. 2006;41: 663–682.
42. Hutchinson J. *The Imperfect Union: A History of Corruption in American Trade Unions*. New York: Dutton; 1970.
43. Editorial: do you know your rights? *New York Times*. April 22, 2012. Available at: http://www.nytimes.com/2012/04/23/opinion/do-you-know-your-rights.html. Accessed March 26, 2014.
44. Summers CW. Employment at will in the United States: the divine right of employers. *Univ Penn J Labor & Employment Law*. 2000-2001; 65:65–86.
45. Creswell J, Abelson R. A hospital war reflects a bind for US doctors. A drive to consolidate. As corporate workers, physicians feel push on bottom line. *New York Times* 2012; CLXII: A1, A18.