Unionization in Health Professions: Causes and Concerns in 1960s Physical Therapy

In 1964, a small news piece, near the back of the February issue of the *Journal of the American Physical Therapy Association*, reported, "New York Chapter Seeks Collective Bargaining."[1] While many readers might have overlooked this three-sentence article as a minor item, the national leadership of the American Physical Therapy Association (APTA) viewed it as a major development with widespread ramifications. APTA President Elizabeth Kolb reacted critically to the news in an editorial placed at the front of the same issue, writing, "This issue would seem to be clear-cut. Is the APTA a professional organization, or is it a trade union?"[2] As Kolb presented it, the New York Chapter's intentions to become a collective bargaining agent threatened APTA's longstanding efforts to be seen as a respected professional organization.

Over the coming months, leaders of the New York Chapter sought to clarify that they too were also opposed to "unionism" and committed to protecting the professional status of physical therapy (PT). Anthony DeRosa argued that his Chapter's decision to engage in collective bargaining was a necessary response to the rise of union activity in New York City hospitals. PTs could only avoid being enrolled in large, national labor unions if they were able to join a unit specific to their profession. The Chapter's entrance into collective bargaining was not initiated by a desire for higher salaries, but rather their move had been the best available strategy to prevent PTs from being "sucked in" to primarily "nonprofessional" labor unions.[3]

Many mid-century professionals questioned whether applying collective pressure to improve their socioeconomic conditions was inimical with professionalism.[4] This issue was especially difficult for health professionals, given their identity as service providers who always put patients first. In their minds, unions were associated with work slowdowns and strikes, which they could not countenance, as well as unskilled blue-collar workers who were subservient to their managers.[5] Particularly in majority female fields like PT and nursing, where professional status was fledgling, hard won, and still tenuous, leaders viewed union activity as risky territory.[6]

---

1 "New York Chapter Seeks Collective Bargaining." *Physical Therapy* 44, no. 2 (1964): 114.

2 Mary Elizabeth Kolb, "Unionism or Professionalism." *Physical Therapy* 44, no. 2 (1964): 89.

3 Anthony DeRosa, "A Professional Problem." *Physical Therapy* 44, no. 5 (1964): 356–57, 356.

4 Joel Seidman, "Economic Activity Among Various Professional Groups," In *Issues in Nursing*, edited by Bonnie Bullough & Vern Bullough, 185–91 (New York: Springer, 1966).

5 Daniel H. Kruger, "Bargaining and the Nursing Profession." *Monthly Labor Review* 84, no. 7 (1961): 699–705; Bonnie Bullough and Vern Bullough, *Issues in Nursing* (New York: Springer, 1966); Joel Seidman, "Nurses and Collective Bargaining." *ILR Review* 23, no. 3 (1970): 335–51; Leon Fink and Brian Greenberg. *Upheaval in the Quiet Zone: 1199SEIU and the Politics of Health Care Unionism* (Urbana: University of Illinois Press, 2009).

6 Barbara Carter, "Medicine's Forgotten Women," In *Issues in Nursing*, edited by Bonnie Bullough & Vern Bullough, 171–77 (New York: Springer, 1966); Helen J. Hislop, "Realities." *Physical Therapy* 44, no. 5 (1964): 329–30.

Scholars have examined labor actions by physicians and nurses,[7] but less attention has been given to collective bargaining among smaller and less publicly visible professions. In examining the unique characteristics and challenges of unionization in American health professions, 1960s PT offers a valuable middle ground in terms of prestige and demographics. PTs had long sought to enhance their professional status in health care and have looked to medicine as a model for advancement.[8] PT was also distinctive in its composition among highly gender segregated mid-century health fields. In the 1960s, about 30% of PTs were men, and male PTs were increasingly being selected for leadership roles in academia, workplaces, state chapters, and APTA.[9] Both of these factors contributed to the unique ways in which mid-century PTs reacted to and negotiated the fractious issues of collective bargaining and professionalism.

Despite APTA leaders' initial opposition, by 1970 many state chapters were engaged in collective bargaining and receiving strategic support from APTA.[10] As it turned out, the misgivings expressed by the Association's national officers did not reflect the opinions of its wider membership.[11] Over time, APTA leaders came to accept that the benefits of unionization outweighed the potential risks. This article examines PTs' evolving perspectives on collective bargaining during the 1960s, with comparisons to nursing and medicine. I argue that, in response to the changing landscapes of health care and labor relations, many PT leaders shifted from perceiving unionization as a threat to their tenuous professional identity, to supporting collective bargaining as a viable strategy for enhancing their socioeconomic and professional interests.

In the 2020s, as union activity once again increases, more expansive and nuanced perspectives on collective bargaining in health fields are needed. Historians of medicine have done surprisingly little work in this area. This oversight risks reifying assumptions that

---

[7] Bullough, *Issues in Nursing* (n. 5); Fink, *Upheaval in the Quiet Zone* (n. 5); Barbara Melosh, *The Physician's Hand: Work Culture and Conflict in American Nursing* (Philadelphia: Temple University Press, 1982); Susan Reverby, *Ordered to Care: The Dilemma of American Nursing, 1850-1945* (Cambridge: Cambridge University Press, 1987); Stephen L. Thompson and Warren Salmon. "Strikes By Physicians: A Historical Perspective Toward an Ethical Evaluation." *International Journal of Health Services* 36, no. 2 (2006): 331–54; Heather Varughese John, *Practicing Physicians: The Intern & Resident Experience in the Shaping of American Medical Education, 1945-2003* (Doctoral Dissertation: Yale University, 2013); Amy Zanoni, *Poor Health: Retrenchment and Resistance in Chicago's Public Hospital, 1950s-1990s* (Doctoral Dissertation: Rutgers University, 2020).

[8] Beth Linker, "Strength and Science: Gender, Physiotherapy, and Medicine in the United States, 1918-35." *Journal of Women's History* 17, no. 3 (2005): 106–32; Beth Linker, "The Business of Ethics: Gender, Medicine, and the Professional Codification of the American Physiotherapy Association, 1918–1935." *Journal of the History of Medicine and Allied Science* 60, no. 3 (2005): 320–54; Andrew J. Hogan, "Accessibility in Health Professions Education: The Flexner Report and Barriers to Diversity in American Physical Therapy." *Social Science & Medicine* 340 (2024): Forthcoming.

[9] Andrew J. Hogan, "Underrepresented Minority Recruitment: Manpower as Motivator in Late-Twentieth Century Occupational Therapy and Physical Therapy." *Bulletin of the History of Medicine* 97, no. 4 (2023): Forthcoming.

[10] Samuel B. Feitelberg, "A Professional Association Faces Up to the Union Problem." *American Journal of Hospital Pharmacy* 27, no. 3 (1970): 203–8.

[11] "Minutes of the House of Delegates, June-July 1965." *Physical Therapy* 45, no. 11 (1965): 1086–92, 1087-1088.

unionization and professionalization are conflicting processes in health occupations. Studying the evolving views and activities of health professions regarding unionization, including less well studied fields like PT, can offer valuable insights on the hesitations, risks, and rewards for fields in pursuing professional and socioeconomic advancement through collective bargaining.

Unionization in Health Professions After World War II

In 1946, the American Nurses Association (ANA) inaugurated an economic security program, which sought to advance nurses' socioeconomic interests through national level leadership and support, and collective bargaining by state nursing associations.[12] ANA's initiative came after decades of hesitancy among nursing leaders, and on the heels of successful collective bargaining efforts by the California State Nursing Association.[13] Even with this development however, collective bargaining in nursing remained limited during the 1940s and 50s, amid doubts among nursing leaders about how union tactics would disrupt the mission and professionalism of nurses, as well as the anti-communist political climate.[14] The Taft-Harley Act of 1947 further undercut the potential for health professionals to unionize, by removing non-profit hospitals employees from protection under the National Labor Relations Act.[15]

Some states still included non-profit hospital workers in their labor laws, and employees in other locales fought for this recognition. During the late-1950s, Local 1199 of the Retail Drug Employees Union expanded its unionization activities into non-profit hospitals.[16] Local 1199's initiatives began with a successful 1958 strike at Montifiore Hopsital in the Bronx. The next year, Local 1199 led simultaneous strikes at six non-profit hospitals in New York City. These actions involved work stoppages by nurses' aids, elevator operators, and other non-professional workers and resulted in increased wages and official grievance procedures.[17] Additional Local 1199-led hospital strikes in 1962 facilitated Governor Nelson Rockefeller's successful push to amend New York State labor laws to include recognition for workers in non-profit hospitals.[18]

While these initial strikes and other labor actions primarily involved non-professional hospital workers, Local 1199 also aspired to organize professional hospital staff. The potential for this was improved by New York State's expanded labor protections.[19] Still, major barriers existed to convincing professional nurses, physicians, pharmacists, and other practitioners that joining a union was in their best interests. Many were opposed to strikes and work slowdowns, which they viewed as unacceptable and threatening to patient care. However, state laws and labor agreements, which prohibited strikes by hospital workers, helped mitigate these concerns.[20]

---

[12] Kruger, "Bargaining and the Nursing Profession" (n. 1).
[13] Ibid.; Melosh, *The Physician's Hand*, 198-202 (n. 7); Reverby, *Ordered To Care*, 197-198 (n. 7).
[14] Carter, "Medicine's Forgotten Women" (n. 6); Melosh, *The Physician's Hand*, 201-202 (n.7).
[15] Estelle Hepton, *Battle for the Hospitals: A Study of Unionization in Non-Profit Hospitals* (Ithaca, NY: School of Industrial and Labor Relations, 1963); Sara Gamm, *Toward Collective Bargaining in Non-Profit Hospitals: Impact of New York Law* (Ithaca, NY: School of Industrial and Labor Relations, 1968).
[16] Fink, *Upheaval in the Quiet Zone*, (n. 5), 25-27.
[17] Hepton, *Battle for the Hospitals* (n. 15).
[18] Gamm, *Toward Collective Bargaining* (n. 15); Fink, *Upheaval in the Quiet Zone* (n. 5).
[19] Ibid., 115-120.
[20] Gamm, *Toward Collective Bargaining* (n. 15); Fink, *Upheaval in the Quiet Zone* (n. 5); Feitelberg, "A Professional Association" (n. 10).

Professional workers also opposed being involved in largely blue-collar and non-professional labor unions and collective bargaining units. To address this barrier, in 1964 Local 1199 established a Guild of Professional, Technical, Office, and Clerical Hospital Employees. Union leaders recognized that creating an autonomous division, where workers had a shared sense of identity, values, and grievances could help in recruiting professionals.[21] Importantly, many health professionals saw themselves as potential future managers, in hospitals or private practice. Unlike most blue-collar workers, health professionals had the academic credentials and qualifying experience needed to eventually move to the other side of the negotiating table.[22]

Still, for many health professionals, even a separate guild for white-collar workers was not enough. They desired a bargaining unit that was specific to their profession.[23] Predominantly female fields, like nursing and PT, were particularly concerned about physicians, governments, employers, and insurers, viewing them as professional, not technical workers.[24] Being part of a guild that included both categories blurred this boundary. Professional associations also came to accept a role in supporting health profession-specific collective bargaining units, recognizing that having their members join separate unions risked dividing their allegiances and dues.[25] As I examine ahead, APTA leaders, influenced by a complex and evolving set of considerations, transitioned in the 1960s from viewing unionization as destructive to PT's professional identity, to recognizing that support for collective bargaining was in the PT profession's best interests.

The Perceived Threat of Unions

In May 1964, Helen Hislop, the editor APTA's flagship journal, pondered her field's future. Would PTs become increasingly valued members of the health care team and seen as professional who put patients first, or were PTs moving toward being, "merely a paid employee of the hospital?"[26] Hislop argued that the field's trajectory would be negatively impacted if APTA or any of its chapters chose to embrace collective bargaining, which she felt would accomplish little, beside suggesting that PTs put their incomes ahead of patients.

Many members of the APTA Board of Directors shared Hislop's concerns, but initially remained conciliatory after the New York Chapter's November 1963 vote to engage in collective bargaining. In July 1964, the Board organized for the New York Chapter to have time to explain its situation to the APTA House of Delegates, the Association's policymaking body. New York Chapter leaders highlighted that its PTs would be forced to join nonprofessional unions, if it did

---

[21] Fink, *Upheaval in the Quiet Zone* (n. 5), 116-117; Al Nash, "Local 1199, Drug and Hospital Union: An Analysis of the Normative and Institutional Orders of a Complex Organization." *Human Relations* 27, no. 6 (1974): 547–66, 556.

[22] Joel Seidman, "Economic Activity" (n. 4); Feitelberg, "A Professional Association" (n. 10).

[23] Fink, 2009, 117

[24] Feitelberg, "A Professional Association" (n. 10); Joel Seidman, "Nurses and Collective Bargaining" (n. 5); Linker, "The Business of Ethics (n. 8); Hogan, "Accessibility in Health Professions Education" (n. 8).

[25] Kruger, "Bargaining and the Nursing Profession" (n. 1); *Minutes, Board of Directors Annual Meeting, June 1965* (New York: American Physical Therapy Association, 1965) (Access courtesy of the American Physical Therapy Association); Thompson, "Strikes By Physicians" (n. 7).

[26] Hislop, "Realities," (n. 6), 329.

not become a collective bargaining agent. The Board also facilitated the creation of an ad hoc APTA committee to assist the New York Chapter in managing its "unique situation."[27]

Meanwhile Elizabeth Kolb, APTA's incumbent president and an outspoken opponent of collective bargaining, was running for re-election against Anthony DeRosa, APTA's Treasurer and a vocal leader and defender of the New York Chapter's actions. In its July 1964 session, the House of Delegates narrowly re-elected Kolb. Hyman Dervitz, another New York Chapter leader, also lost his bid to become Treasurer. It is hard to know if this election was a proxy referendum on collective bargaining. Either way, the outcome shaped APTA's leadership. Kolb had prevailed and as President would remain on the Board, whereas DeRosa's term was up.[28]

By June 1965, the New York State Board of Labor had recognized the New York Chapter as a collective bargaining agent and the APTA Board of Director's conciliatory tone had changed. Twelve of fifteen Board members now supported an APTA Bylaw amendment, "that would absolutely prohibit any chapter under any circumstances becoming a legally constituted collective bargaining agent."[29] As they moved forward with this action, an outside consultant gave the Board's members a stark warning. If APTA state chapters did not themselves become collective bargaining agents, PTs in many states would join larger labor unions—paying dues, and potentially becoming leaders. These unions would be competitors to APTA for members' money, efforts, and allegiances, and would be seen as doing more on socioeconomic issues.[30]

When the APTA Board of Directors presented its recommended Bylaw amendment to the House of Delegates in June 1965, divides among Board members on the collective bargaining issue became apparent, when both majority and minority positions were offered.[31] Notably, Hislop, who as APTA journal editor was present at Board meetings as a non-voting member, had also moderated her stance on unionization. In her editorials that summer, Hislop acknowledged strong disagreements and called for facts, rationality, and unity.[32] As she likely recognized, the Board's majority did not necessarily reflect the concerns and perspectives of APTA members.[33]

How PTs Learned to Stop Worrying and Embrace Collective Bargaining

On June 30, 1965, the APTA House of Delegates defeated the Board of Directors' Bylaw amendment to prohibit collective bargaining by APTA chapters by a large margin in a roll call vote, 260-107.[34] As it turned out, there was little appetite among APTA delegates for restricting the association's role in unionization. Indeed, a handful of other states had already joined the

---

[27] "Summary of 1964 House of Delegates." *Physical Therapy* 44, no. 11 (1964): 885–89, 886.
[28] Ibid., 888.
[29] Feitelberg, "A Professional Association" (n. 10); *Minutes, Board of Directors, 1965* (n. 25), 18-19.
[30] *Minutes, Board of Directors, 1965*, (n. 25), 20.
[31] "Minutes of the House, 1965," (n. 11), 1088.
[32] Helen J. Hislop, "Wanted: Perspective." *Physical Therapy* 45, no. 6 (1965): 537–38; Helen J. Hislop, "Wanted: Unity." *Physical Therapy* 45, no. 7 (1965): 665–66.
[33] James Ronald Morrow, *The Nature of Bases of Physical Therapists' Attitudes Toward the Continuing Professionalization of Their Occupation* (Doctoral Dissertation: Indiana University, 1984).
[34] "Minutes of the House, 1965," (n. 11), 1088.

New York Chapter in becoming collective bargaining agents.[35] Also that year, two New York Chapter members, Hyman Dervitz and Helen Hickey, were elected to the Board of Directors.[36]

By 1966, attention had turned to exploring how, and to what extent, the national Association should support collective bargaining activities by its state chapters. In her presidential address that year, Kolb pondered what portion of limited APTA resources should be invested in supporting collective bargaining. Meanwhile, the House of Delegates voted to form a Study Committee on Socioeconomic Conditions, which was charged to assess and disseminate information related to collective bargaining and conditions of employment, and to develop a policy statement on collective bargaining for House of Delegate's consideration.[37] Samuel Feitelberg, of the New York Chapter, and Dorothy Pinkston were chosen as its co-chairs.

Under the leadership of Feitelberg and Pinkston, the Committee focused on identifying APTA's previous activities, going back to its founding in 1921, that had sought to promote and protect the socioeconomic wellbeing of PTs. Their report, finalized in time the 1967 House Delegates meeting, featured a long list of APTA's involvement in socioeconomic matters. These included, supporting pay raises in 1921 and a minimum salary for government employed PTs in 1939, pushing for enhanced status in the military during World War II, publishing recommended personnel policies in the late 1940s, including a minimum salary, and defining a salary scale for PTs during the mid 1950s. APTA's socioeconomic activities had declined after this, skewing perspectives on the Association's role. Feitelberg and Pinkston's report demonstrated that the state of affairs in the last decade was more of an aberration than a standard for APTA.[38]

In 1967, the Committee recommended, and the House of Delegates approved, the creation of a socioeconomic security program, which would be coordinated and supported by APTA at the national level and involve significant local activities by state chapters.[39] This model was quite similar to the socioeconomic security program adopted by the American Nurses' Association in 1946.[40] Importantly, the resolution recognized APTA's historical and ongoing role in, "protecting and promoting the general and economic welfare of its members," and explicitly acknowledged that collective bargaining could be part of this process.[41] Feitelberg and Pinkston had succeeded in convincing the House of Delegates that promoting the socioeconomic welfare of PTs was a longstanding and fundamental role for APTA as a professional association, and that, in late 1960s America, APTA would be mistaken to prohibit collective bargaining.

Meanwhile, with the New York Chapter already in place as a collective bargaining agent, PTs were able to establish separate bargaining units in individual hospitals, and extract themselves from larger, more diverse labor unions like Local 1199. In 1970, Feitelberg recounted that, while many PTs had initially been hesitant to use collective bargaining to pursue pay increases as well, studies done by the New York Chapter demonstrated that PTs' salaries were low and not keeping up with other fields, like nursing, which had successfully engaged in

---

[35] Feitelberg, "A Professional Association" (n. 10).
[36] "Minutes of the House, 1965," (n. 11), 1091.
[37] Mary Elizabeth Kolb, "The Challenge of Success." *Physical Therapy* 46, no. 11 (1966): 1157–64; "Minutes of the House of Delegates, July 1966." *Physical Therapy* 46, no. 11R 59–68, 66.
[38] "Study Committee on Socioeconomic Conditions." *Physical Therapy* 47, no. 11R (1967): 40–50, 43-44.
[39] Ibid.; "House of Delegates Minutes, July 1967." *Physical Therapy* 47, no. 11R (1967): 66–75.
[40] Kruger, 1961
[41] "House of Delegates, 1967" (n. 39), 69.

collective bargaining. The Chapter was able to negotiate an immediate 20% raise for PTs.[42] As the New York Chapter practiced it, collective bargaining was not the divisive and professionally demeaning "unionism" that many PTs had feared.[43] Once collective bargaining relationships with hospital administrators were established, the benefits for PTs of having a knowledgeable agent to advocate for their professional and socioeconomic interests quickly became apparent.[44]

Collective bargaining as a professional unit did require a distinct playbook. Larger, more diverse, predominantly blue-collar unions typically threatened strikes or work slowdowns and relied on widespread attention and publicity to generate public sympathy and support for their grievances.[45] In their own negotiations, small health professions, like PT, primarily needed to convince hospital management of their expertise, indispensability, and potential for revenue generation. The passage of Medicare had helped to stabilize reimbursement for PT services, a fact that the New York Chapter used successfully to argue for significant salary increases. PTs also brought the issue of education costs to management's attention. Due to low salaries, fewer students were going into PT, and senior therapists were leaving hospitals to seek better salaries elsewhere, leading to workforce shortages and leadership gaps. As Feitelberg highlighted, collective bargaining gave PTs a more powerful voice than they had previously.[46]

Discussion and Conclusions

PT offers a unique and informative case study for examining collective bargaining in 1960s American health professions. The PT field was smaller and less well-known than nursing or medicine, and consistently strived to achieve greater autonomy and status, closer to that of physicians. By the 1960s, PT also had many more men that most historically women's health professions.[47] Notably, many leaders in the New York Chapter's collective bargaining effort were men, whereas the APTA Board of Directors was still 80% women in 1965. In the writings of DeRosa and Feitelberg, one can readily interpret a gendered criticism of APTA's heavily female old guard leadership. Both men, evoking gendered stereotypes, appealed for focusing on "facts," and avoiding "emotionalism" or the dismissal of "touchy" topics.[48] Feitelberg was even more direct in 1970, stating, "We are a profession of which about 30 percent of our membership

---

[42] Feitelberg, "A Professional Association" (n. 10).
[43] Kolb, "Unionism or Professionalism" (n. 2); DeRosa, "A Professional Problem" (n. 3), 356.
[44] Feitelberg, "A Professional Association" (n. 10).
[45] Marie R. Haug and Marvin B. Sussman. "Professionalization and Unionism: A Jurisdictional Dispute?" *American Behavioral Scientist* 14, no. 4 (1971): 525–40.
[46] Feitelberg, "A Professional Association" (n. 10), 206; Hogan, "Underrepresented Minority Recruitment" (n. 9).
[47] Linker, "The Business of Ethics (n. 8); Linker, "Strength and Science" (n. 8); Hogan, "Underrepresented Minority Recruitment" (n. 9).
[48] Notably, Helen Hislop made a similar appeal for privileging facts over emotionalism in 1965. Hislop, "Wanted: Perspective (n. 32); DeRosa, "A Professional Problem" (n. 3); Feitelberg, "A Professional Association" (n. 10), 208; Naomi Rogers, "Feminists Fight the Culture of Exclusion in Medical Education 1970-1990," In *Women Physicians and the Cultures of Medicine*, edited by Ellen S. More, et al, 205–41 (Baltimore: Johns Hopkins University Press, 2009); Alexandra Rutherford, "Maintaining Masculinity in Mid-Twentieth-century American Psychology: Edwin Boring, Scientific Eminence, and the 'Woman Problem'." *Osiris* 30 (2015): 250–71.

are men; the rest are women with mixed feelings about collective bargaining. But as state labor laws were passed . . . most members took a new look and dropped the emotionalism."[49]

In their published criticisms of collective bargaining, female APTA leaders argued that PT was a small field that had little leverage for negotiations, observed that PTs still lacked structural markers of status in hospitals like stand-alone units, and emphasized the field's long pursued but still incomplete recognition as a profession.[50] They were also likely aware that women in nursing were frequently dismissed, by primarily male hospital administrators, when they pursued collective bargaining.[51] Meanwhile, Feitelberg expressed greater confidence about what PTs could achieve at the negotiating table. Male PTs likely felt more self-assured that they could negotiate for their economic interests while maintaining an intact professional identity.[52]

Of course, many male PTs were also concerned about collective bargaining. Charles Magistro, a PT leader in California conveyed that participating in collective bargaining would be "disastrous" for APTA and its professional status.[53] Notably, DeRosa also distanced his goals from traditional collective bargaining ambitions, stating that the New York Chapter's actions had nothing to do with seeking better compensation.[54] A key question then, is what grievances and concerns have been most likely to instigate union activity among health professionals?

The 2020s, like the 1960s, is a period of increased union activity. These broader societal trends can make unionization appear more viable to some health professionals. However, media accounts still present elite health professions' choice to initiate collective bargaining as a surprising and desperate act, which is incongruous with their professional identity.[55] Many PTs felt similarly about the New York Chapter's collective bargaining strategy. Notably, a common instigating thread between 1960s PTs and health professionals in the 2020s is the perceived loss of professional autonomy and status—characteristics that are closely intertwined in health fields.

New York PTs feared being "sucked in" to large, primarily blue-collar labor unions in the 1960s.[56] During the 2020s, established physicians have been lamenting the growing role of health care corporations in controlling how they structure their time and care for their patients. When health professionals perceive that their autonomy is under attack, and their professional status along with it, more "professionalization" may no longer be seen as an effective response.[57]

Sociologists have argued that professionalization involves the creation of "labor-market shelters" that restrict jobs to people with specific credentials, which professional associations define.[58] In studying the forces behind unionization in health professions, scholars might also

---

[49] Feitelberg, "A Professional Association" (n. 10), 208.

[50] Kolb, "Unionism or Professionalism" (n. 2); Hislop, "Realities" (n. 6); Catherine A. Worthingham, "Complementary Functions and Responsibilities in an Emerging Profession." *Physical Therapy* 45, no. 11 (1965): 935–39.

[51] Carter, "Medicine's Forgotten Women" (n. 6), 175.

[52] Feitelberg, "A Professional Association" (n. 10).

[53] Charles M. Magistro, "We Must Work More Closely Together." *Physical Therapy* 44, no. 5 (1964): 357–58, 358.

[54] DeRosa, "A Professional Problem" (n. 3), 356.

[55] Noam Scheiber, "Why Doctors and Pharmacists Are in Revolt." *New York Times* (December 3, 2023): Business Section, 1.

[56] DeRosa, "A Professional Problem" (n. 3), 356.

[57] Marie R. Haug, "A Re-Examination of the Hypothesis of Physician Deprofessionalization." *Milibank Quarterly* 66, no. 2 (1988): 48–56; Scheiber, "Why Doctors" (n. 55).

[58] Eliot Freidson, *Professional Powers*. (Chicago: University of Chicago Press, 1986).

consider the development of bureaucracy shelters, through which professions shield themselves from the top-down control of governments, hospitals, corporations, and unions. This framework helps make sense of the New York Chapter's pursuit of collective bargaining to protect PTs from labor unions. It can also assist in our analysis of present-day physicians' unusual willingness to pursue unionization in response to the growing bureaucratic control of health care corporations.

In many post-World War II health professions, the prospect of unionization was viewed as counterintuitive and unbecoming. As the history of APTA's New York Chapter demonstrates however, collective bargaining could open-up new, more formalized lines of communication with management and provide socioeconomic as well as professional dividends. Additional historical studies of collective bargaining in health professions, beyond nursing and medicine, will offer scholars a wider range of understanding about what factors and concerns lead health fields to a tipping point decision on unionization. These investigations will improve our present comprehension of the causes and likely outcomes of newly initiated collective bargaining efforts.