Buffalo Law Review

Volume 9 | Number 2 Article 2

1-1-1960

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THE NONPROFIT HOSPITAL AND THE UNION

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I. INTRODUCTION

THE question of hospital unionism has come to increased public attention in 1959-1960 by virtue of a series of long strikes against hospitals—46 days in New York, 84 days in Seattle, and over four months in Chicago. In addition there have been increased strike threats and union organizing in Baltimore, Kansas City, Philadelphia, Miami, Rochester and Buffalo.[1] These occurrences raise the question of what our labor policy should be toward hospital unions. Should they receive the same protection in their efforts to organize workers or to bargain collectively that is given to unions in other fields? As a separate question, should they be permitted the right to strike?

Unionism is firmly entrenched in the manufacturing and transportation industries. Though unions are much weaker in white collar fields, there can be little question of public policy regarding the legitimacy of unions in these areas. It is well established that employees have the right to join unions without reprisal from their employers, and that if unions win state or federal labor board elections the employer is legally bound to bargain with them.

This is not the case in the hospital industry. There is some doubt as to what the rights and duties are in this area, and there is great controversy over what they should be. Much of the discussion is emotion-laden and reminds one of similar passions regarding manufacturing unionism in the 1930's. In the New York City hospital strike the same businessmen who prided themselves on the good relations they had developed with unions in their private businesses took, as members of hospital boards of directors, adamant positions against the spread of hospital unionism. It was noted, by newspapers, that union leaders from all branches of the labor movement showed greater militancy and cohesion in support of the hospital unions than they had in any issue for twenty-five years. One periodical addressed itself to this antagonism as follows:

> "The weary old arguments about union interference in the care of patients echo the contentions of publishers early in the history of the Newspaper Guild that unionized reporters would slant the news. Newspapers have been just as conservative and, it is safe to assume, hospitals will be just as efficient after unionization as before it."[2]

In this paper we shall discuss the current legal status of hospital-union relations and shall consider whether there are valid grounds for treating these

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1. 34 Hospitals, No. 1, pp. 112-114 (1960).
2. Editorial, The New Republic, June 1, 1959, p. 7.

relations within a unique legal framework. Since the nonprofit hospitals are the source of the greater difficulties, they will enjoy the greater attention.

II. Nonprofit Hospitals and the Law

A. *Federal Law*

It is noteworthy that the original Wagner Act of 1935 did not exclude non-profit hospitals. Indeed, in the *Central Dispensary* case, the National Labor Relations Board asserted its jurisdiction over such hospitals and was upheld by one United States Court of Appeals.[3] In affirming the Board the Court stated:

> "Respondent's activities involve the sale of medical services and supplies for which it receives about $600,000 a year. It purchases from commercial houses material of the value of about $240,000 annually. It employs about 230 persons for non-professional services and maintenance work and 120 technical and professional employees. Such activities are trade and commerce and the fact that they are carried on by a charitable hospital is immaterial to a decision of this issue. In the case of American Medical Association v. United States[4] this court held that the sale of medical and hospital services for a fee has been considered as trade by English and American common law cases going back to 1793. . . . We cannot understand what considerations of public policy deprive hospital employees of the privilege granted to the employees of other institutions."[5]

Previously, the Board had established that the mere fact that an employer was not organized for profit did not defeat its jurisdiction under the Wagner Act.[6]

In light of the unequivocal language of the Court, above, it is somewhat disappointing to discover that Congress, in enacting the Taft-Hartley Act of 1947,[7] engaged in very little deliberation on the subject of nonprofit hospitals. Nevertheless, Section 2(2) of the Wagner Act was amended to exempt from the coverage of the National Act all hospitals "if no part of the net earnings inures to the benefit of any private shareholder or individual."[8] The Statement of the House managers on the Conference Report[9] indicates that, whereas the House bill originally had exempted all employers who were "religious, charitable, scientific, and educational organizations not organized for profit," the Conference Bill incorporated the Senate exemption which applied only to hospitals. Earlier, the House Committee on Education and Labor reported on its bill's exemption of hospitals as follows:

3. Central Dispensary & Emergency Hospital v. N.L.R.B., 57 N.L.R.B. 393 (1943), aff'd, 145 F.2d 852 (D.C. Cir. 1944), cert. denied, 324 U.S. 847 (1945).
4. 130 F.2d 233 (D.C. Cir. 1942) [court's footnote].
5. 145 F.2d at 853.
6. N.L.R.B. v. Polish National Alliance, 322 U.S. 643 (1944); Christian Board of Publications v. N.L.R.B., 113 F.2d 753 (7th Cir. 1940).
7. Pub. L. No. 101, 80th Cong., 1st Sess. 29 U.S.C.A. § 141, et seq.
8. 29 U.S.C.A. § 142(2).
9. H.R. No. 510, 93 Cong. Rec. 6451 (1947).

> "Churches, hospitals, schools, colleges, and societies for the care of the needy are not engaged in 'commerce' and certainly not in inter-state commerce. These institutions frequently assist local governments in carrying out their essential functions, and for this reason should be subject to exclusive local jurisdiction. The bill therefore excludes from the definition of "employer" institutions that qualify as charities under our tax laws."[10]

Thus it appears that, as far as the House was concerned, nonprofit hospitals are simply not engaged in commerce, "and certainly not inter-state commerce". Therefore their regulation should be left to "local jurisdiction."

Meanwhile, back in the Senate, the drama was unfolding in quite another direction. The bill reported out by Senator Taft's Committee on Labor and Public Welfare made no mention of exempting nonprofit hospitals, and the committee report ignored the question altogether.[11] When the bill reached the floor, Senator Tydings offered the amendment exempting nonprofit hospitals which eventually became part of the Act. In submitting the amendment the Senator stated:

> "Mr. President, this amendment is designed merely to help a great number of hospitals which are having very difficult times. They are eleemosynary institutions; no profit is involved in their operations, and I understand from the Hospital Association that this amendment would be very helpful in their efforts to serve those who have not the means to pay for hospital service, enable them to keep the doors open and operate the hospitals. Employees [sic] of such a hospital should not have to come to the National Labor Relations Board. A charitable institution is away beyond the scope of labor-management relations in which a profit is involved. . . . I do not think the amendment will affect [nurses] in the slightest way as to salaries. I will say to the Senator [Taylor] they can still protest, they can still walk out. . . . I am told it will be a big aid to the community if they are not brought in under the strict scope of labor-management commercial relations where profit is involved."[12]

Senator Taft did not oppose the Tydings amendment. His sole statement on the issue of nonprofit hospitals was as follows:

> "The committee considered this amendment, but did not act on it, because it was felt it was unnecessary. The committee felt that hospitals were not engaged in interstate commerce, and that their business should not be so construed. We rather felt it would open up the question of making further exemptions."[13]

Except for a few questions expressing compassion for the future of nurses under this amendment,[14] nothing further of substance was discussed in the Senate on the subject of nonprofit hospitals. The entire subject occupies but

10. H.R. No. 245, 93 Cong. Rec. 3520 (1947) (Mr. Hartley).
11. Sen. R. No. 105, 93 Cong. Rec. (Daily), April 17, 1947.
12. 93 Cong. Rec. (Daily), May 12, 1947.
13. Ibid.
14. Ibid. (Senator Taylor).

a single page in the Congressional Record, including the entry that "The amendment was agreed to."

What emerges from the congressional history is of interest. Both Congressman Hartley and Senator Taft felt that hospitals were not industries engaged in commerce—and Senator Taft apparently grouped *all* hospitals in this category. Nowhere is mention made of the then recent *Central Dispensary* decision[15] which had held they *were* in interstate commerce, and Senator Taft clearly seemed to ignore that holding.[16] As for Senator Tydings (the proponent of the amendment exempting nonprofit hospitals), the extent of his personal awareness of the problem may be measured by his own words: "I understand from the Hospital Association that this amendment would be very helpful . . . I am told it will be a big aid to the community if they are not brought in under the strict scope of labor-management commercial relations. . . ." And strikes in hospitals did not figure as an evil to be corrected. Nurses "can still walk out" despite the exemption for nonprofit hospitals;[17] proprietary hospitals are subject to the Act, thus permitting their employees to strike;[18] and not even a nation-wide strike of nonprofit hospitals could be forestalled or halted by the National Emergencies provisions of the Taft-Hartley Act.[19] From the record, then, it becomes clear that in so far as the hospital exemption was consciously enacted, it was on the ground that hospitals—but only nonprofit hospitals—should not be considered in commerce.[20]

A remaining distinguishing characteristic of the exempt hospitals is that they enjoy no "profits", unlike proprietary hospitals. But, even here, charitable institutions other than hospitals are subject to the Act when their activities affect interstate commerce;[21] and labor unions, which cannot reasonably be considered profit-making institutions in the commercial sense of the term, are clearly subject to the Act.[22] Whatever may be the significance of a nonprofit status in labor-management relations legislation, no exemption whatever is accorded nonprofit hospitals in the labor reform act of 1959.[23]

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15. Note 3, supra.
16. Note 11, supra, and accompanying text.
17. Note 12, supra: "Mr. Taylor, with that assurance, I shall not oppose it."
18. Proprietary hospitals are subject to the Act. Flatbush General Hospital, 45 L.R.R.M. 1286 (N.L.R.B. 1960); Hospital Hato Tejas, Inc., 111 N.L.R.B. 976 (1955). The Act protects the right to strike. Taft-Hartley Act, § 13, 29 U.S.C.A. § 154.
19. Taft-Hartley Act, § 206, et seq.; 29 U.S.C.A. § 165 et seq. The "commerce" language of these National Emergencies sections differs from the "commerce" language of the body of the Taft-Hartley Act, and resembles the "commerce" language of the Wage-Hour Law, § 2(a), 29 U.S.C.A. § 202(a): ". . . engaged in . . . commerce . . . or . . . in the production of goods for commerce . . . ." Cf. Juarez v. Kennecutt Copper Corp., 225 F.2d 100 (10th Cir. 1955) (Wage-Hour Law does not affect a nonprofit hospital although owned by a manufacturer engaged in commerce).
20. Notes 9-16, supra, and accompanying text.
21. Polish National Alliance v. N.L.R.B., note 6, supra. The House Bill in 1947 would have excluded an "employer" like the Polish National Alliance. See House minority report, H.R. No. 245, 93 Cong. Rec. 3520 (1947). The House version was rejected in Conference. Notes 9-10, supra, and accompanying text.
22. Office Employees Int'l Union v. N.L.R.B., 353 U.S. 313 (1957).
23. Labor-Management Reporting & Disclosure Act of 1959, Pub. Law 86-257, 86th

Since nonprofit hospitals do not fall within the definition of "employer" under the Taft-Hartley Act, the labor-management relations within these institutions neither enjoy the protections nor suffer the prohibitions of the national law. Presumably, then, these relations are subject to regulation by state law as administered by state courts or agencies.[24] Congress has then withdrawn national labor-management regulation from the bulk (the nonprofit hospitals) of the fifth largest industry in the nation—the hospital industry.[25]

B. State Law

In view of the amendment of the National Labor Relations Act by the Labor Management Relations Act of 1947[26] which expressly excluded nonprofit hospitals from the definition of an "employer",[27] together with legislative expressions that the amendment was designed to reinvest states with control over the labor relations of such institutions,[28] it is necessary to turn our attention to the form in which states have been handling the labor relations problems of nonprofit hospitals.

In the states, the legal issue of the status of unions in nonprofit hospitals often involves the state's conception of an "employer" under its labor relations statutes.[29] Where the statute does not expressly exclude nonprofit institutions, the courts have been compelled to interpret the relevant provision much as the federal court was required to do in the *Central Dispensary* case under the original Wagner Act.[30] As might be expected, in this experimental laboratory comprising the collective state courts and legislatures, the state courts have not agreed among themselves. Minnesota, Utah and Wisconsin[31] have held that nonprofit hospitals should be subject to the statutory regulations.[32] Minnesota, for example, has reasoned that the right to bargain collectively and to be protected in union activities should not be dependent upon the nature of the employer's business.[33] Both Minnesota and Utah decisions argue the posi-

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Cong., 1959, section 3(e); 73 Stat. 519. See note 19, supra, with respect to the coverage of the Wage-Hour Law.

24. San Diego Building Trades Council v. Garmon, 359 U.S. 236 (1959).

25. Statistical Abstract of the United States (1959) p. 78. In 1956 the non-governmental hospitals contained 495,000 beds, of which 448,000 were in nonprofit hospitals. Total assets of non-governmental hospitals were $13,035,000,000 and they employed 1,374,000 workers.

26. Notes 7-17, supra.

27. 29 U.S.C.A. § 142(2).

28. Note 10, supra, and accompanying text.

29. Thirteen states currently have comprehensive labor relations statutes: Colorado, Connecticut, Kansas, Massachusetts, Michigan, Minnesota, New York, Oregon, Pennsylvania, Rhode Island, Utah, Wisconsin, Hawaii.

30. Central Dispensary & Emergency Hospital v. N.L.R.B., note 3, supra.

31. Northwestern Hospital v. Public Building Service Employees, 208 Minn. 389, 294 N.W. 215 (1940); Utah Labor Relations Board v. Utah Valley Hospital, 234 P.2d 520 (Utah S. Ct. 1951); W.E.R.B. v. Evangelical Deaconess Society, 242 Wis. 78, 7 N.W.2d 590 (1943); St. Joseph's Hospital v. W.E.R.B., 264 Wis. 396, 59 N.W.2d 448 (1953); St. Francis Hospital v. W.E.R.B., 45 L.R.R.M. 2078 (Wis. S. Ct. 1959).

32. Minn. Stat. Ann. §§ 179.01-.135 (Supp. 1958); Utah Code Ann. §§ 34-1-1 to -15 (1953) (Supp. 1957); Wis. Stat. Ann. §§ 111.01-.19 (1957) (Supp. 1958).

33. Note 31, supra.

tion that the policy of labor relations legislation is to eliminate the causes of strikes and labor-management unrest.[34] This goal of labor peace is at least as attractive in nonprofit institutions, it is argued, as it is in profit-making industries.[35] And, finally, under a standard canon of statutory construction, these decisions have concluded that there is no basis for reading an exception into a definition of "employer" which expressly contained other exceptions.[36] As a consequence of these decisions, the Utah legislature subsequently amended its labor legislation so as expressly to exclude nonprofit hospitals.[37] Minnesota, on the other hand, has legislatively prohibited strikes but has substituted therefor statutory settlement machinery.[38]

On the other hand, the courts of Pennsylvania and Massachusetts determined that exemptions for nonprofit hospitals should be read into their respective labor relations acts.[39] It is apparent that these courts feel that once union activity is protected by statute there will be a rash of strikes. Once this premise is established, it is not difficult to demonstrate that strikes will impair the safety and welfare of the patients and those persons relying on the hospital.[40] Apart from the patients, however, these courts express concern over the fact that the lack of profits make it impossible for a nonprofit hospital to bargain,[41] although some states require bargaining on the part of non-hospital nonprofit institutions.[42] Another ground for decision has been the analogy of the function of these hospitals to functions of the state or political subdivisions thereof—the treatment of charity patients. Once it is established that these institutions are performing functions which otherwise would be the responsibility of the state, it is then concluded that they qualify for the same immunity against strikes, etc., which the state enjoys.[43] In Massachusetts, the legislature in 1958 amended its Emergency Labor Disputes Act,[44] which establishes particularized statutory machinery in cases of failure of collective bargaining, and is applicable to hospitals. The emergency labor legislation of Massachusetts is roughly similar to that of Minnesota[45] and Michigan.[46]

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34. Note 31, supra.
35. 208 Minn. 389 at 394, 294 N.W. 215, at 218 (1940); 234 P.2d 520 at 524 (Utah S. Ct. 1951).
36. Ibid.
37. Note 32, supra.
38. Minn. Stat. Ann. §§ 179.35-.39 (Supp. 1958), discussed infra.
39. Western Pennsylvania Hospital v. Lichliter, 340 Pa. 382, 17 A.2d 206 (1941); Pa. L.R.B. v. Mid-Valley Hospital Association, 38 L.R.R.M. 2299 (Pa. S. Ct. 1956); St. Luke's Hospital v. Mass. L.R. Comm., 320 Mass. 467, 70 N.E.2d 10 (1946).
40. 340 Pa. at 389, 17 A.2d at 210.
41. 320 Mass. at 469, 70 N.E.2d at 12.
42. See N.Y.S.L.R.B. v. Elks Lodge 852, 38 L.R.R.M. 2727 (N.Y. Misc. 1956). Contra: Pa. L.R.B. v. Overbrook Golf Club, 38 L.R.R.M. 2301 (Pa. S. Ct. 1956). And see cases cited note 6, supra. Pennsylvania gallantly refuses to distinguish between an "Overbrook Golf Club" and a small hospital—they are equally "nonprofit."
43. Western Pennsylvania Hospital v. Lichliter, note 39, supra; Petition of Salvation Army, 349 Pa. 105, 36 A.2d 479 (1944).
44. Mass. Gen. Laws Ann. c. 150B (1958), discussed infra.
45. Note 38, supra.
46. Mich. Stat. Ann. § 17.454 (14.2-.8) (Rev. Vol. 1950), discussed infra.

Of the remaining states which have enacted general labor-relations statutes, three of them expressly exclude nonprofit hospitals from their coverages,[47] and do not provide any special machinery for settling nonprofit hospital labor disputes. The four other states having labor-relations legislation do not expressly exclude nonprofit institutions, and there is no judicial decision in any of them relating to the statutory coverage in this field.[48] The line-up in these thirteen states having labor-relations legislation, then, is as follows: One state treats nonprofit hospitals equally with all other employers;[49] five states, by express or implied legislative exclusion, prohibit hospital strikes and offer hospital unions no protection;[50] three states prohibit strikes but substitute for the strike special settlement machinery;[51] and the remaining four states have yet to make known their views on nonprofit hospitals.[52]

New York appears to occupy a unique position in respect of its legal rules on hospital-union relations. New York is one of the states having a labor relations act which expressly excludes nonprofit hospitals. In view of this, hospital unions are forced to acquire rights and privileges for employees without the protection given other unions against employer unfair labor practices.[53] New York also has an anti-injunction statute[54] which does not expressly exclude hospital employers or unions from its coverage. Standing alone the anti-injunction statute would on its face appear to protect from injunction the normal concerted activities of hospital unions. However, in the celebrated decision in *Jewish Hospital of Brooklyn v. Doe*,[55] an intermediate appellate court held that the hospital exemption of the labor relations Act must be read into the anti-injunction Act, thus rendering the hospital-union dispute a non-"labor dispute."[56] Charitable, education and religious associations "fall without the scope of such legislation unless specifically included therein."[57] Further alternative grounds for the decision were expressed by the court:

> "Plaintiff, in caring for the indigent sick, . . . is in fact, if not in name, a governmental agency performing a governmental function which ordinarily belongs to and usually is discharged by the state. . . . The same doctrine that excludes the state and its political subdivisions from the statute requires a holding that a charitable institution such as plaintiff is also excluded." ". . . those involved in a labor dispute

47. Conn. Gen. Stat. c. 370 (1949) (Supp. 1955); R.I. Gen. Laws Ann. Tit. 28, c. 7 (1956); Utah Code Ann. §§ 34-1-1 to -15 (1953) (Supp. 1957).

48. Colo. Rev. Stat. Ann. c. 80, art. 5 (1953); Kan. Gen. Stat. Ann. c. 44, art. 8 (1949) (Supp. 1957); Ore. Rev. Stat. §§ 662.610-.790 (1953); Hawaii Pub. Laws 1945, c. 250 sr. A-68, as amended Act 249, L. 1951, and Act 11, L. 1955.

49. Wisconsin, notes 31, 32, supra.

50. Massachusetts, Pennsylvania, Rhode Island and Utah, notes 39, 47, supra. New York's hospital rule is discussed, infra.

51. Minnesota, Massachusetts and Michigan, notes 38, 44, 46, supra.

52. Note 48, supra.

53. N.Y. Labor Law §§ 704, 706, and 715.

54. N.Y. Civ. Prac. Act § 876-a.

55. 252 App. Div. 581, 300 N.Y.S. 1111 (2d Dept. 1937).

56. "Labor dispute" is defined in N.Y. Civ. Prac. Act § 876-a(10). See 252 App. Div. at 588, 300 N.Y.S. at 1118-1119.

57. 252 App. Div. at 589, 300 N.Y.S. at 1119.

> . . . must be engaged in the same 'industry, trade, craft or occupation.' . . . Obviously plaintiff is not engaged in any industry, trade, craft, or occupation for *profit* within the meaning of the statute."[58] [emphasis added]

Finally, the court added that historically there had never been an abuse of the injunctive remedy in the case of hospital unions, therefore the anti-injunction Act did not intend to extend its coverage to disputes in nonprofit hospitals.[59]

The labor dispute in the *Jewish Hospital* case involved a strike intermingled with a series of patently unlawful acts.[60] The nature of the specific acts, however, does not seem to have been controlling in the court's broad holding. Indeed, in *Society of New York Hospital v. Hanson*[61] the parties conceded[62] and the court held that the decision in *Jewish Hospital* was controlling with respect to the applicability of New York's anti-injunction Act even in a situation where the strike was peacefully conducted. The New York Court of Appeals has never been called upon to decide this question, although it has determined that proprietary hospitals are "employers" within the meaning of New York's labor relations Act[63]—a holding which conceivably will impel lower appellate courts to hold that proprietary hospitals fall within the anti-injunction Act.[64]

The 1959 rash of hospital disputes in New York City has called forth recent judicial allusions to the *Society of New York* and *Jewish Hospital* cases. On the question of the legality of strikes against nonprofit hospitals,[65] the overwhelming majority of these recent decisions is in accord with the older decisions.[66] However, these decisions were not without dissent. In *Mt. Sinai Hospital v. Davis*,[67] one trial court Justice was asked to impose contempt punishment upon union employees for disobedience of an injunction which had been issued by a coordinate Justice.[68] In refusing to cite defendants for contempt, it was stated:

> "Employees of voluntary hospitals do not have the protection of civil service laws or procedures. Nor do they have the benefits derived from state or city service. They must work out their own grievances

58. Id. at 586, 1116.
59. Id. at 587, 1117.
60. Id. at 585, 1115, where the court describes violent mass picketing and sit-down strikes, among others.
61. 185 Misc. 837, 59 N.Y.S.2d 91 (1945), aff'd, 272 App. Div. 998, 59 N.Y.S.2d 835 (1st Dep't 1947).
62. 185 Misc. at 840, 59 N.Y.S.2d at 94.
63. N.Y.S.L.R.B. v. M.P.H., Inc., 291 N.Y. 710, 52 N.E.2d 596 (1943). And see N.Y.S.L.R.B. v. McChesney, 175 Misc. 95, 27 N.Y.S.2d 866 (1940), aff'd, 261 App. Div. 1089, 27 N.Y.S.2d 870 (2d Dep't 1941).
64. See notes 52-62, supra, and accompanying text.
65. Presumably, unions in proprietary hospitals may strike equally with all other unions. Note 63, supra.
66. Mt. Sinai Hospital v. Davis, 44 L.R.R.M. 2182 (Misc. 1959), aff'd, 44 L.R.R.M. 2401 (1st Dep't 1959); Jewish Hospital v. Davis, 44 L.R.R.M. 2273 (Misc. 1959), aff'd, 44 L.R.R.M. 2281 (1st Dep't 1959).
67. 44 L.R.R.M. 2398 (Misc. 1959).
68. Mt. Sinai Hospital v. Davis, 44 L.R.R.M. 2182 (Misc. 1959).

> and redress machinery. That must be done through dealings with the directorial and management staffs of the employer hospitals, none of which is subject to governmental control. Yet the city itself and at least two of the private institutions have and do maintain collective bargaining relations with the employees' union. For the management of the hospitals—plaintiffs—to take the course herein which they so forcefully pursue is more an echo of the nineteenth century than the last half of the twentieth century."[69]

As to the legality of picketing, as distinguished from striking, there is still much uncertainty in New York. There is some authority that picketing in connection with a strike is enjoinable where the effect of the picketing is to deter persons from making deliveries or performing other services for the hospital, and picketing having a like effect in the absence of a strike is apparently likewise enjoinable.[70] In *Prospect Heights Hospital v. Davis*,[71] the New York court was urged to enjoin peaceful organizational picketing on the theory that prior case law *required* the court to do so in every nonprofit hospital dispute. After finding that there was no disruption of hospital services and, at most, the mere threat of a strike, the Court denied the prayer for injunctive relief. In addressing itself to the established decisions, the Court remarked:

> "In none of the case law cited by plaintiff have the rights of free speech and of free organization been challenged, nor has the right to inform others, through peaceful picketing or other demonstrations, of workers' substandard employment conditions, been curtailed or held to be contrary to law. Indeed, these rights have long been embodied in decisional law and, as has been pointed out in Wood v. O'Grady (307 N.Y. 532 . . .), they pre-date both the statutes referred to."[72]

New York state, as we have seen, is one of the few jurisdictions which expressly excludes nonprofit hospitals from the provisions of its labor relations Act[73] and which impliedly excludes them from its anti-injunction Act.[74] Even when a large majority of employees of the non-profit hospital favors the union,[75] it seems clear that the employees may not strike and may engage in only the most inoffensive (and usually ineffective) picketing. The question arises as to whether the hospital-employers have any legal duty to bargain collectively with the union representing a clear majority of their employees, notwithstanding the

69. 44 L.R.R.M. at 2401.

70. Society of New York Hospitals v. Hanson, note 61, supra: Beth-El Hospital v. Robbins, 186 Misc. 506, 60 N.Y.S.2d 798 (1946). Cf. § 8(b)(7), L.M.R.D.A. 1959.

71. 45 L.R.R.M. 2143 (Misc. 1959).

72. Id. at 2145.

73. Notes 55-62 supra, and accompanying text.

74. Ibid. New Jersey and Pennsylvania are the only other states with decisions holding that local anti-injunction statutes are impliedly inapplicable to nonprofit hospitals. Elizabeth General Hospital & Dispensary v. Elizabeth General Hospital Employees Union, 8 L.R.R.M. 1090 (N.J. Ch. Ct. 1941); Western Pennsylvania Hospital v. Lichliter, 340 Pa. 382, 17 A.2d 206 (1941).

75. In Mt. Sinai Hospital v. Davis, note 67, supra, the hospital employees had voted by secret ballot as follows: In Mt. Sinai Hospital, 956 for the union, 59 against; in Beth Israel, 349 for, 8 against; in Lenox Hill, 372 for, 16 against; in Bronx Hospital, 247 for, 6 against; and in Beth David Hospital, 180 for, 4 against. 44 L.R.R.M. at 2401.

union's striking and picketing disabilities. New York's Constitution of 1938[76] provides that "Employees shall have the right to organize and to bargain collectively through representatives of their own choosing." No mention was made in the 1938 Constitutional Convention respecting the applicability of this provision to nonprofit institutions. Arguably, if such a provision effectively imbues employees generally with a right to bargain collectively, it may be such a right as is enforceable against a recalcitrant employer—any employer. However, in the few cases in which the point has been raised, the courts have held that the 1938 constitutional grant is merely declaratory of the law existing at that time—both statutory and case law.[77] One court has pointed out, however, that the "labor dispute" subdivision of New York's anti-injunction statute was amended *after* the 1938 constitution, and the legislature persisted in its original non-exclusion of nonprofit hospitals.[78]

The New York rule in respect of nonprofit hospitals has been in existence since 1937, when the *Jewish Hospital* case was decided. Our investigation indicates that, since that time, New York courts have entertained more lawsuits involving labor disputes in these institutions than the courts of any other state. In many of the New York decisions judges have lamented the fate of the nonprofit hospital employee and have indicated that remedial legislation is in order.[79] Although similar limitations have been placed upon government employees[80] and upon supervisors,[81] it has been pointed out that the nonprofit hospital employee is distinguishable in that he enjoys no government-service benefits and has no individual bargaining power whatever, in most cases.[82] The New York legislature, however, except for the perennial introduction of bills seeking to make nonprofit hospitals "employers," has produced nothing in these years to balance the interests of both the public and the hospital employees. It may be that New York would profit from legislative experiments in other jurisdictions.

In an effort to ensure to nonprofit hospital employees some right of collective bargaining and organizing, and at the same time to immunize the community from the frightful aspect of a hospital strike, legislatures of a few states have made applicable to hospital disputes certain emergency statutory machinery.[83] Similar in general purpose to the National Emergencies provisions of

76. N.Y. Const. art. 1, § 17 (1938).

77. Trustees of Columbia University v. Herzog, 269 App. Div. 24, 53 N.Y.S.2d 617 (1944), aff'd, 295 N.Y. 605 (1945); Quill v. Eisenhower, 113 N.Y.S.2d 887 (Misc. 1952); New York City Transit Authority v. Loos, 154 N.Y.S.2d 209 (Misc. 1956), aff'd, 161 N.Y.S.2d 564 (1st Dep't 1957). Cf. Railway Mail Association v. Corsi, 293 N.Y. 315, 56 N.E.2d 721 (1944) (holding that a union of public employees were subject to the New York Civil Rights Act).

78. Mt. Sinai Hospital v. Davis, 44 L.R.R.M. 2398, 2399 (Misc. 1959).

79. Society of New York Hospitals v. Hanson, note 61, supra; Prospect Heights Hospital v. Davis, 45 L.R.R.M. 2143 (Misc. 1959).

80. N.Y. Civil Service Law (Condon-Wadlin) § 108; Taft-Hartley Act of 1947, § 305, 29 U.S.C.A. § 176.

81. Taft-Hartley Act of 1947, § 14(a); 29 U.S.C.A. § 155(a).

82. Cases cited, note 79, supra.

83. Mass. Gen. Laws Ann. c. 150B (1958); Mich. Stat. Ann. § 17.454 (14.2-.8) (Rev. Vol. 1950); Minn. Stat. Ann. § 179.35-.39 (Supp. 1958).

the national Taft-Hartley Act,[84] each of these statutes makes a strike in a nonprofit hospital enjoinable.[85] However, in each instance the state has recognized the right of hospital employees to organize and to bargain collectively. Michigan and Massachusetts have wisely refused to distinguish between strikes in nonprofit hospitals and strikes in proprietary hospitals, although Minnesota's emergency provisions apply only to nonprofit hospitals.[86] All these statutes have various "cooling-off" periods during submission of the dispute to a hearing. However, the ultimate step in settlement of the dispute differs in each state: in Michigan, an unresolved dispute may merely result in making public the findings of the hearing commission[87] and an injunction against the strike; in Minnesota, compulsory arbitration is provided;[88] and in Massachusetts outright seizure and operation of the hospital by the Governor may result.[89] Although none of these emergency statutes necessarily conforms to American Labor's non-interference tradition, each nevertheless typifies experimentation by government in the accommodation of conflicting community pressures and needs.

III. Social Factors and Hospital Unionism

Questions of public policy must be considered in the light of the historic, social, and economic background from which they arise. In order to evaluate the place of unionism in the hospital, it may be useful to examine the social organization of the hospital. Two social characteristics are of special importance: (1) occupational groups in the hospital are arranged in accordance with a strict hierarchy of authority and status, from the doctors on the top to the dishwashers and cleaning women at the bottom, yet (2) most of the occupational groups, particularly those at the top, possess a certain sense of autonomy and this sense of autonomy tends to make the hospital less of a hierarchy than might seem at first glance.

A. *Hierarchical Structure*

Hospitals have an ingrained hierarchy with the lines between the social positions so tightly drawn (and buttressed by the wearing of special uniforms) that it is often called a caste system. Probably there are more and sharper gradations of status in the hospital than in any other American institution, even the Army. Why should this be?

First, hospitals have a large number of separate occupational groups, each of which has its own special training, its own rights and duties, and even its

84. Taft-Hartley Act of 1947, § 206 et seq., 29 U.S.C.A. § 165 et seq. See note 19, supra.

85. See notes 41-51, supra, and accompanying text.

86. Note 83, supra.

87. Note 82, supra. Cf. N.Y. Labor Law § 800, et seq. A bill to provide for a cooling-off period has been submitted to the 1960 New York legislature. Weekly Legislative Digest (N.Y. Dep't of Labor, Feb. 2, 1960) p. 21.

88. Note 83, supra.

89. Note 83, supra. See Shultz, The Massachusetts Choice-of-Procedures Approach to Emergency Disputes, 10 Ind. & Lab. Rel. Rev. 359 (1957); Bernstein, Enarson & Fleming, Emergency Disputes and National Policy (1955).

own code of ethics. And it is extremely difficult, if not impossible, for a person to move from one category to another. In most other lines of endeavor there is a strong tradition that a man can work his way as far up in the organizational hierarchy as his abilities will carry him, in theory, for instance, that even an uneducated laborer can advance through his own efforts to president. True, promotional opportunities for men without college degrees have declined in recent years, but the tradition remains. Certainly it is still much easier for a worker to become a foreman or a foreman to become a superintendent than it is for a nurses' aide to become a nurse or a nurse a doctor. Thus, the fact that it is virtually impossible to win promotion from one occupation to another tends to rigidify caste lines and to encourage each group to develop a somewhat restricted point of view.

Secondly, hospitals are in the business of saving lives. There is an obvious need for quick decisions, instant obedience, and clearly identified authority when human life is at stake. There is little opportunity for democratic discussion during an operation, for instance. There is great need for order and system. Since mistakes may have fatal consequences, rigidly followed procedures are essential. Instructions of necessity must flow down the chain of command.

Thirdly, hospitals have traditionally been charitable institutions, run by the rich for the benefit of the poor. Until the middle of the 19th century hospitals provided little more than custodial care and sanitary conditions were quite primitive.[90] As a consequence a patient with any means felt (usually with reason) that his chances for recovery were greater at home. Thus, only the poor patronized hospitals and the tradition that hospitals were charitable institutions became well established.

The tradition of *noblesse oblige* was often carried over into personnel policy as well. Hospital personnel administration is often quite paternalistic.

> "Traditionally hospitals kept their costs down by hiring workers at less than prevailing wages. In order to get workers at such low rates, they accepted the otherwise unemployable: the handicapped, the aged, the derelict. Hospital employment came to be seen as a form of charity, a way to give a modicum of self-respect to people who could not find work elsewhere. Social agencies and well-meaning individuals acquired the habit of directing such persons to hospitals for jobs. Here they found housing and meals as well as medical care and oversight. In other words, these jobs gave them a haven in life. They were more than just jobs, but at the same time they were something less than jobs. Hospital employment acquired a stigma of charity."[91]

At least in the past, hospital boards (most of whose members contribute personally to meet hospital deficits) looked upon the hospital itself as a charity. There is still some trace of this past tendency to look upon hospital employees

90. Burling, Lentz and Wilson, The Give and Take in Hospitals (1956) at p 4, citing Goldwater, "Concerning Hospital Origins," The Hospital in Modern Society (Bachmeyer & Hartman, eds., 1943).

91. Id. at 162.

as recipients of charity. Those who give charity often expect the recipients to show a certain amount of gratitude or at least docile submissiveness. The recipients of charity are not expected to talk back.

All three characteristics tend to intensify status differences, create sharp lines between cliques and make it difficult for lower status employees to communicate upward individually. These very characteristics might also make hospital employees ripe for unionization.

B. *Internal Self-Organization*

Yet, though there is a well defined hospital hierarchy there is much less singleness of control than might first appear. A hospital might be considered as a congeries of groups as much as a centralized, unified agency. With the significant exception of non-professional employees, the bulk of hospital personnel belong to professional and semi-professional organizations. These organizations represent the interest of their constituents to the hospital administration. This representation — as we shall see — takes a variety of forms, from attempts to raise the professional status of the group in question, through informal presentations to the hospital administration of the group's case for better economic conditions, to formalized collective bargaining, signed contracts, and formal grievance procedures.

In principle, the hospital administrator is the head man in the hospital. And yet his position is often quite insecure. Until recently the hospital administrator was often a woman, usually little more than a director of nurses. Even today when hospital administration is a separate field of university training, the hospital administrator is often not sure of his power and has little control over the most important of the hospital employees, the doctors. And members of hospital Boards of Directors (and their wives) are more willing to interfere with details of hospital administration than are members of comparable boards in private industry;[92] they feel not only must they run the hospital but they must represent the special interest of the public at large. Further, since there is a strong tradition of volunteer service (ladies aides, the Hospital Guild, etc.), board members feel little hesitancy in volunteering their advice regarding administrative detail.

Doctors occupy a quasi-independent position in the hospital hierarchy. Attending physicians spend only part of their day in the hospital and conduct much of their practice outside. They are paid by their patients, not by the hospital. Consequently they feel that the hospital provides services for them, not that they work for the hospital. In most institutions they have won the privilege of governing themselves and in a sense negotiate for these privileges with management. True, interns and residents are hospital employees in the usual sense, but they owe their loyalty and look for instructions to the chief of service, who in all but the largest institutions works for the hospital on a part time basis.

92. Id. at 43.

> "In a curious sense, unmatched by any other organization, the hospital entertains the most important actors in the medical drama, the doctor and his patient, without being in direct command of either."[93]

Most hospitals have medical staff committees which are elected by the doctors and serve the double function of providing self-government for the doctors and of representing their interests to the hospital. In a very real sense the committee bargains with the hospital regarding a host of matters, ranging from what equipment should be purchased to how patients should be admitted. And in many instances this bargaining is also related to economic matters.

Perhaps this economic bargaining is manifested most clearly by the attempts of radiologists and anesthesiologists in many hospitals to change their position from hospital employee, paid by the hospital, to that of an independent practitioner who derives his income directly from the patient. In some instances anesthesiologists have resigned their employee status and threatened not to provide services unless their terms are met.[94]

In addition to hospital staff committees, doctors provide self-regulation and representation through professional societies such as the American Colleges of Physicians and Surgeons, the various specialty boards, and the American Medical Association. At least the last organization serves a very clearly economic purpose (though it may be argued that the specialty boards help enforce a "closed shop" and keep the labor supply low.)

The doctors special *professional* status (which it should be emphasized includes responsibilities as well as rights) provides a model which profoundly affects the aspirations and behavior of all other hospital occupational groups. Everyone wants to be like the doctors. Hospital administrators, for example, belong to the American College of Hospital Administrators which is closely modeled after the American College of Surgeons, with graded classes of membership, a probationary period before full membership and careful tests before the title "Fellow" is conferred.

More to the point, nurses have also tried to "professionalize" or to give themselves a quasi-independent relationship to the hospital. The National League for Nursing Education and the American Nurses Association have set up standards for accreditation and codes of ethics. In addition, the Nurses Association sponsors an "economic security" program designed to improve nurses' economic status.[95] Many state nursing associations have adopted "employment standards" (the equivalent of contract demands by industrial unions) covering salaries, vacations, holidays, sick leave, overtime pay, and rest room and locker facilities.[96] In New York, for example, it is contemplated that there be "negotiations with the employer . . . an agreement . . . negotiated . . .

93. Id. at 83.
94. 34 Hospitals, No. 1, p. 97 (1960).
95. Schutt, "The ANA Economics Security Manual . . . What It Is and Why," 58 The American Journal of Nursing 312 (1958).
96. E.g., 30 Nurse, No. 3, pp. 6-18 (1958).

[and] the proper grievance procedure."[97] And in its 1958 national convention the Association resolved to take "immediate steps to implement in all hospitals the essential practices of collective bargaining: 1) freedom of employees to organize, 2) free choice of representation, 3) recognition of employers' representatives and bargaining in good faith by representatives of employer and employees, and 4) negotiations and signed contracts."[98]

In spite of the advanced position taken by 1958 convention, there still is considerable dispute within the Association as to how far it should go towards being a union. Many of the state and district associations are unenthusiastic about implementing the full program — and in most instances hospitals have been quite reluctant to agree to formal negotiations or signed contracts. At times the "negotiations" consist of little more than meetings in which nurses present their requests or proposed "employment standards" to the hospital administration. As yet there are few formally negotiated and signed contracts, and those which exist are confined largely to Minnesota and California.[99]

Nurses are not alone in their ambivalence and internal disunity regarding unions. Some chapters — but not all — of the American Chemical Association engage in collective bargaining.[1] Engineers are divided between those who support only "purely professional" organizations which concern themselves with the advancement of knowledge and promoting higher standards of performance — and those who feel there is a place for organizations such as the Engineers and Scientists of America which frankly seek to engage in collective bargaining. As of 1956 unions claimed to represent more than 55,000 engineers.[2] Teachers, too, are divided between the Teachers Union and the National Education Association and its affiliates.

In the hospital, most professional and semi-professional groups have their own organizations: dieticians, X-ray technicians, medical record librarians, laboratory technicians, among others. These organizations are primarily interested in raising professional standards, in providing educational opportunities for its members and in certifying those who have reached various levels of professional competence.[3] In general these groups do not engage in collective bargaining (though there may be a good deal of behind the scenes efforts to

97. Id. at 22.

98. 32 Hospitals, No. 13, p. 100 (1958).

99. A 1957 study which covered 100 of 129 private-voluntary hospitals in Minnesota and 176 out of 288 private-voluntary in California found that in but 25% of the Minnesota hospitals and 10% of the California hospitals were the nurses organized for collective bargaining. The bulk of these organized hospitals were in the San Francisco and Minneapolis areas. Sister Marybelle Leick, A Study of Collective Bargaining in Minnesota and California Hospitals (unpublished M.H.A. thesis, St. Louis Unversity Library) (1957).

1. Northrup, Collective Bargaining by Professional Engineers and Chemists (1946); Northrup, "Collective Bargaining by Professional Societies," Insights into Labor Disputes (Lester and Shister, eds., 1948).

2. National Industrial Conference Board, Unionization Among American Engineers, 5 (1956).

3. It might be suggested that through this device these organizations follow traditional trade union techniques of using training standards as a means of reducing competition for available jobs.

impress the hospital administration with the collective economic interests of their members.)[4] At least one such organization, the X-ray technicians, has taken a strong stand against unionization in words which clearly express the conservative position:

> "Thinking technicians have felt that elevation of our professional status and dignity must come as a result of our increased efficiency as technicians . . . . Those who chose the field of X-ray technology as a career are usually dedicated by a sincere desire to help people. There is every opportunity to inquire into the financial inducements of the field prior to entering it, nor are we normally encouraged to become technicians because of a bright financial future. Much of our remuneration comes from intangibles — the inner satisfaction a man feels when he is giving of himself in service to the unfortunates with whom he deals, the increasing respect which he is gaining from his co-workers and himself, his association with sincere doctors who devote their lives to the care and treatment of the sick and injured . . . . Trained technicians have no sympathy for any organization in the paramedical field which has as its one weapon the collective refusal to work . . . . They reject collective bargaining as a means of forcing a high financial return for the services they give."[5]

Possibly the reluctance of the lower status professional organizations to follow the example of the nurses in collective bargaining may be explained by the fact that these lower status organizations are less sure of their professional position and feel that they must first secure their professional acceptance before engaging in economic activity.

In contrast to dieticians, X-ray technicians, etc., boiler room stationary engineers have little aspiration for professional status. However, stationary engineers in industry normally have a strong sense of craft identification and there is little reason to believe that this is not also true in hospitals. Boiler room stationary engineers traditionally belong to the International Union of Operating Engineers, AFL-CIO and this union claims jurisdiction over hospital boilers as well. The Operating Engineers engage in collective bargaining (either formally or informally) with a number of hospitals which engage in collective bargaining with no other group. And in some instances, the Operating Engineers have organized maintenance workers generally.[6]

Thus there are numerous organizations that represent hospital employees in one way or another, and non-professional employees (other than engineers) are the least organized group in the hospital. Why have not non-professional employees copied the example of their professional colleagues and organized themselves? Why did they wait to be organized from outside by the AFL-CIO instead of engaging in self-organization?

4. In at least one hospital, St. Mary's of Duluth, Minnesota, licensed practical nurses do bargain through their own association. Interview with Sister Marybelle, Administrator, St. Mary's (1960).

5. 31 Hospitals, No. 5, p. 8 (1957), citing Journal of the American Society of X-ray Technicians (Jan. 1957).

6. E.g., note 99, supra.

Since hospital wages are low, many non-professional employees are marginal employees, in the sense that they are almost unemployable elsewhere. They are often older people from minority ethnic groups, and display deviant, passive, or dependent personalities.[7] The wide social gap between themselves and higher management, and the fact that they can be easily replaced all contribute to making them fearful to speak out to higher management by themselves. Further, their poor education and high turnover makes it difficult for them to develop internal leadership. As a consequence, self-organization is quite difficult. Almost of necessity, if they are to be organized at all they must be organized by outsiders who have little to fear personally from higher management. Yet it has been the efforts of outsiders, unions affiliated with the AFL-CIO to organize non-professionals, that have led to the controversies previously cited.

C. *Efforts by Outside Hospital Unions*

To date hospital unions have made relatively little progress, though significant gains occurred in 1959. A 1955 report of the American Hospital Association indicated that 15,000 hospital employees were covered by collective bargaining contracts — 70% in the Minnesota area and the Pacific Coast.[8]

Why have unions been so unsuccessful in organizing non-professional employees? Primarily for the same reasons which have made self-organization almost impossible: the difficulty of developing internal leadership among hospital employees and their reluctance to take the risks involved in joining a union.

Organization has been more difficult because no one union has exclusive jurisdiction over hospitals. The Buffalo drive was conducted jointly by the Laundry Workers, Building Service Employees, and Hotel and Restaurant Employees. In other communities organization has been attempted by the Retail Clerks, State County and Municipal Workers and the Teamsters. The only characteristic these unions have in common is their experience in dealing with lower paid employees. And in special circumstances hospital employees have been organized by such varied unions as the Brotherhood of Railway Clerks, the Gas, Chemical, and Atomic Workers, and the Optical and Instrument Workers[9] — presumably in all cases because these were the dominant unions in the community where the hospital was located.

D. *Resistance to Unions*

Hospital administrators and boards of trustees have shown sharp resistance to unions — in marked contrast to their attitudes toward "professional organization." How can this difference in point of view be explained?

7. Note 99, supra.
8. "Labor," Hospital Law Manual 2 (1959). Probably this figure includes an appreciable number of nurses.
9. Note 99, supra.

First, in most instances, unions have tried to organize the lower end of the status ladder, the cooks, orderlies, cleaning women and other lower paid occupations. Unions have tried to stir up what have traditionally been the most docile of the hospital groups. And these efforts have inevitably resulted in hostility from those of higher status. As a doctor told us, in discussing this problem, "I'll admit that the doctors are organized, but you can't have equality. On one hand you have the creative people who perform the functions for which the hospital was created, and then there are the helpers, who don't require any training and can be easily replaced." Indeed there is a considerable feeling on the part of those on the higher levels of the hospital hierarchy that "We are doing these people a good turn by hiring them. They couldn't find work elsewhere and they are already paid more than they are worth."

Second, the organizations which have sought to organize these lower ranking employees call themselves "unions" and are affiliated with other non-hospital organizations. In general, the most successful white collar and professional bargaining organizations have avoided the label "union".[10] Witness the Actors' Equity, the Air Line Pilots' Association, the American Newspaper Guild, the Engineers and Scientists of America. The word "union" smacks too much of the factory — and white collar workers (including those in white and colored hospital uniforms) tend to think themselves above that. Possibly (the suggestion is facetious) hospital unionization might have been better accepted if the hospital union had called itself the American College of Hospital Employees, and, instead of going on strike, had withheld accreditation and refused to work for hospitals which failed to meet their "economic standards."

Third, hospitals are largely under the control of leading doctors and prominent society leaders. While they may tolerate the polite forms of representation or bargaining practiced by professional organizations, the word "union" is anathema. Few doctors are used to dealing with large groups of employees and society leaders are normally quite anti-union, even those who bargain with unions in their own businesses.

Finally, there is a perhaps-justified fear that unions will bring higher wages and reduced efficiency, thus driving hospital costs even higher (a problem which we discuss *infra*). Further, higher wage rates may make it economically impossible for hospitals to continue to offer a haven for some of the human derelicts who might otherwise not be able to find useful employment.

Fourth, in a number of instances, hospital unions have used strikes as a means of winning recognition. Though it may be argued that the strike is the most effective means of dramatizing the union's claims, strikes tend to alienate the higher status groups in the hospital as well as the public at large.

Thus conflict between the hospital administration and unions is almost inevitable. The fact that in some states, such as New York, there is no legal protection for hospital unionism has given hospitals a legal and even a moral

10. Strauss, "White Collar Workers Are Different!", 34 Harvard Bus. Rev. No. 5, p. 73 (1954).

justification for refusing to deal with employee organizations — even where, as in New York, those employees have voted overwhelmingly for union organization.[10a]

In summary: (1) the interests of higher status hospital employees have been traditionally represented by professional associations, but (2) there is understandable resistance to the attempts to organize lower status employees into unions affiliated with non-hospital organizations.

IV. Should Hospital Unions Be Protected?

Holding aside for the moment the question of whether hospital employees should be forbidden to strike, at least three arguments can be made in favor of placing hospital employees in a special category and denying them government protection when they seek to organize unions.

A. *Impact on Discipline*

First, unions tend to break down discipline. With unions employees may be less willing to give instant obedience to orders — and in hospitals such instant obedience may mean the difference between life and death. Certainly, it is argued, no one should be permitted to argue a grievance when human life is at stake. Thus it is concluded that public policy should not encourage the development of union in industries such as hospitals where discipline is essential — any more than public policy permits the existence of unions in the army.

> "It is my opinion, however, that the hospital field — because of its responsibility for care of the sick and injured — is not the place for strong unionization. It is a field for devoted employees — employees who are interested and well trained to meet the needs of our business — our patients."[11]

Still, as we have seen, the medical staff organization, the American Nurses Association, the American Dietetic Association and other professional organizations represent their members — the ANA even engages in collective bargaining — all without any apparent break down of discipline. Possibly, a union of non-professional employees might show less restraint. And yet, discipline is less essential among the non-professional employees, who merely provide supporting services, than it is among the doctors and nurses who are directly responsible for the preservation of human life.

Actually the picture of a disciplined hospital team of hospital workers — striving together to save human life without thought of self — is considerably exaggerated. Though the authors know of no comparative data, it is their impression, based on discussion with experienced personnel directors in hospitals and industry, that many hospitals tolerate a level of absenteeism, tardiness, and inefficiency, particularly among non-professional employees, that is, considerably higher than in private industry. Without a union, workers may well express their

10a. See note 75, supra.

11. Wood, "They Live and Learn With Unions," 39 Modern Hospital No. 1, p. 75 (1959).

discontent through absenteeism, tardiness, a low level of production, or quitting the job altogether.[11a] Because of these factors the hospital administrator often faces a continuous struggle to keep an adequate work crew intact. Conceivably if unions had a union to express their problems, hospitals might in fact have a more disciplined, efficient work force. If wages were raised through unionism, hospital employment would become more attractive and hospital administrators would no longer have to rely so heavily on marginal, second-rate employees who find it difficult to find jobs elsewhere.

Some evidence as to the impact of unionism on discipline is contained in Sister Marybelle's study.[12] She sent questionnaires to all 417 private-voluntary hospitals in California and Minnesota and received replies from 276 of which 54 were unionized. Among the questions asked was "Was the hospital or patient inconvenienced during negotiations? If so, in what way?" She classified the answers from unionized hospitals as follows:

Minn.	Calif.	Total	
19	18	37	no inconvenience
7	3	10	inconvenience
2	0	2	uncertain
2	3	5	no answer

Most of the hospitals which reported inconvenience said that this was due to a strike. One "described its inconveniences as a general unrest among the employees during the organizing process. Still another reported 'much hostility and untrust in public statements for several years'. Another inconvenience listed by two hospitals was the great amount of time spent by key personnel in negotiations."[13] "One hospital reported a strike of four weeks with pickets causing a serious handicap in hospital operations. A second hospital described a similar picket line and strike, but of shorter duration . . . . The third hospital of this group felt that the ill-feeling amongst the employees and the great amount of time spent by them in discussion during their hours on duty was of sufficient importance to bear mentioning."[14] Other than strikes, the inconveniences were (1) general unrest among employees, (2) hostility and untruth in public statements, and (3) the expenditure of time in negotiations. None of these involve a direct breakdown of discipline, nor was there any mention in the report of any hardships to patients other than the strikes. Of course, the questions related to inconvenience during negotiations. Possibly further inconveniences might arise after negotiations were completed.

Certainly a union contract, by establishing personnel rules, tends to restrict the supervisor's power. Yet the freedom of all hospital supervisors and em-

11a. See Laur, "A Study of Certain Objective Measurements of Head Nurse Performance," (M.H.A. thesis, Univ. of Minnesota) (1960).

12. Note 99, supra.

13. Id. at 19.

14. Id. at 38.

ployees is already restricted by a vast number of rules (mostly concerned, it is true, with maintaining standards of patient care). Still management may retain wide powers to meet emergency conditions even under a union contract. One hospital contract, for example, contains a strong management prerogative clause:

> "The administration and management of the Hospital, direction of employees, the designation and planning of their work, including but not limited to the right to hire, suspend, or discharge for cause, promote or transfer or relieve employees from duty because of lack of work or other legitimate reasons, the right to judge their efficiency or competency in the performance of work assigned, the right to assign them to their work and properly classify them, the right to establish working rules and penalties is vested exclusively in the Hospital."[15]

One of the authors was able to discuss the impact of unionism with the nurses and department heads of a recently unionized hospital. The consensus of opinion was that unionization had resulted in little observable change. Some supervisors noted improved morale, others felt that employees were slightly more willing to talk back and to restrict their work to what they felt was their regular assignment. It was generally agreed that the need to avoid penalty overtime payments (as provided in the union contract) made it more difficult to schedule time off and work assignments.

Some of the problems were due to the parties lack of experience in dealing with each other. For instance (to take the most "serious" problem encountered): a cleaning woman refused to clean the cobweb off a high ceiling on the grounds that this was a man's job. Her supervisor hesitated to discipline her, in part because of fear of the union. The union steward, however, refused to support the cleaning woman's position while the hospital personnel director made it clear that insubordination should not be permitted. The net impact on the incident was to force several supervisors to reassess their supervisory practices.

We have studied the impact of unionism in one hospital only — hardly an adequate sample. Certainly were union-management relations in any hospital to deteriorate seriously, it is not inconceivable that the union might institute wildcat strikes, slow downs, or refusals to obey orders. In this regard the experience of other "essential" industries may be relevant.

Unions exist in many lines of work where discipline is essential, apparently with little harm to the public or breakdown of order. Airline employees of all classes are unionized, as are railroads, and public utilities. To be sure in unionized situations supervisors may have to adjust their supervisory styles, to make greater use of good "human relations techniques" rather than to rely purely on autocratic power. But discipline seems to be maintained adequately well in fields mentioned, even with unions.[16]

15. Agreement between Our Lady of Victory Hospital and Buffalo Hospital Council, AFL-CIO, Art. III, sec. 1 (1959).

16. See, e.g., Johnson, "Disputes Settlement in Atomic Energy Plants," 13 Ind. & Lab. Rel. Rev. 38 (1959).

A possible analogy may be drawn between hospital employees and those who work for the government. Though government employees have generally been denied the right to strike, many belong to unions. The postal unions have represented the bulk of postal workers for over 60 years. Unions have traditionally been active among civilian employees of government shipyards. The State, Country and Municipal Workers Union, AFL-CIO is a fast growing organization claiming today almost 200 thousand members. The International Association of Fire Fighters has had a long history. Though policemen rarely belong to organizations which call themselves unions, almost every large police force has the equivalent of New York City's Patrolmen's Benefit Association, which exists to protect its members' economic interests.

At least eight jurisdictions provide specific grievance procedures for government employees and some of these provide for union participation, particularly at the higher steps.[17] And the TVA, the City of Philadelphia, and the New York City Transit Authority actually bargain with unions and reach signed contracts.[18]

Thus we may conclude (1) experience suggests that the existence of union among hospital employees would not necessarily lead to a break down of discipline, and (2) there is ample precedent for the existence of unions and even collective bargaining in other areas where discipline is required, for instance, among transportation, communications, public utility, and government employees.

B. *Hospitals As Non-Profit Institutions*

Secondly it is argued that hospitals, as non-profit organizations, are in a pecular economic position. They normally make losses and consequently have no leeway in which to bargain. To permit unionization would make their position intolerable.

This brings us straight to the question of medical economics. As we have seen, hospitals were originally conceived as institutions to take care of the poor people; they were charities and expected to operate at a loss. This tradition continues and there seems to be a strong resistance among the general public to paying the full costs of hospital care (witness hospital's great difficulty in collecting bills) — far more resistance than to the paying of doctors bills or for drugs.

More than tradition is involved, however. People go to hospitals in general not because they want to, but because they have to. Going to a hospital is not like buying a new dress or a new hat — something that can be postponed if one wishes. In fact the people who use the hospital most — particularly the aged and disabled — can afford it least, for the very affliction which hospitalizes them normally also makes it impossible to earn a living. For those without insurance a prolonged hospital stay, at $20 or so a day, can be an absolute disaster. Yet

17. Segal, "Grievance Procedure for Public Employees," 9 Lab. Law J. 921 (1958).
18. Ibid.

society has decided that hospital care is such an urgent need that no hospital should turn a patient away purely on the grounds that he cannot pay. And, even for those who can afford to pay, the hospital bill comes at a psychologically bad time; the patient feels that he has suffered enough for illness and he resents the bill as an added injury.

All these factors tend to prolong the earlier tradition that the hospital is a form of charity given by the rich for the poor. It is complicated by the fact that hospital room rates have been rising at an extremely rapid rate — 319.5% from 1935 to 1958, as compared to a 110.7% rise in the cost of living generally and only a 66.1% rise in surgeons' fees.[19] This rise can be explained by two factors: (1) the greatly increased use of expensive equipment and drugs, and (2) the fact that even without unions, hospitals are no longer able to hire employees for little more than room and board. Though hospital wages remain very low on an absolute scale, their *relative* rise has been quite great.

Thus many individuals are unable to pay the full cost of hospital care and others are unwilling to do so. In effect, society has decided that hospital care should be subsidized — that is, that the user should not bear the cost alone (just as education is similarly subsidized and in a different way, so is agriculture). The question remains: who should bear the cost of the subsidy? Hospital workers — or the public generally in the form of taxes or higher Blue Cross and hospitalization insurance rates?[20] And, is the fear that hospital unions may raise hospital costs a valid ground for denying them the rights granted unions in other fields?

For us, to ask the question is almost to answer it. For we see no reason for society to say to the hospital worker "Though employees in other unions are permitted to join unions and improve their economic conditions, you may not do so, since we, society, fear that if you are unionized, you will shift the burden of hospital subsidy from your own shoulders to that of society generally." Surely a society which can afford fin-tailed cars, Miami Beach resorts, race tracks, and the like, can afford to pay decent wages to hospital employees. The hospital workers have at least as strong a claim to high wages as any other group in our society.

It may be a very healthy thing if hospital unions can raise hospital wages to a parity with other groups. This would not force hospitals out of existence. Once the issue is squarely faced, the public which is willing to spend billions of tax money on superhighways, will find the means to spend a smaller amount for hospitals.

C. *Adequacy of Present Personnel Policies*

It may be argued that non-professional employees do not need union contracts or outside unions — that once an adequate grievance procedure is set

19. Garbarino, "Price Behavior and Productivity in the Medical Market," 12 Ind. & Lab. Rel. Rev. 5 (1959).

20. As of 1957, 121,000,000 Americans were covered by hospital insurance. Id. at 7.

up within the hospital then the employees can bring their problems to the attention of the hospital administration without the needless intervention of outsiders. And it is argued that hospitals are making great strides to improve wages and personnel policies so there is little need for unionization.

Certainly there is much validity to this argument. In part, because of fear of unions, many hospital administrators have tried hard to put their hospitals in order. They have established explicit personnel policies, raised wages, provided formal channels through which grievances are to be processed, and have tried to teach their supervisors the essentials of good human relations. Certainly many hospitals are making an impressive effort to improve their standards of personnel administration.

Possibly a purely hospital organization might do a better job of servicing its members' needs than one which is controlled by an outside union which has little experience with hospitals (such as in Buffalo, where the unionizing drive is being spearheaded by an ex-longshoreman and an ex-postal clerk). And yet, as we have seen, non-professional employees, by personality and background, are unwilling to speak up or form organizations of their own. If they participate at all in determining the conditions under which they work, this is most likely to come through outside organization.

In their attempts to stave off unionism a number of hospitals have established elaborate grievance procedures, starting with the employee's own supervisor, through the hospital administrator, to a last step before a committee of the Board of Directors or a public review board. Yet for unskilled, uneducated hospital workers such a procedure may be too formidable a barrier to scale without the assistance of a skilled union representative. John W. Richards, General Secretary of the Toledo Central Labor Union (AFL) commented on the Toledo Plan:

> "I doubt, when there are grievances, that many cases will go to the board. Three Mercy Hospital employees took their grievances to the employees' committee, but it held off so long before it took any action that the men found jobs somewhere else. Suppose a hospital-employee has a grievance and takes it to the hospital grievance committee and it is turned down. He then has to take it to the hospital superintendent. If the superintendent turns it down he then has the privilege of going to the board. I doubt, however, if any employee would go that far. If he takes his grievance to the board his job will be in jeopardy.[21]

In addition, it can be argued that a union contract provides employees a certain protection which cannot be provided when personnel policies are purely at the discretion of management.[22] A contract may even be in management's interest in that it tends to eliminate perpetual haggling over the basic terms of work and provides a frame of reference within which management can make

21. Bruner, "'Toledo Plan' Supporterd by Hospitals and Labor," 93 Modern Hospital, No. 1, p. 76 (1959).

22. For a discussion in a hospital context, see Despres, "What Is a Contract?," 58 American Journal of Nursing 1403 (1958).

day-to-day personnel decisions. (A hospital personnel director told us that the contract provided a convenient excuse for him to turn down requests for special privileges.) It provides an element of certainty which makes it easier for both parties to plan for the future, to know their rights and responsibilities. And there is considerable agreement that in private industry, the impact of the union, the union contract, and grievance procedure has been to compel management to overhaul its personnel policies (and more significantly, *practices*) completely, and not infrequently for the better.[23]

Of course, it is entirely possible that employees in a given hospital may be so satisfied with their wages, working conditions, human relations and grievance procedure that they do not want a union. But, they should have the right to make their own free choice. It should not be imposed on them by management or by the law. Moreover, the very fact that employees are free to join a union should serve as a spur to hospitals to improve their employment conditions.

D. *Hospitals As Quasi-Governmental Services*

Finally, it is argued that since hospital employees perform a public service they are public servants and therefore should not be given a protected right to join a union. But this legal function is scarcely tenable. Public servants receive higher salaries and fringe benefits than do hospital employees and their job security is elaborately protected by civil service regulations. Further, as we have mentioned, unions are very well accepted in the public service. They function as effective lobbyists and in some cases engage in collective bargaining.

In conclusion, the burden of proof for making a special exception in the law should be placed on those who desire to make the exception. We feel that the case for discrimination against hospital unions has not been made. This does not mean that we endorse hospital unions. Indeed, we have grave doubts as to the sensitivity of unions now entering the hospital field to the special problems of hospitals. However, since public policy says that workers in other fields should be free to make an uncoerced decision as to whether they wish union representation, we see no valid reason for denying hospital workers the freedom to make a similar decision.

V. Should Hospital Employees Be Permitted To Strike?

A clear distinction can be maintained between the right to organize and bargain collectively and the right to strike in the hospital industry. The strike is a mere by-product of unionism, not the objective of its existence. Rather, as we have seen, the primary objectives of unionism are improved wages, hours, grievance procedures, seniority systems, job security, et al., and the establishment of mutual obligations to bargain collectively. The fear that unionized

23. Brown & Myers, "The Changing Industrial Relations Philosophy of American Management," Proceedings of Ninth Annual Meeting. Industrial Relations Research Association 84 (1956).

hospitals will imminently and continually threaten the community's health and welfare via strikes of their employees is probably without complete justification —although many of these fearful people have themselves thwarted unionism in hospitals so that there is very little experience upon which to base a contrary view. In the railroad and public utilities industries, where unions are strong and have generally the right to strike, there have been relatively few shut-downs throughout the years. These industries are almost as vital to the community as hospitals. In our investigation, we have found that the vast bulk of hospital strikes have occurred, not because of an "inside" recognized union, but because the employees wanted their union recognized in the face of adamant, uncompromising hospital administrations. If this issue of recognition had been removed, it is not unlikely that the incidence of hospital strikes would have diminished markedly.

But should we permit strikes at all in hospitals? We think the answer to this question cannot defensibly depend upon whether the hospital is proprietary or nonprofit.[24] Effective strikes shutting down hospitals of either type in a wide area would be intolerable. Presumably, if but a single hospital were shut down among many other hospitals, patients might be transferred elsewhere. But even this would pose a threat to individual lives as well as to the community. The recent strikes seem only to have caused some administrative inconvenience,[25] and these strikes have been quite ineffective. We cannot assume that all hospital strikes will be ineffective; the dangers inherent in an effective strike are too awesome. The argument for prohibiting hospital strikes is most persuasive.

But mere abolition of the right to strike is not enough. It is patently unworthy of the law at once to prohibit strikes in nonprofit hospitals[26] and to withdraw from hospital employees any right to compel collective bargaining.[27] Rather, as some jurisdictions have done, the state may, by statute, substitute elaborate hearings and mediation for the strike.[28] Provision for the conducting of elections in hospitals is both desirable and efficacious.[29] A cooling-off period may be required,[30] and arbitration or seizure provided for.[31] The machinery

24. Compare the distinction which is recognized in New York. See cases cited, notes 55, 63, supra, and accompanying text. Certainly a strike in a one-hospital community is no less serious simply because the hospital is proprietary rather than nonprofit.

25. In New York, doctors and nurses continued on duty, and many nonprofessionals continued to work. Strike-breakers were recruited and many doctors' wives and other society women did volunteer work. Paper plates were substituted for china plates, laundry was farmed out, etc. In Toledo, pickets withdrew to permit Teamsters' trucks to pass. Note 23, supra.

26. Jewish Hospital of Brooklyn v. Doe, note 55, supra.

27. See Quill v. Eisenhower, note 77, supra.

28. See notes 80-89, supra, and accompanying text.

29. See, e.g., St. Joseph's Hospital v. W.E.R.B. and St. Francis Hospital v. W.E.R.B., note 31, supra.

30. Notes 80-89, supra. For a discussion of experiences with "cooling-off" periods and the effectiveness thereof, see Stieber, Ten Years of the Minnesota Labor Relations Act (1949), p. 16.

31. See Shultz, note 88, supra; Williams, "Compulsory Settlement of Contract Negotiation Labor Disputes, 27 Tex. L. Rev. 587 (1949); Smith, "The Effect of Public Interest on the Right to Strike," 27 N.C.L. Rev. 204 (1949); Willcox & Landis, "Govern-

which is substituted for the right to strike must include, at a minimum, procedures for the encouragement and enforcement of collective bargaining in good faith. Lacking effective legislative enactment, it is not inconceivable that enforceable private agreements may be successfully bargained for in which satisfactory strike-substitutes may be incorporated.[32]

We feel it is possible to have strong, effective hospital unions notwithstanding they may not have a right to strike. Unions of government employees, for example, have been growing both in size and strength in recent years, and their efforts in collective bargaining have met with notable successes.[33]

The community interests which seem to dictate that hospital employees should not strike probably also dictate that certain types of picketing activity should be prohibited. "Signal" picketing, whereby employees of other employers automatically refuse to make deliveries or perform services at the hospital is certainly as intolerable as a strike of the hospital's employees themselves.[34] But certainly mere "informational" picketing or the use of other means of publicizing a hospital labor dispute should be permitted.[35] There is no discernible reason why hospital employees may not use all the forms of pressure ordinarily permitted government employees.

VI. Conclusion

In this paper we have attempted to suggest that there is a critical imbalance in a most revered social institution, the nonprofit charitable hospital. This imbalance results from a most unfortunate social attitude: the nonprofessional (and apparently *only* the non-professional) hospital employee is somehow naturally considered to be a donor of his services in much the same way in which others are considered regular donors of money or tangible property. He is expected to match, with his labor, the charity of others, however meager his own earnings. But, unlike others who give charity, the hospital employee is not as free to give or withhold his charity at will.[36] Under the multiple flags of public health, hospital "efficiency", and "charity" the hospital employee is effectively denied, unlike any other class of institutional wage-earner, all avenues

ment Seizure in Labor Disputes," 34 Cornell L.Q. 155 (1948); Cushman, "Compulsory Arbitration in Action," 2 Syracuse L. Rev. 251 (1951); Teller, "Government Seizures in Labor Disputes," 60 Harv. L. Rev. 1017 (1947).

32. One agreement has provided for a Citizen Review Board. See agreement between Our Lady of Victory Hospital and Buffalo Hospital Council, AFL-CIO, Art. XVII (1959). The authors do *not* consider this a satisfactory strike-substitute. See Newman, "The Atomic Energy Industry: An Experiment in Hybridization," 60 Yale L.J. 1263, 1364 (1951).

33. Seasongood & Barrow, "Unionization of Public Employees," 21 Cin. L. Rev. 327 (1952); Bernstein, Enarson & Fleming, note 89, supra; Note, "Union Activity in Public Employment," 55 Colum. L. Rev. 343 (1955); Note, "Strikes by Government Employees," 2 Vand. L. Rev. 441 (1949).

34. See Beth-El Hospital v. Robbins, note 70, supra. And see § 8(b)(7), L.M.R.D.A. (1959); 73 Stat. 519.

35. See Prospect Heights Hospital v. Davis, note 71, supra. And see § 8(b)(7), note 14, supra.

36. See Brenner, J., in Prospect Heights Hospital v. Davis, note 71, supra.

for self-improvement. Conceding that his "right" to strike must succumb to acknowledged public needs, we submit that there are no demonstrable reasons for denying him the effective right to organize and to bargain collectively through representatives of his own choosing. He is at least as entitled to such a right as is any other wage-earner.