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HEALTH CARE INSTITUTIONS AND THE TAFT-HARTLEY ACT
AN ASSESSMENT OF THE IMPACT OF THE
1974 AMENDMENTS

DISSERTATION

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By

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The problem with which this research is concerned is that of determining the impact of the 1974 Amendments (Public Law No. 93-360) to the Taft Hartley Act. These amendments provided new coverage to over two million health care workers. The purpose of this study is to determine the impact of this law on labor relations in the health care industry.

Data were collected from materials and interviews with the National Labor Relations Board and the Federal Mediation and Conciliation Service. Interviews were also conducted with labor union representatives, hospital administrators, and government officials. Periodicals, textbooks, legal documents and other materials were examined.

The research is presented in the following order: chapter one, the research problem and methodology; chapter two, the historical legal framework prior to the amendments passage; chapter three, the National Labor Relations Board's decisions regarding jurisdiction and bargaining unit determinations and chapter 4, the unionization of health care facilities. The other chapters include the following information: chapter five,

professional associations in health care; chapter six, the mandated role of the Federal Mediation and Conciliation Service; chapter seven, an analysis of unfair labor practice cases; chapter eight, health care contract negotiations; and chapter nine, summary and conclusions.

Distressed by the frequency and consequences of recognition strikes in nonprofit hospitals, Congress enacted the 1974 Amendments to balance the interest and rights of employers, employees, and the public. The law was designed to establish the mechanisms for health care and bargaining, reduce the opportunity for negotiation impasses, and protect the public interest in the continuity of health care.

The National Labor Relations Board established a \$100,000 gross revenue standard for nursing homes, visiting nurses associations, and related facilities and extended the \$250,000 standard previously applied to proprietary hospitals to nonprofit hospitals.

The National Labor Relations Board is also responsible for establishing bargaining unit guidelines. The health care bargaining unit guidelines are: registered nurses, technical employees, business office clericals, service and maintenance employees.

The expected surge to organize employees of health care institutions has taken place. From approximately 400 elections petitions filed in the two years prior to the amendment the amount increased to 1,451 in 1975 and 1,138 in 1976 for the

two years after the amendment. The total number of NLRB elections followed the increase in petitions. There were approximately 250 elections held annually prior to the amendment with increases to 579 and 710 elections in the two years following the law.

Virtually every known union can be found in the health care field. Five unions contain the bulk of hospital union membership. The unions are the American Federation of Government Employees (AFGE); the American Federation of State, County, and Municipal Employees (AFSCME); the Service Employees International Union (SEIU); the Retail, Wholesale, and Department Stores Union--1199 (RWDSU); and the American Nurses Association (ANA). In the nonprofit, nongovernmental sector, RWDSU and SEIU are the two largest and most active representing about 40 per cent of the total organization.

Due to mandatory involvement under the amendment the Federal Mediation and Conciliation Service caseload has increased substantially. Approximately 1,600 cases per year were added. The Director of FMCS may establish a Board of Inquiry if a strike or lockout activity would have an important impact on the locality. This procedure has been used in less than 5 per cent of all bargaining situations, equalling 134 Boards of Inquiry. From August 25, 1974, to December 31, 1976, there were 129 strikes which occurred out of 2,585 health care bargaining situations.

After the 1974 Amendments became effective, the number of unfair labor practice cases involving health care facilities increased significantly. The actual number of cases in health care increased 159 per cent from 549 in the 1974 fiscal year to 1,423 in the 1975 fiscal year. From 1974 to 1976 there was an increase of 213 per cent, equalling 1,721 cases.

In retrospect, the first years following the amendments have been eventful; National Labor Relations Board cases, court decisions, increased organizing activities. Boards of Inquiry recommendations, and professional associations union functions are the most significant developments. Future research will be able to present a longitudinal analyses of these activities and investigate other important areas of health care labor relations such as nursing homes and clinics.

As collective bargaining in health care cycles from the start up phase to an acceptance level, the level of activity will probably shift. The role of the NLRB will be more to determine unfair labor practices rather than organizing questions. The Federal Mediation and Conciliation Service will see a leveling of their caseload, however as new contracts come up for renewal the chances of strikes occurring will probably increase. The parties involved will be more experienced at bargaining and able to better define positions at the bargaining table.

Furthermore, the demand for employee relations expertise in the health care field has grown. Many new publications,

academic courses, and professional development programs address this complex subject.

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CHAPTER I

INTRODUCTION

Health care is a very large industry that has been rapidly growing. Health care expenditures grew from \$39 billion (5.9 per cent of the Gross National Product) in 1965 to \$120 billion (8.3 per cent) in 1975. According to the Bureau of Labor Statistics, in September, 1975 4 million workers were employed in proprietary hospitals and more than 1.5 million in governmental hospitals, such as Veterans Administration, Public Health, State and Local community hospitals. In addition, another 1.8 million were employed by nursing homes and other health related facilities. Hospital employment increased 232 per cent in the past 15 years.

Recent years have produced explosive advancements in medical technology resulting in increased specialization within the medical profession. There is greater use of sophisticated diagnostic and therapeutic equipment requiring well trained personnel. The extensive changes in the working environment have had direct impact on hospital personnel practices.

In earlier years it was assumed that one entered the health care field to fulfill a personal humanitarian need

to care for the ill and the injured. Most care was administered in hospitals supported by churches and charities. Today, the majority of hospital employees are concerned about many matters including salary, hours of work, promotional opportunities, and general working conditions, as well as matters involving patient care. At the same time, the hospital administration is confronted with more than personnel problems; there is increasing federal regulation in the delivery of health care, additional control over financial reimbursement by third party insurance companies, and greater regulation by community governing boards.

Bureau of Labor Statistics data show that of ten major industries, hospitals ranked ninth in average earnings in 1968 and eighth in 1975. The majority of these workers have not enjoyed the wages and job protections of the average laborer in the same city. For example, nurses aides in Atlanta were paid \$1.03 an hour less than the average laborer rate, in Oregon it was a \$1.85 gap and in Denver, \$1.68. The average hourly earnings of nonsupervisory hospital employees in June, 1975 was \$3.71 per hour and the average factory worker earnings were \$4.75 per hour.

Hospital wages rose 99 cents an hour or 36 per cent from February, 1970 to February, 1975 according to the U. S. Department of Labor, while manufacturing wages during the same five year period rose \$1.38 or 42 per cent. In comparison, the cost of living increased 38 per cent and

semiprivate room rates moved up 63 per cent. In addition to the lag in wages, hospital employees fell behind the private industrial worker in the area of benefits.

Hospital personnel first organized into formal unions in 1920 in San Francisco. Organization has taken place in a multitude of hospitals in the past fifty years. In the past five years labor unions have been active in organizing employees in proprietary and federal hospitals.

The National Labor Relations Act has formed the basis for labor relations policy in this country since 1935. In its original form the Wagner Act applied to private non-profit hospitals, but when the Taft-Hartley Amendments in 1947 were passed, Congress specifically exempted private nonprofit hospitals. Control of these hospitals was then left to state jurisdiction. The legislation and labor relations applications were unsystematic and quite varied.

Distressed by the frequency and consequences of recognition strikes in nonprofit hospitals, Congress enacted the 1974 amendments to balance the interests and rights of employers, employees, and the public in order to provide stability and regularity to employment in the health care industry. Furthermore, Congress also believed that the quality of health care would improve as workers in the nation's health care institutions received wage increases through the collective bargaining process.

The amendments explicitly recognize the unique and distinct nature of the health care industry and, in so doing, have charged the NLRB and the courts with the continuing responsibility to protect and enforce the paramount public interest in unhindered access to effective health care. These special features for the health care industry included an increased notification period for contract modifications, a mandated mediation role for the Federal Mediation and Conciliation Service (FMCS), a unique Board of Inquiry (BOI) procedure, and a ten-day advance strike notice. Congress also directed the National Labor Relations Board (NLRB) to avoid the fragmentation of bargaining units; to give special attention and priority to unfair labor practices; and to provide allowance for transfer of patients from a struck or threatened health care institution. In summary, the 1974 amendments to the National Labor Relations Act (NLRA) were designed to establish and facilitate collective bargaining; reduce the opportunity for negotiation impasses, and; most important, recognize and protect the public interest in the continuity of health care.

It is important to examine the effect of this amendment on health care facilities, workers, and the general public. It is also significant to examine the emergence of the labor-management system within the general collective bargaining philosophy of this country and within the uniqueness of the health care environment.

Statement of the Problem and Purpose

Effective August 25, 1974 employees of nonprofit hospitals were given the basic protection of the National Labor Relations Act. This new coverage of over two million workers provides fertile ground for organizational efforts of unions and professional associations. The purpose of this study is to determine the impact of this amendment on labor relations in the health care industry.

Hypotheses

The amendment of the National Labor Relations Act as stated in Public Law No. 93-360, to include health care institutions, will have a significant impact on labor management relations in the health care industry.

Hypothesis I--There will be a substantial increase in the number of election petitions filed with the National Labor Relations Board and a corresponding increase in the number of elections conducted by the National Labor Relations Board in the health care industry.

Hypothesis II--There will be an increase in the number of cases presented to the National Labor Relations Board related to bargaining unit determination; professional health care associations will plea for separate bargaining units.

Hypothesis III--There will be a significant increase in the number of unfair labor practice charges filed with the National Labor Relations Board in the health care industry.

Hypothesis IV--Under the amendment, the Federal Mediation and Conciliation Service is mandated to proffer mediation assistance in the health care field in certain situations. As a result, there will be substantial activity by the Federal Mediation Service in assisting the parties in contract negotiations.

Limitations of the Study

This study is concerned primarily with nonprofit health care institutions recently covered by the National Labor Relations Act.

Data collected include the two years preceding the amendment, 1972-1974, and the two years since the effective date, August 25, 1974. Additional data are included for purposes of discussion, but are not utilized for statistical analysis unless otherwise stated.

Research Methodology

Data were collected from the National Labor Relations Board (NLRB), the Federal Mediation and Conciliation Service, various publications; and interviews with labor union representatives, government officials, and hospital administrators are presented.

Information regarding organizing activities has been obtained from the National Labor Relations Board. The data include the number of petitions filed, number of elections conducted, which unions were involved, and a record of who

won the elections. Analyses were made by region, types of institution, size, and content of bargaining units.

After certification occurs, contract negotiations begin. The legislation has been designed to minimize work stoppages in health care institutions by utilizing special notice requirements and mediation procedures such as the ability to appoint "Boards of Inquiry." An analysis of these special procedures and Boards of Inquiry has been made.

Unfair Labor practice charges and National Labor Relations Board decisions were carefully examined. The value of the cases and the precedence of the decisions form the labor relations framework for health care facilities. All health care cases heard by the National Labor Relations Board members since the date of the amendment to August 26, 1976 were surveyed.

Definition of Terms

Arbitration--A procedure whereby parties unable to agree on a solution to a problem indicate their willingness to be bound by the decision of a third party.

Bargaining Unit--The group of employees held by an authorized governmental labor board (such as the NLRB) to constitute the unit appropriate for bargaining purposes.

Certification--Official designation by a labor board of a labor organization entitled to bargain as exclusive representative of employees in a certain unit.

Collective Bargaining--As defined in Section 8d of
NLRA:

For the purposes of this section, to bargain collectively is the performance of mutual obligation of the employee and the representative of the employees to meet at reasonable times and confer in good faith with respect to wages, hours and other terms and conditions of employment, or the negotiation of an agreement, or any question arising thereunder, and the execution of a written contract incorporating any agreement reached if requested by either party, but such obligation does not compel either party to agree to a proposal or require the making of a concession.

Collective Bargaining Contract--Formal agreement over wages, hours, and conditions of employment entered into between an employer or group of employers and one or more unions representing employees of the employer(s).

Cooling-off Period--Period during which employees are forbidden to strike under laws which require a definite period of notice before a walkout in order to give mediation agencies an opportunity to postpone or settle the dispute.

Fact-finding Boards--A special panel appointed, usually by a government official, to review positions and facts and make recommendations on major issues in labor disputes. Sometimes called Board of Inquiry.

Health Care Institution--As defined by the NLRA, ". . . any hospital, convalescent hospital, health maintenance organization, health clinic, nursing home, extended care facility, or other institution devoted to the care of sick, infirm or aged persons."

Jurisdictional Dispute--Controversy between two unions over the right to organize and represent a given class or group of employees or to have members employed on a certain type of work.

Mediation--Efforts of a third party to adjust the differences between employer and employees through interpretation, suggestion and advice, short of dictating provisions. In the Federal government, the Federal Mediation and Conciliation Service has this duty to assist parties to labor disputes.

Organizational Picketing--Picketing of an employer in an attempt to induce the employees to join the union.

Proprietary Hospitals--Privately owned hospitals operated for a profit and not included in the nonprofit category due to ownership, source of funds, and profit goal.

Right-to-Work--A term used to describe laws which ban union security agreements by forbidding contracts making employment conditional on membership or nonmembership in labor organizations.

Unfair Labor Practice--Actions of employers or unions that are prohibited as unfair labor practices under the federal or state labor relations statutes.

Voluntary Hospitals--Hospitals whose ownership and source of funds are nonprofit oriented and who prior to the Taft-Hartley amendment could be organized only by voluntary

agreement of the hospital, unless stated otherwise in a state statute.

Outline of the Study

The research is presented in the following order.

Chapter One--Introduction

This chapter presents the research problem and methodology.

Chapter Two--Legislative Labor History

The historical legal framework of collective bargaining leading to the health care amendments is presented.

Chapter Three--NLRB Jurisdiction and Bargaining Unit Determinations

The National Labor Relations Board's decisions regarding the establishment of jurisdictional standards, precedent-setting bargaining unit cases, and subsequent decisions are analyzed.

Chapter Five--Professional Associations

The increased growth of professional associations in health care and their roles in collective bargaining are presented in this chapter.

Chapter Six--Federal Mediation and Conciliation Service

This chapter studies the role of the Service in relation to the Act's special time constraints, mediation mandate,

and Boards of Inquiry provisions designed to facilitate collective bargaining.

Chapter Seven--Unfair Labor Practices

Analyses of the number and types of unfair labor practice cases and National Labor Relations Board decisions are included in this chapter.

Chapter Eight--Contract Negotiations

The number of contract negotiations, the important issues, effects of third party involvement, and mechanisms for impasse resolution are discussed.

Chapter Nine--Summary and Conclusions

A summary and conclusion of the effect the Taft-Hartley Amendment has had on collective bargaining in nonprofit health care institutions.

CHAPTER II

THE LEGISLATIVE LABOR HISTORY FOR HEALTH CARE INSTITUTIONS

The legislative history of labor relations in health care institutions has unique characteristics. To understand the impact of Public Law 93-360, amendment to the National Labor Relations Act, this legislative history must be explored.

The Wagner Act and Health Care Institutions

Before 1935, there was nothing at the federal level pertaining to labor management relations in health care. The Wagner Act (National Labor Relations Act) was enacted in 1935, and that law initially did not provide any exemptions for charitable, religious or educational institutions. Congressional jurisdiction in the Wagner Act was based on the impact of strikes on interstate commerce rather than the profit-nonprofit aspect.

The particular status of charitable hospitals under the Act was first considered when two unions filed petitions to represent employees of Central Dispensary and Emergency Hospital, Washington, D. C. (3). The hospital argued before the NLRB that it should be excluded from the coverage of the

Act because: (1) Hospitals were not engaged in "trade, traffic, or commerce" as defined in the legislation; (2) They were non-profit and the law was designed to cover only profit making enterprises; and (3) Hospital activities were semi-public in nature, and thus, the activity should be treated as a direct arm of the government (which was excluded from jurisdiction) (3). The Board indicated that the hospital was engaged in interstate commerce and that the specific intent of the Act did not hinge upon the financial motives of the organization.

Later, a federal court on appeal upheld the Board decision by stating:

. . . the hospital argues that the spirit or policy of the Act is such that we should read into it an exemption of charitable hospitals . . . we cannot understand what considerations of public policy deprive hospital employees of the privilege granted to employees of other institutions. The opinions . . . holding that charitable hospitals and their non-professional employees are subject to the labor relations acts of those states presenting what seems to us the only tenable view as to the spirit and policy of such statutes (4).

Not all courts followed this decision. Several courts felt that hospitals should be excluded according to the following reasons: (1) Society of New York Hospital vs. Hanson (26) indicated the hospital warranted exclusion due to the nature of the service; (2) Jewish Hospital of Brooklyn vs. "John Doe" (14) utilized the nonprofit criteria; (3) The semipublic status was emphasized in Western Pennsylvania vs. Lichliter (31); and (4) An assumption that a charitable

organization would deal fairly with employees was the basis for the Columbia University vs. Herzog decision (28).

Taking these reasons in turn, Pointer (24, p. 73) argued that the right to organize and bargain collectively has been extended to nonexempt employees, as well as firemen, policemen and public school teachers. He asked if their services are any less critical than those performed by voluntary hospitals. Regarding the nonprofit status, he stated that nonprofit hospitals enter into relationships with many firms whose activities are commercial in every sense. Such transactions do not lose their commercial character even though the hospital has an objective other than profit.

In the third argument related to the semipublic function, Pointer argued that employees of voluntary hospitals are provided with no benefits in the quasi governmental argument that would "subsidize" their exclusion such as guaranteed tenure, grievance appeal panels, or other common civil service security provisions (24, p. 73).

Charitable hospitals argued that as charitable institutions, they would treat employees equitably as a matter of course. This is, of course, a very broad assumption. Burlivy, et al. (2, p. 162) and Coser (6, p. 231) showed hospital workers as underpaid, overworked and treated unfairly as a rule, rather than an exception. Hepner, et al. (13) observed that hospital personnel practices are generally archaic and that employees must suffer the consequences. Available data

show fringe benefits and rates of pay are lower in the hospital industry than in other sectors of the economy.

Taft-Hartley and Health Care Institutions

Senator Millard Tydings made a dramatic plea on the floor of the Senate to exempt charitable hospitals from collective bargaining during the debates on the Taft-Hartley Amendments in May, 1947. He introduced an amendment to exempt nonprofit hospitals from coverage of the Act and this exclusion emerged in the form of Section 2 (2) of the Act which stated that the legislation should not include within its jurisdiction, ". . . the United States or any wholly owned government corporation . . . , or any state or political subdivision thereof, or any corporation or association operating a hospital, if no part of the net earnings inures to the benefit of any private shareholder or individual. . . ." (8).

A brief discussion between Senator Glenn Taylor of Idaho and Senator Tydings illustrates the rationale behind the amendment. Senator Taylor inquired if the amendment would bar the nurses from organizing.

Mr. Tydings. They should not have to come to the National Labor Relations Board as in the case of ordinary business concerns. They are not in interstate commerce. A hospital is a local institution, quite often kept up by the donation of benevolent persons. I hope the Senate will let the amendment go to conference. Employees

of such a hospital should not have to come to the National Labor Relations Board. A charitable institution is way beyond the scope of labor-management relations in which a profit is involved. No profit is involved in this work.

Mr. Taylor. That may be true, but nevertheless, I have in mind that nursing is one of the most poorly paid professions in America; outside the profession of school teaching, it is perhaps the poorest paid, in proportion to the service rendered to humanity. I do not want to place the nursing profession under any handicap in their efforts to obtain an improved standard of living.

Mr. Tydings. I do not think the amendment will affect them in the slightest way as to salaries. I will say to the Senator, they can still protest, they can still walk out. The only thing it does is lift them out of commercial channels of labor-management where a profit is involved. The most of these institutions are maintained by the benevolence of thousands of people who contribute to the community if they are not brought in under the strict scope of labor-management commercial relations where profit is involved.

Mr. Taylor. I understand the Senator. These may not be profit-making institutions, but even so, I feel that, simply because an institution, even one like the Red Cross, is kept up by popular subscription, the professional workers, even employees of the Red Cross, should be permitted a decent living and should not be hamstrung in their efforts to obtain it.

Mr. Tydings. I agree with the Senator.

Mr. Taylor. With that assurance, I shall not oppose it (8).

The implications of the exemption of voluntary nonprofit hospitals from provisions of the Act were clear. Voluntary hospitals had no obligation to recognize or bargain collectively

with employees. Unfair labor practices prohibited in the industrial private sector could occur without penalty in the health care area.

Federal, state, and municipal hospitals were specifically excluded. Proprietary (for profit) hospitals and nursing homes faced uncertain status that would have to be determined by the courts.

Originally, in 1960, the National Labor Relations Board ruled that a 111 bed proprietary hospital located in Flatbush, New York, was not large enough to substantially affect interstate commerce (12). The Board seemed to feel the states would extend control over these labor relations activities.

Seven years later, on November 20, 1967, this doctrine was reversed by the National Labor Relations Board. Two cases were determined: A California hospital; Medical Center Hospital and the Building Service Employees' International Union, AFL-CIO (22), also, a Wheaton, Maryland nursing home; University Nursing Home and the American Federation of State, County, and Municipal Employees AFL-CIO, Local 1 (29).

The Board stated the expected state regulations had not emerged as anticipated; there were too many institutions, and it would be too great an impact on public welfare for them to go unregulated. Guidelines were established for the effect on interstate commerce--dollar standards of \$250,000 gross annual revenue and \$100,000 gross annual revenue were

established for proprietary hospitals and nursing homes, respectively.

The Board stated in the Medical Center case:

. . . the interest of orderly, effective, and uniform administration of our national policy requires the assertion of jurisdiction over proprietary hospitals even in those few states which have legislated labor relations procedures and remedies in this industry (22, p. 52).

Thus, proprietary hospitals, nursing homes and homes for the aged were brought under the Act.

Executive Order 10988 and Health Care Institutions

In 1962, federal governmental hospitals faced control of labor relations activities beginning with Executive Order 10988, issued by President Kennedy on January 17.

This order provided the initial structure for collective action in the federal sector. Federal hospitals such as Veteran's Administration hospitals were included in that order which established mechanisms to ascertain employee wishes regarding representation by providing unit determination and election procedures and provisions to regulate certain unfair labor practices (30). By 1969, 128 government hospitals had granted exclusive recognition to employee organizations in their institutions (19, p. 186).

On October 29, 1969, President Nixon issued Executive Order 11491. This superseded the Executive Order 10988 and brought federal employee relations closer in similarity with

Taft-Hartley provisions. Federal employees were still denied the right to strike, but procedures for settling impasses were established.

State Legislation and Health Care Institutions

At the state level, two groups of hospitals must be examined. First, the nonprofit hospitals and secondly, governmental hospitals--state, county and municipal.

Prior to the 1974 Taft-Hartley amendment, control of the nonprofit hospitals was left largely to state jurisdiction. The legislation and coverage was unsystematic and quite varied. Fifteen states gave nonprofit hospital employees the right to bargain collectively by either specific legislation or court interpretation. These state procedures have been preempted by the federal legislation, but it is useful to examine the provisions of the states in order to see the variety of legislation that existed and the degree of organization in the different states.

The basic difference in the state labor relations laws centered around impasse procedures. New York, Massachusetts, Minnesota, Wisconsin, and Connecticut denied hospital employees the right to strike and hospitals were prohibited from exercising a lockout. Unresolved disputes were to be submitted to binding arbitration.

The Minnesota Law (The Charitable Hospitals Act of 1974) had considerable impact in hospital labor relations.

It extended the benefits of the state labor law to the hospital field, but specifically legislated the strike out of existence and substituted compulsory arbitration as the mechanism for resolving disputes. The statute also exempted hospitals from coverage under the state's anti-injunction law (19, p. 186).

Michigan Law, from 1939, more nearly resembled the new federal amendment. It did not outlaw work stoppages, but did provide for a "cooling-off" period for continued mediation and fact finding with recommendations. Strikes could not occur until ten days after the report was submitted to the Governor.

Oregon had an interesting division pertaining to non-profit hospital employees; one law for registered nurses and licensed practical nurses and another for all other employees. All employees except nurses could engage in work stoppages; the parties could request mediation or fact finding.

In Pennsylvania, there was a partial no strike provision. Oregon and New Mexico had provisions restricting strikes if there was not another hospital within 150 miles (24, p. 72).

Some states had labor laws exempting health care institutions, some had varied coverage, and others had no labor law at all.

The Montana Law covered only nurses and the administration of the law is by the State Board of Health, not the State Labor Department. Also, the law was term legislation with expiration

dates. New Jersey used the courts to regulate hospital labor relations. In the case of Johnson vs. Christ Hospital, the courts held that the New Jersey constitution was to be interpreted as providing representation rights for employees of voluntary hospitals. In disputes over recognition, a court order could call for an election (19, p. 190).

Many states were silent on the subject of hospital labor relations. Some took the stance that where there is a comprehensive labor relations statute, the silence could be for exclusion or inclusion. North Dakota, Utah, Rhode Island, Vermont, and West Virginia specifically excluded charitable hospitals from coverage in their statutes. Pennsylvania and Colorado excluded hospitals from coverage by court decisions.

All of these laws for nonprofit hospitals have been preempted or displaced by the enactment of the federal amendments, if such institutions meet jurisdictional standards.

Some of the arguments against letting the situation related to nonprofit hospitals remain the same, within state regulations, were eloquently expressed by Dr. Pointer, at that time, Assistant Director of the Division of Teaching Hospitals, Association of American Medical Colleges, Washington, D. C.

Dr. Pointer felt two observations were important: First, a consideration that hospitals were no longer local enterprises, but parts of large multiregional health care

delivery networks and therefore, should be regulated as large complex interstate institutions. Second, many state labor laws were outdated, having been modeled after federal legislation that has been revised. Labor statutes contained unfair labor practices for management only, fragmented bargaining units that have not followed NLRB guidelines, and closed shop provisions (24, p. 75).

State, county and municipal hospitals remain uncovered by federal legislation. Many states have regulations and legislation for public employees and many provide coverage for health care employees. Currently, some thirty-seven states protect some segment of the public work force. For the most part, these laws supplant the right to strike with other means such as compulsory and binding arbitration, or fact finding. These laws, however, may only cover certain segments of the public employees and health care workers remain excluded (1).

University Affiliated Hospitals

Another category of hospitals is the university affiliated hospital. Universities were never exempted from the Act, but until 1960, the National Labor Relations Board did not exercise its jurisdiction. When the Board decided to accept coverage, the medical center at a university affiliated hospital was still considered exempt as long as it was separately managed (11, p. 10). In Loyola University Medical

Center and Local 134, I.B.E.W. (20), the Board ruled that the part of the university that is a nonprofit hospital is exempt and therefore, the union could not force the university or the hospital to recognize it as the bargaining agent for seven hospital electrical maintenance workers.

Also, in Duke University and AFSCME (9), the Board ruled a large hospital, 200 miles from campus, was still a nonprofit hospital and therefore, exempt. This case involved two unions. One wanted to represent service employees at the university; the other insisted upon representing both the university and its hospital employees. The ruling indicated the hospital was off limits for representation.

Presently, these university affiliated medical centers are included under the Taft-Hartley amendments as long as they are affiliated with private universities, i.e., Duke University, Temple University, or Baylor University. Those associated with state schools such as the University of Texas Medical Center are still exempt.

"Red Cross" Shifts to "Blue Cross": Charity
Hospitals are Business Institutions

What events and changes in philosophy occurred from 1947 to 1974, from the exemption of hospitals under the Taft-Hartley to the inclusion of health care institutions in the recent amendments? The inclusion by the NLRB of proprietary hospitals placed them under the Act; Executive Order 11491

gave federal employees bargaining rights, and various states had a multitude of approaches. However, the situation of the nonprofit hospital was far from stable and the evolutionary process included many changes.

Nonprofit institutions started originally as charitable institutions, supported by charity as the major source of revenue and often rendering services without charge. Hospitals were administered by volunteer groups and religious orders. Philanthropists (whose main duties were to give gifts and bequests) formed ornamental boards of trustees. By today, there have been significant changes: for example, the source of revenue has shifted. Now, private payers, quasi private payers such as Blue Cross, and governmental payers such as Medicare and Medicaid, currently form the sources of revenue as compared to gifts and bequests of earlier years (11, p. 10).

McCormick (21, p. 2607) stated many hospitals offered their nonprofit status as a justification for paying sub-standard salaries and wages. He feels hospitals expect their employees to subsidize patients by the acceptance of relatively low levels of remuneration. An important point is that other nonprofit organizations including educational, symphonies, theaters, civic agencies, and governments are able to fulfill obligations to clients and employees. Also, McCormick points out the significant fact that "nonprofit status" does not prevent some hospitals from earning a "surplus." Nonprofit means they are not organized for the

purpose of realizing a profit; but a profit or surplus can and often does exist. A 1966 study cited more than one-half of the hospitals surveyed expected to finance fifty percent of their expansion from the surplus of operating revenues over operating expenditures (23, p. 9).

Also, during the past decade, nonprofit hospitals were included in a variety of federal laws such as the Fair Labor Standards Act, Equal Employment Opportunity Act, and Employment Security Amendments.

The Health Care Labor Force

There have been considerable changes in the composition and direction of the work force in health care institutions. This added additional emphasis to change the structure of the law. Minority groups hold many service and maintenance positions in hospitals. They have become more militant, more involved, and have stated, "We have to equalize our relationships and collective bargaining is one method" (5, p. 21).

Unions are in business to organize and organize successfully. Viewing a million-and-a-half unorganized health care workers as fertile ground, and seeing the health care industry emerging as the largest single employer, unions hope to increase their percentage of labor force organization.

The above discussion reflects some of the changes that led to the shifts in legislative thinking.

The Taft-Hartley Amendment and Health
care Institutions

The Ninety-Second Congress

The first bill related to hospital labor law that merited serious attention was introduced by Representative Frank Thompson, Democrat, New Jersey, on October 21, 1971. HR 11357 proposed, " . . . to restore to the employees of nonprofit hospitals the rights guaranteed to almost all other employees by Section 7 of the National Labor Relations Act" (27). The bill proposed to strike Section 2 (2) which had excluded voluntary nonprofit hospitals from the coverage of the Act.

The bill was referred to the full Committee on Education and Labor and in turn, to its subcommittee on Labor which was chaired by Thompson. Hearings were held November 9, 10, and 16, 1971, and January 18, 1972, in Washington, D. C. Hearings were also held on December 10, 1971, in Los Angeles and in San Francisco on December 13. Representatives of the Nixon Administration testified in support of the bill.

James Hodgson, Secretary of Labor, stated in a letter:

In many instances, lack of ground rules for union recognition and collective bargaining in this sector has resulted in uncontrolled tests of strength in which the public as well as the parties suffer heavily. These issues will continue to arise probably with increasing frequency. It is far better that they should be resolved through the orderly procedures of the National Labor Relations Act than through bitter and wasteful confrontation (7).

HR 11357 was reported to the full House Committee on Education and Labor on June 8, 1972, without amendment. The hospital industry believed that there was little chance of the bill's being considered, let alone passed, by the House. The House Rules Committee bypassed the bill and sent it directly to the floor. The bill passed the full House on August 7, 1972, by an overwhelming vote of 295 to 85.

The bill then went to the Senate Committee on Labor and Public Welfare, whose chairman, Harrison Williams, Jr. (D-New Jersey), was very much in favor of the bill's passage. The original plan was to send the bill directly to the floor and avoid committee hearings, but the American Hospital Association's Washington Service Bureau and Allied Hospital Associations were able to obtain a hearing.

At this hearing, which was held August 16, 1972, American Hospital Association representatives testified against the bill. The Association emphasized deficiencies in the areas of (1) strikes, picketing and impasse resolution, and (2) bargaining unit determination (10, p. 69).

The hearing was intended to be a mere formality but Senator Robert Taft (R-Ohio) intervened and a second hearing was scheduled on September 6, 1972. At this hearing, a number of state hospital associations including those from California, Iowa, Missouri, Ohio, and Texas testified in opposition to the bill for a variety of reasons, and some proposed legislative changes. Proposals were advanced

relating to strike alternatives; for example, compulsory arbitration.

Support for the bill began to evaporate and active consideration of HR 11357 seemed to have stopped with the Senate hearing. This appeared to be due to Senator Taft's efforts and a concern by organized labor regarding opening the NLRA for future amendments.

The Ninety-Third Congress

In 1973, seven separate bills incorporating five major proposals were introduced. These were HR 1236/S 794, sponsored by Representative Frank Thompson (R-Ohio) in the House and introduced by senators Alan Cranston (D-California) and Jacob Javits (R-New York) in the Senate; Senator Taft and Representative Young introduced S 2292/HR 10296, respectively; and Representative John Erlenborn (R-Illinois) introduced HR 10086. Two other bills, HR 9730, introduced by Representative Thompson and HR 8677, introduced by Representative Perkins, added to the array of legislative proposals. These bills will be discussed briefly so the evolution of the present legislation can be traced.

HR 1236/S 794.--This bill was identical to HR 11357, introduced by Thompson to the Ninety-Second Congress which had passed the House overwhelmingly. The measure basically proposed dropping the clause from Section 2 (2) of the

Taft-Hartley exempting voluntary nonprofit hospitals. The House held hearings on April 12 and 19, 1973. Organized Labor, especially the Service Employees International Union, worked hard to organize hearings and communicate strong labor support. The hospital associations, in strong opposition, submitted amendments making special provisions for health care facilities. The Senate held hearings on July 31, August 1, and August 2, 1973, on the Senate version, S 794. Similar to the House bill, it proposed to strike the exemption from the Act.

S 2292/HR 10296.--On the first day of the Senate hearings on S 794, Senator Taft introduced S 2292, which included all the amendments proposed by the American Hospital Association in House hearings on HR 1236. Basically, the provisions of the bill included:

1. Elimination of the exemption of nonprofit voluntary hospitals in the Act.
2. Included all "health care" facilities in a broad definition.
3. Provided impasse resolution procedure with ninety-day notices of contract termination and mandatory thirty-day notice to FMCS. Also included was a sixty-day "cooling-off" period.
4. A thirty-day strike notice which could not be instigated except through secret ballot supervised by the Federal Mediation and Conciliation Service.

5. A provision that if these procedures were not followed, it would be an unfair labor practice.

6. An allowance for no more than four bargaining units: professional, technical, clerical, and service maintenance workers.

7. A provision for priority handling by the NLRB for situations involving pickets, strikes, or lockouts and allow injunctive relief for preventing a strike or picket (7).

Also, during the course of the hearings, the Nixon Administration shifted its position. Mr. Robert E. Schubert, under Secretary of Labor, indicated the change in stance by saying, "This Department supported legislation identical to S 794 last year, and we support the concept of S 794 this year. . . . We favor the concept of extending the proven benefits of NLRA to nonprofit hospitals. We also favor some limited safeguards to protect the public" (7).

The companion bill, HR 10296, was introduced in the House by Representative Samuel Young (R-Illinois).

HR 10086.--Representative John Erlenborn's (R-Illinois) bill was very similar to the Taft-Young bill (7), yet differed in the following ways:

1. Did not limit the number of composition of the bargaining units.

2. Eliminated the right to sue for damages as a result of a strike.

3. Included a provision that exempted individuals with certain religious convictions from the requirements of union membership or financial support of a union.

HR 9730.--This interesting bill was also introduced by Representative Thompson. This bill would have eliminated the clause of Section 2 (2) of the Taft-Hartley that dealt with government subdivisions, thereby making nonfederal employees in the public section subject to the provisions of the Act. If this bill and HR 1236 were passed, then hospital employees in all areas except the federal sector would have been covered.

HR 8677.--This bill also sought to cover nonfederal public employees. It did not intend to be an amendment to the NLRA, but rather sought to establish an entirely new law entitled National Public Employment Relations Act (NPERA). The law would cover states and governmental subdivisions and would extend its jurisdiction over state, county, district, and municipal hospitals. The law had provisions similar to the Taft-Hartley, but provided a commission with functions similar to the NLRB and additional impasse procedures.

The Compromise Bill.--Through the efforts of Senator Robert Taft, his staff, members of the Senate Labor Subcommittee, representatives of SEIU, Laborers International, officials of AFL-CIO, and hospital associations representatives, a compromise was reached.

HR 1236/S 794 ("blanket inclusion") and S 2292/HR 10296 ("safeguard measure") were combined to form a compromise package. S 3088 was introduced by Senator Taft on February 28, 1974, and HR 13678 was introduced by Frank Thompson and John Ashbrook in the House. All nonprofit, private hospitals would be included with special provisions for health care facilities in order to provide continuity of patient care.

The Senate Committee on Labor and Welfare, after extensive review of S 3088, discharged the Labor Subcommittee from considering the two previous bills, S 794 and S 2292, and introduced and ordered to the floor, S 3203. This bill was identical to S 3088, but introduction under a different file number permitted the entire committee to act as co-sponsors.

During the Senate debates, held May 2 and 7, 1974, seven amendments were proposed. Six of these were virtually defeated. These six included: (1) an amendment by Seventh Day Adventist Church to exempt church operated hospitals, which was defeated 50 to 36; (2) a sixty-day cooling-off period was defeated 49 to 37; (3) an amendment introduced by Senator John Tower giving the courts rather than the NLRB jurisdiction over unfair labor practices was tabled; and (4) three other amendments which were also tabled. The Senate did accept an amendment to delay the effective day of the bill for thirty days after the enactment (24).

On May 7, 1974, the Senate passed S3203 with a vote of 63 to 25. This version, except for the delay in effective date, was identical to what the Senate and House committees had forwarded.

The House Committee on Education and Labor had reported HR 13678 to the floor on May 14, 1974, and it was subject to floor debate May 30, 1974.

The American Hospital Association urgently campaigned for an emergency disputes amendment by contacting state affiliates and having them telegraph congressional representatives. The campaign proved successful and a sixty-day cooling-off period amendment was passed, but would be selectively applied and a Board of Inquiry would be appointed.

Another amendment was introduced but less successfully. Representative Quie (R-Minnesota) attempted an amendment to allow the NLRB to cede jurisdiction to certain state laws.

Representative Erlenborn's amendment desired an exemption for those individuals having bona fide religious objections to belonging to a labor organization. This passed and was a surprise, since a similar position had failed in the Senate.

With the amendments, HR 13678 passed the House May 30, 1974. A joint committee comprised of thirteen Senate and seven House members was formed to adjudicate the differences in S 3203 and HR 13678 (24).

The day after the House passed HR 13678 George Hardy, President of the Service Employees International Union, said

that the provision for a sixty-day "cooling-off" period that was added to the bill on the House floor made the legislation unacceptable to labor.

In a statement, Hardy said:

Our half-million member union, with 200,000 of these workers in the health care industry, supports bargaining for employees of nonprofit hospitals. A Senate bill passed early in May fills the needs of these workers, and the House bill, before it was amended, did the same. But, with this 'cooling off' period inserted by House conservatives at the last minute, the House bill is unacceptable, and we will not support it (15).

Representative Frank Thompson substituted a thirty-day cooling-off period rather than the sixty-days. Also received favorably was the religious exemption with the additional proviso which required excluded workers to pay equivalent sums to nonreligious charitable organizations.

Representative Thompson, who managed the bill on the floor as Chairman of the Special Subcommittee on Labor, from which it emerged, also said the legislation should bring stability to the hospital industry by reducing recognition strikes and the "incredible turnover in hospital employees" (16).

The version of the bill resulting from the conference committee was reported to the House and Senate. The Senate overwhelmingly approved the bill on July 10, 1974, by a vote of 64 to 29. The House vote was very close, 205 to 193, but the bill passed on July 11, 1974. The bill placed

an estimated 7,000 nonprofit hospitals and other health care institutions under provisions of the Taft-Hartley Act (17).

President Nixon signed S 3203 into law on Friday, July 26, 1974, and due to the thirty-day extension, the Taft-Hartley amendments became effective August 25, 1974. No Presidential statement accompanied the action (18).

Service Employees' President George Hardy stated the new law brings "first class citizenship and protection to these workers."

The SEIU president remarked:

Although strikes will still be able to legally take place, the bill's machinery reduces their probability. Workers don't like to strike any more than employers like being struck. Thanks to the climate and machinery created by this bill, we are able to look forward to improved relations in the health care industry.

America's hospital workers are the true 'working poor,' more often than not earning the bare federal minimum wage, and receiving no benefits whatever. Now, with this law, previously unrepresented workers will have the federally-guaranteed chance to seek union representation and pull themselves into the mainstream of this nation's economic life (18).

As discussed in detail in the following chapters, the law set up unique procedures for handling labor disputes in health care institutions. Special notice and conciliation procedures were included to facilitate settlements without work stoppages. These amendments apply to all private hospitals--proprietary and nonprofit--and to all other

health care institutions defined as including health maintenance organizations, clinics, nursing homes, extended care facilities or other institutions devoted to the care of the sick, aged or the infirm. Federal, state, and municipal hospitals are exempt, as are administrative employees in the health care field.

In summary, Public Law 93-360 passed by the 93rd Congress on July 26, 1974, became effective August 25, 1974. This amendment to the National Labor Relations Act provides coverage to health care institutions defined as any "hospital, convalescent hospital, health maintenance organization, health clinic, nursing homes, extended care facility, or other institution devoted to the care of sick, infirm or aged person. . . ."

In order to provide continuity of health care there is a ninety day notice requirement by the employer or labor organization for contract renewals or modifications (instead of a sixty day notice for other industries covered by the National Labor Relations Act). The Federal Mediation and Conciliation Service must be notified sixty days prior to termination or expiration of an existing contract (in contrast to thirty days for other industries). In addition, on initial contract negotiations, once a labor organization has achieved recognition, a thirty day notice to the mediation service is required. (No such provision exists for other industries).

At the direction of the Federal Mediation and Conciliation Service, the health care institution and the labor organization will be required to participate in the mediation process on both renewal and initial contract negotiations. Prior to the expiration of the notification periods on renewal and initial contracts, and at the discretion of the director of the Federal Mediation and Conciliation Service, an impartial Board of Inquiry could be established to investigate a labor/management dispute and to make a written report of its findings.

Another significant notice provision is that a written notice must be given by the labor organization to the health care institution and to the Mediation Service ten days prior to engaging in any picketing, strike, or other concerted refusal to work. (There are no strike or picketing notice provisions in the NLRA for other industries).

Another provision especially for a health care institution is that an employee who is a member of a bona fide religion, body, or sect which historically has held conscientious objections to participation or support of labor organizations will not be required to join or financially support such organizations as a condition of employment.

There are several provisions in the Senate Committee reports that reflect the intent of Congress in several key areas. A caution to avoid fragmentation of bargaining

units and establishment of special priority attention and handling by the National Labor Relations Board of cases involving an unfair labor practice at a health care institution is expressed. There is also to be an allowance for transfer of patients from a struck or threatened health care institution to another institution and other limited assistance without jeopardy of secondary strikes or boycotts against the assisting institution.

The law was heralded by many, hated by several, and feared by more. Critical areas of decision loomed ahead, but very importantly, the direction and belief in the free collective bargaining system was once more affirmed.

CHAPTER BIBLIOGRAPHY

1. Advisory Committee on Intergovernment Relations, Labor Management Policies for State and Local Government, Washington, D. C., 1976.
2. Burlivy, Temple, et al., The Give and Take in Hospitals: A Study of Human Organization in Hospitals, New York, G. P. Putnam and Sons, 1956.
3. Central Dispensary and Emergency Hospital, 44 NLRB 533 (1942).
4. Central Dispensary and Emergency Hospital vs. NLRB, 145 F 2d 852 (D. C. Cir., 1944). Appealed, 342 U. S. 847, 65 Supreme Court 684 (1945).
5. Christopher, W., "Hospitals and Unions Come to Grips," Hospital Topics, (May, 1974), 21.
6. Coser, Rose, "Alienation of the Social Structure: A Case Analysis of a Hospital," The Hospital in Modern Society, MacMillan, 1963, 231-265.
7. Coverage of Nonprofit Hospitals Under National Labor Relations Act, 1973. Hearings before the Subcommittee on Labor of the Committee on Labor and Public Welfare, United States Senate, Washington, D. C., 425-432.
8. 93rd Daily Congressional Index, May 12, 1947, 5129-5130.
9. Duke University and American Federation of State, County and Municipal Employees, AFL-CIO, 194 NLRB 31 (1971).
10. Emanuel, William I., "Nonprofit Hospitals and the NLRA Exemption," Hospital Progress, (January, 1973), 69.
11. Epstein, Richard L., "Labor Relations in Hospitals and Health Care Facilities Before the National Labor Relations Act Amendments: Proprietary versus Nonprofit Hospitals," Proceedings: Labor Relations in Hospitals and Health Care Facilities, Bureau of National Affairs, 10.
12. Flatbush General Hospital, 126 NLRB 145 (1960).

13. Hepner, James O., et al., Personnel Administration and Labor Relations in Health Care Facilities, St. Louis, Mosby, 1969.
14. Jewish Hospital of Brooklyn vs. "John Doe," 252 App. Den. 581, 300 N. Y. Supp. 1111, 1 LC, paragraph 18058 (N. Y., 1937).
15. 86 Labor Relations Reporter 106, 6-10-74.
16. 86 Labor Relations Reporter 107, 6-10-74.
17. 86 Labor Relations Reporter 221, Vol. 86, No. 23, 7-22-74.
18. 86 Labor Relations Reporter 307, 8-5-74.
19. "The Legal Setting," Hospitals, 186-190.
20. Loyola University Medical Center and Local 134, I.B.E.W., 194 NLRB 30 (1971).
21. McCormick, William, Jr., "Labor Relations in Hospitals," American Journal of Nursing, Vol. 70, No. 12 (December, 1970), 2607.
22. Medical Center Hospital, 168 NLRB 52.
23. "The Plight of Nonprofit Hospital Employees," The Laborer (November, 1973), 9.
24. Pointer, Dennis Dale, "Hospital Labor Relations Legislation: An Examination and Critique of Public Policy," Hospital Progress (January, 1973), 72-75.
25. Rice, R. Q., "Analysis of the Hospital as an Economic Organism," Modern Hospital (April, 1966).
26. Society of New York Hospital vs. Hanson, 185 Misc. 937, 59 N.Y.S.S. 2d 91, 10 LC, paragraph 62965 (Sct. N. Y. Co., 1945).
27. Remarks by Representative Thompson before 92nd Congress, October 21, 1971, HR 11357.
28. Trustees of Columbia University vs. Herzog, 269 App. Den. 24, 9 LC, paragraph 60942 (1941).
29. University Nursing Homes, Inc., 168 NLRB 263 (1967).

30. Vosloo, William B., Collective Bargaining in the United States Federal Civil Service, Chicago, Public Personnel Association, 1961.
31. Western Pennsylvania vs. Lichliter, 340 Pa. 382, 11 A 2d 206, 3 LC, paragraph 60942 (1941).

CHAPTER III

NATIONAL LABOR RELATION BOARD: HEALTH CARE

JURISDICTION AND BARGAINING

UNIT DETERMINATIONS

The rights of employees under the National Labor Relations Act are not self-enforcing. Congress established the National Labor Relations Board to ensure that employees could exercise their rights, and to protect the parties from unfair labor practices. The NLRB consists of the Board itself (composed of five members), the General Counsel, and the NLRB regional offices.

The Board has two main functions: to conduct representation elections and certify the results, and to prevent employers and unions from engaging in unfair labor practices. In both functions the processes are begun only when requested in writing. The Regional office handles these requests, called "petitions" for election requests and "charges" for unfair labor practices.

The NLRB can direct elections, certify the results, and act to prevent unfair labor practices only in cases that "affect commerce." In reality this can extend to all but the most local businesses. However, the Board does not act in all cases affecting commerce. The requirements for exercising

the Board's power or jurisdiction are called "Jurisdictional Standards."

Jurisdictional Standards

Historical Background

The National Labor Relations Board involvement with the health care industry did not begin on the effective date of the health care amendments. Congress was well aware of this when passing that legislation. Certain jurisdictional questions arose before the amendments and some have occurred since. The immediacy and directness of the effect upon interstate commerce of the activity in question is utilized by the Board as a test of its jurisdiction (21, p. 238). Therefore, the Board can balance various factors in determining jurisdiction over nonprofit entities.

In the case of NLRB vs. Central Dispensary and Emergency Hospital (1942) (10), the Board asserted jurisdiction over a proprietary hospital. However in 1947 when Congress amended the National Labor Relations Act, the term employers was also amended so as not to include ". . . any corporation or association operating a hospital, if no part of a net earnings enures to the benefit of any private shareholder or individual" (21, p. 239).

Even with this exemption, jurisdiction was established over hospitals which were an integral part of an establishment whose nonhospital operations otherwise met applicable

jurisdictional standards (24). Also, hospitals that were established to treat on-the-job injuries and were owned and operated by a nonhealth care employer (31) and hospitals whose operations affected national defense (25) were covered.

Labor unrest grew and the states were not rapidly extending labor relations protection to the hospitals. The Board concluded in 1967 that proprietary hospitals, nursing homes, and related facilities should be under its jurisdiction. Jurisdiction was extended to proprietary hospitals whose annual gross revenues exceeded \$250,000 in the Butte Medical Properties Case (8). Profit oriented nursing homes were covered by the University Nursing Home, Inc. decision to include nursing homes with an annual gross income of \$100,000 or more (59). In 1970 the Board extended its jurisdiction to cover nonprofit nursing homes in Drexel Home, Inc. (18). The nonprofit hospitals were the major facilities remaining exempt from Board jurisdiction.

Health Care Amendments

Senator Taft stated: "In summary the time has come to place private nonprofit hospitals under the salutary provisions of the National Labor Relations Act. Labor relations legislation to meet the needs of this industry must apply evenly to all private health care institutions (15)."

The amendments were passed and became effective August 25, 1974. The amendments define a health care institution as any

. . . hospital, convalescent hospital, health maintenance organization, health clinic, nursing home, extended care facility, or other institution devoted to the care of the sick, infirm, or aged person (37).

There is a distinction between patient care facilities and those services which are purely administrative health connected facilities. The statutory definition is considerably broad and has potential for administrative or judicial expansion (21, p. 237).

Current Jurisdictional Monetary Standards

The Board is empowered to exercise jurisdiction over employers engaged in interstate commerce but it may decline to do so if it feels that the effect is so minimal not to justify government expenditures (21).

The Board generally establishes standards based on the dollar volume of the employer's annual gross revenues. The Board does not regard these as absolute and may modify these limits when it wishes to broaden jurisdiction (21). The Board has also declined jurisdiction over industries whose operations are deemed "local" in character.

Senator Taft expressed the hope the Board would continue the current standards but also thought higher standards would be appropriate due to inflationary trends (15). Senator Williams viewed the act as being mandatory in its all inclusive nature, certainly not requiring more exclusive standards (16). Representative Ashbrook and Thompson issued

a joint statement to the House in which they generally agreed, but sought to clarify, remarks by Senator Williams. They stated the House Education and Labor Committee was "fully aware" of existing monetary standards for assertion of jurisdiction and had "no intention of disturbing them or limiting the Board's discretion for changing them or issueing new standards if it so chose" (17).

In East Oakland Community Health Alliance, Inc. (19), the Board announced its minimum monetary standard for asserting jurisdiction over privately operated health care institutions. The Board determined the following:

(1) To retain a \$100,000 annual gross revenue standard used previously for nursing homes, visiting nurses associations and related facilities.

(2) To extend to private hospitals of any type an existing \$250,000 a-nual gross revenue standard for private or profit hospitals.

(3) To estblish a \$250,000 annual gross revenue standard to apply to other health care institutions including health maintenance organizations and health clinics (19).

Murphy, Jenkins and Penello were the three Board members in the majority. Fanning dissented in part, concurring with the \$250,000 standard for hospitals, but objecting to the \$250,000 standard for the other health facilities.

In this East Oakland case the decision points out that it is the amount of income rather than the source of income

that the Board looks to in applying the jurisdictional standard. The fact that the Employer's revenues come mainly from federal revenue sharing rather than direct patient fees did not affect the basis for asserting jurisdiction (19). Therefore in East Oakland, despite the local nature of the operations of a community nonprofit health clinic, the Board claimed jurisdiction over the clinic on the basis of annual gross revenues in excess of \$250,000.

Charitable Institutions

The Board has had some fluctuation in its attempts to assert jurisdiction over charitable institutions. In 1971 in The Children's Village, Inc. (13) and Jewish Orphans Home (27) (both nonprofit institutions treating emotionally disturbed children) the Board asserted jurisdiction. It did in both cases explicitly state that it was not establishing specific jurisdiction standards for these operations.

However in Ming Quong Children's Center (36) a similar facility, the Board concluded that:

We erroneously departed, in Children's Village and Jewish Orphans Home from our congressionally approved general practice of declining jurisdiction over nonprofit charitable organizations. . . . 'Wisdom too often never comes, and so one ought not to reject it merely because it comes late,' we recognize the error in this departure from previous practices and shall act to correct it herein (36).

The Board therefore declined jurisdiction in Ming Quong (May, 1974) and dismissed the petition.

In June 1976, in the leading case Rhode Island Catholic Orphan Asylum, d/b/a, St. Aloysuis Home (48) the Board overruled Ming Quong Children's Center and asserted jurisdiction over the employer, a charitable nonprofit institution treating emotionally disturbed children. The Board concluded that the health care amendments now treated all charitable and non-charitable health facilities alike, therefore all charitable institutions should be treated the same whether or not they were specifically subject to the amendments (48). The "substantive purpose" of the institution should govern what discretionary jurisdictional standard should be applied (48). The majority determined that since the operation, which involves the specialized care and custody of children, had a total income of \$459,000, far exceeding the \$250,000 gross revenue standard, the Board should assert jurisdiction (48).

Jenkins, Walther, and Fanning were in the majority. Murphy and Penello dissented, stating the legislative history of the Act demonstrated the intent of Congress to exclude in all but "exceptional circumstances" charitable institutions other than nonprofit hospitals (16). They felt Ming Quong should not have been overruled, and that jurisdiction should not be asserted in Rhode Island.

In Chicago Lighthouse for the Blind (12), the Board rejected a regional director's finding that it was a charitable institution and therefore should be declined. Jenkins and

Walther noted that "charitable employers are now classified according to what they do--as with any other employer. . . ." (12).

In Beverly Farm Foundation (5) a Board majority dismissed some unfair practice charges against the employer because the conduct occurred prior to the passage of the health care amendments. Prior to the passage of the amendments the Board would have declined jurisdiction over the employer, a nonprofit corporation operating a home for mentally retarded persons in view of its charitable purpose, as in Ming Quong. At the same time the Board adopted the administrative law judges findings that the misconduct after the amendment's passages violated the act (5).

Other Jurisdiction Concerns

The NLRB has ruled in a number of cases that political exemption does not apply if the government owned hospital is leased to a private employer for administration purposes. In Bishop Hospital (6), the Board examined the relationship to the local government and the degree of control over employees, i.e., hiring, firing and disciplinary action.

Also the NLRB has asserted jurisdiction over outpatient clinics (Charles Circle Clinic) (11), community hemodialysis units (Bio Medical Applications of San Diego) (6), and custodial care services (Lutheran Welfare Service) (33).

Summary

The Board views its jurisdiction responsibilities under the 1974 amendments to continue to include jurisdiction over the previously covered for-profit facilities, to include charitable institutions, and to exclude government owned hospitals unless operated autonomously by a private employer. The NLRB established a \$100,000 gross revenue standard for nursing homes, visiting nurses associations and related facilities, and extended the \$250,000 standard previously applied to proprietary hospitals to nonprofit hospitals.

Bargaining Units Determination

The determination of which employees should be grouped together for collective bargaining purposes in the health care industry is a difficult task. To understand how this is accomplished, one must understand the requirements of the National Labor Relations Act, the role of the National Labor Relations Board, and the intent of Congress when it amended the Taft Hartley Act to extend coverage to the health care field.

Legislative History and Requirements

The National Labor Relations Act, Section 8(d), states:

For the purposes of this section, to bargain collectively is the performance of the mutual obligation of the employer and the representative of the employees to meet at reasonable times and confer in good faith with respect to wages, hours, and other terms and conditions of employment (37).

Section 9(a) provides that the employee representatives that have been

. . . designated or selected for the purposes of collective bargaining by the majority of the employees in a unit appropriate for such purposes, shall be the exclusive representatives of all the employees in such unit for the purposes of collective bargaining (37).

The final decision on what unit is appropriate for bargaining purposes is made by the National Labor Relations Board, under the NLRA. Section 9(b) states that the Board shall decide in each representation case whether, ". . . in order to assure to employees the fullest freedom in exercising the rights guaranteed by this Act, the unit appropriate for the purposes of collective bargaining shall be the employer unit, craft unit, plant unit, or subdivision thereof" (37).

Although the Board has delegated authority to the regional directors to decide the "appropriate" units in most cases, the decision is still, officially, the Board's determination. Basically, the Board must decide two questions: (1) the size of the unit, and (2) the composition of the unit.

The determination of an appropriate unit is often a crucial factor in organizing health care facilities because the work force is extremely diverse. Since certain groups of employees may be pro-union or anti-union, the size and composition of the unit is not an unusual item to be disputed between the parties.

The size of the unit particularly has had a direct impact on the success or failure of union organizational drives. A Bureau of National Affairs survey conducted in 1975 revealed unions sought to organize smaller units, while hospital administrators preferred to bargain with larger units.

The Board's decision is binding, the U. S. Supreme Court has determined, unless it is arbitrary or capricious or "lacking in a rational basis" (34). A bargaining unit must consist of two or more employees who share common employment interests and conditions and may reasonably be grouped together for purposes of collective bargaining.

The broad discretion of the Board has some statutory limitations. Section 9(b)(2) provides that the Board shall not combine professional and nonprofessional employees in the same unit, unless a majority of the professional employees involved vote to be included in the mixed unit (37).

Section 9(b)(2) provides that the Board shall not hold a proposed craft unit to be inappropriate simply because a different unit was previously approved by the Board, unless a majority of the employees in the proposed craft unit vote against being represented separately (37). Section 9(b)(4) prohibits plant guards from being included in the same unit with other employees (37).

For the most part, the appropriate bargaining unit is determined on the basis of the common employment interests

of the employees involved. The Board attempts to combine those employees who share "substantial mutual interests in wages, hours, and other conditions of employment" (22, p. 39). Factors considered include the method of wage determination and supervision. Also, the number of hours worked, benefits enjoyed, and degree of interaction with other employees is considered along with the very important factors of work responsibilities and required skills (29).

Similarity of skills and working conditions is very important because this indicates these employees have common problems and similar interest areas. Employees doing more than one kind of work are usually placed where they spend most of their time. Even employees having different skills but subject to the same working conditions may have sufficient interest in being placed in the same bargaining unit.

In addition to the above factors, the Board gives major consideration to the following:

1. Any history of collective bargaining
2. The desires of the employees concerned
3. The extent to which the employees are organized.

Section 9(c)(10) prohibits the Board from making the extent of organization a controlling factor (37).

The history of bargaining is important; however, it can be overturned if there are strong reasons for designating a different unit. Also, the length of bargaining history must

be considered (53). In addition, past practice will not be considered if the pattern was based on racial factors.

The Board will normally recognize bargaining units as "appropriate" if both parties stipulate this is the desired unit even though the Board's policy might be to usually designate those units as "inappropriate". Stipulations that run contrary to the provisions or purposes of the Act or well established Board policies are not normally honored.

Employee desires become important when all other considerations are equal. In these circumstances, the Board usually waits till the outcome of the election to determine employee desires. This was derived from the Globe Machine and Stamping Company case (46) and became known as the "Globe" doctrine. In that case, the Board found the considerations of three separate units as desired by three craft unions and the consideration of a single unit as desired by an industrial union were equally balanced. Therefore, the Board decided the desires of the employees, as expressed in separate elections, would be the determining factor in deciding what would be appropriate.

Sometimes, independent units possess a substantial amount of autonomy that reflect separate interests of the employees. The Board may then fragment the employee work force (40); therefore, the nature and organizational structure does have some impact on the Board's decisions.

However, taking the interest of the public into account in Delaware--New Jersey Ferry Company vs. NLRB (39), the Third Circuit Court would not enforce a Board decision placing deckhands and ship officers of a ferry company in the same unit. The Court stated:

The point here is not what the officers want, nor what the men want, nor what the company either wants or is willing to acquiesce in, but rather, what is the public interest. The Board's duty to serve the public interest cannot be affected by the desires or acquiescence of the parties (39).

Congressional Committee Reports

The health care industry amendment does not provide any specific provision for definition of appropriate units in the hospital context. Committee reports caution that ". . . due consideration should be given by the Board to preventing proliferation of bargaining units in the health care industry" (47).

Senator Dominick (47) appended the Senate Committee on Labor and Public Welfare Report by personally stating he felt the uniqueness of health care institutions had not been adequately addressed and that he felt the proliferation of bargaining units might pose serious threats.

During the debates, Senator Taft stated, "There is a definite need for the Board to examine the public interest in determining appropriate bargaining units . . ." in the health care institutions, citing the aforementioned Delaware--New Jersey Ferry Company for support of this concept (14, p. 7311).

Senator Taft consequently introduced a provision limiting health care institutions to four bargaining units. This was rejected, but was the basis for the instruction to the Board in the Committee Reports to limit the number of bargaining units.

Senator Taft remarked that health care institutions:

. . . are particularly vulnerable to a multiplicity of bargaining units due to the diversified nature of the medical services provided patients. If each professional interest and job classification is permitted to form a separate bargaining unit, numerous administrative and labor relations problems become involved in the delivery of health care (14, p. 6940).

Senator Williams, a little more optimistic than Senator Taft, expressed confidence in the Board's ability to deal with the bargaining unit problem. He stated:

. . . the National Labor Relations Board has shown good judgment in establishing appropriate units for the purposes of collective bargaining, particularly in wrestling with units in newly covered industries. While the Board has, as a rule, tended to avoid an unnecessary proliferation of collective bargaining units, sometimes, circumstances require that there be a number of bargaining units among nonsupervisory employees, particularly where there is such a history in the area or a notable disparity of interests between employees in different job classifications.

While the committee clearly intends that the Board give due consideration to its admonition to avoid an undue proliferation of units in the health care industry, it did not, within this framework, intend to preclude the Board acting in the public interest from exercising its specialized experience and expert knowledge in determining appropriate bargaining units (16).

The Committee Reports were specifically favorable to the action of the Board in the case of Four Seasons Nursing Center (23) and Woodland Park Hospital (61). In Four Seasons,

the union sought to represent the maintenance employees (2 out of 140 employees). The finding was that the duties performed did not require a high degree of skill or training, nor were the interests distinct and separate enough to justify a distinct unit.

In the Woodland Park Hospital case, the Board overruled the previous Ochner Clinic case that had found the unit of "radiological technologists" appropriate (43). In Woodland Park Hospital, the union desired separate units of clerical, technical, and other employees. The Regional Director ruled that there was not sufficient separateness of interest. The Board concluded a finding of a separate unit of X-ray technicians would lead to fragmentation of units.

The Committee Reports also expressed approval regarding the "Extendicare of West Virginia" case (20) indicating broad unit specification. However, the Committee did not necessarily express approval of the particular decision in which the LPN's were a separate unit and the technical, service and maintenance employees were another. The employer had requested an all employee unit which Member Kennedy had thought appropriate as in Butte Medical Properties.

The health care industry has wide varieties of skill levels and diverse groups of labor organizations attempt to represent these individuals. For example, the Ohio Hospital Association testified before the Subcommittee on Labor of the

Senate Committee on Labor and Public Welfare that there are at least twenty

. . . different professional and technical groups which have indicated an interest in representing their members in collective bargaining in hospitals. In addition, craft unions . . . could be expected to seek representation rights for hospital employees performing craft related work, as well as unions representing employees in specific types of hospital related industries (32).

Although the NLRB still has flexibility in determining the bargaining units, it seems clear that congressional sentiment indicates broadly based and fewer units in health care institutions.

NLRB "Guidelines" for Bargaining
Unit Determination

Because of a desire to develop guidelines, the NLRB decided to hear oral arguments on types of employees who may be grouped for collective bargaining in private health care institutions. In the announcement setting the hearing for January 27, 1975, the Board said it was "primarily interested in argument as to what unit or units would be appropriate" in the health care cases involving Newington Children's Hospital at Newington, Connecticut; Duke University at Durham, North Carolina; Sisters of Saint Joseph of Peace at Bellingham, Washington; Mount Airy Psychiatric Center of Denver, Colorado; and Saint Catherine's Hospital of Dominican Sisters of Kenosha, Wisconsin (32).

The unions involved included National Union of Hospital and Health Care Employees, International Union of Operating

Engineers, Retail Clerks International Association, and the Service Employees International, all AFL-CIO affiliates.

Ralph E. Kennedy, NLRB member, disagreed with the holding of oral arguments. He felt the legislative history of the amendments and the filed briefs adequately covered the issues. He wanted the issues promptly determined and stated, "Delay in the resolution of these issues is undesirable for the employers, the unions and the employees in the health care field" (32).

In Table I, the bargaining units ordered in 150 contested elections from September, 1974, to May, 1975, show the inconsistency in unit determination prior to the Board's adoption of guidelines.

Hospital Position.--At the oral hearings, employers urged a strong stance on "nonproliferation" on bargaining units. However, the unions recommended greater flexibility in unit determination because they felt the emphasis on nonproliferation was a thin disguise to make organizing more difficult.

Presenting the views of the American Hospital Association, Richard Epstein, Attorney, said the hospital industry is different due to the nature of patient care. Most patients have "no option" about being admitted, nor who cares for them. Also, the patient is dependent on a variety of employees caring for him whose duties interlock (60).

William J. Emanuel, Attorney for California Hospital Association, agreed with Epstein and reflected on the "horror

TABLE I

TYPICAL TYPES OF BARGAINING UNITS ORDERED IN ELECTIONS
 SEPTEMBER, 1974 TO MAY, 1975*

Type of Unit	Number of Cases in Which Unit was Ordered
Registered Nurses	21
Licensed Practical Nurses (LPN)	14
LPN's and Service Employees	10
LPN's Technical, Service and Maintenance	11
Clerical Employees	11
LPN's, Technical, Clerical, Service, and Maintenance	6
Technical, Service, and Maintenance	6
All Employees	4
Other Professionals, LPN's, Technical, Clerical, Service, and Maintenance	3
Security Guards	3
Service	3
LPN's and Service	2
Maintenance	2
LPN's Technical, and Service	2
Other Professionals	2
Technical	2
LPN's and Technical	2

*Source: Rosmann, Joseph, "One Year Under Taft-Hartley,"
Hospitals, December 16, 1975.

story" of New York hospitals where he concluded, the Board decided units of nonprofessionals and forgot about professionals. He stated the NLRB should give "no weight whatsoever" to previous state board decisions (60).

Another hospital association representative, Wayne J. Fowler, Colorado Hospital Association, proposed two units, a simple division of professionals and nonprofessionals. Fowler responded to Member Fanning by saying interns, registered nurses, pharmacists, and some technicians might appropriately be included in the same professional unit. In agreement with the two unit approach were the Hospital Association of Pennsylvania, the New Jersey Hospital Association, and the Association of Delaware Hospitals (60).

Union Position.--The representatives of professional associations and unions, however, subscribed to another theory (52). The American Nurses Association, represented by Murray Gordon, noted that registered nurses must have two to four years specialized education, are subject to a national licensing procedure, and nurses have exclusive responsibility for the provision of nursing care and establishment of said standards. He also stated including registered nurses in other professional units would dilute their sense of responsibility.

Attorney Robert Silazi argued for the National Federation of Licensed Practical Nurses that the LPN's are highly skilled

technical employees with sufficient community of interest to be represented apart from other employees (60).

A. I. Zwerdlery, Attorney for the State, County and Municipal employees, favored four separate units--professional, service and maintenance, office clerical, and technical. Another union representative, Lester Ashee (SEIU), favored three units--professionals, service employees (including technicians) and office clericals (60).

In the eight decisions handed down May 6, 1975, the NLRB established guidelines for bargaining unit determinations in private health care industry. All five members of the Board; Murphy, Fanning, Jenkins, Kennedy, and Pennelo, participated in the decisions, but split in most of them.

The precedent was set to generally establish only five types of bargaining units in hospitals: registered nurses (RN); other professional employees; licensed practical nurses (LPN) and technical employees; business office clericals; and service and maintenance employees.

Three particular cases require close perusal to understand these classifications: Sisters of St. Joseph, Barnert Memorial Hospital Center, and Mercy Hospitals of Sacramento.

Mercy Hospitals of Sacramento, Incorporated

In the Mercy Hospitals of Sacramento, Incorporated, Sacramento and Carmichael, California and Service Employees Local 250 Case (35), several important aspects emerged. The

Board ruled that the nonprofit general hospital and the acute care facility, which is located thirteen miles away from the hospital, constitute a single employer in view of the functional integration between all operations.

Registered Nurses.--Perhaps the most significant determination in this case involves allowing registered nurses "if they are so sought and they so desire" to be represented for purposes of collective bargaining in a unit separate from all other professional health care employees (35).

The Board found

. . . in view of nurses' peculiar role and responsibilities in health care industry and their impressive history of exclusive representation and collective bargaining, they possess interests evidencing a greater degree of separateness than those possessed by most other professional health care employees (35).

The Board has, in the past, recognized the separate interests of registered nurses and has routinely established separate nurse units for collective bargaining purposes (26). One example would be in Consolidated Vultee Aircraft Corporation, where the following notation was made:

The Board has consistently recognized that nurses constitute a well-defined professional group whose training, skill and duties differ from those of other employees, and that a unit confined to nurses is appropriate for the purposes of collective bargaining (38).

The fact that nurses are required to attend accredited nursing schools, are required to take and pass uniform national licensing examinations, and to acquire and maintain state licenses to practice had significant impact on the

decision. Also under consideration was the fact "the duties and responsibilities with respect to patient care cannot by law and licensure be delegated to any other employees, including other professionals, and must therefore be performed exclusively by registered nurses" (35).

Other Professionals.--Another major question addressed in the Mercy Hospitals case regards other professional employees. Again, the Board is cognizant of the sentiments of the committees as noted by Senator Taft:

The issue of proliferation of bargaining units in health care institutions has also greatly concerned me during consideration of legislation in this area. Hospitals and other types of health care institutions are particularly vulnerable to a multiplicity of bargaining units due to the diversified nature of the medical services provided patients. If each professional interest and job classification is permitted to form a separate bargaining unit, numerous administrative and labor relations problems become involved in the delivery of health care (14).

The Board realized the variety of functional and educational responsibilities of other professional groups, but stated to grant a separate unit to all such professional groups would result in an "undue" proliferation of bargaining units. The Board stated that even though there is diversity of skill, interests, and working conditions, that this is no more diverse than employees in production and maintenance units of private industry. Moreover, it is granted that there does exist a "commonality of professionalism." Therefore, in the Mercy Hospitals case, the Board concluded that a unit consisting of all professional employees excluding

registered nurses would be appropriate for the purposes of collective bargaining.

An interesting item occurs at this point. The Board did not direct an election to be held for other professionals since no labor organization desired to represent employees in an all professional unit if a separate unit was found appropriate.

In the dissent, Member Kennedy felt a unit of all professional employees is appropriate. He said: "In my view, an all professional employee unit is not only an appropriate unit, but is the 'most appropriate unit'." Kennedy did not want to separate the registered nurses because he did not perceive a sufficiently distinct community of interest apart from the other professional employees (35). Kennedy also did not feel a sufficient show of interest existed in order to direct an election for the unit of registered nurses.

The Board did direct an election to be held for the service and maintenance employees, finding that they constituted a unit appropriate for collective bargaining under the Act. Member Kennedy concurred.

Office Clericals.--The Board overruled the 1974 decision in National Medical Hospitals (41) on the matter of clerical employees. This decision had been issued prior to the oral arguments. The distinction is recognized between clerical employees who perform mainly business type functions and other types of clerical employees whose work is more related

to service and maintenance functions. The office clericals generally work in the business office and the other clericals work away from the business office on various floors of the hospital. Member Kennedy felt a sufficient show of interest had not been submitted by the business office clericals and so stated in his dissent (35).

UNIT A: All registered nurses and nurse permittees employed at Mercy General Hospital, Mercy Convalescent Hospital and Mercy Children's Hospital, Sacramento, California, and at Mercy San Juan Hospital, Carmichael, California, excluding all other employees, guards, and supervisors as defined by the Act.

UNIT B: All full-time and regular part-time service and maintenance employees, including licensed vocational nurses, graduate vocational nurses, nurse assistants, ward clerks, surgical technicians, ACC clerks, X-ray technicians, cardio-pulmonary technicians, respiratory therapy technicians, EKG technicians, pharmacy clerks, computer programmers, printing assistants, technicians to receiving clerk, housekeeping technicians, food service workers, laundry workers, department aides, all employees of the maintenance and engineering department and all clerical employees other than business office clerical employees, employed at Mercy General Hospital, Mercy Convalescent Hospital and Mercy Children's Hospital, Sacramento, California, and at Mercy San Juan Hospital, Carmichael, California, excluding all other employees, guards, and supervisors as defined by the Act.

UNIT C: All business office clerical employees, including clerks 1, 2, and 3, keypunch operators, keypunch operator trainees, computer operator 1's, senior transcribers, and PBX operators employed at Mercy General Hospital, Mercy Convalescent Hospital and Mercy Children's Hospital, Sacramento, California, and at Mercy San Juan Hospital, Carmichael, California, excluding all other employees, confidential employees, guards, and supervisors as defined by the Act.

Barnert Memorial Hospital Center

In Barnert Memorial Hospital Center and National Union of Hospital and Health Care Employees (RWDSU, District 1199) (2), the Board faced the issue of technical employees. There seemed to be two major questions to be answered: (1) Should technical employees be in a separate unit from service and maintenance employees? and (2) What categories constitute technical employees?

The Board had traditionally held a unit of all technical employees in industry to be appropriate and has stated it "does not normally include . . . technical employees" in a unit of service and maintenance employees (7).

In examining the position of technical employees in the health care field, the Board asserts "there is continuing reason to approve separate units of technical employees" whose "specialized training, skills, education and job requirements establish a community of interest not shared by other service and maintenance employees" (2). Many times, this separate community of interest is evidenced by the fact that such employees are certified, registered, or licensed.

The Board did not feel the finding of two units was proliferation because even in Senator Taft's proposal, separate technical and service and maintenance employee units were introduced.

Dissenting Opinion.--In dissenting, Members Kennedy and Penello felt the Board had contributed to proliferation by finding a separate unit of technical employees (2). They would include the technical employees in the service and maintenance employees unit. They also refer to the Sheffield Corporation case where the Board abandoned the policy of automatically excluding all technical employees (54). Kennedy and Penello emphasize Congressional intent and the necessity of evaluating individual cases in indicating their dissent. Disputing the majority's reliance upon certification or licensing by state or private agencies, the dissenters assert that the "standards" for such certification or licensing vary greatly and that "a national labor policy" is not furthered "by abdicating" to such agencies "the primary duty imposed upon us by Congress."

The specific classifications for the two units are given as follows:

In Case 22-RC-6184: All regular full-time and part-time employees in the service and maintenance areas including nurses aides and orderlies; dietary employees; housekeeping employees; coffeeshop employees; cafeteria employees; central room service employees; storeroom employees; engineering and maintenance employees; boilerroom employees; unit clerk; aides including morgue assistant, physical therapy aide, pharmacy aide; lab aide and X-ray aide; and in addition, all EEG technicians; EKG technicians; darkroom technicians; noncertified operating room technicians employed by the Employer at its hospital facility location at 680 Broadway, Paterson, New Jersey, but excluding all administrators, professionals, confidential, office and clerical employees, and technical employees, registered nurses, patient care technicians, pharmacists, social workers, therapists,

dieticians, medical record librarians, medical laboratory technologists, chemists, guards, supervisors as defined in the Act and all other employees not included (2).

In Case 22-RC-6190: All regular full-time and part-time X-ray technicians; respiratory care technicians; infant care technicians; licensed practical nurses; registered and non-registered technicians in the laboratory; psychiatric technicians; certified operating room technicians; orthopedic technicians; orderly-orthopedic technician trainee employed by the Employer at its hospital facility located at 680 Broadway, Paterson, New Jersey, but excluding all Administrators, professionals, confidential, office and clerical employees, registered nurses, patient care technicians, pharmacists, social workers, therapists, dieticians, medical record librarians, medical laboratory technologists, chemists, guards, service and maintenance employees, supervisors as defined in the Act and all other employees not included (2).

Looking at the various classifications, the inclusions of EEG technicians in the service and maintenance unit and the X-ray technicians in the technical unit appears worthy of scrutiny. Applying the criteria of the Board, it appears the EEG technicians receive instruction for a period of two to four weeks, they are not certified and do not exercise independent judgment in the administering of the test, nor do they interpret test results.

In contrast, the X-ray technician must complete a two-year training course and have 300 clinical hours before becoming licensed in New Jersey. Independent judgment is utilized in the types and positioning of the X-rays.

Obviously, at times, the criteria will not be as neatly defined and easy to apply. This is another reason for the Kennedy and Penello dissent.

Sisters of Saint Joseph of Peace

The Board directed an election to be held for all full-time and part-time business office clerical employees, determining this to be an appropriate unit for the purposes of collective bargaining for reasons stated in Mercy Hospitals of Sacramento (55). Medical records employess and ward clerks were excluded from the unit since only one of three medical record areas was located near the business office and these employees were gone about half of the time. Also, ward clerks spent 95 per cent of the time in ward stations and were supervised by nursing personnel. Therefore, it was concluded that they did not share a community of interest with the business office clericals and would be more appropriate in a broader unit of service and maintenance employees (55).

Other Unit Determinations

The Board decisions in the precedent setting cases were to assist regional directors in making appropriate unit determinations. There is still dissent on the Board in interpretation of the Congressional mandate and there have been some departures in the already established framework.

In Saint Catherine's Hospitals (51), the question of licensed practical nurses (LPN's) was decided by placing them in a broad technical unit. Member Kennedy would include the

technical employees in one broad unit of all nonprofessional employees and Member Penello would include the technical employees in a service and maintenance unit.

Yet, in Bay Medical Center (3), the Board determined a unit of LPN's need not be included within a technical unit. There was a previous history of separate representation involved. In Otis Hospital, Inc. (44), a separate unit of LPN's was approved under the rationale that it did not contravene the purposes of the Act.

This Board majority supported its decision by stating that by allowing the parties broad latitude collective bargaining is encouraged. An element of flexibility is considered desirable and is supported by legislative history according to the Board majority.

Member Kennedy dissented in the finding that a separate unit of licensed practical nurses was appropriate. He felt the majority decision to be in direct contrast to its decision to be in direct contrast to its decision not to honor the parties' stipulation regarding LPN's in Barnert Memorial Hospital.

The majority replied that the "parties on Barnert agreed to exclude LPN's but from different units." Board policy is to treat such a unit normally as "inappropriate" as it did not run counter to the provisions of the Act or to Board Policy. Member Penello did state that in the absence of a

clear stipulation by the parties he would not have the unit to be appropriate.

In Southwest Community Hospital (57), a Board panel also agreed to a stipulated unit that was different from the lead hospital cases. In this case, a unit consisting of licensed practical nurses, nurses aides, orderlies, ward clerks, housekeeping, dietary, and maintenance employees was approved (57).

The Newington Children's Hospital (42) has an appropriate unit of service and maintenance employees, including hospital clerical employees, but excluding LPN's, other technical employees, and business office clericals. This case seems to indicate the difficulty which may occur in trying to classify employees in a business office clerical unit or in a service and maintenance unit.

In the service and maintenance area, some confusion continues. In Shriner's Hospitals for Crippled Children (55), a request was rejected for a separate unit of five stationary engineers. Yet, in Kansas City College of Osteopathic Medicine (30), a unit of powerhouse employees that were separately located and supervised was approved. Also, the Board found a unit of boiler room employees appropriate in Saint Vincent's Hospital (53), due to the fact they were separately licensed and did not share a common work area or time shift with other employees.

Chairman Murphy indicated she would "continue to find appropriate a traditional powerhouse unit or a maintenance department unit in a hospital or other health care facility where such a unit is sought and shown to be appropriate on the facts." Member Penello distinguished St. Vincent's Hospital from Shriner's Hospitals for Crippled Children by identifying St. Vincent's as composed of licensed craftsmen engaged in traditional craft work performed in a location that was separate and distinct from other employees (53). The engineers at Shriner's performed other services through the entire health care facility (55).

In both Riverside Methodist Hospital (49) and St. Joseph Hospital (52), the Board majority found the units inappropriate for plant operations and maintenance and engineering department. It was felt the employees did not possess a community of interest that was distinct and separate from the other service and maintenance employees. Also, in Baptist Memorial Hospital (1), a unit of engineering employees was inappropriate because they were not found to represent a craft unit. Many jobs were of an unskilled nature and often the skilled jobs, such as electrical wiring, were sub-contracted. These decisions indicate the Board may consider departures from the guidelines when a previous history or distinct interests may be involved.

The issue of single location unit in a multiple location health care operation was examined by the Board. In

Saddleback Community Hospital (50), the Board stated the pharmacists in the medical clinic pharmacy and the hospital pharmacy shared substantial community of interest and therefore were denied separate units. The majority evaluated factors such as centralized control of labor relations, common ultimate supervision, and close community of interest as evidenced by similarity in job duties, skills and employee benefits. The dissenters pointed to lack of contact between the two facilities, different wage rates, and different requirements as reasons for supporting separate units.

In Baptist Memorial Hospital, the Board also refused to limit a unit to a single location. A unit of service employees at the employee's Lamar Unit, approximately one mile from the main hospital, was considered inappropriate because the Lamar unit was "functionally and operationally integrated with the main hospital unit" (1).

Another case, Kaiser Foundation Health Plan of Oregon, rejected a single unit of psychotherapists. The employer maintained a hospital and seven clinics. The psychotherapists were all located at one clinic; however, the majority found, due to highly centralized and high integrated management, there was a community of interest shared by other professionals. The dissenting members, Fanning and Jenkins, felt the psychotherapists were physically and functionally distinct from the others (28).

The professionals, other than registered nurses, do not have distinct bargaining histories. In two cases, the Board decided to deny separate representation for professional units. In Kaiser Foundation Hospitals (28), pharmacists, and in Terry Industries of Oregon (58), psychiatrists, were found to have "commonality of professionalism" and not be entitled to separate units. This makes one speculate on the physicians in the future and if they will be able to have a separate unit.

A decision which is covered in more detail in Chapter V, Professionals and Unions, should be mentioned here. In Cedars-Sinai Medical Center (9), the Board determined residents, interns and clinical fellows are "students" rather than "employees" within the meaning of the Act and thus, not entitled to the protection of the Act, thereby eliminating them from coverage altogether. This decision has been heavily attacked and even Congressional representatives have stated this was not the intent of the Act.

Summary

While the Board has approved units conforming to the "eight cases" framework or "guideline cases," administrators and unions alike should remain aware of unique factors that might influence the Board to accept variations of these "case" units.

Bargaining unit determination is still in a state of flux, however, the guideline cases have offered some continuity of decision making. The majority of the disagreements stem from various interpretations of the Congressional mandate to avoid undue proliferation of bargaining units and also the applications of traditional Board unit criteria. There should be interesting cases in the future to be examined as the industry becomes more sophisticated in labor relations and as the institutions change.

CHAPTER BIBLIOGRAPHY

1. Baptist Memorial Hospital 225 NLRB 69 (1976).
2. Barnert Memorial Hospital Center 217 NLRB 132 (1975).
3. Bay Medical Center 218 NLRB 100 (1975).
4. Bay Medical Center 224 NLRB 14 (1976).
5. Beverly Farm Foundations 225 NLRB 70 (1976).
6. Bio Medical Applications of San Diego, Inc. 216 NLRB 155 (1975). Also see Bishop Randall Hospital 217 NLRB 185 (1975).
7. See, e.g., Bulldog Electric Products Co. 96 NLRB 642 (1951).
8. Butte Medical Properties 168 NLRB 266 (1967).
9. Cedars-Sinai Medical Center 223 NLRB 57 (1976), motion for reconsideration denied in 224 NLRB 90 (1976).
10. Central Dispensary and Emergency Hospital 44 NLRB 533 (1942).
11. Charles Circle Clinic 215 NLRB 84 (1975).
12. Chicago Lighthouse for the Blind 225 NLRB 46 (1976).
13. The Children's Village, Inc. 186 NLRB 953 (1971).
14. 120 Congressional Record, 6940/7311 (May 2-7, 1974).
15. 120 Congressional Record, S12108 (May 7, 1974).
16. 120 Congressional Record, 12104 (July 10, 1974).
17. 120 Congressional Record, E4849-4850 (July 18, 1974).
18. Drexel Home, Inc. 182 NLRB 1045 (1970).
19. East Oakland Community Health Alliance, Inc. 218 NLRB 193 (1975).

20. Extendicare of West Virginia 203 NLRB 170 (1973).
21. Feheling, Lawrence F. "Amendments to the National Labor Relations Act--Health Care Institutions," Ohio State Law Journal, 36 (1975), 235-298.
22. Fifteenth Annual Report of the NLRB, 39 (1950).
23. Four Seasons Nursing Center 208 NLRB 50 (1974).
24. General Electric Company Kaedlec Hospital 89 NLRB 533 (1950).
25. Hospital Hato Tejas, Inc. 111 NLRB 155 (1955).
26. See, e.g., Hudson Motor Car Co. 45 NLRB 55, 11 L.R.R.M. 99 (1942); Consolidated Vultee Aircraft Corp. 56 NLRB 1785, 14 L.R.R.M. 209 (1944); 59 NLRB 1276, 15 L.R.R.M. 199 (1944); 108 NLRB 591, 34 L.R.R.M. 1044 (1954); American Steel and Wire Company, 58 NLRB 253, 15 L.R.R.M. 50 (1944); Consolidated Steel Corp. 61 NLRB 97 (1945); Standard Oil Company (Indiana) 80 NLRB 1022, 23 L.R.R.M. 1189 (1948); Diversified Health Services, Inc., d/b/a. Convalescent Center of Honolulu 180 NLRB 461, 73 L.R.R.M. 1038 (1969). Accord: Doctor's Hospital of Modesto, Inc. 193 NLRB 833, 76 L.R.R.M. 1784 (1971); enfd. 489 F 3d 772, 65 L.R.R.M. 228 (C.A. 9, 1973).
27. Jewish Orphan's Home of Southern California d/b/a Vista Del Mar Child Care Service 191 NLRB 32 (1971).
28. Kaiser Foundation Hospital NLRB, 89 L.R.R.M. 1763 (1976).
29. Kalamazoo Paper Box Corp. 136 NLRB 134, 49 L.R.R.M. 1715 (1962).
30. Kansas City College of Osteopathic Medicine NLRB, 90 L.R.R.M. 1189 (1975).
31. Kennecott Copper Corporation 99 NLRB 748 (1952).
32. 88 Labor Relations Reporter, 46 (12-30-74).
33. Lutheran Welfare Service of Illinois 216 NLRB 96 (1975).
34. May Department Stores Co. vs. NLRB 326 U.S. 276 (1945).
35. Mercy Hospitals, Case Nos. 20-RC-12299, et al., 217 NLRB 131 (May 5, 1975).

36. Ming Quong Children's Center 210 NLRB 125 (1974).
37. National Labor Relations Act, as amended, 1974.
38. 56 NLRB 1785, 14 L.R.R.M. 209 (1944).
39. NLRB vs. Delaware-New Jersey Ferry Company, 128 F 2d 130 (3rd Cir., 1942).
40. NLRB vs. Kostel Corp., 440 F 3d 341 (7th Cir., 1971).
41. National Medical Hospitals, Inc. of San Diego, d/b/a.
42. Newington Children's Hospital NLRB 89, L.R.R.M. 1513 (1976).
43. Ochner Clinic 172 NLRB 55 (1971).
44. Otis Hospital, Inc. NLRB 89, L.R.R.M. 1445 (1975).
45. Phelps Dodge Corp. 98 NLRB 726, 29 L.R.R.M. 1405 (1952).
46. See also: Pittsburgh Plate Glass vs. NLRB, 313 U.S. 146, 156 (1940).
47. Representative No. 766, 93rd Congress, 2nd Session 5 (1974).
48. Rhode Island Catholic Orphan Asylum d/b/a St. Aloysius Home 224 NLRB 70 (1976).
49. Riverside Methodist Hospital 223 NLRB 158 (1976).
50. Saddleback Community Hospital 223 NLRB 45 (1976).
51. Saint Catherine's Hospital NLRB 89, L.R.R.M. 1070 (1975).
52. Saint Joseph Hospital 228 NLRB 23 (1977).
53. Saint Vincent's Hospital NLRB 91, L.R.R.M. 1513 (1976).
54. Sheffield Corp. Case NLRB 49, L.R.R.M. 1513 (1976).
55. Shriner's Hospitals 217 NLRB 138 (1975).
56. Sisters of Saint Joseph of Peace 217 NLRB 125 (1975).
57. Southwest Community Hospital 226 NLRB 136 (1976).

58. Terry Industries of Oregon NLRB 89, L.R.R.M. 1045
(1975).
59. University Nursing Home 168 NLRB 263 (1967).
60. White Collar Report, No. 930 A-3, 4, 5, 6, 7 (1-31-75).
61. Woodland Park Hospital 205 NLRB 144 (1974).

CHAPTER IV

UNIONIZATION OF HEALTH CARE FACILITIES

Hospital Industry and Its Environment

The health care industry is the fourth largest in the U. S. Economy and employs approximately 4,000,000 people (35). The hospital industry is one of the economy's growth areas and has a resource size that rivals any other in the private section. The growth of the industry in the last fifteen years reflects three major external factors: (1) expansion of third-party hospitalization coverage, (2) changing nature of medical technology, and (3) increasing affluence and changing demographic characteristics of our population (24, p. 7). Thus, for a variety of reasons, the demand for hospital services has been substantially increasing and will continue to increase in the future.

A particular area of paramount importance in the health care industry is that of increasing employment and the effective utilization of personnel. Since the hospital industry is service in nature, it is therefore labor intensive. As a result, the rising demand for service, increasing occupational specialization and advancements in technology have resulted in the need for more hospital employees. Figure 1 shows the growth in health care employment from 1959 to 1974.

The Union Movement

Faced with increasing demand for services, increasing costs and greater manpower needs, the trend toward aggressive unionization has had a direct impact on the way in which hospital administrations address these situations. Several factors have contributed to the increased momentum of the union movement: (1) the substantial increase in white collar classifications has resulted in union organizers directing their efforts to this white collar segment. The Department of Labor states that by 1980, there will be 49.3 million white collar workers, more than all other categories--blue collar, farm workers, etc.--put together, (2) the changing philosophy of professionals from being adverse to being proponents of collective bargaining, (3) the legislative changes incorporated by several states, the Executive Order and the amendments to the Taft-Hartley Acts have provided an environment more conducive to organization efforts, and (4) the growing tendency for the predominantly female work force to become more liberated and militant.

Although union activity in hospitals is basically a post World War II phenomenon, some union efforts go back as far as the early 1930's. Most of the hospitals in the San Francisco Bay area have been organized since that time. In Washington, D. C., hospital organization took place in the 1940's and

New York organization dates to the 1950's (1). Most of the substantial activity in hospitals has occurred in the last fifteen years.

In 1961 and 1967, the American Hospital Association conducted surveys concerning collective bargaining activities by hospitals and employee organizations. In 1961, the survey showed 221 union agreements in nonfederal hospitals (20). Surveying over 7,000 member hospitals in 1967, the American Hospital Association found 731 had agreements with a third party as bargaining agent and a total of 1,311 hospitals had some other collective action by employees (20, p. 67).

Bureau of National Affairs' Survey 1971; 1975

In June 1971, the Bureau of National Affairs, Inc. published its first survey on hospital organizing. According to the survey, more than one-third of the nation's hospitals experienced union organizing attempts during 1968-1971, with one-fifth of these efforts resulting in recognition. After the passage of the Health Care Amendments to the Taft-Hartley, the Bureau of National Affairs completed another survey.

At the time of the amendments's passage, approximately 12 per cent of the covered workers were unionized (33). NLRB statistics indicate unions have been winning almost 60 per cent of health care organizing efforts compared with a 48 per cent win rate in the remaining private sector. Historical studies indicate union victories are usually greater

when a field is new, so it may be that the union win ratios will decline to the national average after more time has passed.

Factors in Organizing Hospitals

The single most important factor that kept hospital organizing behind other industries was the lack of supportive legislation. Now that the legislative story has changed, so has the organizing picture. However, there have been other deterring factors in health care organizing:

1. Difficulty and expense in organizing hospital employees. One reason for this might be the high turnover rates in hospitals make it difficult for the union to launch a successful campaign.
2. Lack of one big hospital union. The hospital industry is the only major industry which has not produced an international union with the particular focus of the industry. There is a proliferation of unions that increases the complexity of health care organizing.
3. Civil rights aspects of hospital unionization. Many entry level positions are filled by nonwhites. Blacks, Chicanos and Indians frequently fill these positions at various locations. Local 1199, RWDSU held many of its campaigns based on "Soul Power" but this has shifted. Occasionally, the "union power" was held to be at variance with "minority power."

4. Lack of cooperation from other unions in the community. Sometimes, the industrial unions find they have little understanding of the problems of hospital employees.

5. Strong opposition from the hospitals. Stating that unions will be disruptive and interfere with quality patient care, hospitals have maintained strong positions against health care organizing activities (8).

The above factors are difficulties faced by union organizers. How, then, would a union evaluate the organization possibilities? Basically, the union does not want to spend money in an organizational campaign unless it feels there is a strong opportunity to be successful.

Concerns and Issues of Health Care Employees

Why do employees join unions?--Unions derive their strength from helping the employee fulfill certain needs and goals. If the union does a better job than management, it will receive the employees' support. The health care employee is not any different and will join a union if he believes membership will assist him in achieving any of his undrealized goals.

The AFL-CIO presented in the American Federationist a profile study of union voters. The five leading reasons for voting for a union were ranked by 500 persons. The results, in descening order, were:

1. Insurance of better pay and job security through collective bargaining.
2. Improved fringe benefits.
3. Fairness, especially in promotions and seniority rights.
4. Establishment of a grievance procedure.
5. Better worker control over speed-ups, production standards and quotas (1).

A recent study conducted by Dr. Matthew Goodfellow covered 379 National Labor Relations Board representation elections of which the union won 281 (74 per cent). The purpose of his study was to determine why workers of a variety of occupations chose the union to deal with their dissatisfactions (13, p. 33).

Union victories resulted from three major reasons:

1. Undesirable working conditions. This area includes such things as working conditions due to abusive, arbitrary and tyrannical supervisors (as perceived by the workers) and physical working conditions, such as rest areas, lack of eating space, etc.

2. Employee anti-company sentiment also develops in areas where management seems to be indifferent to employee complaints and suggestions regarding the work environment.

3. The failure to communicate. This subject has been studied by social researchers for many years, yet it still

ranks high in employee dissatisfaction with management. Many union campaign promises may have been exaggerated or based on half truths but the employees had no way to evaluate them due to management's failure to establish communication mechanisms.

Checklist of Susceptibility

Goodfellow has devised a checklist on how susceptible an organization would be to unionization. The following checklist relates directly to his three major reasons for union victories.

1. Number of shifts. Goodfellow indicates the first shift is most loyal to the organization and the latter shifts are less loyal. This occurs partly due to poorer supervision on the late shifts and often the employees may feel forgotten and left out of the organization.

2. Female-Male ratio. At the risk of offense, statistics have indicated greater susceptibility among males for union activities.

3. Housekeeping. Lack of attention to aesthetics of the workplace, such as dusty stockrooms, poor eating facilities, and unpaved parking areas, make employees feel there is little concern about them.

4. Wage rates. Wage rates are good reasons for joining a union but often not the primary reason. Wage related issues are important. Are merit increases given regularly and fairly?

Are there differentials based on length of services, skills and are these differentials distributed equitably?

5. Incentive pay. Are quotas established fairly?

6. Overtime practices. There are two considerations here. One is scheduling overtime on a nonvoluntary basis and the other is nonrotating, sporadic overtime assignments.

7. Seniority. Employees feel strongly about seniority whereas management always desires the right to place skill and health into the decision making.

8. Promotional policy. In-house promotions must be encouraged for incentive and morale.

9. Job Transfer. Supervisors habitually sabotage promotions and job transfers so they will not lose a good worker from their department. Various types of job opportunity listings should be used. Hospitals that encouraged internal promotions and transfers had less difficulties with union organizers.

10. Fringe benefits. A common error has been to under-rate the importance of fringe benefits. Most employees are more concerned about job security and stability than money.

11. Discipline and grievance procedures. These go together along with an employee handbook. There must be printed rules about what is punishable, what is not, and to what degree. Most successful, untroubled, nonunion companies had some mechanism for employee appeals.

12. Money. Most employees would like more money but the feeling that management does not treat them fairly, decently and honestly is what makes an employee sign a union card and support unionization.

13. Treatment. This belief of how management treats them is a "gut feeling" based on management's effort and attitude. If money were the sole source of worker dissatisfaction, how could the strikes in the well paid major industries be explained? Large hospitals in Goodfellow's study showed a high percentage of losses due to lack of personal contact with the workers (13, pp. 33, 34).

How does the health care employee rank issues?--What reasons are given for them to join the union in the unique health care area? In a paper presented to the Institute of Radiologic Technologists, Laner states four important areas appeal to workers to join unions in the health care field. The major area, according to Laner, is economic consideration. On the surface, the economic appeal is the major attraction. It receives the most publicity, both formal and informal, and economics are of a major concern to most people. Health care employees are tired to being the ones to subsidize patient care and/or inefficient facility operations (12).

For example, in Chicago, in 1960, fourteen years prior to the Taft-Hartley Amendment, Mount Sinai Hospital experienced an organizing campaign directed toward nonprofessional hospital workers. These employees were dissatisfied about

the following items: (1) low wages; (2) being asked to do a variety of jobs; (3) being shifted from one floor to another during the course of one day; (4) no time-and-a-half for overtime; (5) shifts being changed without notice to the employees; (6) no extra pay for working on holidays; (7) differing allowances for leave; (8) one week vacation; (9) no seniority rights; (10) no job security; and (11) no notice or warning when fired (12).

According to Gittler, attorney for Hospital Employees Labor Program (HELP), health care employees are ready for organization. One reason is because they are a large identifiable group with a community of employment interest. Also, the wage rates of nonprofessionals have not kept pace with the wage rates in industry, even for the same skills. Professionals in health care had a very wide range of wage rates above nonprofessionals (12, p. 18).

In addition to low wages, Gittler finds that working conditions are poor and personnel policies frequently absent. Some of the problem areas have been in jurisdictional disputes between departments and over employees. Often confusion exists between departments, medical staff and hospital administration (12, p. 18).

Another problem area is the unique twenty-four hour a day, seven day a week, three hundred and sixty-five days a year operation of hospitals and some other health care

facilities. Many times, scheduling devices and job descriptions are overlooked (12, p. 18).

The biggest problem facing most health care employees has been the lack of a fair and effective grievance procedure. According to Gittler, many hospitals that they organized had "very attractive, very colorful, very expensive little handbooks . . . on glossy paper with very attractive covers and little cartoons running through them. Title: 'Personnel Policies'" (12, p. 19). Yet, states Gittler, in most situations, the hospital administrator cannot tell you what is in that little book. He says it is bad enough to deny personnel policies but it is worse to deny policies that have been distributed.

Gittler states:

Unions are organizing hospitals therefore because there is a large, readily identifiable group of workers with a community of interest who have an economic need and the union can fill this need. The union cannot fill this need because of any inherent power or because of the power of the strike; or because of all other things you have read about unions in the newspapers. The unions can fill these needs for one primary reason, and this is particularly true in the hospital area: the unions . . . have an expertise in organizing, in negotiating, in dealing with people. Generally, hospitals do not. Hospital administrators do not (12, p. 19).

Areas of Hospital Vulnerability.--These ideas are not just from the union's viewpoint. Richard Hacker, an executive of a hospital management consulting firm in Chicago, described vulnerabilities of hospitals that might be used in organizing to discredit management and win support of the union.

He describes as vulnerabilities: inequitable rotation for weekend, evening and night shift workers; irregular and substandard performance appraisals; lack of seniority policies; lack of uniformity among hospital departments in the application of personnel policies; grievance procedures that favor managers and supervisors; wage and salary plans that do not establish proper relationships among various jobs and skills; lack of opportunity for promotion and transfer within the hospital; lack of opportunity for personal training and development; and lack of leadership for ensuring the rights of the employees (16).

The above issues were selected from data from attitude surveys conducted by the hospital consulting firm over ten years and with 18,000 hospital employees (16). For example, on the question of performance appraisal, 42 per cent of the respondents did not believe their performance appraisal interview was conducted properly by their immediate supervisors. Hacker states that rather than strengthening employee relations, the performance review can instead create hostility and prompt charges of unfairness (16, p. 45).

Regarding wages, the attitude survey indicated that 54 per cent of the employees did not believe their wages compared equitably with employees of other departments and 53 per cent did not believe they were paid fairly for the work they performed (16, p. 46).

In health care facilities the work force is diverse and several hundred job classifications might exist. State and national regulations and accreditation programs require licensing for various jobs. These factors cause complications for promotions and transfers. Management could assist employees in preparing career paths; however, only 36 per cent of the employees surveyed indicated that their supervisors had discussed with them their future in their hospitals (16, p. 46).

The following data depicts some of the attitudes of employees about leadership and supervision in the organization:

Forty-one per cent believed that the problems of their departments or of members of their work groups were listened to and were resolved by administrators and supervisors.

Fifty-five per cent believed that their immediate supervisors were flexible in handling situations or problems that warranted change.

Fifty-six per cent believed their supervisors properly handled complaints and work area problems.

Forty-nine per cent believed they could speak up freely without being criticized (16, p. 47).

Hacker remarked on some subtle changes in the last ten years. Employee compensation has improved but employee attitudes have become less positive. He feels the impact of the financial pressures of hospitals has made an impact on the human aspect of the industry. Hospitals will have to develop approaches to managing human resources that will improve morale if they wish to minimize the risk of unionization.

BNA Survey.--According to the 1971 Bureau of National Affairs Report an important appeal was made in the organizing drives by Local 1199 of the Retail, Wholesale and Department Store Union, involved in almost half of all health care organizing. This union has combined the civil rights and labor movement issues to appeal to nonprofessional hospital employees which are composed largely of workers from minority groups. Minorities see an opportunity for improvement of their socioeconomic situation, especially in a large urban hospital. An example of this theme in the literature is found in a pamphlet: "Black workers unite to force the establishment to meet demands for one hundred dollars per week pay: join our organizing crusade to wipe out poverty wages and promote union and human rights" (33, p. 1).

According to the BNA survey, other hospitals that experienced organizing effects exclusive of Local 1199 said the major themes were traditional wages and security, without the civil rights connection (33). In 1975 only two hospitals even mentioned civil rights. An example of RWDSU literature is found in the Appendix.

Organizing Themes

In the 1975 survey, the Bureau of National Affairs revealed surprisingly most of the initial union contacts were made by the employees rather than by the unions. Job

security and having a voice in management were important union organizing themes (33). The organizing themes in addition to the appeals for higher wages included the area of professional pride (33).

Administrators felt the unions based too much of their campaigns on areas of traditional management concern. According to the BNA survey, there appeared to be no correlation between the organizing techniques and the size of the hospital involved. Many administrators thought the union contacting the employees at home was counterproductive.

Generally the traditional organizing techniques were utilized: handbilling, small group meetings, telephone calls, letters to employees; homes, motel room invitations with refreshments, informal communications with employees, and mass meetings (33).

Since the health care amendments the largest number of employees organized by any one union at any one health facility was the nearly 1,400 workers at the Washington Hospital Center in Washington, C. C. represented by the Service Employees International Union (SEIU). The bargaining unit consists of workers in over 100 job titles, including technicians and laundry personnel. SEIU had campaigned at the hospital two years previously and had been defeated by twenty-six votes. After two years lack of improvement in working conditions provided SEIU with a substantial victory (33). The BNA survey

indicated SEIU was the most frequently mentioned union organizer.

A theme that can appeal to civil rights or an economic situation relates to the concept of human dignity and respect. One union which uses this theme very graphically is the American Federation of State, County and Municipal Employees. In one of their leaflets used in Ohio, an employee is shown kneeling in prayer before the protruding stomach of his boss, who is made to appear both wealthy and villainous. This employee is in this predicament because he had gone to his boss, alone, to engage in individual bargaining. On the other side of the brochure proud, confident employees, smile while standing around a large table as their boss signs what must be a union contract. The message to be communicated is you sit as an equal with a boss to bargain for what you want. One cannot help but note in the second picture, the boss seems to have lost weight and does not appear quite as affluent. This scenario could appeal to anyone who has suffered the pains of not being considered an equal for whatever reason: sex, race, age or religious preference.

As the union approaches the more professional employee the appeals change emphasis and become more oriented toward career development and patient care. Nurses, therapists, and technologists are encouraged to utilize their professional associations for bargaining purposes.

These are some of the general themes that have run through past health care organizing campaigns, but they are not the only ones. Many hospitals have unique situations with unique problems.

Generally when employees decide to join a union they are not necessarily being disloyal to the hospital or to the functions they are hired to perform. They have found increasing difficulty in accomplishing any improvements by individual means and choose to try to implement change through collective action.

Why Workers Reject Unions

Why then, do workers reject unions? Is it merely the antithesis to why they join?

Having to join and pay dues is a reason many people vote against unions. Anti-union voters chose as their second most influential reason that the union was not needed (16). It seems therefore that the presence of a good, solid, participative personnel program, is extremely important in union defeats. Also, management must establish a strong campaign against the union.

Besides the aspects of high wages and good benefits, the front line supervisor must have a positive attitude toward the employees. The supervisor must know how to show enthusiasm, encourage employees, be able to communicate and to listen, and be able to give orders and mete fair discipline.

After the union lost in an election the changes most frequently effected by management were:

1. Establishment of regularly scheduled meetings with employees.
2. Institution of a formal grievance procedure.
3. Concerted effort to deal promptly with employee complaints.
4. Job postings.
5. Promotion from within (16).

The most effective technique before and after union organizing is good communication. New goals and aspirations continually will appear; both unions and management will have to be aware of these changing needs.

In the 1971 BNA survey hospital management found the concern for patient care and threat of disruption by a union to be their most effective responses. Another effective response was why pay for what you already have suggesting that the union would receive employees' dues without winning anything extra in wages and benefits. In the survey hospital personnel directors felt the first line supervisor was the key to success or failure. An effective communication and training program had to be established (33).

The 1975 BNA survey indicated both changes and similarities. Management seemed to be less likely to generalize in their tactics. Charges that unions do not belong in hospitals and unions are detrimental to patient care were

the exception rather than the rule (33). Those hospital administrators who successfully defeated the campaigns credited their success to meeting individually and in small groups with employees and to identify professional associations as nothing more than labor unions. Yet as in 1971, the primary influence was the responsibility of the first line supervisor (33).

Several reasons can explain this influence: Supervisors are symbols of authority, they usually have seniority and may be older than those they supervise, often they themselves have come from the ranks, frequently they are natural as well as appointed leaders (33). First level supervisors are permitted to discuss in non-coercive ways the impact of unionism with the employees. One administrator stated for BNA, "in hindsight, we should have been more attentive to developing supervisors over the years--better communication" (33, p. 1).

Unionization, according to Rakich, need not be detrimental to the organization. Even though an adversary relationship will probably exist, this need not be destructive. The concern of administrators should be to assess the advantages and disadvantages, the costs and the benefits of keeping an organization union-free. If the administration objectively concludes that the effects of a union are not constructive, the concern should then be how to provide a

work environment where the majority of employees will not feel the need to organize themselves. In almost every instance the administrations' lack of perception and response to the legitimate needs of their employees gives rise to an organization drive (24, p. 7).

Chronology of a Hospital Union Campaign

A classic example of a hospital unionization campaign is described by Ernest Helin, Director Employee and Administrative Services, Wuesthoff Memorial Hospital, Rockledge, Florida. Helin describes the Florida Nurses Association campaign at Wuesthoff Memorial Hospital in "Hospital Topics" (4). All exhibits were taken from that article.

The campaign began with a letter, Exhibit One, sent to nurses' homes to announce an initial organizational meeting. Helin remarked that the initial meeting was held at a church, and all meetings were either held at churches or at individuals' homes. This proved somewhat embarrassing to one pastor whose parishioner was the past president of the hospital's Board of Trustees.

Some information that was distributed by the Florida Nurses Association was a handout entitled "Florida Nurses Association Collective Bargaining and You."

The Florida Nurses Association, which has a 'no-strike' policy, is a professional organization dedicated to assuring that:

1. Nurses receive fair compensation and benefits for their professional services.
2. Employment conditions are conducive to providing high quality nursing care, and
3. Professional nurses have the right and responsibility to determine standards of nursing practice.

To accomplish this, the FNA endorses and uses the Collective Bargaining process. . . . The Florida Nurses Association seeks to represent nurses in public and/or private employment, as requested by these nurses (4, p. 53).

After the initial organization meeting, Mr. Boyle, Hospital Administrator, received a formal request (Exhibit Two) for voluntary recognition as the exclusive bargaining agent for staff nurses. Since the campaign was not even one month old, the administration had a good faith doubt that the FNA did represent a majority of staff nurses. The administrator responded with a letter (Exhibit Three) to that effect.

Wuesthoff Hospital had always maintained a consistent no-solicitation policy. This policy applied to Charitable organizations as well as unions; therefore, the hospital did not risk an unfair labor practice charge in this area.

A letter (Exhibit Four) sent to hospital trustees by the nurses caused considerable concern in three areas, according to Helin. One, the statement that nurses will take an active role in establishing standards of nursing

September 11, 1974

Dear Staff Nurse:

This letter is in regard to our telephone conversation during the week of September 9, 1974.

A committee of your fellow Wuesthoff Nurses desires your attendance at a meeting, with a goal of organizing a unit of our nurses in association with the Florida Nurses Association (FNA).

A representative of the FNA will be present to inform us of our professional rights and proper procedure for organizing a unit.

Date: September 24, 1974
Time: 1:00 P.M. to 5:00 P.M.
Place: St. Marks Episcopal Church
(Thursby Hall), Cocoa,
Florida

There will be a meeting at 1:00 P.M. and a repetition of that meeting at 3:30 P.M. so that all shifts may take advantage of this opportunity. A question and answer period is planned following each session so that we may become fully informed.

Committee for Organization
of Wuesthoff Hospital Nurses

Exhibit I.--Letter announcing initial organizing meeting (4, p. 54).

September 25, 1974

Mr. John H. Boyle, Administrator
Wuesthoff Memorial Hospital
110 Longwood Avenue
Rockledge, Florida 32955

Dear Mr. Boyle:

The Florida Nurses Association has been designated by the staff nurses employed at Wuesthoff Memorial Hospital as their exclusive representative for the purpose of bargaining collectively on all terms and conditions of employment.

If your hospital has a good faith doubt that this Association in fact represents these nurses, we are prepared to establish our status (in any lawful way). We are prepared to meet with you at a mutually convenient time to establish procedures for bargaining an agreement.

We would appreciate a prompt response and your voluntary recognition of this Association as the designated representative of the nurses at Wuesthoff Memorial Hospital.

If your response is negative or not received, we will petition the National Labor Relations Board on October 14, 1974, for recognition to represent the nurses.

Sincerely,

Barbara Lumpkin, R.N.
FNA Economic and General
Welfare Program

Exhibit 2.--Letter requesting recognition (4,
P. 54).

October 11, 1974

Barbara Lumpkin, R. N.
FNA Economic and General Welfare Program
Florida Nurses Association
P. O. Box 6985
Orlando, Florida 32803

Dear Ms. Lumpkin:

This will acknowledge your letter of September 25, 1974. The administration and management of Wuesthoff Memorial Hospital has always been and will continue to be concerned with improving the status of all employees.

I do have a good faith doubt that your association does in fact represent the nurses employed at our hospital and therefore could not meet with you to establish procedures for bargaining an agreement.

Yours very truly,

John H. Boyle
Administrator

Exhibit 3.--Letter refusing recognition (4, p. 55).

October 30, 1974

Member
Board of Trustees
Wuesthoff Hospital

Dear Sir:

As a member of the Board of Trustees of Wuesthoff Hospital, we believe your goal is quality patient care for the citizens of this community. We, as members of the Wuesthoff Hospital Professional Nurses Unit, also have as our ultimate goal quality patient care given by nurses who have an active role in establishing standards of nursing practice.

We are aware that you have received information to the fact that the Staff Nurses of Wuesthoff have formed a unit that will permit us to have a voice in our profession. This will continue to be our policy in the coming years.

Enclosed is the factual information from the Florida Nurses Association which we feel will be of value to you in understanding our goals.

Sincerely,

The Wuesthoff Hospital
Professional Nurses Unit

Exhibit 4.--Letter from nurses to hospital trustees (4, p. 56).

practice was threatening to traditional staff and management domains. Secondly, the FNA does not use the word union but instead, says unit. This gives management the task to educate them that this is indeed a union. Thirdly, the hospital administrators felt the reference to the nurses providing factual information seemed to imply that the hospital's information was less than factual.

The National Labor Relations Board held a representation hearing and the appropriate bargaining unit was agreed by both parties to be:

. . . all full time and regular part time registered professional nurses, including staff nurses, certified registered nurse anesthetists, general duty registered recovery room nurses, intravenous therapy nurses, nurse epidemiologists, in-service instructor nurses, and general duty operating room nurses employed by the employer (4, p. 55).

When the bargaining unit was defined, various groups within the unit began to question the appropriateness of their inclusion. The nurse anesthetists formally challenged their inclusion by asking the administrator to delete them from the bargaining unit. A motion was filed by the hospital to exclude them and this was approved by the Florida Nurses Association and granted by the National Labor Relations Board (4).

Helin perceived the nurses' attitude toward management to deteriorate during the campaign. They appeared to resent that management should campaign against them. In effect,

the nurses argued that hospital management should retain a neutral position (4, p. 57).

With 106 registered nurses eligible to vote, 54 voted for the Florida Nurses Association and 41 voted against. The Florida Nurses Association was certified on January 13, 1975, as the exclusive bargaining agent for all staff registered nurses (4, p. 58).

Helin feels that understanding this chronology and utilizing the following strategy, management could win a recognition election. He suggests:

1. Management must try to define widely encompassing bargaining units. If professional groups are permitted to dictate inclusion or exclusion, the results will be catastrophic fragmentation.
2. Start your campaign early. Once your professional employees have become members of their association, they have taken the first step to a "yes" vote for unionization.
3. Meet with small groups. Inform. Educate. Make the professional challenge his associations' labor relations expertise.
4. Define labor terms correctly, their association cannot or will not.
5. Develop a good relationship with the press. The community is interested. It is their hospital!
6. Beware of the responsibility that the hospital has for the acts of its agents. Advise the trustees and medical staff that they may be considered hospital agents and that their behavior may be considered unlawful by the National Labor Relations Board (4, p. 58).

Union Organizing Activity

From 1969 to 1973, approximately 1,000 NLRB elections had been conducted in health care. Over 50 per cent involved the Service Employees International Union and 15 per cent involved Local 1199 of the Retail, Wholesale and Department Store Unions (1). Table II illustrates the membership.

The first election held after the health care amendments was won by the Firemen and Oilers on September 25, 1974, in Kansas City, Missouri. The union received certification for a forty person unit of supply processing and distribution employees at the Kansas City College of Osteopathic Medicine (6).

During the remaining 1974 year (August-December) after the amendments went into effect, the NLRB received 267 election petitions. Increased organizing activity has continued. The most noticeable fact about unions in hospitals is their heterogeneity and variety. Virtually every known union can be found in the health care workers representing approximately 200,000 health care workers in the United States (35). The AFGE has the largest hospital membership among federal employees, and the state and local hospital employees are often represented by AFSCME. Among the many other unions engaged in health care organizing are the Hotel and Restaurant Employees, the Office

TABLE II
NATIONAL UNIONS IN THE HEALTH FIELD--MEMBERSHIP¹

Organization	1960	1968	1970	1972	1974
Service Employees (Estimated members in health field) ²	272,000 NA	389,000 90,000	435,000 125,000	484,000 150,000	500,000 200,000
Retail, Wholesale (Estimated members in health field) ³	143,000 NA	175,000 NA	175,000 50,000	198,000 70,000	180,000 80,000
Nurses Association (Estimated number of nurses covered by contracts) ⁴	NA 7,800	204,000 30,200	181,000 40,000	157,000 NA	196,000 69,202
Operating Engineers	291,000	350,000	393,000	402,000	415,000
Licensed Practical Nurses	NA	NA	NA	26,599	25,977
Retail Clerks	342,000	552,000	605,000	633,000	651,000
State, County (AFMCS)	210,000	364,000	444,000	529,000	648,000
Teamsters	1,484,000	1,755,000	1,829,000	1,855,000	1,973,000
Hotel and Restaurant	433,000	459,000	461,000	485,000	452,000

¹Total union membership taken from Directory of National Unions and Employee Associations, 1975 (BLS Bulletin, 1937), 1977.

²SEIU convention proceedings, The Service Employee, and congressional testimony.

³RWDSU convention proceedings.

⁴ANA data.

and Professional Employees, International Brotherhood of Teamsters, the United Mine Workers, the Laborers International, and Operating Engineers. The absence of one large hospital union has made the industry a target for any union desiring to compete for union membership.

Nurses usually are active in state units affiliated with the American Nurses Association. The leading state nurses associations are located in California, Minnesota, New York, Oregon, and Washington. Nurses at times have been included in other bargaining units and as such, may be found in the Retail Clerks Union and the Teamsters Union. The Licensed Practical Nurse Association is the principal organization for practical nurses and is very active in Minnesota and New York City (35).

Increased organizing activity continued in 1975, and in the first nine months significant union victories occurred. Three unions that have concentrated primarily on organizing in the health care industry showed strong gains. In 1975, the National Union, Local 1199, won 31 of 49 elections to represent 1,534 employees; the Service Employees International Union won over 80 per cent of its elections to represent 1,104 employees; and the American Nurses Association constituents won bargaining rights for more employees than any other union, winning 32 of 42 elections to represent 2,227 nurses (34).

In 1976, the first nine months are comparable. The Service Employees won 43 of 62 elections to represent 1,580 new employees, the Retail and Wholesale Union (RWDSU) was victorious in 24 of 34 elections representing 695 white collar employees, and the American Nurses Association through the state affiliates won 37 of 43 elections to gain bargaining rights for 2,555 nurses (35).

The Service Employees International Union (SEIU), the Retail, Wholesale, and Department Store National Union, Local 1199, and the American Nurses Association state affiliates were the leaders in numbers of contracts and numbers of represented employees. Health care membership in the first two groups represents about 40 per cent of the total organization. ANA has 35 per cent of its members covered by contracts.

SEIU, Local 1199, and the Retail Clerks (RCIA) are industrial type unions and have organized all job categories including professionals. ANA is a craft type union and represents primarily registered nurses. Some nurses groups are members of other unions however.

A brief description of SEIU, RWDSU, and RCIA follows. An in-depth look at the American Nurses Association is presented in Chapter V.

Service Employees International Union

The SEIU membership is composed of employees working in private, nonprofit, and public institutions such as hospitals, nursing homes, or other health facilities, colleges, universities, private and public utilities, department stores, industrial plants, and places of amusement (28). Officers of the International include a president, a secretary-treasurer, nine vice-presidents and thirty-five executive board members. George Hardy, the International President, succeeded George Sullivan in 1971. The President provides the thrust for the direction of SEIU and has the power to negotiate and enter into national, regional, or area collective bargaining agreements. Also the President directs the research, education, legislative, publications, and political education activities of the international.

Originally chartered as the Building Service Employees International Union in 1921, it was not until 1968 that its name was changed to Service Employees International Union. In hospital bargaining SEIU engaged in organizing attempts in Brooklyn in 1935 (10, p. 435), but it was not until 1958 that a Brooklyn hospital came under contract (11, p. 3). In 1959 a master agreement was obtained by SEIU Local 144 with the Association of Private Hospitals which covered thirty-two private proprietary facilities (11, p. 3).

On the West coast, Franklin Hospital in San Francisco was organized in 1941, and following that the other non-profit hospitals obtained contracts. When the National Labor Relations Board asserted jurisdiction over nursing homes and convalescent centers, Local 250 was able to organize 53 nursing homes with over 2,537 workers in a year and a half (15, p. 109).

Several examples of SEIU's thrust in health care organizing include: 18 hospitals in Minnesota as early as 1959, the 1958 "Toledo Plan" in Seattle, contracts with 45 nursing homes in Philadelphia, forming HELP in Chicago with the Teamsters, and many other organization efforts across the country (37, p. 73).

Health care conferences and committees.--In 1973, the National Conference of Physicians Union was formed for the purpose of coordinating local unions composed of physicians. By 1976, SEIU reported 1,000 physician members. Locals were located in New York, Iowa, Louisiana, Montana, Nevada, Washington, and Illinois (31, p. 84).

The committee on hospitals and nursing homes is based on a four point program:

1. Expand organizing activities in hospitals and nursing homes.
2. Hold regional educational conferences to instruct locals in the economics, organizational structure, and philosophy of the industry.

3. Develop organizing and pamphlets and bulletins.
4. Direct legal counsel to develop strategy which would prevent the fragmentation of hospital employees into a multitude of small weak bargaining units and to deal with the question of appropriate bargaining units (31, p. 85).

Legislative goals adopted included mandatory coverage of unemployment insurance, social security, and workmen's compensation. Bargaining goals announced at both the 1972 and 1976 conventions included:

1. Wage, fringe benefits and working condition parity for nursing home employees in relationship to acute hospital employees, as already achieved by some locals;
2. Clearly defined levels of promotional opportunities and career ladders, including the necessary provisions of leaves for education and training. Establishment of senior or lead classifications, not only as a career or promotional incentive, but to compensate for added skills and responsibilities.
3. Prohibitions against excessive work loads and unsafe working conditions.
4. Establishment of industry-wide retirement plans providing portability and vesting provisions so that employees do not lose accrued credits when their employment transfers from one establishment to another.
5. Absolute guarantee of time and one-half pay after eight or more hours of work per day, so that no ten-hour day programs can be instituted by a hospital or nursing home (31, p. 85).

During the 1976 convention the committee on hospitals and nursing homes offered the following program: (1) establish a national clearing house arrangement among their key attorneys in the various regions with the responsibility to

formulate a consistent approach to problems and uniform answers, (2) hold an international conference on hospital and nursing homes annually, (3) encourage adoption and implementation of federally funded career advancement incentive programs covering non-licensed as well as licensed personnel, (4) oppose any form of mandatory continuing education legislation requiring attendance at an academic setting rather than on-the-job training or in-service training, (5) achieve a federal reimbursement program through Medicare and Medicaid whereby full cost reimbursement is guaranteed with a built-in economic adjustment formula, and (6) implement a more intensive public relations program to disseminate information through the media to enlighten the general public on progress made in hospitals and nursing homes by SEIU local unions (31, p. 86).

The SEIU plays a substantial leadership role in health care bargaining. Each issue of its "Service Employee" gives an account of another success in health care organizing. The officers have given SEIU this direction and the research, educational, and communications support needed to sustain the strong position of leadership.

Retail, Wholesale and Department Store Union:
Division, National Union of Hospital and
Health Care Employees

The RWDSU was a result of a schism in the Retail Clerks International Association (RCIA) that occurred in 1937

(17, p. 78). Periodically merger talks have been held but as yet the two remain separate.

In 1937, Local 1199 joined the RWDSU after having been both an independent and an AFL affiliate. Local 1199 was led by Oscar Lerner, former pharmacist and Leon Davis, former drug clerk. Their organizing targets were registered pharmacists and other drug store workers in New York. In 1955, Local 1199 had 5,000 members employed in retail pharmacies.

By accident Local 1199 expanded from retail pharmacies to the hospital field. In 1957, Davis hired Godoff, a former Teamster organizer. Mr. Godoff shifted his efforts with Maimondes Hospital to Local 1199 and hospital representation had begun. By Spring 1959, twenty-five institutions were faced with Local 1199 organizing committees and six institutions were faced with demands for recognition. Local 1199 struck the six institutions for forty-six days when the demands for recognition were not met. In 1969, the union created a National Organizing Committee to broaden its horizon beyond New York. Medical College Hospital in Charleston, South Carolina, was the first to feel the attention of this new committee (19).

On December 16, 1969, the RWDSU established the National Division of Hospital and Nursing Home Employees. According to Max Greenburg, then RWDSU president, this was to coordinate the organizing efforts in health care facilities (26).

On November 29, 1973, the division was renamed the National Union of Hospitals and Health Care Employees and became an approved separate division of RWDSU (27).

The National Union defines its jurisdiction as including all professional, technical, clerical, service, maintenance, and all other employees in health care institutions such as medical centers, hospitals, nursing homes, pharmacies, and other related services (27).

New York, New Jersey, and Connecticut units provide the largest membership base with District 1199 representing 62,000 members in 200 nursing homes and hospitals. In 1974, Baltimore District 1199E reported 7,500 workers in 17 facilities and District 1199C in Philadelphia represented more than 6,000 members (27). In total the National union represents workers in approximately 23 states.

Leon Davis, has been President of formidable District 1199 since 1934. The union has been described as having "union power plus soul power" (31, p. 94). Officers of the National Union include the president, an executive vice-president, secretary-treasurer, secretary, executive secretary, and a minimum of one vice-president representing each district in the National Union (as illustrated in Figure 2).

District 1199 is the largest unit within the National union and has several divisions within the organization: the Hospital Division; the Guild of Professional, Technical and Office Employees; the Drug Division; and the RN Division

(League of Registered Nurses). The divisions are further divided into chapters and areas. Members of each division vote on contracts and activities affecting its membership. The special RN Division was created after 1199 decided to rescind its policy regarding refraining from organizing nurses in New York. The District now represents 1,500 nurses in the New York Area (29).

Other professional workers are represented by the National union. In 1976, 680 professionals represented by the Professional and Technical Employees Association affiliated with 1199C. Members include social workers, dieticians, psychologists, physician assistants and others (32). The group seemed to decide that power spoke louder than professionalism to employers (32).

RWDSU, the National Union, and District 1199 have made a strong impact on hospital organizing. The influence and pattern setting will continue to play a dramatic part in the future.

Retail Clerks International Union

The Retail Clerks date back to 1890. It was called the Retail Clerks National Protective Association and was an AFL affiliate. In 1946 the name became Retail Clerks International Association (RCIA), and in July 1977, the name was changed to Retail Clerks International Union (RCIU). The Retail, Wholesale, and Department Store Union left the organization in 1937.

Many of the 700,000 members joined as a result of mergers. The Boot and Shoe Workers Union joined in 1975 and brought 30,000 members. Merger considerations have been explored with the Amalgamated Meat Cutters and Butcher Workers of North America and also a recent rejoining of RWDSU.

Membership includes persons engaged in the sale, distribution, or provision of consumer products; or services in such occupations as sales-persons, pharmacists, and others determined by the executive board to be within RCIA's jurisdiction (17).

The RCIU has represented nurses, office, and non-professional workers since 1952 in locations such as Minneapolis and Akron, Ohio (17). The Registered Nurses Guild was established in 1966 in Los Angeles to compete with the California Nurses Association (46). Organizing efforts in health care have intensified since 1973. A special nursing home organizing team was formed and a professional division was created to organize doctors, nurses, pharmacists, and technicians (22).

In addition to organizing the unorganized, the union attempted to recruit several independent professional groups. In 1976, the Society of Radiologic Technologists became part of RCIU. Also, locals of 1,000 technicians and scientists at hospitals in Washington and Oregon affiliated with RCIU

in 1976. They had been represented by the independent National Economic Council.

The Retail Clerks have recently become more aggressive in their health care organization efforts. Attempts to grow by merger and consolidation also appear to have high priority for the RCIU.

National Labor Relations Board
Representation Cases

The Taft-Hartley Act requires an employer to bargain in good faith with the duly chosen representative of his employees. The Act does not specify a particular procedure for designating this representative, but it must be clearly the majority. The Act does authorize the National Labor Relations Board to conduct elections. These elections may be the result of a petition filed by employees, a labor organization, or by an employer faced with a claim for recognition. The Board then has the authority to conduct elections, determine the appropriate bargaining unit, and certify a collective bargaining representative following the election. The Board may also be requested by employees, or a labor organization to decertify incumbent bargaining representatives (2).

Table III shows the representation cases in health services handled by the NLRB since 1972. The stabilization that existed prior to the amendment showed dramatic change.

In 1976, unit clarification cases represented almost 25 per cent of total NLRB clarification cases (31, p. 217).

TABLE III
NLRB REPRESENTATION CASES IN HEALTH SERVICES

Fiscal Year	All Health Care Representation Cases*	RC	RM	RD	UD	AC	UC
1972	404	360	20	24	9	0	4
1973	414	358	25	31	15	1	3
1974	461	380	37	44	11	5	6
1975	1,451	1,332	76	43	15	2	57
1976	1,138	1,033	44	61	20	3	92

Source: NLRB Annual Reports, 1972-1976, Washington, D.C.

*Representation cases are coded by NLRB by the first letter R. In combination with another letter; RC, RD, RM, it indicates a petition for investigation and determining a question of representation.

RC: A petition filed by an employee or labor organization to seek an election for the determination of a collective bargaining representative.

RM: A petition filed by an employer seeking an election to determine the majority existence of a collective bargaining representative.

RD: A petition filed by employees alleging the certified union no longer represents the majority of bargaining unit employees and seeking an election to determine this.

UD: Union Deauthorization Case.

AC: Amendment of Certification Cases.

UC: Unit Clarification Cases.

The National Labor Relations Board held 1,537 elections from 1974 to 1976. As indicated by Table IV, the amendment caused a steady increase in actual representation elections.

TABLE IV
NLRB REPRESENTATION ELECTIONS IN THE
HEALTH SERVICES INDUSTRY

Fiscal Year	Total Elections	Won	Lost	Per Cent Won
1968	80	66	14	82.5
1969	120	73	47	60.8
1970	120	76	44	63.3
1971	196	136	60	69.3
1972	250	155	95	62.0
1973	254	164	90	64.5
1974	248	151	97	60.9
1975	579	346	233	59.7
1976	710	416	294	58.6

Source: NLRB Annual Reports 1968-1976, Washington, D.C.

The NLRB does not isolate the American Nurses Association in its election data. They are listed as independents. This makes the top five active unions in health care to be SEIU, RWDSU (District 1199), RCIA, Teamsters, and AFSCME. These election wins are shown in Table V.

TABLE V
TOTAL ELECTIONS WON BY FIVE MOST ACTIVE
HEALTH CARE UNIONS

Union	Total Won	Fiscal Year 1975	Fiscal Year 1976	First Nine Months Fiscal Year 1977
SEIU	306	97	132	77
1199	154	50	72	32
RCIA	69	17	22	30
Teamsters	62	24	21	17
AFSCME	38	10	24	4

Source: NLRB Election Reports, 1975-1977, Washington, D. C.

Election activity is concentrated in the Northeast and California; however, activity has been widespread geographically. According to Cooper, elections have been held in forty states, District of Columbia and Puerto Rico. He found 58 per cent of the activity the first year following the amendment was in Michigan, California, New York, Illinois, Ohio, and Pennsylvania (5). This is little different from the previous eight month period before the amendment. The same states accounted for 57 per cent of all election activity. Also, according to a study, states which experienced high election activity between 1968 and 1970, were California, Michigan, Massachusetts, Missouri, Connecticut, Washington, New York and Illinois (5).

The number of contracts and employees in bargaining units of the top ten unions in 1976 are shown in Table VI.

TABLE VI
TOTAL NUMBER OF EMPLOYEES IN BARGAINING UNITS
AND COLLECTIVE BARGAINING SITUATIONS
AS OF DECEMBER 31, 1976

Organization	Number of Employees in Bargaining Unit	Number of Contracts
Service Employees	156,099	838
Retail, Wholesale; National Union of Hospitals and Nursing Homes	98,625	412
Nurses Association	66,650	411
Operating Engineers	4,785	162
Licensed Practical Nurses	8,574	124
Retail Clerks	6,755	80
State, County (AFMCE)	14,618	75
Teamsters	5,944	73
Hotel and Restaurant	2,286	28
Office and Professional	4,604	33

Source: FMCS internal data taken from final reports submitted by mediators.

Summary

As anticipated, the passage of the health care amendments brought many changes in health care facilities and in the unions engaged in organizing health care facilities.

Many studies show workers unionize in health care for basically the same reasons in private industry: lack of individual protection, such as seniority and grievance procedures; poor wage and salary plans; and lack of development opportunities. Some areas of the health care industry are particularly vulnerable due to the twenty-four hour round-the-clock care provided at most facilities.

Workers who reject unions tend to do so because the supervisor was a good communicator, the hospitals were able to influence the professionals with professionalism, and the attention was given to employee needs.

Union activity has increased substantially in health care. In the nonprofit, nongovernmental sector, RWDSU and SEIU are the two largest and most active. The NLRB has held almost 2,000 elections in health care since the amendments, with the unions winning approximately 60 per cent. Election activity has been occurring mainly in the Northeast and California.

Organizing and election activity is still the thrust of most health care unions. In the future its emphasis should diminish since the more fertile territory will be gone.

CHAPTER BIBLIOGRAPHY

1. AFL-CIO American Federationist (January, 1975), 15-17.
2. Annual Reports, National Labor Relations Board, Washington, D. C.
3. Billington, Glenn E., "Hospitals, Unions, and Strikes," Cleveland-Marshall Law Review, 18 (January, 1969), 70-81.
4. "Chronology of a Hospital Union Campaign," Hospital Topics (March-April, 1976), 53-58.
5. Cooper, Martin W., "Trends in Organization in the Health Care Industry," UHA Reporter (Summer, 1976), 4-10.
6. Election Reports, National Labor Relations Board, Washington, D. C., 1968-1977.
7. "1199 Fact Sheet," 1199 News, 11 (June, 1976), 6.
8. "Factors in Organizing Hospitals," Hospitals, 43 (1969), 196-198.
9. Federal Mediation and Conciliation Service, internal data.
10. Gamb, John S., "Hospitals and the Unions," Survey Graphic, 26 (August, 1937), 435-437.
11. Gamm, Sara, Toward Collective Bargaining in Nonprofit Hospitals: Impact of New York State Law, Bulletin 60, Ithaca, New York, Cornell University, October, 1968, 3.
12. Gittler, Marvin, "What do Unions Want in Hospitals, Anyway?" Paper presented to American College of Radiology, October, 1972.
13. Goodfellow, Matthew, "Checklist on Susceptibility to Union: How Organizer Robs Your Hospital," Hospital Topics (January, 1973), 33-36.
14. Gotbaum, Victor, "Influence of the Labor Movement on Hospital Affairs," Hospitals, 44 (January 1, 1970), 72-76.

15. Gottlieb, Sanford, "How Unions are Doing in Hospital Campaigns," Modern Hospital, 94 (March, 1960), 109.
16. Hacker, Richard L., "Organizational Systems for Change Offer an Alternative to Unions," Hospitals, 50 (December 1, 1976), 45-47.
17. Harrington, Michael, The Retail Clerks, New York, John Wiley and Sons, 1962, pp. 78-79.
18. Kelingartner, Archie, "Nurses, Collective Bargaining, and Labor Legislation," Labor Law Journal, 18 (April, 1967), 236-245.
19. Metzger, Norman, and Dennis D. Pointer, Labor Management Relations in the Health Service Industry: Theory and Practice, Washington, D. C., Science and Health Publications, Inc., 1972.
20. Miller, Jon D., and Stephen M. Shortell, "Hospital Unionization: A Study of the Trends," Hospitals, 43 (August 16, 1969), 67-73.
21. "New Union Rights for Hospital Workers," Mutual Broadcasting System interview with Thomas R. Donahue, Executive Assistant to the President of the AFL-CIO, September 10, 1974.
22. "Nursing Home Employees Organizer," Retail Clerks Advocate, 77 (March, 1974), pp. 11-15.
23. Osterhaus, Leo B., "The Effect of Unions on Hospital Management: Part 2--Factors Stimulating and Inhibiting Unions," Hospital Progress, 48 (July, 1967), 77.
24. Rakich, Jonathon S., "Hospital Unionization: Causes and Effects," Hospital Administration, 18 (Winter, 1973), 7-18.
25. Retail Clerks International Association, Proceedings of 15th Annual Convention, Washington, D. C., April 20-23, 1972.
26. Retail, Wholesale, and Department Store Union, AFL-CIO, Proceedings of the Eleventh Constitutional Convention, Bar Harbour, Florida, June 1-5, 1970.
27. Retail, Wholesale, and Department Store Union, AFL-CIO, Proceedings of the Twelfth Constitutional Convention, Bar Harbour, Florida, June 3-7, 1974.

28. SEIU Constitution and By-laws, Revised and Amended April 22, 1976.
29. Signing up Registered Nurses in New York," Health Labor Relations Report, 1 (February 21, 1977), 10.
30. "Study finds Union Activity on Increase in Hospitals," Hospitals, 45 (August 16, 1971), 110-111.
31. Tanner, Lucretia Dewey, "The 1974 Taft Hartley Amendments," an unpublished study done for the Federal Mediation Service and Department of Labor, Washington, D. C., 1977.
32. "Temple Health Professionals Affiliate with Union," Health Labor Relations Report, 1 (November 16, 1976), 5-6.
33. White Collar Report No. 945 (May 16, 1976).
34. White Collar Report No. 973 (November 28, 1975).
35. White Collar Report No. 1027 (December 17, 1976).
36. White Collar Report No. 1011
37. Wood, Donald, "They Live and Learn with Unions," The Modern Hospital, 93 (July, 1959), 73-74.

CHAPTER V

PROFESSIONALS IN HEALTH CARE ORGANIZATIONS

Registered Nurses

Historical and Organizational Perspective

The American Nurses Association has evolved over a long period of time. The American Society of Superintendents of Training Schools for Nurses of the United States and Canada was formed in 1893 in an attempt to standardize the quality of nursing. Since this organization was not open to everyone, the Nurses Associated Alumnae of the United States and Canada was created in 1896. In 1912 the American Nurses Association (previously named Nurses Associated Alumnae) and the National League for Nursing Education (the renamed Society of Superintendents) published the official journal of the nursing profession, the American Journal of Nursing (1, p. 108).

The American Nurses Association became the largest and more representative group; organized as a federation of fifty-four constituent state nurses associations. Presently American Nurses Association membership consists of registered professional nurses employed in all occupational subdivisions of the nursing profession. Programs and policies of the ANA are determined by its House of Delegates. Representation

occurs dually: first, through general membership and second, through the occupational specialty groupings. This is duplicated in the state and district organizations (1, p. 110).

The ANA recognized eight occupational sections: counselors, executive secretaries and registrars; educational administrators, consultants, and teachers; general duty nurses; nursing service administrators; occupational health nurses; office nurses; private duty nurses; and public health nurses (1, p. 111). Figure 3 illustrates the structure of the ANA.

In 1946, the ANA responded to a challenge by its president in her opening speech to the convention. "If the nursing profession is ready to take on hours, salaries, economic advancement, enlargement of nursing resources while maintaining standards and possible reconstruction of its own organizational structure, we shall this week make nursing history" (5, p. 11).

The delegates did make history by voting to establish the Economic and General Welfare program which included the following goals:

. . . wider acceptance of the forty hour week and establishment of minimum salaries, increased participation of nurses in the actual planning and administration of nursing service through the nurses association, development of collective bargaining techniques by state nurses associations, restriction of nurses to one organization which can act as a bargaining agent, and elimination of barriers to the employment of minority racial groups (5, p. 11).

From 1950 to 1968, the ANA held a no strike policy to be in existence. Professional nurses had voluntarily relinquished the right to strike in return for assurances that employers would deal with them equitably. This policy was rescinded in 1968 because it became increasingly apparent that many employers were not acting in good faith. The decision regarding strikes was placed in the hands of the state associations, the groups that conduct the collective bargaining.

The Texas Nurses Association structure, as illustrated in Figure 4, shows the wide variety of concerns and committees. The Economic and General Welfare Commission is responsible for the efforts toward collective action. The effort currently comes under the auspices of the Professional Services Program.

Efforts toward representation of professional nurses in collective bargaining had been thwarted due to the diverse laws that existed. The ANA supported legislation for twenty-seven years to enhance nurses' roles. Until the Health Care Amendments to the Taft Hartley Act, 70 per cent of the nurses were employed in exempt facilities. However, even with 30 per cent or 200,000 nurses eligible, only 50,000 were covered by contracts by 1971. Now that the amendments provide bargaining opportunities for 495,000 registered nurses, an estimated 7,000 health care institutions could be affected (5).

The Nurse as a Professional and as a Unionist

Problems of Professionals.--The professional exists as a member of a special group to which admission is gained only after advanced or specialized study. The professional seeks peer recognition and has pride in acquired knowledge. One of the major differences between professional and non-professional employees is that the professional expects to have a role to play in deciding how the job should be performed. All too often this does not occur and dissatisfaction is the result. The professional then feels a lack of respect (8, p. 120).

A quote regarding industrial engineers could be easily interpreted to read registered nurses. Mr. Kleingartner of UCLA stated,

Management equates professionalism with loyalty to management, and perceives unions as threatening the loyalty of engineers. Any engineer who joins a union is perceived as disloyal and by extension as behaving unprofessionally. [However,] management opposition to engineer unionism reflects purely managerial interests more than a concern for high professional standards. I would guess that management opposition would be just as strong if professional societies attempted to bargain (33, p. 233).

In health care facilities it has been found that issues involving quality of patient care (i. e., the number of doctors available in emergency rooms, improvement of nursing staff, availability of therapists, etc.) are of great concern at all professional levels. Salary is the other major

issue, although this diminishes at higher pay levels. This issue has more significance to nurses than to the higher paid pharmacists. All groups want greater impact on institutional decision making (8, p. 120).

Nurses are experiencing greater concern over their own practice and professional standards. Nurse Ada Jacox is convinced that "nursing as represented by the professional organization, must help nurses in their growing efforts to gain more control over their own practice" (59, p. 1946). She also believes:

Nurses have a great deal of knowledge about how to improve patient care. Many nurses are becoming less passive about what happens to patients and to nurses themselves in our contemporary health care system. They are increasingly seeing the value of using collective bargaining, and collective action more generally, to improve both economic and practice conditions.

For a group of nurses to act collectively to improve care received by patients is professionalism in the truest sense. For such nurses--and potentially for the profession itself--there is a new sense of power, fed by a new awareness of rights, sense of conviction, and feeling of worth. The power is in more than their determination to change things; it is in the knowledge that together they can do it (59, p. 1951).

Dual Identity

There has emerged in the modern day nurses association two separate identities. It is a professional association engaged with the concerns of health care, including education and training of nurses and the collecting, organizing

and imparting of information related to the improvement of, and developments in, the delivery of health care (17, p. 46). It is also a labor organization with the goals and structure that characterize the traditional representative of employees with respect to wages, hours and working conditions (17, p. 46).

This is illustrated in the statement of philosophy from the Texas Nurses Association Professional Services Commission.

Professional nurses adhere to standards in the Code for Nurses.

The Concept of professional ethics is promoted through the process of collective bargaining.

Professional nurses have the right and responsibility to participate in determining the terms and conditions of employment.

Professional nurses have an obligation to implement the ANA standards of care on the employment setting.

Professional nurses have an obligation to promote the welfare of nurses to the end that all people may have better nursing care.

Professional nurses have the right to engage in collective bargaining and to withhold services (64, p. 15).

At the American Bar Association National Institute on Hospitals and Health Care Facilities, a panel addressing the issue was composed of Epstein, former president of the American Society of Hospital Attorneys; Gordon, representative of the committee of interns and residents; Zimmerman, president of the American Nurses Association; Dorn, attorney for

District 1199 RNDSN; and Baird, Lutheran Hospital Society Attorney (36).

Epstein remarked about the changes undertaken in the last decade by professional associations, including those at health care organizations, where they now have the dual identity of association and labor organization. Epstein remarked on the complications this dual identity causes in the relationship with the hospital. He examined the requirements of the Taft Hartley Act which he felt are fundamentally inconsistent with common hospital practices, such as payment of association dues. Hospitals cannot ignore the union identity of an association like the American Nurses Association. The ANA cannot ignore the fact that it has declared itself a labor organization; the NLRB views it as a labor organization, and it uses a labor organization's weapons (36). Epstein remarked he felt resolution of the dual identity problem would be for ANA to restructure its organization and to divide its two functions (36).

Zimmerman addressed herself to Epstein's remarks regarding ANA restructuring by stating ANA had considered doing so, but chose instead to let the state associations become involved in collective bargaining questions. The state associations disclaim control over collective bargaining itself, this is conducted by the local chapters. Zimmerman cited the local's autonomy in contract negotiations,

determination of work stoppages, and executing contracts. Epstein maintained that local chapters are highly related to state associations (36).

This discussion related to Anne Arundel General Hospital (4) and Sierra Vista Hospital, Inc. (60), in which the hospitals argued that the state nurses associations were not labor organizations because they had management members. The associations contended that the unit petitioning for representation was not the state association but a separate, smaller unit. The Board agreed with the nurses association in both cases.

Baird said although he accepts nurses associations as labor organizations, he is concerned about unfair labor practice violations (36). Section 8(a)(2) of the Act forbids employer domination or illegal assistance and support of a labor organization. He cited an example, that before the nurses association was certified as the bargaining agent, the hospital treated the association as a professional association only and allowed it privileges including using hospital space for meetings. When the association became a union, Baird inquired if the hospital had the obligation to end the privileges or must it continue them based on past practice (36)?

Similar to that example is where the hospital formerly paid the association dues. Section 302 of the Taft Hartley

outlaws employer payments to employee representatives. Cases outside the health care field have consistently held employer payment of union dues to be unlawful support of unions.

The problems raised by dual identity of professional associations extend into bargaining. Zimmerman pointed out that under the "obligation of their license, their commitment, and the demands of their patients, nurses are obligated to perform in the best interest of their client," and that means getting involved in patient care issues traditionally decided by management (36, p. 75).

Gordon noted that traditional bargaining deals with wages and working conditions. However, he did state that issues involving purely patient care, or that are purely educational, are not mandatory subjects for bargaining unless they have an effect on wages or other working conditions (36).

Management Domination

Since the 1974 amendment, employers of nurses begin claiming the State Nurses Associations (SNA's) were "management dominated" and therefore not bona fide collective bargaining representatives of the nurses. The first management domination case was Anne Arundel Hospital vs. Maryland Nurses Association (4). The hospital contended that MNA was dominated by management nurses. The NLRB ruled this was not

so and that the employers contentions were not supported by substantial evidence.

Since the 1975 Anne Arundel case several other cases have gone before the Board on the same charge and all have been found in favor of the State Nurses Association--no management domination. These cases were as follows:

10-24-75 Oak Ridge Hospital vs. Tennessee Nurses Association (46).

1-30-76 Crestline Memorial Hospital vs. Ohio Nurses Association (13).

8- 5-76 St. Patrick's Hospital vs. Montana Nurses Association (57).

8-31-76 Sierra Vista Hospital vs. California Nurses Association (60).

In spite of these Board decisions there have been several reported attempts by employers to get administrative, midmanagement, and certain clinical nurses to withdraw membership from ANA. There have been difficulties with questions of "supervisor taint" in elections, but the issue of "management domination" in terms of the economics and general welfare program seems to be consistently determined by the board. The State Nurses Associations operate the Economic and General Welfare Program independently from the Association's Board of Directors.

ANA feels continual professional activities in areas of collective bargaining as well as standards of nursing practice

are important because the organization's programs are designed by nurses for nurses and therefore better able to handle nursing questions.

Bargaining Units for Nursing Personnel

Two basic questions have to be answered regarding representatives for nursing personnel. One, what bargaining units are appropriate and two, who are the supervisors and who are the employees? A department of nursing is usually the largest and most complex of any departments in a health care facility. In structure there would normally be a director of nursing, one or more assistant directors, nurse supervisors, head nurses, staff or general duty nurses, practical nurses, nursing aides, orderlies and attendants. In complex structures there may be ward secretaries, team leaders, ward managers, charge nurses and nurse specialists.

The nursing team actually administering patient care may consist of nursing assistants or aides, practical nurses, and registered nurses. These groups have been determined by the Board to be entitled to different bargaining unit classifications.

Nursing Assistants.--In Heights Medical Center, Inc.
(21), nursing assistants were placed in nonprofessional units which include service and maintenance employees. These nursing aides would normally be under the supervision

of a registered nurse and they would have to make few independent decisions.

Licensed Practical Nurses.--In the landmark case, St. Catherine's Hospital of Dominican Sisters (55), the NLRB held the licensed practical nurses (LPN) could not form a separate bargaining unit at that hospital. The LPN's were required to be in a unit composed of the hospital's technical employees. A service and maintenance unit was deemed not acceptable in Clarion Osteopathic Hospital (9) since LPN's require state licensing and completion of a one or two year post high school training course. They perform more functions than the nursing assistants such as some treatments, medications, blood pressure, temperature, and other patient care activities. Inclusion in a unit of registered nurses (RN's) did not meet the requirements either in Presbyterian Medical Center (50), since LPN's generally receive orders from RN's, have less schooling, are more limited in the functions that can be performed, and have less opportunity for advancement.

Since Congress desired to avoid proliferation of bargaining units the inclusion of LPN's in the technical units seems understandable, however the NLRB has created some degree of confusion. In St. Catherine's Hospital (55), the Board found LPN's to have common interest with the technical group in terms of specialized training and certification

requirements. They also usually have the same working hours and same salary range. Also in Trinity Memorial Hospital of Cudahy (65), LPN's were found to be technical employees based on training, licensing, and job duties. In Barnert Memorial Hospital (42), the Board refused to recognize the exclusion of LPN's from a technical unit even though both parties agreed to the exclusion.

Confusion seemed to occur after the Otis Hospital (47) decision where the Board held it would accept and deem appropriate a separate unit of LPN's if the parties, both union and hospital, agreed on such a bargaining unit. In a footnote the Board said the difference in Barnert (42) and Otis (47) was that in Barnert the parties could only agree to exclude LPN's but could not agree as to the bargaining unit, but in Otis the parties agreed to what the appropriate units should be. The Board calls this a shared perspective and it is a precondition to excluding LPN's from a unit of technical employees.

Generally LPN's are not supervisors and even when left, especially in evenings, in charge of patient care the LPN gives only routine directions. In Mountain Manor Nursing Home (41) the Board found that charge nurses whose responsibilities are limited to routine care are not supervisors. This was also the situation in Pinecrest Convalescent Home (49), where the board held a charge nurse LPN was not a

supervisor even though she could initial time cards, accept absenteeism calls, and give aides permission to leave early. The cases determining LPN status as supervisor or employee are limited and not as difficult as those involving RN's.

Registered Nurses.--The registered nurse as the professional and most educated member of the nursing team provides the direction for the care of the patient. The RN utilizes professional judgment in providing direct care to patients and in evaluating whether good and adequate care is being given by others, whether medical directives are being carried out appropriately and whether records are adequately maintained within the unit so that continuity of care can go on despite shifts in personnel.

Registered nurses have a joint professional concern (that of providing quality patient care) and all their education and training is directed at fulfilling this professional responsibility. Because of their training, education, history of separateness, and unique status within the hospital organizational structure, RN's may be represented in a separate bargaining unit composed solely of RN's. The lead case was Mercy Hospital of Sacramento (40) where a separate unit of RN's was upheld and RN's could not be forced into a unit of hospital professionals if they did not so desire. In Dominican Santa Cruz (15), RN's could choose to be included in an all inclusive unit of professionals. The

singular community of interest among RN's allows them flexibility in selection of their own unit regardless of the union's choice.

In Memorial Clinic Ltd. (39), the Board overruled a regional director's decision that in a small health facility RN's could be included in nonprofessional unit because they performed many functions considered nonprofessional. The Board decided on the basis of schooling, licensing, and other duties their distinct professional status remained even at very small health facilities where they had to perform other functions.

Separate units for hospital and clinic registered nurses will be found if the two groups have separate and distinct community of interests such as a history of separate units, little or no interchange, separate supervision, separate work scheduling, and separate personnel policies. However, in Kaiser Foundation Hospitals, Inc. (31), the board held that if hospital RN's chose representation by a union that already represented clinic RN's then the two units would be combined.

In St. Rose de Lima Hospital, Inc. (58) the Board held that a unit of RN's at a hospital did not include two RN's who were members of the religious order that owned the hospital. In St. Anthony Center (54) the Board expressed the reason for this ruling. Members of religious orders had

different interests than lay employees and different terms and conditions of employment. Moreover, conflicts of loyalty could result from their simultaneous membership in the bargaining unit. If the employee belongs to a different religious order than that which controls the facility, then he or she will probably be treated like a lay employee for purposes of unit determination.

The Commerce Clearing House analysis of RN positions includes the following categories: nurse practitioner, nurse anesthetists, clinicians, continuing education personnel, tumor registrar, administrative and quasi administrative, hospital nursing school staff, head nurses, charge nurses, and graduate nurses (6). All facilities do not have each classification of nurse but all will have some of these categories.

Head Nurse, Charge Nurse, Team Leader.--Many difficulties and conflicts have arisen over determining the supervisory status of the RN. Almost all registered nurses exercise independent judgment and professional authority to direct employees. Currently the ANA position is that the term supervisor "should be limited to registered nurses who truly and substantially possess and exercise authority over other registered nurses" (6, p. 9097). They feel the transitory or limited authority nurses have over other employees is not supervisory but rather a manifestation of their professional

role in nursing care. ANA states: "The primary difference between professional and supervisory status of the registered nurse is that the professional acts in the interest of the patient, whereas the supervisor acts in the interest of the employer" (6).

The positions of head nurse, charge nurse, and team leader come close to supervisory but each case seems to be determined on its own facts, especially the facts related to scope of authority. Generally, but not always, head nurses are in charge of the various floors of the hospital during the day, charge nurses perform duties parallel to those of the head nurse, but are usually in charge of the floor on night and evening shifts. A team leader is usually assigned by the head or charge nurse and coordinates patient care employees such as LPN's, aides, etc.

In Presbyterian Medical Center (50), head nurses were found to be supervisors and were excluded from the bargaining unit. The head nurses issued discipline, recommended wage increases, and were responsible for the unit's operation even when off duty. The charge nurses and team leaders were included in the RN unit and declared non-supervisory since their duties were limited to a professional capacity in performance of the professional duty of maintaining patient care.

In Newton Wellesley Hospital (44) head nurses could not recommend hiring, firing or approve discipline, or schedule

changes. They were essentially resource personnel and therefore could be included in the bargaining unit rather than excluded as supervisors.

Supervisors were both head and charge nurses in Gnaden Huetten Memorial Hospital (20). They both spent eighty per cent of their time in discipline, training new employees, and making work assignments. In Meharry Medical College (38), charge nurses were not supervisors because they only gave general direction to employees in performance of normal patient care.

Team leaders are normally included in the bargaining unit but the issue of head nurses and charge nurses remains a case by case question related to the kinds of decisions the individuals can make in their position.

Graduate Nurses, Nurse Permittees, and Graduate Nurse Technicians.--The above categories include those nurses who have had their schooling but have not yet become state licensed. The Board permits these nurses to be included in the unit with registered nurses and to vote in a representation election, subject to challenge.

Hospital Nursing School Staff.--In Jersey Shore Medical Center (35), the Board held a bargaining unit limited to faculty members at a hospital nursing school was inappropriate. The faculty were registered nurses and even though having a

higher degree of education there was still a broad community of interest with hospital staff RN's. In Newton Wellesley Hospital (44), the Board determined that department chairpersons should be included in an RN unit since they did not have the power to appoint, promote, or retain faculty members.

Nurse Anesthetists.--The Board has held in Kaiser Foundation (31) that nurse anesthetists are RN's who have taken additional training and should be included with RN's rather than an overall professional unit.

Clinicians.--Another category of highly skilled RN's is the one of clinician. Clinicians were held to be supervisors in St. Mary's Hospital Inc. (56) and excluded from a RN unit. Clinicians consult with other nurses who have problems with patient care. Significant supervisory functions were performed by a clinician and there was considerable authority that went substantially beyond patient care.

Nurse Practitioner.--Nurse practitioners are a relatively new highly skilled nursing category. Normally at least two additional years education is required to become a nurse practitioner and they may then examine patients, make diagnosis, and prescribe medication and therapy. In Rockridge Medical Care Center (51) the Board held that nurse practitioners could be included in a unit of RN's. Dissenting was Betty

Murphy. She felt that nurse practitioners were a new and separate class of health care specialist. The employers had felt a separate unit would be appropriate because they received 20 per cent more salary than RN's and participated in medical staff meetings with physicians. Since this is a relatively new health care position, duties and responsibilities may change and cause the Board to examine this category again.

Administrative and Quasi Administrative.--These positions are often filled by RN's but are removed from the patient care function. In Newton Wellesley (44), two groups were excluded from the RN unit even though the individuals filling the positions were RN's. Admitting officers were nurses but the job was held to be purely clerical rather than professional. Also the financial aid and admissions coordinator was found to lack a community of interest with the RN staff as her position was purely administrative.

In Trustees of Noble Hospital (66) the utilization review coordinator was included in the RN unit. She was required to be a RN, was in constant contact with the RN's, and her job was to promote health service efficiency in order to maintain a high quality of patient care.

"On Call" Part Time Nurses.--In Newton Wellesley Hospital (44), the "on call" nurses were included in the bargaining

unit even though they did not work on a prearranged schedule and did not share fringe benefits extended to other employees. They shared a strong community of interest with other registered nurses. It was also found in the above case the "on call" nurses worked longer periods of time and on a more frequent basis than part time permanent nurses the employer had already agreed to include in the bargaining unit.

The titles and decisions faced by the Board show that nursing is a generic profession with increasing area specializations. The new challenges that will be contemplated will use these categories as frameworks. The RN's constitute a separate professional unit if they so desire. If these other categories desire to move into their own separate units it may be quite difficult in light of the Congressional mandate of nonproliferation. The questions of supervisory status seem to need further refinement so that the solutions will not have to be on a case by case interpretation.

Representation of Nurses

An important question is, "Who best represents the members of a specific health care discipline in collective bargaining, the professional organization of that discipline or an outside agency" (2, p. 103).

The American Nurses Association's response is that nurses are to be represented by their professional association. As far back as 1896, when the association was founded, one of

its goals was "to promote the usefulness and honor the financial and other interests of the nursing profession," (2, p. 103). The association's Economic and General Welfare program was founded in 1946. In late 1973, the ANA announced the launching of an aggressive campaign to organize the nation's 800,000 registered nurses.

There are basically two reasons behind the ANA position:

1. The ANA and its constituentents believe that nurses should be represented by their professional association as opposed to outside labor unions, many of which are virtually unfamiliar with the health care field.
2. Nurses are increasingly asking for more voice in ensuring a higher quality of health care for all Americans and in upgrading their own economic conditions (2, p. 107).

Cosimo Abato, a Baltimore labor relations attorney said, "The only way that nurses will have some say in the practice of their profession is through collective bargaining. If the ANA and its state affiliates do not represent nursing, someone else will" (2, p. 112).

As Table VII illustrates, the increase of RN's under collective bargaining agreements has been substantial.

Nurses and Contract Negotiations

The nurses who participated in work stoppages prior to the amendment did so normally for recognitional purposes. Since the amendments, most work stoppages have related to economic and working conditions issues. The following

TABLE VII
 COVERAGE OF RN'S UNDER COLLECTIVE
 BARGAINING AGREEMENTS

Year	Number of Contracts	Number of Nurses
1960	N/A	8,000
1965	9	9,685
1966	121	16,850
1967	166	24,011
1968	277	30,191
1970	322	38,116
1974	475	65,000

Sources: M. F. Arnold, ed., Administering Health Systems, Issues and Perspectives, Aldine, Chicago, 1971; and E and GW Hotline, Vol. II, No. 13 (August 1, 1975), 1.

examples are presented to illustrate the problems that prevail in many of the work stoppages.

Examples are also presented to illustrate patterns in contracts. A complete analysis of health care contracts is completed in a subsequent chapter. Nurses tend to combine economic and patient care issues in order to obtain an acceptable contract. Nurses represent the largest concentration of health care employees and therefore these contract provisions are very important and are used by other health care employees as a pattern setting agreement.

Charity Hospital, New Orleans.--The final vote was 388 for strike and 74 against. The nurses principal grievance was the patient-nurse ratio imbalance, which they said frequently left one nurse in charge of fifty patients. Also

complaints related to using rollers (stretchers) for beds and other patient care items had high priority (37).

Pennsylvania Nurses Association, Harrisburg, Pa.--State nurses supported state employees in a work stoppage. Three thousand three hundred nurses took part in the action but returned to work voluntarily after forty-eight hours. PNA Executive Director, Kathryn Grove said,

PNA nurses felt compelled to take the action for professional reasons, and I emphasize professional. Indeed it was an economic strike, but one has to understand this state's employment classification system. In some cases, nurses are making salaries below those in nonprofessional categories . . . (61, p. 2).

Florida Nurses Association.--Nurses at Wuesthoff Memorial Hospital in Rockledge, Florida, became the first in the state to sign a contract under the amended NLRA. RN's established committees aimed at more nurse input in decision-making matters relating to patient care and at improving communication between nurses and administration. Additional educational pay premiums were part of the contract including salary increases of 16 per cent during the life of the agreement based on increases in the Consumer Price Index (19).

Oregon Nurses Association.--Nurses in Albany and Cowallis, Oregon, signed two year agreements. The agreements provided for 10 per cent the first year, 8 per cent the second year, and increases in shift differential and "on call" premiums;

dental insurance was added to the benefit programs. Both contracts will require membership or the payment of association dues as a condition of employment the second year (11).

In Roseburg, nurses signed a three year contract which increased salaries 14 per cent, 8 per cent, and 8 per cent. The contract included improvements in the maximum accumulation of sick leave, pension, and insurance, and added a dental plan in the second year. The contract called for a fair share provision and orientation time to teach the contract. Pay increases are now tied to twenty hours inservice or other educational training (11).

Rogue Valley Memorial Hospital nurses signed their first contract which gave each nurse a ten per cent salary increase, established a dental plan, increased "on call" differential, provided for check off, and a wage reopener in one year. A nursing care committee and grievance arbitration was also in the new contract (11).

Winsted Hospital, Connecticut.--In Connecticut, RN's employed at the Winsted Hospital represented by CNA ratified a two year contract and averted a threatened strike. The new contract gave nurses an average fifteen per cent pay increase expanded vacation time, health benefits, and a Professional Performance Committee composed of managerial and nonmanagerial nurses (61).

Youngstown Hospital, Ohio.--At the Youngstown Hospital 585 RN's represented by the Ohio Nurses Association ratified a two year agreement six hours before a strike deadline. Salary increases and a cost of living clause were won, as well as Saturday differential, and pay differentials for intensive care units, cardiac care units, and recovery and emergency room. Contract revisions relating to patient care also included a provision that no RN would be permanently assigned to the previously mentioned areas unless she had had nine months experience in a medical-surgical unit. Other revisions included a new paid subscription drug program, additional holiday and an increase in sick leave accumulation (67).

Honolulu Nurses, Hawaii.--Six Honolulu hospitals were struck for nineteen days by 800 nurses. The resulting settlement included a two year contract with a 13 per cent wage increase. The new contract provided for increased coverage in the medical plan, as well as a drug and vision plan. The settlement did not include the demands of cost of living allowances, annual wage increments, or increased pension benefits (22).

Texas Nurses Association, Houston.-- Texas nurses have had difficult times achieving recognition in health care facilities. RN's at the Texas Institute for Rehabilitation

and Research in Houston were the first unit in the state to seek representation in a private facility since passage of amendments to the National Labor Relations Act. The petitioning activity began in the summer of 1975, but countless legal postponements and NLRB hearings and appeals delayed certification of the unit until the fall of 1977. Even though the early struggles have been difficult the Texas Nurses Association is committed to the philosophy of free collective bargaining, as previously stated in their commission statements (64).

Summary

Nursing has undertaken a difficult task: maintaining and improving professionalism and improving the economic and general welfare condition of its members. There are problems associated with using the Nursing Association as the labor representative. These problems relate to the role of nursing directors, supervisors, and the nursing membership. Also, past relationships with hospitals tend to change due to activity as a labor organization. Concerns regarding representation include the nurses association's knowledge of health care versus the traditional labor union's knowledge of labor relations, contract negotiations, etc. Nursing is committed to patient care but will withhold their services in the short run to accomplish long range objectives. Most recent contracts have increased salaries, enhanced

medical benefits, and provided for joint committees to investigate patient care issues.

Collective Action by Interns, Residents,
and Attending Physicians

Physician's Unions

Four years ago physician's unions were virtually unknown, even though in 1961 the first collective bargaining association of physicians in the United States was founded in New York City. This was called the Doctors Association of the New York City Department of Health. Now at least 16,000 doctors belong to some 26 organizations committed to collective bargaining (70). The two largest physician's unions are the National American Federation of Physicians and Dentists (AFPD) and National Physicians Council (NPC).

The larger of the two, AFPD, formed its national organization in 1972 by banding together seven local units (15). The NPC became unaffiliated with AFPD over the issue of its choice of AFL-CIO affiliation (71). Both AFPD and NPC are federations. The national organizations are primarily concerned with increasing membership, establishing new locals, facilitating communication, identifying common problems, and national lobbying efforts. Actual bargaining and grievance handling is conducted by the locals (71).

The Nevada Physicians Union (an NPC affiliate) was the first physicians union chartered by the AFL-CIO. One reason

given for the union was stated by Bob Anderson, union spokesman, "they believe the labor movement is the nation's second largest purchaser of health care services. . . ." He said they feel that "by linking up with the labor movement, they will have the ability to assist unions in developing the more comprehensive, economical and most necessary medical services that their members require" (69, p. 10A). Another important area of emphasis of the Nevada union was when physicians signed an ultimatum vowing not to see Medicaid patients in the office unless an agreement was reached with the State authorities. The physicians saw patients at nearby hospital emergency rooms but the cost was three times as much. The agreement that was reached dropped all requirements for prior authorization of Medicaid patients, provided a 19 per cent increase in reimbursements, and established a state sanctioned union advisory committee on Medicaid (62).

The American Medical Association's official position is that "Dual representation of physicians by unions and by their professional organizations would be diverse and counter-productive" (71, p. 1). It is now the policy of the AMA that "It is appropriate for medical societies to aid, assist individually and collectively in resolving disputes with hospitals and others" (10, p. 121). However, most of the union leaders are quick to point out they are not trying to supplant the medical societies. Often union spokesmen advise medical societies to concentrate on medical,

educational, and scientific endeavors and leave financial and socioeconomic matters to the unions.

Critics of the union movement remark it matters little whether one discussed a union or society, the powers are there. They feel they will lead to mediocrity in medicine and are dividing forces when medicine needs to be united in the face of third party pressures (71).

At a presentation to the American Medical Association's leadership conference, physician union leaders made several points:

1. Medical unions were created as a separate socioeconomic arm to fight interference from third parties, namely insurance carriers, government, and hospitals. It was first organized medicine (medical societies) that had failed to do that.

2. Presently unions are concerned with socioeconomic needs but would like to represent the political interests of physicians, leaving scientific and educational matters to the AMA.

3. Physicians feel they no longer have autonomy or professional integrity to determine how their practice is run or what happens to their patients (68, p. 6).

Dr. Marcus, San Francisco union member, said, "The AMA is a general practitioner in a day when the services of a neurosurgeon is called for. Power is needed to

enforce a commitment to quality medical care. The key word is power" (68, p. 6).

In contrast, the former president of AMA remarked he felt physicians were above unionism. They need a professional society rather than the union ethic of bargaining for prices and working conditions (68).

Yet the AMA Executive Vice-President, Dr. Sammons, told the Wall Street Journal: "We don't think there's anything (the unions) can do that the AMA isn't already set up to do. Medicine has arrived at that point in history that it has had to realize it must speak with a more united voice . . ." (10, p. 121).

Pointer, in analyzing the social legitimacy of physician collective action believes physicians belong to a strong profession and are especially cohesive on issues critical to their profession. They have tremendous power to enforce their demands (18, p. 21). He states physicians are now and soon will be demanding to negotiate issues formerly within hospital management's exclusive domain, or issues such as malpractice which are beyond the control of any single element of the health care organization (18, p. 22).

The most significant collective action of physicians was not related to a labor issue but to the cost of malpractice insurance. The Southern California Physicians

slowdown to protest the cost of malpractice insurance cost California hospitals \$21.9 million and affected 12,915 hospital employees (48). According to a hospital council survey the loss represented nearly 18.6 per cent of the total gross revenues of the 65 hospitals reporting losses during the strike, which began in December, 1975, and ended in February, 1976 (48). Although this was not a labor strike to gain a contract the effects of collective action can be observed.

Withholding of physicians' services has been given increased acceptance as a legitimate method of expression for doctors. There will be strikes by physicians in the future, and there will be threats of strikes. One writer puts the problem in proper perspective:

Coping with a strike by physicians requires skills that you have probably never before used to such an extent: the diplomacy of a Kissinger, the stamina and maneuverability of an O. J. Simpson, and the faith of a pope (23, p. 64).

Interns and Residents

The house staff of residents and interns have been the most active and the most militant in the physicians' union arena. About 55,000 recent medical school graduates make up the house staffs of 1,500 U. S. hospitals (26). In many states a new graduate must serve a hospital internship before receiving a license for general practice. Further residency at a hospital under the supervision of senior physicians is

required to obtain certification in specialties. In their two to seven years of internship and residency, house staff members provide much of the day to day care in hospitals, especially public hospitals.

A pioneer in house staff organizing was the Committee of Interns and Residents (CIR) formed in New York in 1957 (18). With a full time staff, newspaper and dues checkoff, the CIR represents 3,000 house staff members at twenty-one hospitals. The committee has also taken an active role in legislative matters on all levels, in exposing poor hospital conditions to the media, and protesting medical budget cuts. Murray Gordon, counsel for CIR, insists that negotiable items should not be limited to wages and hours but should include patient care, the quality of the training experience for the intern and resident, and the type of work performed (3).

In March, 1976, the CIR members went on strike and walked the picket line for four days. The impasse that caused the strike was the demand by CIR to limit on duty hours to a maximum of eighty hours in one week and twenty-four hours consecutively. Also a ban on out of title work--duties usually performed by orderlies and aides--was sought (3). The CIR and the League of Voluntary Hospitals reached a settlement understanding for committees to be established to produce guidelines for work schedules and grievance handling on out of title duties. The CIR felt a substantial victory had been gained, but the hospitals did not view it

in that light (3). Dr. Pomeroy, director of Mount Sinai Hospital, assessed the strike by saying:

The CIR won national visibility and organizing strength for the willingness to pull a strike at a hospital. The hospitals won basically continued control of the training program and sufficient limitations on the authority of the new standing committee to assure our trustees that we won't have a runaway situation (3, p. 17).

Another observer, John V. Connorton, executive vice-president of the Greater New York Hospital Association, said:

This strike will in the long run prove more traumatic to hospital administrators and trustees than our earlier difficulties with job actions by nonprofessional employees. In the strike by interns and residents, the hospitals were dealing with people who had enjoyed a greater measure of exposure to the educational process and who were extraordinarily well equipped to take advantage of the mechanisms of communication, challenge, and collective action to achieve what they believed to be legitimate objectives (3, p. 17).

In other collective action the Highland Association of Interns and Residents (HAIR) held a "heal-in" to promote demands for better medical facilities and to obtain higher pay. The interns and residents admitted people to the hospital who previously would have been treated as outpatients. Patients were soon placed in conference rooms and hallways. The director threatened to call the National Guard and protested the actions as unethical and morally wrong, but HAIR won. The interns and residents received a 5 per cent increase in pay and were promised expanded x-ray services, a night lab technician, and a specialist for treating chest diseases (26).

Another widely publicized work stoppage was by the resident doctors and interns at Cook County Hospital in 1975. The House Staff association, representing 450 striking physicians, ended an eighteen day strike by agreeing to 6 to 8 per cent salary increases bringing annual pay to \$12,200-\$17,000, a reduction in working hours from 100 hours per week to 80 hours a week, and to improved patient care (12). In the final document, the patient care demands were separated from the main body of the contract and divided into two appendixes--one for immediate goals and the other for long term goals. An end to out of title work, such as drawing blood samples, completing paperwork, transporting patients, and performing other duties that housestaffs contend should be performed by nonphysician personnel was also part of the contract (12).

Interns and Residents: Employees or Students?--The Cook County dispute and its repercussions were brought into the discussion at the American Medical Association convention, where the House of delegates did affirm that interns and residents, being employees as well as students do have collective bargaining rights and therefore by implication the right to strike (62).

This philosophy has not been upheld by the National Labor Relations Board. In a landmark decision (7), the Board ruled on March 19, 1976, that interns, residents, and clerical fellows are students rather than employees and, as such, are

not entitled to collective bargaining rights under the Act. The decision involving Cedars-Sinai Medical Center, Los Angeles and the Physicians National Housestaff Association (PNHA) was a crippling blow to the growing union movement of young doctors.

Reaction to NLRB Ruling.--The reaction to the ruling was bitter. Dr. Robert Harmon, President of PNHA, stated:

By cynically classifying them as students, the NLRB has given hospitals official approval to continue to exploit young doctors by using their medical skills then paying them like orderlies. The administration picked NLRB has publicly affirmed that the profits of hospital employees are more important than the welfare of workers or the sick (74, p. 4).

The Association of American Medical Colleges' President, Dr. John A. Cooper, said the NLRB decision "will further strengthen the traditional student teacher relationship which is largely responsible for the superior training American physicians receive" (29, p. 17).

National Labor Relations Board member, John Fanning, the lone dissenter on the four to one decision, feels strongly the board erred in its "exploiting the semantic distinction between employee and student." Much of Fanning's criticism centered on his belief that Congressional intent was that residents and interns would be considered employees when it amended the law (29). The majority of the Board felt the relationship between the housestaff and hospitals was primarily educational, and since the physicians were ruled not

to be employees, their housestaff association could not be a labor organization; therefore, their petition was denied (7).

Reaction from doctors groups was extremely strong around the country. Some felt there would be an increase in the number and severity of labor disputes in hospitals (74). Hospitals may decide to recognize housestaffs on an individual basis and some felt public sector states bargaining laws might still apply to resident and intern "employees." Steve Diamond, the executive director of PNHA, said: "I'm sure there are going to be strikes around the country. We may have to pull out all the stops, vis a vis Cook County. We can't let an agency of the government kill us off because of some ill considered political considerations" (29, p. 17). The President of PNHA, Robert Harmon, said hospital strikes may be the only cure (29) to the NLRB decision.

The road is still twisted and turning. In the words of Dr. Connorton, New York, in regard to the strikes and discord: "In all probability," he says, "it may be viewed as the opening bars of a long and potentially highly discordant national symphony. Hospital administrators and physicians as well only can hope that the sour notes will be muted" (3, p. 17).

"The New York State Labor Relations Board," Judge Gillinoff said, "retains the same jurisdiction it previously

possessed, since the NLRB ruled that hospitals are not employers as defined by the NLRA with respect to disputes relating to interns, residents, and clinical fellows" (24, p. 19). The New York State Supreme Court's ruling coincided with the October 14, 1976, ending of the CIR's nine day strike against New York City voluntary hospitals. Recognition was the only strike issue (24).

Following this action by the New York Court the NLRB issued its revised ruling in a case involving Kansas City General Hospital and Medical Center (32). The Board issued this ruling to eliminate any doubt that the majority of the board believes that state jurisdiction over residents, interns and fellows has not been preempted by the federal statute. The majority opinion stated that the unnecessary language included a finding that the hospital is not an employer within the meaning of Section 2(2) of the Act for the purpose of any disputes involving residents, interns, and fellows. This language, according to the majority, was not in any way crucial to the result, but "it has proved to be subject to varying interpretations with regard to its impact on related preemption questions" (72, pp. 19-20).

The NLRB went on to say that its Cedars-Sinai ruling to deny house staff bargaining rights "has not put hospital residents and interns beyond the reach of national labor policy." Rather the NLRB said the Cedars-Sinai case "held

that to extend them collective bargaining rights would be contrary to that very policy" (25, p. 18).

John Fanning, newly appointed NLRB Chairman, filed the sole dissent in both Cedars-Sinai and Kansas City. He felt the Board has removed federal and state intervention possibilities for peaceful solution of labor disputes involving housestaffs. As a result, Fanning says, disputes "will be resolved solely in accordance with the militancy and economic resources of the contending parties" (25, p. 18).

Court Challenges.--In March 1977, the Physician's National Housestaff Association (PNHA) filed suit in the U. S. District Court for the District of Columbia to overturn the NLRB ruling in Cedars-Sinai. The PNHA suit charged that NLRB acted contrary to Congress' intent in enacting the 1974 amendments to the Taft-Hartley. The Association cited the legislative history and a bill sponsored by Representative Thompson to support its position. HR 2222 "would make crystal clear the will of Congress by expressly including interns and residents" (73, p. 20). PNHA President, Dr. Asimus, predicts many strikes this year if the NLRB egregious mistake is not corrected soon (73).

On September 21, 1977, the U. S. Court of Appeals for the Second Circuit ruled that Congress completely ousted state jurisdiction and therefore are barred by national labor policy from attempting to secure collective bargaining rights through state labor relations boards (30).

The court history leading to this decision is very interesting. After the passage of the Health Care Amendments in 1974, a number of housestaff organizations filed election petitions with the NLRB. In March, 1976, the NLRB issued the Cedars-Sinai Medical Center decision where the board held that while housestaff possessed certain employee characteristics, they are primarily engaged in graduate educational training, and thus were students rather than employees (7). On this basis the Board determined housestaff should not be given collective bargaining rights and dismissed the petition.

The Committee of Interns and Residents (CIR) filed an election petition with the State Labor Relations Board (SLRB). In July, 1976, the SLRB dismissed the petition on the ground that federal labor law had preempted the field (Misericordia Hospital Medical Center, 39 SLRB N32).

The CIR brought suit in the New York State Supreme Court to compel the SLRB to accept jurisdiction. That court ruled that the SLRB was free to accept jurisdiction over the labor relations of housestaff (Committee of Interns and Residents of New York State, Labor Relations Board, 338 NYS 2nd 509). The following month the NLRB issued an opinion in Kansas City General Hospital that explained its feeling of intent to preemption. In light of that decision the state court vacated its prior decision (45).

In the interval between the two New York Supreme Court decisions, the NLRB began the action involved in the most recent decision and sought to enjoin the SLRB from holding elections for housestaff. Judge Meskill stated: "If the NLRB erred in its treatment of housestaff unions, the solution is clearly not to create a patchwork of state-governed labor unions" (20, p. 12).

There is also a case pending in the U. S. District Court for the District of Columbia where CIR is challenging the discretion of the NLRB. Judge Meskill said: "If the NLRB abused its discretion in Cedars-Sinai, those proceedings will correct the error. If the Board's action is upheld, however, the CIR may not seek to circumvent it by proceeding before the SLRB" (30, p. 13).

Congressional Reactions.--Chairman Frank Thompson of the House Labor Subcommittee on Labor Management Relations maintained that the clearest departure to date from the intent of the amendments was taken by the NLRB in the Cedars-Sinai decision. He stated before the American Bar Association that the disruption caused by housestaff organizing was a primary reason for the amendments' passage (28).

This was not supported by Ohio Senator Robert Taft who served on the Labor Committee at the time of the amendments' passage. He said the committee did not treat the housestaff question and suggested the current organization of the medical

teaching system makes collective bargaining inappropriate (28).

House Labor Subcommittee hearings on the Status of Interns were held in April, 1977, in conjunction with the HR 2222 proposed by Chairman Thompson. The term professional employee would be designated to mean:

. . . any employee, in the medical profession, including any intern, resident, fellow, or other such trainee in a professional medical training program who is receiving a stipend or compensation for work performed in connection with such program or for performing related work . . . (28, p. 165).

Witnesses for the health care industry argued that the amendment would have a detrimental effect on medical education. John A. Cooper, M. D., president of the Association of American Medical Colleges, made several points during his testimony. He stated no clear distinction can be drawn between the last two years of medical school where the individuals are clearly students and the period of graduate education during which they serve their internship and residency requirements. Cooper stated the stipends received by interns and residents are not to enable them to earn a living but rather help them fulfill educational requirements. Also he felt the inequality of student-teacher bargaining power would create difficulties. In response to a question by Representative Ashbrook, Cooper agreed an adversary relationship exists between interns, residents and the teachers. Feeling the NLRB jurisdiction would limit dispute settlement rather

than promote it, Cooper declared the "medicine" is "worse than the disease" (28, p. 291).

American Hospital Association Senior Vice-President Leo J. Gehrig, M. D., stated that standards are set by the Coordinating Council of Medical Education and the Liaison Committee on Graduate Medical Education. He felt collective bargaining with hospital management would be inappropriate since they did not set the standards (28).

In support of the pending legislation were representatives of the Physicians National Housestaff Association (PNHA), the American Medical Association (AMA), and the American Medical Students Association.

Murray Gordon, PNHA's general counsel, compared the National Intern and Resident Matching Program, under which hospitals obtain interns and residents, to the draft system in professional sports (28). He also noted that 35 per cent of the U. S. interns and residents are graduates of foreign medical schools, and recalled when Congress considered limiting the number of foreign interns the response was that their services were not part of an "exclusively educational process" (28, p. 291). He felt the process of collective bargaining can be viable with the educational process and cited his years of experience with CIR of New York State.

Gordon stated to the subcommittee:

. . . it is a distortion of the reality of collective bargaining . . . to consider that housestaff officers are not employees with respect to whom it is fair,

wise, precedented, and expedient to provide the peaceful machinery of NLRA for the resolution of conflict as to matters such as their hours, wages and terms and conditions of employment (28, p. 291).

William J. Mangold, representing the American Medical Association, testified that AMA felt the process of collective bargaining is appropriate to determine conditions of employment and that housestaff should be under the protection of the rights under the National Labor Relations Act. He acknowledges a duality of a graduate medical training but feels without their contribution patient care would suffer greatly (28).

The House Labor Subcommittee on Labor Management Relations approved HR 2222. The subcommittee cleared the bill by a vote of nine to three with Republicans John Erlenborn (Illinois), Shirley Pettis (California), and Mickey Edwards (Oklahoma) voting against it. A companion bill (S1884) has been introduced in the Senate by Senators Alan Cranston and Donald Reigle.

Summary

The physician's unions have been more active in recent years although the 1974 amendments do not appear to have affected the growth dramatically. In contrast the housestaff union of residents and interns were growing rapidly until the NLRB Cedars-Sinai decision determining they were in fact students, not employees of their respective hospitals.

Legislation has been proposed to correct this interpretation after the court processes failed to do so.

As the health industry moves into new sophistication in collective bargaining, it would seem a sad commentary for the most valuable human resource in the industry to be still subjected to striking for recognition, having no recourse for unfair labor practices, and to be wholly dependent on the free play of economic forces.

CHAPTER BIBLIOGRAPHY

1. Allutto, Joseph A., "The Professional Association and Collective Bargaining: The Case of the American Nurses Association," Administering Health Systems Issues and Perspectives, edited by M. F. Arnold, Chicago, Aldine, 1971.
2. "ANA: Can a Professional Association be a Trade Union, Too?" Hospitals, 48 (September 1, 1974), 103-114.
3. Appelbaum, Alan L., "The Meaning of the New York Strike," Hospitals, 49 (April 16, 1975), 17.
4. Anne Arundel Hospital vs. Maryland Nurses Association, 200 NLRB 39 (1975).
5. Arnold, Pam, and Jim Loveless, "ANA in Action," The American Nurse (November, 1974), 11-14.
6. "Bargaining Units for Nursing Personnel," Commerce Clearing House 9097 (1976).
7. Cedars-Sinai Medical Center, 223 NLRB No. 57 (1976).
8. Chamot, Dennis, "Professional Employees Turn to Unions," Harvard Business Review (May-June, 1976), 119-127.
9. Clarion Osteopathic Community Hospital, CCH NLRB 16025 (1975).
10. "Collective Bargaining for Physicians 'Something New' in AMA Policy," Hospitals, 50 (January 1, 1976), 121.
11. "Contract Negotiations Reviewed," Oregon Nurses Association (November, 1975), 4.
12. "Cook County Hospital: Politics and Power Plays," Hospitals, 50 (March 16, 1976), 1102.
13. Crestline Memorial Hospital vs. Ohio Nurses Association, 1976.
14. "Doctors OK New Contract in Chicago," Dallas Morning News, November 13, 1975.
15. Dominican Santa Cruz Hospital 218 NLRB 182 (1975).

16. E and GW Hotline, Vol. II, No. 13 (August 1, 1975), 1.
17. Epstein, Richard and Bruce Stickler, "The Nurse as Professional and as a Unionist," Hospitals, 50 (January 16, 1976), 44-49.
18. "Era of Medical Unionism Dawning," Hospital Progress (June, 1976), 20-22.
19. "FNA Negotiates First Contract in Private Sector," E and GW Hotline, II, No. 11 (October 24, 1975), 2.
20. Gnaden Huetter Memorial Hospital 219 NLRB 79 (1975).
21. Heights Medical Center, Inc. CCH NLRB 16, 528 (1976).
22. "Honolulu Nurses End 19-Day Strike," Hospitals, 50 (March, 1976), 23.
23. Hospitals, 50 (September, 1976), 64.
24. "Hospital Headlines," Hospitals, 50 (November 16, 1976), 19-20.
25. "Hospital Headlines," Hospitals, 50 (December 16, 1976), 18-20.
26. "Hospital Headlines," Wall Street Journal (August 15, 1975), 1.
27. "House Action on Hospital Housestaff," 97 LRR 165 (February 27, 1978).
28. "House Hearings OK Status of Interns," 94 LRR 291 (April 11, 1977).
29. "House Staff are Students, Not Employees," Hospital, 50 (April 16, 1976), 17.
30. "Interns and Residents Barred from Seeking Rights before State Boards," Government Employee Relations Report 728:13 (October 3, 1977).
31. Kaiser Foundation Hospitals, Inc. 219 NLRB 22 (1975).
32. Kansas City General Hospital, 93 LRRM 1363 (November 22, 1976).
33. Kleingartner, Archie, "Professionalism and Engineering Unionism," Industrial Relations (May, 1969), 233.

34. 89 LRRM 1173.
35. 93 LRRM 1172.
36. 95 LRR 75, 5-23-77.
37. Lee, Vincent, "46 More Nurses at Charity Hospital Agree to Strike," Times-Picayune, New Orleans (August 13, 1975), 1.
38. Meharry Medical College, 219 NLRB 57 (1975).
39. Memorial Clinic Ltd., 220 NLRB 217 (1976).
40. Mercy Hospitals of Sacramento, Inc. 217 NLRB 131 (1975).
41. Mountain Manor Nursing Home 204 NLRB 71 (1975).
42. Nathan and Miriam Barnert Memorial Hospital 217 NLRB 132 (1975).
43. "National MD Union Awards Locals OK," American Medical News (December 11, 1972), 1, 12.
44. Newton Wellesley Hospital 219 NLRB 80 (1975).
45. NLRB vs. Committee of Interns and Residents, et al., No. 1447 (September 21, 1977).
46. Oak Ridge Hospital vs. Tennessee Nurses Association 220 NLRB 9 (1975).
47. Otis Hospital Inc. 219 NLRB 55 (1975).
48. "Physicians Strike Costly, Hospital Survey Shows," Hospitals, 50 (September 16, 1976), 23.
49. Pinecrest Convalescent Home CCH NLRB 16, 891 (1976).
50. Presbyterian Medical Center 218 NLRB 152 (1975), 227 NLRB 135 (1977).
51. Rockridge Medical Care Center 221 NLRB 119 (1976).
52. Rosasco, Louise C., "Collective Bargaining: What's a Director of Nursing to do?" Hospitals, 48 (September 16, 1974), 79-113.
53. "RN's: Supervisors or Professionals," Professional Services Program, Texas Nurses Association (1976).

54. St. Anthony Center, 220 NLRB 139 (1976).
55. St. Catherine's Hospital of Dominican Sisters, 217 NLRB 133 (1975).
56. St. Mary's Hospital, Inc. 220 NLRB 92 (1975).
57. St. Patrick's Hospital vs. Montana Nurses Association 225 NLRB 110 (1976).
58. St. Rose de Lima, Inc. 223 NLRB 224 (1975).
59. Schutt, Barbara, "Collective Action for Professional Security," American Journal of Nursing, 73, No. 11 (November, 1973), 1946-1951.
60. Sierra Vista Hospital vs. California Nurses Association 225 NLRB 115 (1976).
61. "SNA Highlights," E and GW Hotline, III, No. 6 (May 14, 1976), 2.
62. "Strikes by Physicians," Journal of American Medical Association, 235, No. 7 (February 16, 1976), 156.
63. "Strikes: Housestaff; Strikes: Attending Physicians," Hospitals, 50 (April 1, 1976), 22.
64. Texas Nurses Association District Manual on Professional Services Program, Austin, Texas, October 1975, revised 1976.
65. Trinity Memorial Hospital of Cudahy, Inc. CCH NLRB 16039 (1975).
66. Trustees of Noble Hospital 218 NLRB 221 (1975).
67. "Two Year Agreement at Youngstown Hospital," White Collar Report, 1036 (February 25, 1977), A-12.
68. "Union Gains Laid to Medical Society Failures," American Medical News (February 26, 1973), p. 106.
69. "Union Gamble Taken by Nevada Doctors," Dallas Morning News, March 17, 1975, p. 10A.
70. "Unionization of Professional Societies," Conference Board Report No. 690, New York (1976).
71. "Unions 'still here, Growing'," American Medical News (September 13, 1974), pp. 1, 8.

72. White Collar Report, BNA No. 1022 (November 12, 1976), pp. 19-20.
73. White Collar Report, BNA No. 1037 (December 16, 1976), pp. 18-20.
74. "Young Doctors Lose NLRB Fight," Dallas Morning News, March 23, 1976, p. 4A.

CHAPTER VI

THE ROLE OF THE FEDERAL MEDIATION AND CONCILIATION SERVICE IN HEALTH CARE COLLECTIVE BARGAINING

The Federal Mediation and Conciliation Service (FMCS) is an independent agency created in 1947 under Title II of the Taft-Hartley Act. The Director of FMCS is appointed by the President with advise and consent of the Senate.

The national office of the Service is in Washington, D. C. There are eight regional offices headed by regional directors that direct the field work of federal mediators. The mediators, known as commissioners, are strategically located throughout the United States.

The mission of the Federal Mediation and Conciliation Service is stated by the Service as follows:

Promoting the development of sound and stable labor management relationships.

Preventing or minimizing work stoppages by assisting labor and management to settle their disputes through mediation.

Advocating collective bargaining mediation and voluntary arbitration as the preferred process for settling issues between employees and representatives of employees.

Developing the art, science and practice of dispute resolution.

And, fostering constructive joint relationships of labor and management leaders to increase their mutual understanding and solution of common problems (4, p. 81).

Two major types of cases generally result in FMCS involvement: (1) disputes affecting national health and safety, and (2) other serious disputes between unions and employees engaged in activities affecting interstate commerce.

The health care amendments (Public Law 93-360) of the National Labor Relations Act mandate the Federal Mediation and Conciliation Service to utilize mediation and board of inquiry procedures where the parties are unable to resolve their differences through their own resources. Special modifications and provisions for health care affect FMCS specifically.

Notification Procedures

The notice requirements for the health care industry differ from other private sector industries. Notification procedures have been extended in order to minimize work stoppages in the health care industry.

Section 8(d) has been modified for health care institutions as follows (27):

- (A) The notice of Section 8(d)(1) shall be ninety days; notice of Section 8(d)(3) shall be sixty days; and the contract period of Section 8(d)(4) shall be ninety days.
- (B) Where the bargaining is for an initial agreement following certification or recognition, at least thirty days' notice of the existence of a dispute shall be given by the labor organization to the agencies set forth in Section 8(d)(3).

These provisions mean that either party desiring to terminate or modify a labor agreement involving employees of a health care institution must serve written notice of such intention upon the other party to the contract ninety days (instead of the sixty days in the non-health care private sector) prior to the actual or proposed termination or modification date. The notification requirement to FMCS must take place sixty days (instead of the thirty days in non-health care private sector) prior to the actual or proposed termination or modification date.

The Congressional Committee Reports make it very clear that, as in non-health care cases, the FMCS would be notified thirty days after the 8(d)(1) notice and that in health care institution cases, the FMCS would have at least sixty days to attempt, by mediation and conciliation, to bring the parties to agreement (2).

It is also important to note, according to remarks by Senator Taft, that while all these new provisions applying specifically to health care must be upheld, all of the other existing prohibitions and requirements of Section 8(d) will also apply to health care, including the prohibitions on strikes and work stoppages during these periods (2).

The contract, therefore, must remain in full force and effect without strike or lockout, for a period of ninety days (instead of sixty days) after the notice of termination

or modification is given, or until the expiration date of the contract, whichever occurs later.

In cases of initial contracts, a new provision, Section 8(d)(B) requires a labor organization in a health care institution to give at least thirty days' written notice to FMCS when a dispute arises, following certification or recognition. The ten-day notice provision of Section 8(g) is subsequent to this thirty-day notification, thereby creating a forty-day minimum period before a strike or picketing could lawfully begin. The loss of employee status provision would also apply during the forty-day period.

Normally, the notices should be served on someone who has been designated to receive the notice or through whom the institution will actually be notified. Notices to the FMCS should be directed to the regional office or to the national office. Upon receipt of a notice of dispute, the regional director will assign a federal mediator to proffer mediation assistance in the dispute.

Legal Requirements

Section 8(d)(C) states:

- (C) After notice is given to the Federal Mediation and Conciliation Service under either clause (A) or (B) of this sentence, the Service shall promptly communicate with the parties and use its best efforts, by mediation and conciliation, to bring them to agreement. The parties shall participate fully and promptly in such meeting as may be undertaken by the Service for the purpose of aiding in a settlement of the dispute (27).

The intended impact of these provisions is substantial. Senator Taft expressed it in the following manner:

The health care institution and labor organization will be required to participate in mediation at the direction of the FMCS. Unlike private industry, where mediation is discretionary with the disputants, parties in the health care industry are statutorily obligated to utilize FMCS services. This provision insures the active involvement of the Federal Mediation Service who will attempt, by use of its expertise, to adjust the disputes expeditiously (2, p. 6934).

In regards to Section 8(d)(C), the requirement that the FMCS mediate health care disputes means that all health care disputes will receive a mediator assigned to the case, but the degree of active involvement depends primarily on the dispute (4, p. 26).

The new Section 8(d) provision expressed this congressional intent and indicates that Section 8(a)(5) or 8(b)(3) would be violated if a party in a health care institution dispute refused to participate fully and promptly in meetings undertaken by FMCS. This is in contrast with other sector institutions as in the Midas International Corporation (26) where the NLRB found no per se refusal to bargain in a refusal to participate in mediation. In health care, the parties must participate or charges may be filed by the opposing party with the NLRB. National Health Care Coordinator, FMCS, Nicholas Fernandis, specifically mentioned that FMCS is not an enforcement body and does not itself file any such charges with the NLRB (6).

Mediation assignments are made through the regional offices to the approximately three hundred mediators located in eighty field offices through the United States. Upon receipt of an assignment, a mediator contacts both parties and proffers assistance. Each mediator attempts to hold at least one or two bargaining sessions with the parties before the end of thirty days. This is related to provisions regarding Boards of Inquiry appointments which must be made within thirty days of receipt of notice.

Federal Mediation and Conciliation Service Caseload

Mediators file final report forms for each collective bargaining situation. Health care cases do not receive any special designations. The standardized reports are submitted after (1) negotiations are resolved, (2) negotiations remain unresolved, or (3) the case is referred to the NLRB (31, p. 148). The reports include number of mediation sessions, information on the parties, mediation issues, and other pertinent dispute activity information. Interim reports made during the course of negotiation are called status reports.

Due to the mandatory involvement under the amendment, the Federal Mediation and Conciliation Service caseload has increased substantially. From August 26, 1974, to December, 1976, the Mediation Service recorded 3,545 health care cases (15, p. 4).* No records were kept previous to the law's

*Actual number of different cases minus duplication equals 2585 (15).

passage, but a survey conducted at the time of the amendment indicated 140 health care cases in progress on September 1, 1974 (4). The number had more than doubled by October 1, increasing to 294, and had increased to 700 by January 1, 1975. The original projection of case activity was for 750 cases during the ten months of the Fiscal Year 1975 in which FMCS had health care responsibility. The total caseload almost doubled that projection (7). Since the enactment of the law, FMCS has averaged 500 active health care cases (4).

Approximately 1,600 cases per year have been added to the caseload. Table VIII illustrates the caseload status as of September 1, 1975, a little over one year after the passage of the amendment. During Fiscal Year 1975, 1,400 cases were recorded, 906 closed during the year, and the remaining 494 retained for Fiscal 1976. Between August 15, 1974, and September 1, 1975, two months after the end of Fiscal Year 1975,* 921 cases had been closed (30, p. 389). According to Searce and Tanner, these cases represented 1555 employees in the bargaining units and 617,679 workers in the health care institutions. As illustrated in Table IX,

*The Government 1975 Fiscal Year ran from July 1, 1974 to June 30, 1975. The Government 1976 Fiscal Year ran from July 1, 1975 to October 1, 1976. Annual health care data usually runs from August 1974 (date of enactment) to August 1975, 1976.

TABLE VIII
CASELOAD STATUS--FMCS*

September 1, 1975

Case Status	Regions								Service-wide Totals
	1	2	3	4	5	6	7	8	
Pending	154	40	13	77	59	20	96	52	511
Renewals and/or Reopeners	107	13	2	47	31	12	60	23	295
Initial Contracts	47	27	11	30	28	8	36	29	216
Closed Preceding Month	26	7	--	15	11	--	40	18	117
Total Caseload Since 8-25-74 (Since 7-1-75 in region 8)	468	151	29	253	176	50	433	78	1,638

*Source: Searce, James F. and Lucretia Tannery, "Health Care Bargaining: The FMCS Experience," Labor Law Journal, Vol. 27, No. 7 (July, 1976).

27 per cent involved initial contracts and 62 per cent involved contract renewals, compared to 9 per cent of all FMCS cases with initial contracts and 82 per cent renewals (30, p. 391).

For Fiscal Year 1976, 1,869 cases were recorded, 1,692 closed during the year and 177 were retained for Fiscal 1977 (13). By May, 1977, total caseload had reached 3,949 (25). Table X shows the cumulative increase in cases from those in progress at the effective date of the amendment to May, 1977.

TABLE IX
COMPARISON OF FMCS HEALTH CARE CASES TO TOTAL
FMCS DISPUTE CASES

Type of Negotiation	Health Care		Total Dispute	
	Number of Cases	Per Cent of Total	Number of Cases	Per Cent of Total
Initial Contract	248	27.0	1,807	9.1
Contract Renewals	575	62.4	16,311	82.5
Contract Reopeners	97	10.5	1,422	7.2
Exceptional Grievances	7	.1	231	1.2
Totals	921	100.0	19,717	100.0

Source: Searce, James F. and Lucretia Tannery, "Health Care Bargaining: The FMCS Experience," Labor Law Journal, Vol. 27, No. 7 (July, 1976).

Hospital negotiations represent about 50 per cent of the total health care caseload, but represent 70 per cent of the total number of employees. Nursing homes accounted for 30 per cent of the negotiations but represented only 15 per cent of the employees. Other health care disputes covered convalescent hospitals, health maintenance organizations and other health care facilities (30, p. 394).

Following the national trend of union organization, the health care institutions that have been organized tend to be located outside of the South and Southwest. The areas of the two coasts, Northeast and West, appear to have the highest concentration.

TABLE X
CUMULATIVE TABLE OF FMCS HEALTH CARE CASES

Date	Number of Cases
September 1, 1974	140
October 1, 1974	294
December 1, 1974	417
January 1, 1975	700
July 1, 1975 (FY 1975)	1,400
September 1, 1975 (First Year)	1,638
January 1, 1976 (FY 1976)	2,096
October 1, 1976	2,762
November 1, 1976	3,269
December 1, 1976	3,545
May 1, 1977	3,949

Source: Federal Mediation and Conciliation Service, Internal Data.

Following the higher degree of organization, there is higher FMCS activity in the same coastal regions where over one-half of all health care caseload is concentrated. Region I, which includes Massachusetts and New York, equaled over 30 per cent of the total caseload. Region VII provides over 20 per cent of the total caseload and Region VIII (a new region since July 1, 1975) provided a total caseload of almost 9 per cent, and 12 per cent for Fiscal 1976 (13, p. 30). These regions include California and Washington.

Health care cases for FMCS tend to correlate with total FMCS cases by region, but not in direct proportion as all FMCS cases. As shown in Table IV, California had 20 per cent of total health care cases but only 9 per cent of the total FMCS cases. Table XI shows the number of health care cases and their relationship to the total number of FMCS cases by FMCS region for Fiscal Year 1975. Health care cases represent about 10 per cent of the total FMCS caseload (30, pp. 391, 393.

The states with the highest number of total cases in Fiscal Year 1975 are California, Illinois and Pennsylvania. Of these, only California is also a leader in health care cases. The top three in health care include California, Michigan and New York.

Eleven states had a higher percentage of health care cases than percentage of all FMCS cases. These states were Connecticut, Massachusetts, New York, Maryland, Pennsylvania, Michigan, California, Hawaii, Montana, Oregon, and Washington. Regions I, IV, and VII had a higher percentage of total health care cases than all FMCS cases due to the concentration of the eleven states in those regions.*

*Note: In September, 1975, Region VII was divided into two. The new Region VIII includes Alaska, Oregon, Utah, Montana, Colorado, Washington, Idaho, Wyoming, and part of Nevada with Region VII covering the remaining five states.

TABLE XI

NUMBER AND PER CENT OF TOTAL AND HEALTH CARE
CLOSED FMCS CASES BY REGION AND STATE
FISCAL 1975**

	Total Cases		Health Care Cases	
	Number of Cases	Per Cent of Total	Number of Cases	Per Cent of Total
Region I Total	1,199	13.6	240	26.6
Connecticut	144	1.3	24	2.6
Maine	33	0.4	1	0.1
Massachusetts	291	3.3	61	6.6
New Hampshire	33	0.4	--	--
New Jersey*	207	2.3	18	2.0
New York	472	5.4	134	14.5
Puerto Rico	--	--	--	--
Rhode Island	31	0.3	2	0.2
Vermont	18	0.2	--	--
Virgin Islands	--	--	--	--
Region II Total	1,090	12.4	99	10.7
Delaware	27	0.3	--	--
District of Columbia	80	0.9	3	0.3
Maryland	101	1.1	19	2.1
New Jersey*	143	1.6	6	0.7
Ohio*	10	0.1	1	0.1
Pennsylvania*	606	6.9	66	7.2
Virginia*	75	0.8	--	--
West Virginia	48	0.5	4	0.4
Region III Total	707	8.0	16	1.7
Alabama	134	1.5	1	0.1
Arkansas	2	--	--	--
Florida	99	1.1	3	0.3
Georgia	85	1.0	3	0.3
Kentucky*	15	0.2	--	--
Louisiana	74	0.8	1	0.1
Mississippi	33	0.4	--	--
North Carolina	70	0.8	2	0.2
South Carolina	14	0.2	--	--
Tennessee	172	2.0	4	0.4
Virginia*	9	0.1	2	0.2
Region IV Total	1,189	13.5	143	15.5
Indiana*	9	0.1	--	--
Kentucky*	155	1.8	--	--
Michigan*	409	4.6	107	11.6
Ohio*	616	7.0	36	3.9

TABLE XI--Continued

	Total Cases		Health Care Cases	
	Number of Cases	Per Cent of Total	Number of Cases	Per Cent of Total
Region V Total	1,540	17.5	99	10.7
Illinois*	585	6.6	35	3.8
Indiana*	256	2.9	4	0.4
Michigan*	20	0.2	2	0.2
Minnesota	362	4.1	30	3.2
North Dakota	31	0.3	--	--
South Dakota	18	0.2	--	--
Wisconsin	268	3.0	28	3.0
Region VI Total	1,438	16.4	30	3.2
Arkansas*	75	0.8	1	0.1
Illinois*	87	1.0	3	0.3
Iowa	238	2.7	7	0.8
Kansas	126	1.4	1	0.1
Missouri	428	4.9	18	2.0
Nebraska	61	0.7	--	--
Oklahoma	76	0.9	--	--
Texas*	347	3.9	--	--
Region VII Total	1,632	18.6	294	3.19
Alaska	28	0.3	1	0.1
Arizona	40	0.4	3	0.3
California	782	8.9	187	20.3
Colorado	93	1.1	2	0.2
Hawaii	31	0.3	5	0.5
Idaho	46	0.5	--	--
Montana	66	0.7	8	0.9
Nevada	51	0.6	3	0.3
New Mexico	33	0.4	1	0.1
Oregon	142	1.6	23	2.5
Texas*	19	0.2	--	--
Utah	17	0.2	1	0.1
Washington	272	3.1	60	6.5
Wyoming	12	0.1	--	--
Totals	8,795	100.0	921	100.0

*Geographical area of state divided between two FMCS regions.

**Source: James F. Searce and Lucretia Tanner, "Health Care Bargaining: The FMCS Experience," Labor Law Journal, 27, No. 7 (July, 1976), 387-397.

Thirteen states did not have any health care cases at all in Fiscal Year 1975. These were primarily in the South and Midwest.

Ten-Day Notice Requirement

One of the principal changes of the National Labor Relations Act by Public Law 93-360 is the addition of Section 8(g). Section 8(g) states:

A labor organization before engaging in any strike, picketing, or other concerted refusal to work at any health care institution shall, not less than ten days prior to such action, notify the institution in writing and the Federal Mediation and Conciliation Service of that intention except that in the case of bargaining for an initial agreement, following certification or recognition, the notice required by this subsection shall not be given until the expiration of the period specified in clause (B) of the last sentence of Section 8(d) of this Act. The notice shall state the date and time that such action will commence. The notice, once given, may be extended by the written agreement of both parties (27).

In the case of bargaining for an initial agreement, the law provides that thirty days' notice of a dispute must be given to the agencies set forth in Section 8(d)(3). When this notice requirement is combined with the ten-day notice provision, it indicates an effective period of forty days exists during which time the parties can attempt to negotiate a meaningful settlement. Figures 5 and 6 show the time frames and applicable sections of the law.

Due to the need to avoid disruption of patient care, the Congressional Committee Reports state that failure to give

<u>Certification-Notice</u>	Sec 9 (a)
<u>FMCS/State Notice (30 days)</u>	Sec 8 (d) (4) (B)
<u>FMCS appoints BOI</u>	Sec 213 (a)
<u>BO Invest. & Rpt.</u>	Sec 213 (a)
<u>(15 days) Status Quo</u>	Sec 213 (c)
<u>Strike Notice</u>	Sec 8 (g)
<u>(10 days)</u>	

- (1) Certification and unspecified number of days (until FMCS/State notice given) of direct collective bargaining.
- (2) Thirty-day FMCS/State notice and start of mediation involvement.
- (3) Within ten days after FMCS notice, FMCS may appoint a Board of Inquiry.
- (4) Within fifteen days after establishment, BOI findings and recommendations reported to parties.
- (5) Fifteen-day (or more) period of status quo with resumed collective bargaining and mediation.
- (6) One-day notice with date and time of strike to party and FMCS, but only after FMCS/State notice has run its thirty-day term.

NOTE: NLRB has determined that if strike or lockout does not occur within seventy-two hours of date and time given, a new notice must be given to run for a period of ten more days, or new date mutually agreed and FMCS advised.

Fig. 5--Time Periods for Initial Contracts

<u>Parties/Notice (90 days)</u>	<u>Expiration</u>	Sec 8(d)(4)(A)
<u>FMCS/State Notice (60 days)</u>		Sec 8(d)(4)(A)
<u>FMCS appoints BOI</u>		Sec 213(a)
(30 days)	<u>BOI Invest. & Rpt.</u>	Sec 213(a)
	(15 days)	<u>Status Quo</u>
		Sec 213(c)
		<u>Strike Notice</u>
		Sec 8(g)
	(10 days)	

- (1) Ninety-day parties/notice and thirty days of direct collective bargaining.
- (2) Sixty-day FMCS/State notice and start of mediation involvement.
- (3) Within thirty days after FMCS notice, FMCS may appoint a Board of Inquiry.
- (4) Within fifteen days after establishment, BOI findings and recommendations reported to parties.
- (5) Fifteen-day (or more) period of status quo with resumed collective bargaining and mediation.
- (6) Ten-day notice with date and time of strike to party and FMCS.

NOTE: NLRB has determined that if strike or lockout does not occur within seventy-two hours of date and time given to run for a period of ten more days, or new date mutually agreed and FMCS advised.

Source: Federal Mediation and Conciliation Service, internal data.

Fig. 6--Time Periods for Contract Renewals

statutory notice required by Section 8(g) could be met with remedial action under Section 10(j) of the Act (16), which normally is an injunction against continued action until the merits of the complaint can be examined by the NLRB.

The Senate and House Reports state:

The ten-day notice is intended to give health care institutions sufficient advance notice of a strike or picketing to permit them to make arrangements for the continuing of patient care. It is not the intention of the committee that a labor organization shall be required to commence a strike or picketing at the precise time specified in the notice; on the other hand it would be inconsistent with the committee's intent if a labor organization failed to act within a reasonable time after the time specified in the notice. Thus it would be unreasonable in the committee's judgment, if a strike or picketing commenced more than 72 hours after the time specified in the notice. In addition, since the purpose of the notice is to give a health care institution advance notice of the actual commencement of a strike or picketing, if a labor organization does not strike at the time specified in the notice, at least 12 hours notice should be given of the actual time for commencement of the action (17, p. 374).

Mandatory mediation, extended notice provision, and ten day strike notices have all contributed to the very low strike rate in health care. The rate of 3 per cent in all FMCS health care situations contrasts with the rate of 13 per cent for all FMCS cases (15, p. 4).

Fact Finding and Boards of Inquiry

Notice requirements, time restrictions, and mandatory mediation are not the only provisions applicable to the Federal Mediation and Conciliation Service in the Act. Section

213 was added to provide for participation by the health care institution and the labor union in conciliation at the direction of FMCS.

Conciliation of Labor Disputes in the
Health Care Industry

Sec. 213. (a) If, in the opinion of the Director of the Federal Mediation and Conciliation Service a threatened or actual strike or lockout affecting a health care institution will, if permitted to occur or to continue, substantially interrupt the delivery of health care in the locality concerned, the Director may further assist in the resolution of the impasse by establishing within 30 days after the notice to the Federal Mediation and Conciliation Service under clause (a) of the last sentence of section 8(d) (which is required by clause (3) of such section 8(d) or within 10 days after the notice under clause (b), an impartial Board of Inquiry to investigate the issues involved in the dispute and to make a written report thereon to the parties within fifteen (15) days after the establishment of such a Board. The written report shall contain the findings of fact together with the Board's recommendations for settling the dispute, with the objective of achieving a prompt, peaceful and just settlement of the dispute. Each such Board shall be composed of such number of individuals as the Director may deem desirable. No member appointed under this section shall have any interest or involvement in the health care institutions or the employee organizations involved in the dispute (27).

Fact finding in labor disputes is a step beyond mediation but short of arbitration. The parties usually maintain a status quo for a brief period of time until a third party neutral can investigate the dispute and issue a report which usually includes recommendations. The neutral must decide which facts should have priority in the collective bargaining relationship. The Board of Inquiry is designed to provide fact finding in an attempt to avoid health care strikes.

If the Director of FMCS concludes that strike or lock-out activity will substantially interrupt the delivery of health care in the locality concerned, the Board of Inquiry may be established.

Ken Moffett, Director of Mediation Services, commented on the difficulty FMCS has in initial contract negotiations (18). He indicated many unions file notices as a matter of self protection. The investigation of health care in the locality and the effect of a strike must commence even though bargaining is progressing. This is due to the ten day notice requirement in Section 8(d), (B). Included with these time restraints is the additional requirement that the Board is to make a written report to the parties within fifteen days after its establishment and this report will recite the findings of fact along with recommendations for a prompt, peaceful and just settlement of the dispute. Moffett also made clear that once a Board of Inquiry is appointed, a union cannot simply withdraw its notice of a dispute. Both parties must request the dismissal of the Board and state they do not intend to interrupt patient care through a strike or contract termination dispute (18).

A reason for the concern of the parties when a Board of Inquiry is appointed is that once the Board is established, and for fifteen days after its report has been issued, the parties may not change the status quo "in effect prior to the

expiration of the contract" or "in effect prior to the time of the impasse," except by agreement (5, p. 272).

Appointment of Boards of Inquiry

The Federal Mediation and Conciliation Service followed a strict interpretation of the law until November, 1974, on whether or not to appoint a Board of Inquiry. FMCS then began to consider more fully the potential impact of the Board of Inquiry on the entire collective bargaining system and what assistance it could be to the process, as well as the question of interrupted health care in the community (30, p. 389).

As the law specifies, a two-stage approach is now used to determine appointments of boards of inquiry. The potential impact of a strike or lockout on the community is considered; i.e., the size of the facility (number of beds) and its occupancy rate, feasibility of transfer of patients, whether the hospital offers unique or critical services, and the critical nature of the involved workers' duties (30, p. 389).

After examining these factors, the second stage is evaluating the possible impact that convening a Board of Inquiry would have on collective bargaining in this case; e.g., would it assist in a peaceful settlement? According to Searce (30, p. 389), this factor is viewed from the point of the stage of the negotiations, the communication and relationships between the parties and the mediation service, the types of

issues involved, the probabilities surrounding a work stoppage and what contributions could be made by the Board of Inquiry.

The appointment of a Board of Inquiry is not an automatic event. There are many criteria considered, but there is no one rule covering the determinations for appointment. Each health care dispute is evaluated on the merits of its own particular set of circumstances before any decision is finally made (30).

In order to give some flexibility under the stringent time requirements, the Mediation Service developed a stipulation form which, when properly utilized, allows an appointment of a fact finder outside the time constraints in the amendment (30, p. 390).

The dates involved in the stipulation appear to vary according to the case and thus, has been used in only a few situations. Even then, the appointment of a Board of Inquiry is not mandatory. According to Searce:

As of January 1, 1976, 66 Boards of Inquiry and 17 Factfinding Boards had been appointed. A BOI is appointed within the time limits set by the amendments, conducts factfinding proceedings, and has 15 days in which to issue a report. The Factfinding Boards are distinguished from BOI proceedings in that they are established outside the time requirements and are appointed as "special consultants" to the Service. This procedure is elected by the parties. In both BOI and Factfinding Board proceedings, FMCS is responsible for the costs (30, p. 390).

Once the determination to appoint a Board of Inquiry has been made, certain guidelines are usually adhered to as follows:

Guidelines for Board of Inquiry

1. The composition of a Board of Inquiry shall be determined by the National Director of FMCS or his designee.
2. A BOI may consist of one person.
3. A BOI of more than one person shall consist of a Chairman and a Member, or Members. The Chairman shall have those responsibilities generally associated with such designation.
4. All communications between the BOI and the parties shall be through the Chairman, unless otherwise provided.
5. A BOI will be deemed to be established upon receipt by its member(s) of the official written appointment communication from the National Director.
6. The National Director of FMCS shall substitute a BOI in the event a vacancy occurs after establishing a one person BOI.
7. The National Director of FMCS may make a substitution in the event a vacancy occurs after establishing a multi-person BOI.
8. A BOI shall serve a term of office in keeping with statutory limitation or submission of its findings and recommendations, whichever occurs first.
9. The BOI shall place itself in communication with the parties to the dispute as soon as possible after receipt of official appointment.
10. The BOI shall select a time, place, and date of such proceedings as it deems necessary. The suggestions of the parties may be considered.
11. The BOI shall determine the order of proceedings.
12. The BOI will conduct proceedings in a manner that it determines will most expeditiously enable it to receive full information, evidence, and arguments from the parties, including any written submissions which in its sole judgment are warranted.

13. The BOI will maintain an appropriate record of proceedings. Due to statutory time limitations, no transcript shall be made.
14. Parties to the proceedings before a BOI may have representatives of their own choosing.
15. A BOI shall have full control over participation in proceedings by anyone other than the parties.
16. The failure of a party to cooperate with the BOI does not preclude the BOI from conducting an ex parte proceeding.
17. The BOI shall determine questions and claims associated with the dispute during its term of office.
18. A party shall bear the cost and expense for its witnesses and such documents or other materials it submits.
19. Each party shall receive the BOI written findings and recommendations by mail or personal service at the address listed in the Office of Arbitration Services for its designated representative.
20. The BOI will provide a copy of its written findings and recommendations to the Office of Arbitration Services and the designated FMCS mediator at the same time copies are delivered to the parties.
21. Conference facilities of the appropriate FMCS office may be made available to a BOI when practical (12, pp. 1-3).

The Federal Mediation Service has decided that copies of the Board's recommendations are to be given only to the parties and the FMCS. Therefore, any distribution of the reports must be made by the parties. FMCS did reserve the right to issue a specific report if a case calls for special action (30, p. 15). Service Employees President George Hardy claims that the union has the right to all Board of Inquiry reports under the Freedom of Information Act (14, p. 15).

Board of Inquiry Caseload

From August 25, 1974, to January 1, 1977, 122 Boards of Inquiry and special Fact-Finders were appointed (15, p. 3). In the first year under the Health Care Act, FMCS appointed fifty-eight boards of inquiry. Three were appointed in the same case because of unresolved issues. In the second year, sixty-one were appointed. As of May, 1977, FMCS total health care industry caseload equaled 3,949 cases and in these, 134 Boards of Inquiry had been appointed (31). FMCS originally projected appointing Boards to one of every four disputes but a review of the criteria led to a substantial decline after November, 1974. Of the 134 appointments which have been made seven involved reappointments. This was done under a stipulation agreement that the original Board would operate as a fact finder (31). There have been 15 strikes in which Boards of Inquiry were appointed (31). The 134 BOI's that have been appointed have included 87 different individuals. All but 10 Boards were single member panels; six had three members, and four had two members (31).

From September, 1974, to December, 1976, only 29 fact finding boards were appointed outside the time constraints of the amendments. Fewer fact finding boards were appointed than Boards of Inquiry. During the first eight months of 1977, health care boards and fact finding boards average three a month.

The 134 Boards were named to disputes involving 113,000 bargaining unit employees, which in turn had an impact on another 237,000 employees working at the health care facilities, according to Nicholas Finandis, FMCS (9). More than 42 per cent of Board of Inquiry cases have dealt with the National Union of Hospital and Health Care Employees, Local 1199. Finandis attributes this to the pre-amendment bargaining atmosphere where arbitration and fact finding were the norm rather than the exception for resolving impasses (9). The Service Employee International Union and the various state nurses associations have each utilized more than 17 per cent of the Board appointments (31). These three organizations; SEIU, District 1199, and the State nurses associations, accounted for 76 per cent of FMCS Board of Inquiry activity and for more than two-thirds of the total health care caseload (31). Table XII shows the number of boards by region. The most appointments have been in Region I. Of the fifty-four appointed in Fiscal Year 1975, thirty-nine were in that region which includes New York and Massachusetts. Seven were appointed in Region VII. Region I and Region VII were also the leaders in total FMCS health care cases. Four were appointed in Region II, two in Region III, and two in Region VI (14).

TABLE XII
 NUMBER OF BOARDS BY REGION
 August 26, 1974--December 31, 1976

Region	Type of Board ^a				Total	
	Boards of Inquiry		Fact Finding			
	Number	Per-centage	Number	Per-centage	Number	Per-centage
1	51	56.0	12	41.4	63	52.5
2	14	15.4	6	20.7	20	16.7
3	11	12.1	1	3.4	12	1.0
4	1	1.1	0	0.0	1	0.8
5	1	1.1	1	3.4	2	1.7
6	2	2.2	1	3.4	3	2.5
7	11	12.1	8	27.6	19	15.8
8 ^b	0	0.0	0	0.0	0	0.0
Totals	91	100.0	29	100.0	120	100.0

^aFigures may not equal 100.00 per cent because of rounding.

^bRegion 8 was formed in July, 1975, from states formerly in Region 7. One BOI and one fact-finding board were established in states in Region 8, but before the change.

Source: Federal Mediation and Conciliation Service, internal data.

Characteristics of the Parties
in BOI Proceedings

Unions in BOI Disputes.--As illustrated in Figure 7, the BOI's were basically held in hospitals. District 1199 was involved in 45.8 per cent of the Boards, but only 15 per cent of the negotiations. The SEIU was only involved with 15 per cent of the Boards but was active in 32 per cent of the negotiations.

Other unions which have been parties in BOI disputes include the Operating Engineers, Retail Clerks, Steelworkers, and AFSCME (7).

Facilities in BOI Disputes.--Table XIII shows the type of Board by type of facility and by the union. Most BOI's were appointed to Local 1199. The fact finding boards, appointed only after a stipulation agreement has been signed, seemed most popular with the nurses associations.

In comparing facilities by region where BOI's were appointed, Region 1 had almost 67 per cent BOI's in hospital cases. States with the largest number of fact finding boards for hospital labor disputes were in New York, Pennsylvania, and California (31, p. 224).

Characteristics of Boards of Inquiry
and Fact Finders

Criteria for Boards of Inquiry members includes competency in fact finding, mediation, arbitration, and experience

TABLE XIII

TYPE OF BOARD BY TYPE OF FACILITY AND UNION*

Type	Board of Inquiry		Fact-Finding		Total	
	Number	Per-centage	Number	Per-centage	Number	Per-centage
Facility						
Hospital	63	69.2	21	72.4	84	70.0
Nursing Home	18	19.8	3	10.3	21	17.5
Other	10	10.9	5	17.2	15	12.5
Totals	91	100.0	29	100.0	120	100.0
Union						
District 1199	47	51.6	8	27.9	55	45.8
SEIU	13	14.3	5	17.2	18	15.0
Nurses Associ- ations	14	15.4	9	31.0	23	19.2
Other	17	18.7	7	24.1	24	20.0
Totals	91	100.0	29	100.0	120	100.0

*Percentages may not total 100.0 because of rounding.

Source: Federal Mediation and Conciliation Service, internal data.

in the health care field. Arbitrators listed on the FMCS roster were asked about their exposure to health care problems and availability to serve on short notice, a major concern since board members must contact the parties, arrange a meeting, and write recommendations within fifteen days.

Although 93.3 per cent of the board members are on the roster of arbitrators, appointments are not just limited to those on the roster. A number of individuals have been appointed including FMCS national office persons and in one case a mediator from one region was sent into another region (31, p. 267).

Types of Negotiation Involving BOI's

Seventy per cent of the appointed fact finders were in situations other than initial contracts, either renewals or reopeners. The type of Board appointed is not influenced by the status of the negotiation (31, p. 227). The majority are cases for contract renewals.

Only twenty-one states have had any BOI appointments. Over 50 per cent of the initial contract BOI appointments were in Region I. Region I utilizes the most boards whatever the level of negotiation as shown in Table XIV. Although only 10 per cent of the Boards were established in Region 3, 23 per cent of these were disputes on initial contracts (31, p. 225).

TABLE XIV
TYPE OF NEGOTIATION BY REGION

Region	Type of Negotiation ^a							
	Initial		Renewal		Reopener		Total	
	Num- ber	Per- centage	Num- ber	Per- centage	Num- ber	Per- centage	Num- ber	Per- centage
1	18	51.4	42	54.5	3	27.5	63	52.5
2	3	8.6	15	19.5	2	25.0	20	16.7
3	8	22.9	3	3.9	1	12.5	12	10.0
4	1	2.9	0	0.0	0	0.0	1	0.8
5	2	5.7	0	0.0	0	0.0	2	1.7
6	1	2.9	2	2.6	0	0.0	3	2.5
7	2	5.7	15	19.5	2	25.0	19	15.8
8 ^b	0	0.0	0	0.0	0	0.0	0	0.0
Totals	35	100.0	77	100.0	8	100.0	120	100.0

^aFigures may not equal 100.00 per cent because of rounding.

^bRegion 8 was formed in July 1975 from states formerly in Region 7. One BOI and one fact-finding board were established in states in Region 8, but before the change.

Source: Federal Mediation and Conciliation Service, internal data.

In comparing type of health care facility with initial versus renewal cases, the nature of the facility seems to have impact on the appointment of BOI's. Hospitals have utilized fact finding to a much greater extent than nursing homes in contract renewals. Proportionately there does not appear to be much difference in the type of negotiation and the particular union involved as shown in Table XV.

Board of Inquiry Procedures

Federal Mediation representative Finandis said that in 19 of the 134 Board appointments no hearings were held (9). In some cases the 15 day terms expired before hearings could be held. In others the parties were meeting and requested the Board not to call any hearings. Some parties met in extended bargaining and reached agreement prior to their hearing dates essentially to avoid having a Board thrust upon them, Finandis stated (9). In 50 per cent of the cases only one formal session was necessary, but in some cases as many as nine Board sessions were required.

To evaluate the Board of Inquiry procedure, the Federal Mediation and Conciliation Service reviewed Board of Inquiry reports, conducted a telephone survey with Chairpersons of Boards, and asked the Regional Directors and mediators to comment on the procedures.

According to Searce and Tanner, 53 board reports were examined with 33 per cent (seventeen) containing no

TABLE XV
 TYPE OF NEGOTIATION BY TYPE OF HEALTH CARE
 FACILITY AND UNION

Type of Institution	Type of Negotiation			Total
	Initial	Renewal	Reopened	
Hospital	19	59	6	84
Nursing Home	10	9	2	21
Other	6	9	0	15
Totals	35	77	8	120
<u>Union</u>				
District 1199	15	38	2	55
SEIU	5	10	3	18
Nurses Association	6	15	2	23
Other	9	14	1	24
Totals	35	77	8	120

Source: Federal Mediation and Conciliation Service, internal data.

recommendations. In eleven situations, the Board suggested the parties continue bargaining. In the remaining six of the seventeen, the parties settled prior to the Board's issuing a report through informal conferences with the fact finder or prior to a Board hearing (30).

The number of days of hearings varied from less than a day to four days. In thirteen cases, one day or less was necessary for a hearing. In three cases, two days were

needed; in five cases, three days; and in four cases, four days (25, p. 55).

This is interesting compared with the information compiled by FMCS to show that the average number of days worked by each Board is four, with a range of one day to a high of twenty days (30). The variety is explained by the appointment of some persons to more than one situation.

The fees and expenses of the Boards are paid by the FMCS as provided by Section 213 (2). Each party pays for its own expenses of witnesses and documents. The average cost of each Board is approximately \$600.00 (28).

In surveying Board Chairpersons, it was discovered that in 75 per cent of the meetings, mediation techniques were used alone or with fact finding procedures. Generally, the Boards believed their using mediation reduced the number of issues (a problem in initial contract situations) which in a few cases involved as many as twenty to thirty (14). Twenty-six of the forty-six persons who had served as Boards felt the procedures met the needs of the parties by providing a direct, positive force (30). Some seem to feel the unknown element of a Board expedited bargaining and settlement in advance of a hearing.

However, even those who felt the Board results were positive criticized certain aspects of the procedure. Most felt the time restrictions should be changed by extending the fifteen days or some other procedure.

Depending on the circumstances of the dispute, the mediator may continue mediation concurrent with the Board of Inquiry period, or may suspend meetings until the Board has ceased to function. The mediator may attend as an observer in Board of Inquiry meetings but would not participate in any official capacity (28).

Board of Inquiry Issues and Recommendations

According to the Legislative Committee reports:

The actual conduct and 'frame of reference' of the Board of Inquiry, of course, are not dictated by the legislation. While the input of the Board will be developed through practice it was suggested that the Board consider the Congressional intent of redressing past discrimination against employees in nonprofit health care institutions. Consequently, it was recommended that the Board consider (a) a comparison of the annual income of the employees in question and those employed in enterprises of a similar size in the locality, (b) adequate protection for job security and fringe benefits, (c) cost of living increases, (d) career advancement, (e) equal employment opportunity, (f) equal pay, (g) the possibility of grievance resolution without the resort to strikes, and (h) job training and skills (3, p. 8004).

Issues.--Issues presented to Boards of Inquiry have for the most part been the same as those of other parts of the private sector. Over 50 per cent of the issues submitted to Boards involved wages and other economic issues. Included in this were the front loading of wage increases and cost of living increases (25). Another important issue is the union trying to follow the pattern which has been set by another health care institution (30). The problem in initial

contracts becomes a dilemma of equity versus ability to pay. Especially in initial contracts, the employees are usually considerably behind the pattern. Table XVI presents the ten most commonly cited issues.

In 25 per cent of the cases before Boards, questions of fringe benefits were submitted. Specifically, hospitalization and general health and welfare benefits emerged and again, unions wanted to follow the pattern (25, p. 57). Another frequently discussed issue is the length of the contract. The length of the contract in health care cases can be compared to total FMCS dispute cases (30). In total FMCS cases almost 50 per cent have three year or more contracts, while in health care cases 20 per cent have three years or more. In health care cases 44 per cent have two year contracts compared to FMCS total cases of 31 per cent with two years.

Due to the around-the-clock necessity for patient care, work schedules create many issues. Weekend work is often a problem area. Unions want employees to have alternate weekends off and employers want maximum scheduling flexibility. Boards generally try to suggest language giving employees time off when possible. Along with work schedules comes the issue of shift differentials. In the health care industry, third shift has not generally received an additional premium as compared with second shift, a practice common in other industries (30, p. 394). The Boards often have to rely on

TABLE XVI
TEN MOST COMMONLY CITED ISSUES BY TYPE OF BOARD

Issues	Board of Inquiry	Fact Finding	Total
Wages	52	17	69
Insurance	37	11	48
Sick Leave	30	11	41
Pensions	33	8	41
Holidays	30	11	41
Vacations	25	12	37
Shift Differential	26	7	33
Contract Duration	26	7	33
Training Fund or Tuition Allowance	18	8	26
Uniform Allowance	16	8	24

Source: Federal Mediation and Conciliation Service, internal data.

information presented by the parties in terms of practices peculiar to the health care industry, a practice which has evoked considerable criticism.

Other issues include pensions, staff development, check-off, holidays, specialty differentials, and probationary periods (25, p. 57). Issues involving patient care are brought to the fore by professional units. Table XVII indicates the number of issues by region, with Regions One and Two having

TABLE XVII
BOARD OF INQUIRY AND FACT-FINDING REPORTS

Number of Issues by Region ¹				
Region	Mean Number of Issues		Range Number of Issues	
	BOI	Fact Finding	BOI	Fact Finding
1	11.66	9	2-27	2-17
2	12	14.6	3-33	5-22
3	9.22	12	4-21	12
4	6	0	6	0
5	8	0	8	0
6	0	14	0	14
7	6.83	7.4	1-14	1-5
8 ²	0.0	0.0	0	0
Totals	10.62	10.3	1-33	1-22

¹Based on 55 Board of Inquiry and 20 fact finding reports.

²Region 8 was formed in July, 1975, from states formerly in Region 7. One BOI and one fact-finding board were established in states in Region 8 but before the change.

Source: Federal Mediation and Conciliation Service, internal data.

wide variety. The type of units and length of the bargaining relationships seem to be important factors in the kind of issue brought before the Boards as shown in Table XVIII.

Recommendations.--At least one specific recommendation was noted by seventy-five Boards and fact finders (31, p. 288).

TABLE XVIII
 NUMBER OF ISSUES BY TYPE OF BOARD AND
 LEVEL OF NEGOTIATIONS

Number of Issues	Number of Boards		
	Boards of Inquiry	Fact-Finding	Total
1 - 5	14	5	19
6 - 10	19	5	24
11 - 15	9	6	15
16 - 20	7	2	9
Over 20	6	2	8
Totals	55	20	75
Mean Number of Issues	10.62	10.3	10.53

Number of Issues	Type of Negotiations			Total
	Initial	Renewal	Reopener	
1 - 5	3	11	5	19
6 - 10	9	14	1	24
11 - 15	4	11	0	15
16 - 20	6	2	1	9
Over 20	3	5	0	8
Totals	25	43	7	75

Source: Federal Mediation and Conciliation Service, internal data.

Table XIX indicates the type of Board by contents of reports. Recommendations were absent in those reports in which: (1) the case was settled, (2) a stipulation agreement was signed, (3) the dispute centered on a unit certification or classification issue, (4) the appointment of a Board resulted in a court dispute, and (5) one situation where the fact finder recommended that the parties renegotiate after a third party payor decision on cost reimbursement was issued (31, p. 272).

In eleven cases out of thirty-one, both parties accepted the recommendations completely. Both the union and health care institution separately turned the recommendations down an equal number of times. In four cases, both union and management rejected the recommendations (25, p. 56).

Negotiations continued after the fact finders' report was issued in all but four cases. Eleven health care institutions utilized the fact finder's report in their bases for final settlement. In three institutions, a strike did occur, but the fact finders' report was the basis for final settlement in two cases out of the three. Eight institutions modified the fact finders' report, somewhat, in terms of timing of implementation (25, p. 56).

Over 70 per cent of the reports issued for initial contracts, and almost 60 per cent of reports on renewal or reopener disputes offered specific recommendations on at least one issue of disagreement (31, p. 273).

TABLE XVIX

ANALYSIS OF THE BOARD OF INQUIRY PROCEDURE

Contents of Reports	Type of Board by Contents of Reports					
	Boards of Inquiry		Fact-Finding Boards		Total	
	Number	Percentage	Number	Percentage	Number	Percentage
Recommendations issued	55	60.4	20	69.0	75	62.5
Total recommendations issued	36	39.6	9	31.0	45	37.5
Totals	91	100.0	29	100.0	120	100.0
Parties to start or continue collective bargaining	16		0		16	
Dispute settled before BOI meeting or before report issued	11		6		17	
Stipulation agreement	4		1*		5	
Certification or unit clarification issued	2		1		3	
Renegotiation after third-party payor decision	0		1		1	
Court Dispute	3		0		3	

*Recommendation stipulation for binding arbitration if failure to reach agreement.

Source: Federal Mediation and Conciliation Service, internal data.

Board of Inquiry Evaluation

Labor.--Remarks of the parties regarding Board of Inquiry activities are diverse. George Hardy, President of Service Employees International Union, criticized the small number of boards appointed. He has cited several situations in which a board was requested but no appointment made. He wants Inquiry Boards in all health care contract disputes. He also felt too many of the persons appointed lacked experience in health care. He said the federal fee for consultation of \$138 per day was too low to attract many of the top arbitrators (24, p. 9).

Henry T. Wilson, however, feels more positively toward the Boards of Inquiry. Serving as legal counsel, Federal-Public Service Division, Labours International Union, he stated:

Anything that can prevent a hospital strike is important and desirable in the labor-management field. The establishment of Boards of Inquiry had not been considered by the FMCS prior to their adoption in the committee report. There has been real success, and, yes, even some strikes. The effectiveness of the Boards will increase as experience grows (32, p. 95).

Also, remarks by Jack Frye, attorney, Professions Economic Counsel, after involvement in a Board of Inquiry meeting with Harrisburg Polyclinic Hospital and Pennsylvania Nurses Association, are very supportive. He stated in a letter:

The recommendations of such a federally appointed neutral will exert great influence on both management and employee negotiators at any hospital. The Board of Inquiry procedures are of great potential value to

nurses and other hospital employees, provided a well prepared case is presented, and fair settlements without interruption of services are very much in the public interest. I expect these hearings to be increasingly important in hospital labor relations (11, p. 1).

Management.--Baltimore management attorney Samuel Cook has yet another view. He said that the recent experience in negotiations with District 1199 led both sides of the table to conclude the Board of Inquiry was a "total waste of time." He felt the opportunity to settle was there before the Board was appointed but neither side would give up anything that might be ruled on by the Board so serious negotiations halted thirty to fifteen days before the expiration date. Cook declared the parties engaged in a "war of statistics" before the Board when they should have been negotiating. He also felt that Inquiry Boards "always split the difference" on outstanding issues (23, p. 358).

In a survey to determine what both parties felt regarding the BOI procedure, eight respondents felt the fact finder was knowledgeable in the industry, nine respondents felt the fact finder was not. Three others hedged their responses with "not completely," "somewhat," and "at best in a peripheral way." Three parties felt the recommendations were not objective (25, p. 55).

In terms of asking if the procedure assisted the bargaining process, nine felt negatively and sixteen responded

positively. Seven persons felt the procedure was counter-productive. One felt it was just an exercise since it was nonbinding (25).

A greater percentage of management than labor found both BOI procedures and recommendations useful. Management was more positive on the recommendations, whereas labor was more positive on the Board procedures (31, p. 293) as shown in Table XX.

Board of Inquiry, Arbitrators, Fact Finders.--Arbitrator Eva Robbins commented that theoretically, there exists fifteen days in which to hold hearings and make recommendations. However, in one of her experiences, the parties were deeply enmeshed in mediation and therefore, she only had three days to hold the hearing, examine a tremendous amount of paperwork, and issue a report and recommendations. Given these complications, she still favored continued mediation efforts because she felt it created an optimistic atmosphere and continued pressure to reach a settlement (22).

Also, Board members would like to be appointed after an impasse has developed rather than early in negotiations. FMCS reported 60 per cent of the Boards believed that the parties had not engaged in adequate bargaining prior to the Board's appointment (30). In other situations, Boards believed that the parties had reached an impasse but a strike was not imminent.

TABLE XX
USEFULNESS OF BOI PROCEDURES
AND RECOMMENDATIONS

	Management View	Labor View
Value of BOI Procedure:		
Very helpful	33.8	26.8
Somewhat helpful	24.4	32.4
Not much help	20.6	23.9
A hindrance	16.2	16.9
Value of BOI Recommendation:		
Very helpful	29.4	27.1
Somewhat helpful	35.3	28.8
Not much help	17.6	28.8
A hindrance	17.6	15.3

Source: Federal Mediation and Conciliation Service, internal data.

Positive comments about the Board procedure were: (1) the parties were forced to develop supportive data for their positions; (2) the Boards served as a face-saving device; and (3) at times a Board acts as a catalyst to get the parties to start negotiating (31, p. 292).

FMCS Evaluation by Regional Directors, Mediators, Washington Staff.--FMCS Regional Directors felt the timing

of appointments was a matter of concern. Most said it would be more helpful to have a Board when a true impasse was reached. The Regional Directors and Mediators felt the Board of Inquiry reports would then be helpful to the bargaining procedure because mediators could use the findings in the mediation process (14).

Finandis cited a survey of FMCS mediators that had been assigned to health care disputes. Thirty-three per cent felt the Boards were cooperative and aided in contributing to the eventual settlement. Another one-third said there was some positive effect, and the remaining one-third said there was no effect or the effect was negative (21).

The mediators felt that mediation was most effective after the Board issued its reports to the parties, and they felt that changes in the timing of the appointment would improve the process (14). They felt the parties had a tendency to structure their bargaining position for the BOI and thus delay serious negotiations (31, p. 292).

Fifty per cent of the mediators polled on health care cases noted differences in the bargaining of health care versus other industries. These differences include the issues of patient care and professional standards. The larger size of bargaining committees and the inexperience of the parties resulted in overly heavy reliance on attorneys (30).

It appears that Boards of Inquiry do have a place in the process of health care bargaining but caution in appointment, both in timing and personnel, must prevail. Former Director, FMCS, and Secretary of Labor, William J. Usery, commented, "A contract whose terms are written by third parties, no matter how wise and well meaning, is simply no substitute for an agreement between the parties themselves" (33, p. 48).

FMCS Legal Battle Regarding Boards of Inquiry

The area receiving the most criticism from persons serving on boards, the mediators, and the parties themselves, is the time requirements imposed on the Boards of Inquiry. Although this criticism includes the fifteen-day time period for the Board, it also expressly includes the time of appointment.

The Federal Mediation and Conciliation Service has undertaken legal battles on behalf of its interpretations of the time limits within which Boards of Inquiry must be appointed. The Service maintains the period during which such appointments can be made extends for thirty days after the last day permitted for the giving of notice [Section 8(d)]. Several employers have argued that the day the FMCS actually receives the notice starts the time period (23).

In Affiliated Hospitals versus Searce (1), the U. S. District Court rejected the FMCS interpretation. The

Affiliated Hospitals court observed the major question is the "rather fine semantic question whether Congress, when it said 'within thirty days after the notice to the [FMCS] under Clause (a) . . . ' meant 'within thirty days after the giving of notice' or 'within thirty days after the last day permitted for the giving of notice'" (1, p. 2945). The court interpreted Congressional intent to mean thirty days after the actual giving of the notice.

In Sinai Hospital versus Searce (29), the FMCS argued the Affiliated Hospital decision was in error due to two reasons: (1) additional legislative history not examined in Affiliated Hospitals, and (2) that the imposition of the strict thirty-day time limit frustrates the intent of Congress by forcing decisions too early in the course of negotiations (29).

The U. S. District Court of Maryland in the Sinai case examined the Conference Committee Reports and other evidence in the Congressional Record. The court determined the times should run from the last date on which notices could be legally given; the time schedules are in reference to the contract termination date which is the only fixed date. All others are variable. The court, then, upheld in Sinai Hospital versus Searce, that the appointment was timely (29).

In Sinai Hospital versus Searce, the Court also examined the prerequisites to Board of Inwurity appointments. The Court interprets the Statute as requiring the FMCS Director

to ascertain two things. The first question is the existence of a threatened strike or lockout affecting the health care institution. The Court sees three alternative interpretations. One is that an impasse has occurred and strike is imminent; two is the possibility that the contract is ending and without agreement, a strike will probably occur, and if so, will affect the delivery of health services. The third alternative suggested is an interpretation where bargaining has slowed down and is not making progress and there is reason to believe that a strike is more than a mere possibility but less than a certainty (20).

The second required finding by the Statute is that if the strike or lockout were to occur it would substantially interrupt the delivery of health care in the locality (20).

In Sinai Hospital versus Searce, the Court required the National FMCS Director to state whether he has made the aforementioned findings. The Court said, "There must not be just a possibility because the contract is over, but there must be some substantial reason to believe there may be a strike. It doesn't have to reach the level of an inevitability or an impasse" (29, p. 2890).

Both cases are on appeal and Judge Winter, U. S. Court of Appeals, Fourth Circuit, reinstated a preliminary injunction against the Board of Inquiry in the Sinai case. He stated, "If a Board of Inquiry is illegally constituted and undertakes to make findings and recommendations, I have

little doubt that the parties to the labor negotiations will suffer irreparable injury" (23, p. 358).

Mr. Herbert Fishgold, former General Counsel, reviewed the differences in the court decision at a recent Health Care Advisory committee meeting. He felt the policies adopted by the agency were working well even though both courts concurred that FMCS had been gazing into a crystal ball in determining when and if an appointment should be made.

Mr. Fishgold stated:

Going to the merits, the statute in issue is, I cannot resist the temptation to say, an example of a disturbing trend of increasingly obtuse piece of legislation adopted by Congress in recent times. The Congressional intent is, to borrow a phrase from the Supreme Court, not glaringly bright (15, p. 13).

The U. S. Court of Appeals has ruled in Sinai Hospital versus Searce that Sinai Hospital was entitled to a preliminary injunction enjoining the Board of Inquiry that was appointed by the Director of the Federal Mediation and Conciliation Service from investigating issues concerning collective bargaining negotiations between the hospital and the union; and appointment of the board was made outside the thirty day time period established by Section 213(a) of the Labor Management Relations Act (29). The interpretation is the appointment must be made within thirty days after the actual receipt of the notice by FMCS not within thirty days of the last date permitted for the giving of such notice.

Third Party Payers

Third party payers (insurance companies and state and federal government) are creating increasing pressures on the parties at the health care bargaining table. Nicholas Finandis, national health care representative of the Federal Mediation and Conciliation Service, feels the increasing control third party payers are exercising is threatening the bargaining process (20). In Fiscal Year 1975 the Council on Wage and Price Stability noted third party payments constituted 67.4 per cent of total expenditures for personal health care, and for hospital health care 92 per cent of all payments were from third party sources (8).

According to Herbert Fishgold, General Counsel:

In no other industry or sector of our economy, except for the public sector, are the parties at the bargaining table confronted with the specter of this so-called third party payer, not at the bargaining table, yet having the final authority to pass on or reimburse a labor cost arising from contract negotiations (20, p. 2355).

Fishgold perceives a seemingly insurmountable (20) problem when the objective of the Board of Inquiry is a set of recommendations to achieve a prompt, peaceful and just settlement of the dispute, but these recommendations exceed the approved limits of a health care commission.

One Board in New York City recommended third party payers be persuaded by a joint committee to increase the present level of per diem rate of reimbursement (30).

Another Board report stated, "Section 213 of the NLRA does not provide for the third party payers to be present at, nor are they properly party to, the negotiations" (30, p. 392).

Fishgold predicts it may become more difficult for the parties at the table to avoid having the third party payers getting involved in the bargaining process. He says labor and management will have to examine " . . . in greater detail the potential for the implications of involving the third party payers in the collective bargaining process on the industry's terms . . ." (20, p. 2355).

Phillip Ross, Professor of Industrial Relations at Cornell, prepared a paper for the FMCS stating third party payers will become increasingly important as they attempt to gain more control over cost (19).

Lucretia Dewey Tanner, FMCS Office of Research, noted at a meeting of the Health Care Advisory Committee that the Maryland State Review Commission took the position that there was no need for catch-up wage increases and the only wage increases for hospital employees should be based on the Consumer Price Index (19).

Joseph Rossman, American Hospital Association, said, "Cost control efforts can be categorized, by degree of severity, into four major types" (19, p. 57). One type is when Blue Cross and Blue Shield compare area institutions to determine equity of costs for reimbursement purposes.

Another type involves a state review structure under which, Blue Cross-Blue Shield and other insurance programs set up educational programs, conduct periodic review of costs, and put institutions to the test of justifying their expenditures. The next stage involves negotiations between the third party payers and the institutions. The negotiations result in cost figures for several categories with allowable percentage increases. Anything beyond what is agreed to in negotiations must be absorbed by the institution. The most severe system is operative in New York, New Jersey and Maryland. Under this system, the state rate commission has the ability to review all charges and rates of reimbursement. This may be soon established in other states including Indiana, Minnesota, California, and Pennsylvania.

These factors surely affect the bargaining process and can make settlement difficult. Paul Yager, Regional Director of Region I, presented an example to the Health Care Advisory Committee. The Metropolitan Nursing Home Association was faced with a strike threat when the state did not give it enough money to finance a ten dollar per week pay increase and payment for all sick leave. The money was withheld pending an audit of eligibility of patients but the audit was delayed due to a shortage of auditors in New York, because of layoffs (19). Yager said in some instances there really is not a bargaining disagreement but instead, a

question of whether the money can be extracted from the third party payer (19).

Further discussions of the third party payer is included in Chapter VII, Collective Bargaining in Health Care Facilities. The difficulty of handling the problem of the third party payers has not been resolved, but there seems to be substantial concern and agreement that in the future the impact may be even greater.

Office of Technical Services

In striving toward the goals of the Service's Mission Statement, the Office of Technical Services carries a diverse load. In response to the Health Care Amendments, the FMCS has conducted programs for the American Hospital Association, the American Nurses Association, and many additional health care institutions, unions, and universities.

Also, an announcement has been made of the plans for a year-long study of the effects of the Health Care Amendments by the Office of Technical Services; Mr. Jim Powers and Ms. Lou Tanner will be directing the project (31). Some of the information to be examined will include Board of Inquiry appointments, roles of the Board, and stipulation procedures for delayed fact finding (15).

Health Care Advisory Committee

William J. Usery, National Director of the FMCS at the time of the Amendment's passage, established a Labor-Management

Health Care Advisory Committee to advise the FMCS on desired improvements and provide other feedback information (31).

No meetings were held in Fiscal Year 1975, as a year of experience was considered necessary prior to discussion. The first meeting was held in July, 1975, and has been followed with meetings approximately every six months.

Fourteen members serve on this committee with seven representatives for labor and seven from management (24, p. 15). Labor's representatives include: George Hardy, President SEIU; Leon Davis, President of District 1199; Mary Munger, Chairman of the American Nurses Association's Commission on General and Economic Welfare; James Housewright, President of Retail Clerks; Thurman Radford, Director of the Industrial Division of the Laborers International Unions; J. C. Turner, President of the Operating Engineers Union; and Mrs. E. Pauline Wright, President of the National Federation of Licensed Practical Nurses.

Management affiliates serving the committee included: Joseph Rosman, of the American Hospital Association; Donald Barry, President of the American Nursing Home Association; William J. Abelow, Executive Director and Counsel of the League of Voluntary Hospitals and Homes of New York; Russell Williams, President of the California Hospital Association; Wilbur Lindgren, Vice-President for Employee Relations of the Kaiser Foundation Health Plan, Inc.; and A. Samuel Cook, a Baltimore attorney representing health care institutions.

Members of the committee received data regarding experience under the Taft-Hartley Amendment and discussed ways of improving mediation assistance in the health care industry. The committee was originally formed to help in the transition of the amendments coverage. The last meeting of the advisory committee was held in Washington, D. C., December 6, 1976. On July 8, 1977, the committee was abolished in accordance with the current administration's objectives of eliminating advisory committees.

Summary

The Federal Mediation and Conciliation Service has clearly felt the impact of the Health Care Amendments to the Taft-Hartley Act. In the two years since the passage of the Act, health care added over 3,200 cases to the caseload. The average number of active cases for health care is five hundred. Due to special provisions of the law, such as mandatory mediation and increased notification time limits, a high caseload is expected to continue. The most active regions are Region I, which includes New York and Massachusetts, and Region VII, which includes California.

Another addition to the Act is Section 8(g), providing for ten days notice by a labor organization prior to striking or picketing. This is to help provide continuity in patient care and enable FMCS to continue working toward dispute resolution.

During the 1975 Fiscal Year, forty-six strikes were recorded, which was a 4 per cent strike rate compared to the non-health care private sector rate of 15 per cent. During 1976 Fiscal Year, this figure dropped to 3 per cent in health care and 13 per cent in non-health care private sector.

The unique portion of the Act is also the area that seems to cause the most difficulty--the appointment of the Boards of Inquiry. Legal interpretation is being sought in the matter of the BOI timing of appointment. Also under criticism is the fifteen-day time limitation for hearings and written findings. There have been over 122 Boards appointed in the two years following the enactment of the amendment.

The FMCS has had a greatly increased caseload and other responsibilities carrying out their roles as defined in Public Law 93-360. The organization has had to gain expertise regarding the law and the health care industry and then has, in turn, had to share this with others. It is anticipated the caseload will continue to increase as more initial contracts are negotiated and as contracts begin to come up for renewal. Despite increased caseload, and new requirements, it appears the FMCS has certainly made a smooth transition into extensive involvement in the health care industry.

CHAPTER BIBLIOGRAPHY

1. Affiliated Hospitals v. Searce, 93 Labor Relations Reference Manual 2307, 2945 (November, 1976).
2. 119 Congressional Record 6934, Washington, D. C., May 2, 1974.
3. 119 Congressional Record 8004, Washington, D. C., July 10, 1974.
4. Federal Mediation and Conciliation Service: Twenty-Eighth Annual Report. Washington, D. C., Fiscal Year 1976.
5. Feheley, Lawrence F., "Amendments to the National Labor Relations Act," Ohio State Law Journal, 36 (1975), 269-281.
6. Statement by Nicholas Finandis, FMCS Health Industry Coordinator, Washington, D. C., April 9, 1975.
7. Finandis, Nicholas, "Health Care Industry Monthly Statistics," Memorandum dated April 9, 1975.
8. Finandis, Nicholas, "Address to New York University's 29th Annual Conference on Labor," White Collar Report No. 998, Bureau of National Affairs, May 28, 1976.
9. Finandis, Nicholas, "Role of FMCS in Impasse Resolution under the NLRA Amendments," Proceedings of a Conference Presented by the American Arbitration Association and the Federal Mediator Service Bureaus of National Affairs, 1976.
10. Memorandum by Herbert Fishgold, FMCS General Counsel, dated October 3, 1974.
11. Letter from Jack Frye, Attorney, Professions Economic Counsel, to Economic and General Welfare Staff, State Nurses Association, January 28, 1976.
12. "Guidelines for Boards of Inquiry," memorandum published by Federal Mediation and Conciliation Service, Washington, D. C., October 11, 1974.
13. Statement by Vincent L. Guy, Federal Mediator, Dallas, Texas, March 1, 1976.

14. "Report of Health Care Industry Labor Managements Advisory Committee Meeting," Federal Mediator and Conciliation Service, Washington, D. C., August 20, 1975.
15. "Report of Health Care Industry Labor Management Advisory Committee Meeting," Federal Mediation and Conciliation Service, Washington, D. C., December 6, 1976, 1-14.
16. House Representative No. 1051, 93rd Congress, 2nd Session 5 (1974); Senate Representative No. 766, 92nd Congress 2nd Session 4 (1974).
17. 86 Labor Relations Reporter 374, Bureau of National Affairs, August 26, 1974.
18. 87 Labor Relations Reporter 144, Bureau of National Affairs, October 7, 1974.
19. 91 Labor Relations Reporter 57, Bureau of National Affairs, January 19, 1975.
20. 92 Labor Relations Reporter 90, Bureau of National Affairs, May 31, 1976.
21. 92 Labor Relations Reporter 174, Bureau of National Affairs, June 28, 1976.
22. 93 Labor Relations Reporter 183, Bureau of National Affairs, November 8, 1976.
23. 93 Labor Relations Reporter 358, Bureau of National Affairs, December 13, 1976.
24. The Mediator, Federal Mediator and Conciliation Service, Vol. 2, No. 8, Washington, D. C., August-September, 1975, 9.
25. Metzger, Norman, "NLRA Boards of Inquiry have been Used Sparingly," Hospitals, I (July 1, 1976), 55-57.
26. Midas International Corporation, 150 NLRB 486, (1964).
27. National Labor Relations Act, as amended by Public Law 93-360, 93rd Congress 53203 (1974).
28. R_x for Labor Peace. A handbook by the Federal Mediation and Conciliation Service, Washington, D. C., Government Printing Office, 1975.

29. Sinai Hospital v. Searce, 93 Labor Relations Reference Manual 2890 (1976) and 96 Labor Relations Reference Manual 2355 (1977).
30. Searce, James F. and Lucretia Tanner, "Health Care Bargaining: The FMCS Experience," Labor Law Journal, Vol. 27, No. 7 (July, 1976), 387-397.
31. Tanner, Lucretia Dewey, Research Staff, Federal Mediation and Conciliation Service, Director of Research Project, "1974 Amendments Effect on Health Care," (1977).
32. Usery, William J., "An Interview with the Director of the Federal Mediation and Conciliation Service," Hospitals, 48 (September 16, 1974), 45-48.
33. Wilson Henry T., "Boards of Inquiry: From Labor's Viewpoint," Labor Relations in Hospitals and Health Care Facilities, Bureau of National Affairs, 1976, 95.

CHAPTER VII

CONTRACT NEGOTIATIONS

Initial Contract Negotiations

Once a union gains recognition as a bargaining agent for a group of employees in a health institution, its foot is solidly in the door and it is usually there to stay. Once certified, a union cannot be decertified for a minimum of one year. Thus the health administrator usually has to bargain with union at least once. Also as a point of information, unions are seldom decertified as bargaining agents (46, p. 54).

Certainly union organization of hospitals and other health care facilities is not likely to subside. Quite the opposite, more health institutions are being unionized every day.

According to Joseph Rosmann, manager of the American Hospital Associations department of hospital employee relations and training, the health care industry has 2,500 collective bargaining contracts in 1,600 hospitals (1,300 non-federal) (40). He presented these statistics at a series of AHA seminars in June, 1976. About 18 per cent of the workers and 23 per cent of the hospitals now are covered by collective bargaining contracts (40). The number of contracts

has been rapidly increasing due to union successes in securing petitions for elections and the ability of the union to win over 60 per cent of the elections (40, p. 68).

Table XXI shows how the states rank in the following categories: numbers of bargaining situations, employees in bargaining units, and number of initial contracts.

An institution's efforts to prevent a union from gaining legal recognition may fail because workers perceive basic inequities. Once a union is recognized there is usually enough employee support to insure its continued survival.

Most health administrators have not yet had to negotiate a labor agreement. Currently only approximately 20 per cent of all nonprofit hospitals have a collective bargaining agreement with a union (46). However, the impact of labor activity continues to be felt. According to the Federal Mediation and Conciliation Service, many hospitals have been or will be embarking on contract negotiations for the first time, especially as the high rate of union organizing success continues. FMCS reported that about one-fourth of the health care cases in which it has been involved were for initial contracts (30). FMCS estimates over 1,500 hospital contracts were negotiated in 1976 affecting 200,000 employees (16).

A host of factors must be considered when negotiating the first labor agreement between union and management because a great deal can be won or lost at this initial negotiation. One labor attorney has warned:

TABLE XXI

THE STATES RANKING ACCORDING TO NUMBERS OF BARGAINING
SITUATIONS, EMPLOYEES AND INITIAL CONTRACTS

State	Bargaining Situations	Employees in Units (All Contracts)	Number of Initial Contracts
California	1	2	2
New York	2	1	1
Michigan	3	3	3
Massachusetts	4	6	9
Pennsylvania	5	4	4
Washington	6	5	5
Ohio	7	7	7
New Jersey	8	10	8
Minnesota	9	9	10
Illinois	10	8	6
Wisconsin	11	12	11
Oregon	12	13	13
Connecticut	13	14	12
Missouri	14	16	14
Maryland	15	11	17
Montana	16	24	16
Iowa	17	21	15
Hawaii	18	20	21
West Virginia	19	18	29
District of Columbia	20	17	19
Indiana	21	23	20
Georgia	22	26	18
Alabama	23	22	22
Tennessee	24	15	23
Florida	25	28	24
Rhode Island	26	27	30
Nevada	27	30	27
Texas	28	29	25
Kentucky	29	19	28
Colorado	30	25	26
(Remaining have fewer than 5 Contracts)			

Source: Federal Mediation and Conciliation Service, Internal data.

It is here, more than any time or any contract thereafter, that foresight plays its most prominent role because the first contract is the skeleton of all future contracts. It may be taken as a seldom-disproved axiom that whatever basic concessions are made in the original contract will endure for as long as that employer and that union have contractual relations (46, p. 56).

In a recent study by Demarko, Robinson, and Houk, 25 hospital management groups and 23 union groups were examined. The initial bargaining priorities of newly organized health care institution employees were, in order of priority: (1) better wages, (2) greater union security, (3) strong seniority provision dealing with promotions and layoffs, and (4) workable grievance procedures (31, p. 46).

Of the 23 unions, 22 rated wages and union security as top ranking items. Eighteen of the unions and 14 of the 26 management groups expressed a preference for binding arbitration in the resolution of grievances. Unions in large hospitals gave higher rankings to seniority, bidding for job opportunities, paid vacations, and health and disability insurance than did unions at the small hospitals (31).

Some basic points to keep in mind when entering negotiations for the first time are:

1. Lack of precedence can be a help or hindrance. The negotiations are not restricted by past practice but every item, every word is debatable.

2. First negotiations can be very long and difficult. Every item will be considered carefully by management to prevent erosion of management rights.

3. The tendency to think about the length of the contract must be overcome to consider the long range precedents.

4. Compromise is difficult in initial negotiations because each side is inexperienced and thinks it has more to lose. One union often looks at the first negotiation as "Gotcha" and the management feels "We've been had."

5. The union is under great pressure to produce a favorable contract, so there will be hard bargaining until a favorable contract is reached (38).

Dr. Spirn has listed some lessons to be learned about co-existing with the union. He feels hospital administrators should:

1. Assume the union will not disappear
 2. Make the hospital's labor relations activities more professional
 3. Research the opposition thoroughly
 4. Establish firm but equitable personnel policies
 5. Consider the role of arbitrators in labor relations
 6. Finally, learn something about labor relations
- (46, p. 55).

Hospital Contract Provisions

One way of looking at contract provisions is that they are the result of a process in which the actors are severely constrained by environmental conditions. In this examination

of hospital contracts, the environment is that of the U. S. hospital industry and the government regulators that guide it; the primary actors are hospitals, employees, and unions. While in one sense every hospital-union bargaining relationship is unique, the industrial relations system concept suggests that similarities in environmental conditions or in actor characteristics may cause similarities in contracts. However, where environmental conditions, organizational characteristics, and participating occupations are quite different contracts themselves may be quite dissimilar.

This examination of hospital contracts is based on a four year study by Hervey Juris under a grant from the National Center for Health Services Research (28). Analysis of the contract provisions included a varying pattern of contracts according to hospital profiles (SMSA size, bed-size, ownership and region) and bargaining unit characteristics (professional, technical, nonprofessional and combined).

Juris analyzed 817 contracts by concentrating on elements that distinguished hospital contracts from those in all industry. Results from a survey sent to 7,165 hospitals presented a data base of 6,199 hospitals that responded. Twenty-three per cent (1,418) of the hospitals indicated they had at least one union contract in existence (27).

Unionized hospitals are more likely to be in Standard Metropolitan Statistical areas of more than one million; to represent disproportionately larger bed size categories; to be publicly owned and to be more heavily concentrated in the West, Northeast, and the North Central regions of the United States as shown in Table XXII. The extent of collective bargaining varies widely from region to region ranging from 38 per cent of the hospitals in the central region to 27.5 per cent in the Pacific (27).

Juris also requested contracts from 1,100 unionized hospitals. He received 817 contracts from 576 hospitals. In comparing their profile with the questionnaire respondents, the only significant variation was type of ownership. The researchers dropped Federal hospitals due to the wide variations in employment processes (27, p. 506).

Indications from this study are that the number of items involved as collective bargaining issues is phenomenally larger than industry in general, but hospitals have done a better job of keeping the level of benefits down (11).

Duration of Contracts

Hospital contracts tend to be shorter in duration than other industries, as indicated in Table XXIII. Juris considers this could be related to the newness of the bargaining

TABLE XXII
 EXTENT AND NATURE OF UNIONIZATION OF
 UNITED STATES HOSPITALS, 1976

Characteristics	All U. S. Hospitals (7,165)	Responding Hospitals (6,199)	Unionized Hospitals (1,418)	Contract Samples (576)
SMSA Size				
Non SMSA	46%	46%	26%	27%
Less than 250,000	9	9	10	8
250,000 to One Million	17	18	18	14
Over One Million	28	28	46	51
Bed Size				
0-99	49%	46%	23%	21%
100-399	22	22	22	24
200-399	17	18	26	28
400 +	13	14	29	28
Control				
Government-Nonfed	32%	32%	31%	35%
Government-Fed	5	6	20	1
Church	11	12	7	11
Voluntary	39	39	36	49
Proprietary	13	11	6	4
Region				
West	13%	12%	22%	28%
Northeast	18	18	34	31
North Central	28	30	28	31
Other	41	40	16	10

Source: American Hospital Association as cited by Hervey Juris, "Labor Agreements in the Hospital Industry," Labor Law Journal (August, 1977), 505.

relationships, the high proportion of hospitals with government related budgets on an annual or biannual budget, the existence of wage-price controls, high rates of inflation, and the relative absence of cost of living adjustments clauses in hospital agreements (27, p. 506).

TABLE XXIII
DURATION OF COLLECTIVE BARGAINING CONTRACTS

Length of Contract	Hospitals	All Industry
1 year or less	23	5
2 years	50	21
3 years	25	70

Source: Hervey Juris, "Labor Agreements in Hospital Industry," Labor Law Journal (August, 1977), p. 507.

Wage Related Data

Wage related provisions were included in the Juris study. Table XXIV shows some of these provisions and their comparison with industry.

Shift differentials are found in 58 per cent of the hospital contracts, as opposed to 82 per cent of the BNA sample (28). There is an increasing incidence of shift differential with increases in bed size and a decreasing incidence of shift differential with increases in bed size and a decreasing incidence with increases in SMSA size (27, p. 508).

TABLE XXIV
WAGE RELATED DATA

Wage Related Data	Hospitals	All Industry
Deferred Wage Increases	64	88
COLA (Cost of Living Allowance)	7	36
Wage Reopeners	29	8
Shift Differential	58	82
Reporting Pay	29	71
Severance Pay	9	36
Unscheduled Call-In Pay	48	62
Stand By--On Call Pay	46	3
Hours and Overtime		
Sixth Day	11	17
Seventh Day	19	18
Saturday	11	52
Sunday	14	68

Computed from:
Hervey Juris, "Labor Agreements in the Hospital Industry: A Study of Collective Bargaining Outputs," Labor Law Journal (August, 1977), p. 341.

Hervey Juris and Joseph Rossman, Charles Maxey, Gail Bentivegna, "Nationwide Survey Shows Growth in Union Contracts," Hospitals, 51 (March 16, 1977), p.

Juris is undergoing further data analysis to examine urban-suburban differences, but the data was not presently available. In the large metropolitan areas the shift differential may not be as necessary in order to attract an adequate labor force (27).

Reporting pay (29 per cent) is significantly lower than other industries (71 per cent), as is unscheduled call-in pay (48 per cent versus 62 per cent) (21). However the BNA

industry information for scheduled stand by pay for people on call is significantly lower (3 per cent) than the hospital contracts (46 per cent) (27, p. 508).

Premium pay for Saturday and Sunday in hospitals, which are seven day a week, twenty-four hour facilities, is 40 to 50 per cent lower than that in industry. Also severance pay appears in only 9 per cent of the hospital contracts, as opposed to 36 per cent of the industry sample.

Juris highlights significant differences in holidays and paid sick leave provisions. Table XXV illustrates holiday pay provisions.

TABLE XXV
HOLIDAY AND HOLIDAY PAY PROVISIONS

	Hospital Contracts Per Cent	All Industry Per Cent
Provision for paid holidays	95	91
Number of paid holidays		
6 or less	10	6
7	23	10
8	23	12
9	11	29
10	23	42
Compensation for holiday work		
Equal time off	53	NA
1 1/2 times regular pay	0	2
2 times regular pay	8	16
2 1/4 or 2 1/2 times regular pay	17	43
3 or more times regular pay	2	32

Source: Hervey Juris, "Labor Agreements in the Hospital Industry," Labor Law Journal (August 1977), 509.

In 94 per cent of the hospital contracts paid sick leave is included but only 33 per cent of the industry sample have this provision. Table XXVI presents a frequency distribution of total paid days off calculated to determine if the paid sick leave compensated for the difference in holidays. Juris notes that the mean, median, and mode all fall within the 19-20 days off and that appears to be generous. Government ownership has the greatest number of paid days off, as does the Northeast, and the larger the SMSA, the more paid days off (27).

Probably due to the high incidence of nurses contracts, there exists 76 per cent paid maternity leave in hospital contracts as opposed to 38 per cent in industry. Personal leave provisions are more equal, 66 per cent for the hospital compared to 73 per cent for all industry (27).

Joint study committees, often used to take issues off the table, were found in 41.2 per cent of hospital union contracts. Such committees for involvement in some kind of decision making mechanism were evident in 73 per cent of the professional contracts, 52 per cent of the technical unit contracts, 16 per cent of the nonprofessional contracts, and 40 per cent of the combination agreements. The joint study committee performs a different function in industry. In hospital negotiations this is basically used to treat issues out of the usual wages, hours, and, working conditions subjects and yet avoid negotiating over patient care items.

TABLE XXVI
TOTAL PAID DAYS OFF (EXCLUSIVE OF VACATION)

Number of Days Off (Holidays, Personal Days, Paid Sick Days)	Hospital Contracts (%) (N = 759)
1 - 9	7
10 - 18	14
19	16
20	17
21	10
22	10
23 - 25	16
26 or more	10

Categories	Holidays	Personal Days	Paid Sick Days
By Bargaining Unit	20 days	20 days	20 days
Professional	38%	21%	41%
Technical	35	22	43
Nonprofessional	41	19	40
Combination	35	11	54
By Control (Ownership)			
Government	30%	17%	53%
Church	52	29	18
Other Nonprofit	40	15	45
Proprietary	36	14	50

TABLE XXVI--Continued

Categories	Holidays	Personal Days	Paid Sick Days
By SMSA Size			
50,000 population	46%	27%	27%
50,000 - 250,000	44	23	33
250,000 - 1,000,000	38	16	46
Over 1,000,000	32	11	58
By Bed Size			
0 - 99 beds	43%	24%	33%
100 - 199 beds	38	25	37
200 - 399 beds	36	17	47
400 + beds	43	8	49
By Single vs. Multiple Hospital System			
Single	39%	19%	42%
Multiple	29	9	62
By Region			
Northeast	24%	4%	72%
North Central	58	16	26
West	29	26	44

Source: Hervey Juris, "Labor Agreements in the Hospital Industry," Labor Law Journal (August, 1977), 510.

Also, 47 per cent of the hospital contracts provided for educational leave (27).

Union Security Provisions

The employer is responsible for the delivery of health care in a cost constraining environment. The employees (and their unions), while they may be concerned with delivery of high quality health care, also have an interest in their own economic security, due process, and individual job security. The union entity in itself desires certain contract guarantees related to its status with the employer. Union security issues are normally concerned with membership recruiting, generation of dues, union access to employees at the work place, and protection for union officers (28).

Union Membership.--Union security provisions range from no contract language on membership (open shop) to mandatory membership (union shop) with a variety of options in between. Several variables--the power of the union, whether the hospital is located in a right to work state, etc.--will determine which of these options is selected. Ownership (public versus private) is another important factor contributing to the type of mandatory membership language likely to be found in a labor agreement (28).

In the private sector the bargaining power of the parties seems to be the determining factor. In the public

there is a strong attitude carried over into public hospital collective bargaining that holds that voluntary action and not coercion should be the dominant factor in relations between public employers and employees. This could be due in part to the age of the relationships in the public sector.

In general, mandatory membership language in contract construction is significantly more likely to occur in the private sector than in the public sector, while open shop clauses seem more likely to take place in public sector contracts as shown in Tables XXVII and XXVIII. In the public sector, according to Juris, the important variables were single versus multiple hospital contracts and region, while city size and bed size category were less important. About half of the private sector contracts have a union shop and half of the public sector show an open shop. The agency shop and maintenance of membership showed a slightly higher incidence in public sector contracts, while the modified union shop was twice as prevalent in the private sector as the public (28).

In addition to differences related to public versus private hospitals, there are also differences by occupation, city size, bed size, region and type of control. In the private sector the incidence of open shop clauses was substantially higher among professional and technical units

TABLE XXVII
 EXTENT AND NATURE OF MEMBERSHIP PROVISIONS IN
 281 GOVERNMENT UNION CONTRACTS

Hospital Characteristics	Percentage Reporting Provisions			
	Union Shop	Modified Union Shop	Agency Shop	Maintenance Membership
Occupation				
Professional	24%	20%	19%	23%
Technical	29	20	13	12
Nonprofessional	35	20	13	23
Combination	12	40	55	42
SMSA Size				
Non SMSA	47%	20%	30%	26%
Less than 250,000	0	0	8	0
250,000 to 1 Million	41	73	17	9
More than 1 Million	12	7	45	65
Bed Size				
0-99	18%	20%	24%	21%
100-199	23	7	15	14
200-399	41	7	17	9
400+	18	67	4	7
Multiple Hospitals (Assoc.)	0	0	40	49
Region				
Northeast	0%	7%	4%	37%
North Central	53	60	77	30
West	47	33	19	33
Open Shop				
				25%
				9
				16
				50
				28%
				6
				16
				50
				14%
				17
				10
				13
				46
				30%
				25
				45

Source: Hervey Juris, et al., "Nationwide Survey Shows Growth in Union Contracts," Hospitals, 51 (March 16, 1977), p. 73.

TABLE XXVIII

EXTENT AND NATURE OF MEMBERSHIP PROVISIONS IN
504 PRIVATE SECTOR UNION CONTRACTS

Hospital Characteristics	Percentage of Contract Provisions				
	Union Shop	Modified Union Shop	Agency Shop	Maintenance Membership	Open Shop
Occupation					
Professional	12%	7%	32%	24%	39%
Technical	10	7	19	11	28
Nonprofessional	43	50	18	36	14
Combination	35	36	31	29	19
SMSA Size					
Non SMSA	16%	21%	30%	24%	41%
Less than 250,000	5	3	18	5	15
250,000 to 1 Million	13	22	18	29	13
Over 1 Million	66	53	34	42	31
Bed Size					
0-99	11%	3%	11%	8%	23%
100-199	32	26	26	21	24
200-399	25	36	37	44	29
400+	25	22	15	21	15
Multiple Hospitals	7	12	11	7	10
Region					
Northeast	34%	29%	34%	50%	21%
North Central	30	45	39	27	41
West	36	27	27	23	38
Control					
Church	15%	14%	13%	19%	26%
Not-for-Profit	76	85	85	79	72
Investor Owned	9	2	2	2	2

Source: Hervey Juris, et al., "Nationwide Survey Shows Growth in Union Contracts," Hospitals, 51 (March 16, 1974), p. 74.

than among nonprofessional and combination units, while non-professional union shop clauses outnumbered professional and technical union shop clauses by a ratio of three to one (28).

Non-SMSA cities and cities of 250,000 to one million in population each accounted for about 40 per cent of public sector union shop clauses. In the private sector, city size was also a significant distinguishing variable. Non-SMSA's accounted for almost one-half the open shops, while SMSA's greater than one million accounted for two-thirds of the union shops (28).

Single hospitals versus multiple hospital contracts proved to be a useful distinction only for the public sector contracts, where all the union shop clauses and all modified union shop clauses were found in single rather than multiple hospital contracts. In contrast almost one-half of the open shop clauses were found in multiple hospital contracts (28).

Because all but 38 of the 817 contracts for which information was available were in three regions, these were the only ones used to distinguish regional differences. In the public sector contracts there were marked regional differences, especially in the Northeast and North Central states. The Northeast accounted for one-third of the maintenance of membership clauses and open shop clauses, but no union shop clauses. The North Central region accounted for more than one-half of the union shop clauses and modified union shop

clauses, and three-fourths of the agency shop clauses. In the private sector the differences are less dramatic but still present. The Northeast accounted for only one-fifth of the open shop and one-half of the maintenance of membership clauses. The North Central accounts for one-third of the union shop, and two-fifths of the modified union shop clauses and the open shop clauses (28).

Ownership, or control, of hospitals in the private sector also provided a useful information for distinguishing among contracts. Church affiliated hospital contracts equaled one quarter of the open shop and 15 per cent of the union shop clauses. Other not-for-profit hospital contracts accounted for approximately four-fifths each of union shop clauses, modified union shop, and agency shop clauses. Proprietary hospital contracts accounted for very few union shop and open shop provisions (28).

Other forms of union security are included in a variety of contracts, such as dues checkoff, bulletin boards, pay for time spent on union business, superseniority, nondiscrimination for union membership, discipline and discharge notice, and hiring hall.

Dues Checkoff.--In 79 per cent of 817 hospital contracts payroll deductions of dues and remittance to a local union officer was found by Juris (27, p. 507). In the private sector industry category, 86 per cent provided dues checkoff

(27, p. 507). By region, the Northeast included checkoff more frequently than did the North Central and the West (28). Bargaining unit or bed size category did not affect this provision significantly. Church affiliated hospitals granted checkoff in only about 57 per cent of their contracts, whereas the government and proprietary hospitals granted checkoff in almost 80 per cent.

Bulletin Boards.--Communication is important to union security and the union considers one or more places in a hospital where notices could be posted an important communications tool. In the 817 contracts analyzed by Juris, 272 had no language on bulletin boards. Sixty-two per cent included some limitation on the union's freedom to post (28), generally by specifying the nature of the material or by requiring that management approval is necessary before an item can be posted. Posting with no limitation only occurs in about 4 per cent of the hospitals (28).

Pay for Time Spent on Union Business.--In 49 per cent of the analyzed hospital contracts no provisions were made for pay for time spent on union business (28). However, other contracts do follow the more common individual practice of allowing time off for grievance handling and arbitration. Also contract negotiation preparation and meetings were included.

Superseniority.--Only 11 per cent of the contracts provided language for superseniority (28). Layoffs had not been a problem in the hospital industry so these protections were not viewed as critical. However, 75.4 per cent of all hospital agreements did provide for layoff procedure, but only 65.6 per cent provided for recalling workers (28). These figures are compared to 85 per cent of the private industrial contracts that provide for both layoff and recall.

Nondiscrimination for Union Members.--The Taft-Hartley Act prohibits an employer from discriminating against employees for union membership or for engaging in protected activities. In the hospital industry 59 per cent of the contracts carry an additional specific prohibition against discrimination for union membership, as opposed to 43 per cent of all industry contracts (28). This probably is a result of the new status of organizing, the numerous open shops and weaker forms of union security that exists in health care.

Hiring Hall.--Thirteen per cent of the Juris sample provided for a hiring hall (28). The private sector hospitals had hiring hall provisions ten times more frequently than the public hospitals. Also it was four times more likely to be used among nonprofessionals than professionals and more prevalent in cities with over one million in population (28).

Strong union security clauses are a basic measure of the union's power. The unions in private sector hospitals compare favorably with private industry in terms of union security, even though union shop provisions are twice the percentage in private industry. With respect to the future of union security issues, it appears more attention will be given to tighter shop clauses and checkoff provisions. Unions must insure their financial base and organizational foothold. There are areas of significant difference, including intraindustry variances in control, city size, and composition of the bargaining unit.

Employee Discipline

Collective bargaining establishes rules to operate by for a certain period of time. The provisions of a contract establish a set of rules binding on both the union and management for the duration of the contract. Effective rules on discipline and discharge, on one hand, support the exercise of necessary and legitimate managerial authority, and, on the other hand, protect employees from arbitrary or capricious supervision (26, p. 69).

Grievance procedures are intended to provide a mechanism for resolving disagreements over the interpretation of contract language and to provide assurance that the rules agreed to in negotiations will be implemented and administered fairly. Such procedures may involve a final step in appeal to a third

party neutral. This may be an arbitrator who delivers a final and binding decision. The union generally agrees to this procedure in exchange for its right to strike over alleged contract violations during the life of the agreement. This protects labor and provides management with some stability in the life of the contract (13).

Discipline and Discharge.--Unions, in general, do not contest management's right to administer discipline, but they do insist that employment rules be equitable, that they be uniformly and fairly administered and that employees have available an effective means to challenge the propriety of specific policies and actions. Unions and management alike have contributed to widespread acceptance of standards of uniformity and equity. Among these standards are:

Disciplinary actions require just cause; both the employer rule and disciplinary action are to be reasonable.

Rules must be made communicated to all employees.

A complete investigation of the facts should be provided to insure due process.

Rules and disciplinary actions should not reflect prejudice and bias. They must be nondiscriminatory (26, p. 70).

Contract provisions frequently reflect elements of progressive discipline. Usual examples are those that specify the types of discipline appropriate to specific offenses or that list situations for which discipline will

be exercised. Such contract provisions may create a requirement in procedure, for example, advance notice of impending disciplinary action to the employee and/or to the union. Also periodic removal of past actions, such as warnings and suspensions, from a personnel file can be included.

Reasons for Discipline and Discharge.--Contracts that provide for disciplinary action usually fall into two categories: those that contain a list of specific offenses and those that provide that discipline is warranted for "just cause" or "cause." Table XXIX shows in the hospital industry 52 per cent rely solely on the cause or just cause type of provision (26). Agreements in the hospitals have a higher proportion of the cause and just cause type of provision than is found in a sample of private sector industry agreements. In the private sector industry 79 per cent of the contracts specify cause or just cause and 67 per cent also list specific types of infractions. In the hospital industry 22 per cent mix cause provisions with lists of specific offenses. Only 3.5 per cent rely only on specific offense lists (26).

Mandatory Discharge for Specific Offenses.--Among the contracts which list specific offenses some provide a list of serious offenses for which discharge is mandatory or automatic.

TABLE XXIX
 INCIDENCE OF VARIOUS PROVISIONS IN
 HOSPITAL UNION AGREEMENTS
 (817 CONTRACTS)

Provisions	Percent Continuing Provision
Clauses Stating Reasons for Discipline and Discharge	
No provision	18.5%
"Just cause"	40.3
"Cause"	11.9
"Just cause" or particular offense	17.1
"Cause" or particular offense	4.8
Specific offense	3.5
Not specific	3.9
Specific Causes for Discharge	
No provision	18.5
No list	52.2
Unauthorized absences	18.7
Intoxication	4.9
Unauthorized work stoppage	4.8
Dishonesty, theft	5.8
Insubordination	4.3
Incompetence	1.6
Misconduct	1.0
Failure to obey safety regulations	.6
Other causes	7.6
Requirements for Notice of Discipline	
No provision	68.5
Notice to employee only	4.0
Notice to employee and union	7.0
Advance notice to union	3.3
Simultaneous notice to union	3.5
Union after the fact	13.5
Limitations on Discipline	
None specified	92.9
Limitations specified	7.0

TABLE XXIX--Continued

Provisions	Percent Continuing Provision
Records of Past Discipline	
No provision	91.2
Records permanent	0.6
Records removed after a period	4.5
Records removed--time not specified	0.1
Records removed--time varies with type	2.4
Nonspecific	1.1

Source: Hervey Juris, et al., "Employee Discipline No Longer Management Prerogative Only," Hospitals, 51, May 1, 1977, 72.

Unauthorized absences is the most frequent offense that can lead to discharge with 18.7 per cent of the agreements containing that provision (26). Less frequently listed offenses include dishonesty, theft, intoxication, unauthorized work stoppage, and insubordination.

Procedural Requirements.--Relatively common among industry contract provisions relating to disciplinary action and discharge procedures are those that require advance notice of impending disciplinary action. Such provisions may require notice be given to the employee, the union, or both. Some contracts state that while no advance notice is required, the employer must formally notify the union of disciplinary action or discharge action simultaneously with the action or shortly after the fact (26, p. 71).

Hospital contracts appear to give management somewhat greater flexibility than do industry contracts. Only about one-fifth of hospital contracts include any notification requirement in disciplinary cases other than discharge, as opposed to an all industry average of two-thirds (20).

In discharge cases the notification requirement is somewhat higher; 33 per cent of the hospital agreements, compared to an all industry average of 59 per cent, require some form of formal notification of dismissal action (26). In the majority of cases, formal notification to the union is mandatory.

Procedural requirements also exist that concern the retention in employee records of information on past disciplinary action. In the hospital industry, such provisions are relatively few, occurring in less than 10 per cent of the contracts (26, p. 71).

Hospital contracts generally contain a policy that requires that disciplinary actions be restricted to cases of just cause or where a specific violation has been committed. On the other hand detailed procedural requirements for the administration of discipline are generally lacking in hospital contracts. Tacit understandings often exist that supplement the formal contract provisions as to procedure, and rules developed on the basis of grievance settlements (including arbitration awards) may eliminate the need for highly detailed contract language.

Grievance Procedures and Arbitration

Grievance Procedures.--A grievance is any complaint by an employee or by a union (sometimes by the employer or employer association) concerning any aspect of the employment relationship. The complaint may be real or fancies, arbitratable or nonarbitratable under the contract. An arbitratable grievance usually refers to the interpretation or application of the terms of the collective bargaining agreement (39, p. 171).

Grievance procedures provide the means by which these complaints can be heard and reviewed without jeopardy to the party filing the complaint. In nonunion companies, some employees have grievance procedures where either an appointed management official or a management employee committee does the final decision making. In union facilities grievances are taken by the aggrieved employee to his immediate supervisor. This is often done orally; it may be done without the presence of the shop steward, and if not settled satisfactorily can be appealed to the next step. If not settled, the grievance moves through one or more steps of the management and union hierarchy. The last step in grievance machinery is usually final or binding arbitration (13, p. 120).

In 1973, formal grievance procedures were included in more than 95 per cent of private sector labor agreements, around 90 per cent of the labor agreements covering state

and municipal workers, and in excess of 82 per cent of the labor agreements covering federal employees. It is fairly safe to assume that as of present day, close to 100 per cent of labor agreements--private, municipal, state, and federal--include formal grievance procedures (38, p. 193). The same situation apparently characterizes the hospital industry; 97 per cent of the hospital contracts in the Juris study included grievance procedures and 87.9 per cent provided for final and binding arbitration. In addition, 4.4 per cent provided for advisory arbitration (26, p. 72).

The number of steps required to achieve the objectives of grievance processing will depend upon such factors as the nature of the bargaining units, past history of negotiations, the size of the two parties, industry patterns, personalities of the negotiators, and other factors (38, p. 196). In industry the steps in the grievance procedure may be from two steps to as many as six or seven steps. The most common number of steps found in grievance structures is three and the next most common, four (38, p. 196). The more steps in a grievance procedure, the more formal it can be expected to be. Small companies usually have short simple procedures; larger companies usually have multi-step procedures (13, p. 121). As indicated in Table XXX, most procedures in hospital contracts have between three and five formal steps (26).

TABLE XXX
 DISTRIBUTION OF HOSPITAL UNION CONTRACTS BY
 NUMBER OF STEPS IN FORMAL
 GRIEVANCE PROCEDURE

Number of Steps in Grievance Procedure	Percentage of Contracts Reporting (817 Contracts)
No provision	2.9%
1 step	0.4
2 steps	7.8
3 steps	20.4
4 steps	46.5
5 steps	18.1
6 steps	2.4
7 steps	0.1
Other	1.2

Source: Hervey Juris, et al., "Employee Discipline No Longer Management Prerogative Only," Hospitals, Vol. 51 (May 1, 1977), 72.

Scope of Grievance Procedure.--Provisions establishing the scope or coverage of the grievance procedure fall into two general classifications: limited and unlimited. In 68 per cent of the labor contracts containing a grievance procedure, the scope of the scope of the grievance is included. Of these, 81 per cent restrict the subject matter of the grievance procedure to the interpretation or application to the contract, while 18 per cent allow broad latitude as to what might be appealed to the grievance procedure (13, p. 194).

According to the Juris study, of the 97 per cent of hospitals with a grievance procedure, 75 per cent do not restrict the type of issue that may constitute a formal grievance and only 20 per cent more provide for the exclusion of some issues as shown in Table XXXI. Similarly, while about 80 per cent of hospital contracts provide for binding arbitration of grievances, 67 per cent of those contracts with binding arbitration place no limitation on the types of issues that may be taken to arbitration (26). Public sector hospitals are somewhat less likely to provide grievance procedures, least likely for professionals, in larger cities, in multihospital arrangements, and in the West Coast states (26).

Cost of Grievance Processing.--Unions will often try to negotiate contract provisions to supplement formal grievance procedures. Fifty-four per cent of agreements guarantee paid time for representatives who present, investigate, or handle grievance cases. Thirteen per cent pay for time lost by grievants and witnesses during investigation and settlement, including arbitration of grievances (38, p. 200). Such provisions for paid time exist in a little less than 50 per cent of the hospital contracts (26, p. 72).

Arbitration Issues Excluded.--The issues referable to arbitration are usually the same as the issues covered by the

TABLE XXXI

DISTRIBUTION OF SUBJECTS EXCLUDED FROM GRIEVANCE
AND ARBITRATION PROCEDURES IN PUBLIC AND
PRIVATE HOSPITAL UNION CONTRACTS

Excluded Subjects	Percentage of Contracts Excluding Subject			
	Grievance		Arbitration	
	Public Contracts N = 284	Private Contracts N = 512	Public Contracts N = 284	Private Contracts N = 512
Wages	2.1%	2.5%	12.0%	7.8%
Hospital Adminis- tration	4.6	6.3	9.2	12.9
Supplementary Benefits	4.6	3.5	3.5	4.9
Job Security	0.0	2.0	2.5	2.9
Union Security	0.0	0.0	0.0	0.0
Other	9.2	9.8	16.5	10.5
Other (including civil service issues)	9.5	0.4	13.7	0.8

Source: Hervey Juris, et al., "Employee Discipline No Longer Management Prerogative Only," Hospitals, Vol. 51 (May 1, 1977), 72.

grievance procedure. In some instances the parties have specifically excluded certain issues from the grievance procedure. The public and private sector hospitals have some differences in subjects excluded for arbitration.

Wages are excluded in 12 per cent of public hospital contracts as opposed to 9.8 per cent of the private contracts.

However, in almost 13 per cent of the private contracts, issues related to administration of the hospital are excluded. In 13 per cent of the public sector agreements, civil service issues are excluded from the arbitration process (26, p. 72). Also, public facilities have more contracts with advisory arbitration. Some regional differences exist. The Northeast does not show public contracts with advisory arbitration; however, 59 per cent of the contracts have exclusions. The West shows 26 per cent advisory arbitration and 54 per cent binding arbitration (26, p. 73). In private hospital agreements advisory arbitration is negligible; however, restrictions on issues are found in the larger hospitals, larger cities, and the North Central region (26).

There is widespread acceptance of final and binding arbitration as in private industry. Public hospitals may have civil service systems that cause restrictions in their use of grievance procedures and binding arbitration.

Work Stoppages in Health Care Institutions

Work stoppages have occurred both before and since the 1974 amendment. By placing nonprofit health care institutions under the Taft-Hartley Act, Congress hoped to reduce the number of work stoppages, particularly those caused by union attempts at recognition. The special provisions of the health care amendments were also designed to limit the numbers of strikes.

Table XXXII presents the Bureau of Labor Statistics information on work stoppages. Work stoppages have risen as more bargaining units gain recognition and more contracts must be negotiated (6).

TABLE XXXII
WORK STOPPAGES IN MEDICAL AND
OTHER HEALTH SERVICES
(PRIVATE SECTOR ONLY)

Year	Stoppage Beginning in Year		Days Idle
	Number	Workers Involved	
1967	27	1,550	71,400
1968	28	6,000	59,500
1969	43	5,900	84,000
1970	49	6,000	102,400
1971	36	3,700	46,900
1972	47	9,100	116,600
1973	56	43,300	336,200
1974	44	14,300	263,700
1975	63	11,300	197,500
1976	71	49,500	609,400

Source: BLS Bulletins, "Analysis of Work Stoppages."

Note: BLS and FMCS data differ. BLS strikes are based on the calendar year and also include stoppages occurring during the contract term. FMCS information is based on fiscal years, and include those situations in which a mediator had some contact with the parties.

The Federal Mediation service recorded 129 strikes between August 25, 1974 and December 31, 1976. Only eight of the striking parties had experienced a previous work stoppage (47, p. 342). Table XXXIII shows the total number of cases, strikes, and percentage in health care cases for each region. The percentage of work stoppages in health care is substantially lower than for all other industries, as represented in total FMCS case load. This may be misleading because FMCS presence is mandated in health care, as opposed to voluntary in other industries (47, p. 343).

TABLE XXXIII
WORK STOPPAGES IN HEALTH CARE CASES

Date	Health Care Bargaining Cases		Health Care Strikes		Strikes as a Percent of Total Health Care Bargaining
	Total	Average Per Month	Total	Average Per Month	
8/25/74- 8/31/75	922	77	41	3	4.4%
9/1/75- 12/31/76	1,664	104	88	6	5.3%

Source: Federal Mediation and Conciliation Service, internal data.

Since the amendment, the number of bargaining cases closed each month increased 35 per cent and the number of strikes doubled (31). The first year of the amendment strikes represented 4.4 per cent of all closed cases, the second year,

5.3 per cent. Forty per cent of the strikes in health care were over first contracts as opposed to other industry groups of 13 per cent (31).

Most of the strikes involved less than 100 workers as shown in Tables XXXIV and XXXV. About 33 per cent of all work stoppages occurred at nursing homes or homes for the aged. In about 25 per cent of strikes, the FMCS case was closed because an unfair labor practice charge was filed, the institution was closing, or the strikers were replaced (47, p. 346).

TABLE XXXIV

ALL INDUSTRY AND HEALTH CARE CASES BY
FMCS REGIONS (1974 TO 1976)

FMCS Regions	All Industry			Health Care Case		
	Total	Strikes	Percent of Strikes to Cases	Total	Strikes	Percent of Strikes to Cases
1	3,102	320	10.3%	714	40	5.6%
2	2,711	439	16.2	259	20	7.7
3	1,887	258	13.7	49	4	8.2
4	2,383	438	18.4	397	19	4.8
5	3,433	441	12.8	310	10	3.1
6	2,678	311	11.5	88	5	5.7
7	2,194	245	11.2	510	18	3.5
8	1,468	157	10.7	268	13	4.9
Totals	19,856	2,609	13.1	2,586	129	5.0

Source: Federal Mediation and Conciliation Service, internal data.

TABLE XXXV
 HEALTH CARE COLLECTIVE BARGAINING CASES AND
 STRIKES BY NUMBER OF EMPLOYEES
 (1974-1976)

Health Care Employees Involved	Collective Bargaining Cases	Strikes	Percent of Strikes to Cases
10,000 or more	2	1	50.0%
5,000 - 9,999	3	-	.0
2,000 - 4,999	14	4	29.0
1,000 - 1,999	24	2	8.0
500 - 999	42	4	10.0
200 - 499	271	22	8.0
100 - 199	438	26	6.0
51 - 99	588	31	5.0
21 - 50	725	31	4.0
20 or more	479	6	1.0
Totals	2,586	129	5.0

Source: Federal Mediation and Conciliation Service, internal data.

An interesting observation was noted in comparing nursing home facilities to hospitals in strikes. The comment was that if a strike in a nursing home lasts longer than a day, it will be a long strike. This is because the public does not exert pressure on the parties to resolve the dispute compared with the pressure from hospital strikes (47, p. 346). The average

duration of a nursing home strike is 52 days compared to 16 days for work stoppages in hospitals (47, p. 346).

Duration and Location of Strikes

The Bureau of Labor Statistics calculates the duration of a strike by weighting the length of each stoppage by the number of workers involved to arrive at a mean duration. An unweighted duration would be to add the total days lost and divide by the number of strikes. The duration shows to be 52 days, as a weighted measure for 1974-1976.

The average length of strikes in health care facilities is 18.1 days. This rate is affected by the 40,000 member, 11-day strike involving District 1199 and the League of Voluntary Hospitals of New York. The average length is 27 days with that removed. This is then comparable with the Bureau of Labor Statistics information for other industries (6).

In 1974, 34 per cent of the work stoppages were in the 30 days or more category. In 1975, 57 per cent were 30 days or more. About 50 per cent of total health care versus 43 per cent of all strikes last 30 days or longer.

In the 129 strikes which occurred, almost half took place in the New York Metropolitan area or in cities with over 100,000 population. Fifteen per cent took place in populated cities of 20,000 to 100,000 and 6 per cent were in rural areas (47).

Characteristics of Strikers

The 129 strikes involved 72,000 workers. Table XXXVI shows that strikes tend to occur in the larger units and yet 94 strikes occurred in units of 200 or less (47, p. 352). Two unions represent over one-half (53 per cent) of the total number of strikes. The remaining five in the Table represent 34 per cent of the total number of strikes. These seven unions had 112 strikes, or 87 per cent of the total number.

TABLE XXXVI
HEALTH CARE STRIKES BY UNION*

Unions	Number of Strikes	Number of Employees in Unit	Number of Days Lost
SEIU	36	8,398	1,852
District 1199	32	47,426	1,882
ANA Affiliates	14	5,141	487
Teamsters	10	389	569
AFSCME	9	3,323	214
RCIA	6	644	476
Operating Engineers	5	246	364
Totals	112	65,567	5,844

*NOTE: These are the top seven unions representing 87 per cent of the strikes that occurred. The remaining were single incidents.

Source: Bureau of Labor Statistics, internal data.

Strike Issues

Most strikes were related to wage issues. In 60 per cent of every health care strike, wages, ability to pay, or health and welfare benefits were cited by mediators as the major issue (47, p. 354). Forty per cent of the strike issues were classified as nondirect money cost items. Issues such as union security, contract expiration dates, work rules, and professional codes would be included in that category as shown in Table XXXVII.

TABLE XXXVII
MAJOR STRIKE ISSUES IN HEALTH CARE CASES

Issues	Number of Times Strike Issue	Per Cent of Total
Wages	42	28%
Ability to Pay	31	21
Union Security	18	12
Health and Welfare Benefits	12	8
Work Rules	8	5
Union Recognition	7	5
Training Programs	3	2
Personality Conflict	3	2
Contract Expiration Date	3	2
Other Issues (Single)	4	3
Other Issues (Multiple)	18	12
Not Available	4	3
Totals	151	100%

Source: Federal Mediation and Conciliation Service, internal data.

Issues in health care strikes differ from those in all industries. Union security accounts for only 5 per cent as opposed to 12 per cent in health care cases. Pensions, insurance, and other welfare benefits account for one per cent in all industry compared to 8 per cent in health care.

Length of Negotiations

The amount of time required for contract notices was increased for health care institutions. The initial contract requires 120 day notice to the other party and 90 day notice to FMCS. Contract renewals requires 90 days notice to the other party and 60 days notice to FMCS. These time requirements are 30 days longer than other industry. In addition, the 10 day strike notice must be given before a work stoppage occurs. This increased timing was to promote early negotiations.

Mediators surveyed by Tanner, Office of Research, FMCS, were asked how long the parties had been negotiating prior to the work stoppage. Responses ranged from two days to one year before the work stoppage. Twenty-nine responded that bargaining began before the required 90 day notice was sent to the other party. Thirty of the strike participants began negotiations between the time notice was given to FMCS and the ten day notice to the parties (47). In most cases negotiations extended well beyond the expiration date. Forty-three indicated that negotiations went beyond the termination date for an average of 55 days (47).

Preparation for a Strike

Health care institutions were given a unique opportunity to prepare for strikes by the ten-day notice provision in the Taft-Hartley amendment. The degree of preparations vary considerably among the institutions. Table XXXVIII shows the results as mediators were asked by their National office to comment on the preparations made by management in the struck institutions. In some situations more than one option was taken. In 30 per cent other sources of assistance were required. Eight per cent actually moved patients and in 20 per cent of the strikes replacements were hired for the striking employees. Strike replacements or moving patients did not normally occur until after the strike had been in progress for 30 days (47, p. 358).

An analysis by region shows that although over a third of the strikes were in Region 1, one-half of the striker replacement situations occurred there. Region 2 facilities generally took no action or operated with a reduced staff. Region 8 had three institutions that utilized supervision (47, p. 357).

Mediation in Strikes

In all strike situations, a mediator was involved. However, 17 per cent or 22 of the strike cases occurred before a mediator had held a joint meeting session with both the

TABLE XXXVIII
MANAGEMENT STRIKE PREPARATIONS

FMCS Report on Measures Undertaken	Number of Mediator Responses
None	15
Normality with Adjusted Staff Numbers	16
Limit Service Provided	11
Utilized: Volunteers	10
Supervisors	16
Guards	10
Moved Patients	10
Replaced Strikers	26
No information available	15
Total	129

Source: Lucretia Tanner, et al., FMCS Unpublished Report on 1974 Health Care Amendment, p. 356.

parties (47). This is below the 40 per cent level which all industry statistics indicate (6). Mediation in health care is mandated by the amendment.

The number of joint meetings held during strikes is also higher than in all industry. In the 129 strike situations, 1,032 meetings were held; an average of eight per strike compared to industry figures of five (47). Of the eight joint sessions, an average of 4.4 were held before the stoppage actually took place and three to six after the strike began (47).

Mediators attempt to postpone the contract deadline in order to enable further mediation efforts or hold a conference on the deadline date. The health care industry seems to respond to these attempts. This gives the mediator greater opportunity to seek resolution of the conflict.

Strikes and Boards of Inquiry

The purpose of the Board of Inquiry procedure included in the amendments was to provide another mechanism to avert a work stoppage. The Board, selected by FMCS, hears the positions of the parties and issues recommendations for dispute resolution. Out of the 120 Board of Inquiry and fact finding appointments, fifteen resulted in a strike situation. The same approximate percentage of strikes resulted whether a Board was appointed or the parties agreed to the specially-stipulated fact finding procedure (47).

In approximately 70 per cent of all BOI disputes the ten-day strike notice had been issued. Not all notices resulted in a work stoppage as shown by only 15 Board-strike cases (47, p. 367).

Similarities of Board involved and all health care cases include the length of the strike, 52 days for both. During BOI procedures, a total of seven strikes lasted over 30 days and three lasted over 100 days. This was about the same ratio as all health care strikes. In about 50 per cent of the Board strikes, the institutions moved patients or replaced strikers compared to 20 per cent for all health strikes (47).

Resolution of the Strike

Federal Mediation statistics show that in 95 per cent of all bargaining situations (strike and nonstrike) the parties are able to eventually reach an agreement (47). According to the Bureau of Labor Statistics over 75 per cent of all strikes end with a contract. About 4 per cent of strikes are broken and in 1 per cent of all stoppages, employers go out of business (6). Stoppages ended with formal agreements in 80 per cent of all those recorded by Bureau of Labor Statistics, and in health care statistics, 55 per cent.

In an analysis of 111 health care strikes, the following information was obtained. Seventy strikes resulted in a contract; in five, the facility was closed; in nine, decertification elections were held; in eight, strikers were replaced; and in ten, the union gave up in the attempt to obtain a contract and left. Even when an agreement was eventually reached problems occurred. After 206 days on strike one union signed the contract without obtaining its major strike issue, a union shop clause. In another strike, the institution permanently shut its doors four days after signing the agreement (47).

Strikes are concluded by contract in three out of four hospitals compared to two out of every five nursing homes as shown in Table XXXIX.

TABLE XXXIX
RESOLUTION OF STRIKES BY HEALTH CARE INSTITUTION

Strike Resolution	Total	Hospitals	Nursing Home	Other
Contract	70	46	15	9
Facility Closed	5	1	4	-
Decertification	9	3	4	2
Strikers Replaced	8	1	7	-
Union Left	10	6	4	-
Other (legal, etc.)	9	3	5	1
Totals	111	60	39	12

Source: Federal Mediation and Conciliation Service, internal data.

Strike resolution in the form of a written contract appears to be less favorable the longer the strike progresses. Strikes of over four months are unlikely to be settled with a formal agreement.

Strikes occurring around the country have some geographic differences. All three strikes that occurred in Region 6 were concluded without a formal agreement; six out of seven strikes in Region 5 reached a contract agreement (47).

Statistical Story of Two Strikes

The National Union of Hospital and Health Care Employees, District 1199 struck all member institutions of the New York

City League of Voluntary Hospitals and Homes from July 7 to July 17, 1976. The previous contract negotiations had also resulted in a strike from November 5 through November 12, 1973.

In 1976 the hospitals had developed contingency plans to cope with the strike since the 1974 amendments had legalized hospital strikes. These contingency plans included the following: stock piling essential supplies; categorizing patients as (a) those who could be sent home, (b) those who probably could be sent home, or (c) those who definitely required care; consolidating patients into fewer wards; and assigning all functions that normally would be performed by the striking workers to supervisors, professional personnel, and volunteers remaining on the job (5). Also, the Board of Health authorized the New York City Health Commissioner to declare a health emergency, if necessary, to allow delivery and sanitation trucks to pass through the picket lines.

Brody and Stamm carefully analyzed a specific institution (larger than 1,000 beds) in New York City, to determine (1) the gross and the net monetary losses as a result of the strike, and (2) any effects the first strike had on management's preparation for future strikes (5, p. 57). To make the study a meaningful comparison, the 11-day 1976 strike was adjusted to an 8-day base to conform with the 1973 strike. In addition, pay scales and per diem reimbursement rates were adjusted to maintain comparability (5, p. 57).

In order for Brody and Stamm to determine the loss of patient visits and patient days for each strike, the number of visits/days in each strike month was compared with the average monthly number of visits/days in the three months prior to the strike and the three months after the strike, thus eliminating seasonal fluctuations (5, p. 58).

The number of days or visits lost because of the strikes in the emergency department, outpatient department, and the medical/surgical units were calculated as follows: (1) the average monthly number of days/visits for the three months prior to and the three months after the strike month was calculated, and (2) the actual number of days/visits that occurred during the strike month is subtracted from above.

The emergency department lost 877.5 visits in 1973, and 264.0 in 1976; the outpatient department lost 3,816.0 visits in 1973, and 9,199.5 in 1976; and the medical/surgical units lost 2,667.5 days in 1973, and 2,433.0 in 1976 (5, p. 58).

A shift in priorities seemed to have occurred between the 1973 and 1976 strike. The hospital moved from attempting to offer all services to emphasizing emergency care. The researchers noted other interesting developments. The emergency department operated more effectively during the 1976 strike than it did during the 1973 strike. The percentage of decline in visits was lower in the 1976 strike

than was the 1973 strike. The outpatient department provided fewer services during the 1976 strike than in the 1973 strike. The emergency department, the outpatient department, and the medical/surgical units had the largest loss of patient revenue. The 1976 strike resulted in an estimated total gross loss of \$1,001,001.22; a 70 per cent increase over the 1973 loss of \$588,935.34.

This cannot be the true comparison because adjustments must be made for the lengths of the strikes and per diem reimbursement rates. The 1973 strike lasted 8 days and the 1976 strike lasted 11 days. The figures adjusted by the researchers allow for comparability and show the total loss to the hospital for 1976 was \$496,973.59, a 15.6 decrease from 1973 loss of \$588,935.43 (5, p. 58).

During the strike, effective hospital operations were maintained by using administrative and nonbargaining unit personnel. The overtime and fringe benefits paid to these employees was 20 per cent less in 1976 compared to 1973. Adjusting the figures for length of strike comparability, the figures appear to be 46 per cent less (5).

Policy changes account for the substantial difference. Administrative and nonadministrative employees were paid time and a half in 1973. In 1976 only nonexempt, non-administrative employees were paid overtime.

The hospital eliminated certain expenses in 1976 such as additional security and food costs. During 1976 the

cafeteria operated as usual with the employees paying for their own meals. A cooperative arrangement was made with the police department to increase the number of officers at the hospital, thus eliminating funds spent on private security services (5, p. 60).

In comparing the gross versus net costs of the two strikes, the gross costs for the 1976 strike were substantially lower than the 1973 strike. However, the net costs of the 1976 strike were higher because New York State did not adjust the reimbursement rates as it did in 1973. The reimbursement was frozen. The hospital received the following from third parties in 1973: Blue Cross \$330,000; Medicare, \$365,000 and Medicaid, \$285,000; for a total of \$980,000. In 1976, there was not any reimbursement from Blue Cross or Medicaid and the Medicare portion was \$220,000; a total of \$220,000 reimbursement (5, p. 61).

This policy by New York State had a devastating effect. In 1973 the gross cost of the strike was \$1,004,000 and in 1976, \$727,000. To achieve the net cost, subtract the amounts of reimbursements from the gross costs. The net cost result is \$24,000 for 1973 ($\$1,004,000 - \$980,000$) and \$507,000 for 1976, ($\$727,000 - \$220,000$) (5, p. 61).

The efforts of the hospital seemed to have a dramatic effect on lowering the gross cost of the 1976 strike even though it was three days longer. Elimination of certain

expenses, such as outside security, and some overtime reduced costs. Treatment attention was concentrated in the emergency department and the medical-surgical units. The New York State freeze on reimbursement rates had a severe effect on the net cost, making it substantially greater than in 1973.

Health Care Expenditures and Reimbursements

As the Council on Wage and Price Stability indicated, the cost of a day of hospital care has increased 1,000 per cent since 1950 compared with an increase in consumer prices of 125 per cent (15). In fiscal year 1975, hospital expenses per adjusted patient day rose 15.8 per cent (45).

Not just hospital costs but all of health costs have risen dramatically. An examination of these costs increases and their payment is necessary to evaluate the role of the third party payer in collective bargaining negotiations discussed below. In fiscal year 1975 total public and private health expenditures reached 118.5 billion dollars (45). About 46.6 billion dollars was spent for hospital care and 22 billion dollars was spent for physicians' services. As illustrated in Figure 9, over fifty cents of health dollars spent was on hospital and physician care (45).

Health care is generally financed by four general methods:

- (1) direct payments by the patient for services rendered to him

Between 1950 and 1975 the percentages of hospital costs paid by private insurance companies rose from 29.3 per cent to 43.6 per cent, and the percentage paid by the government doubled (20). The average payment per day of a hospital stay by the consumer after the third party payments are subtracted is \$7.75 in 1950, and \$18.93 in 1975. As a fraction of earnings the net cost of hospital care has remained the same (20).

The Council on Wage and Price Stability states:

Although the consumers pay the full cost of the more expensive hospital care through higher insurance premiums, and higher taxes, at the time illness occurs, this reflects the choice of the patient and his physician and the 'net' cost of the hospital care.

The report continues:

There is now substantial evidence that consumers are responsive to the net price of hospital care, that is, that patients, guided by their doctors, demand more services when a larger part of their costs are offset by insurance. Hospitals respond to this increased amount of demand for expensive care by raising their costs per day and using the extra revenue to provide a more expensive style of care (15, p. 16).

Third Payers and Contract Negotiations

The fact that more than 80 per cent of hospital operating revenues depend on public and private insurance programs increases the participation of organized consumers and external but interested persons in the decision making process that affects organization, delivery and the cost of health services (20).

Two important issues are involved in the cost-reimbursement approach:

1. The identification of costs for which there is to be reimbursement.

2. The level implied in the term reasonable.

The "cost pass through" mechanism is what hospitals have been utilizing and this is what gives the third party payers a direct interest in the decisions made at the bargaining table. Confronting the hospitals now are constraints on the use of the cost pass through mechanism. There is an ever increasing interference by the government and quasi government agencies in the hospital management functions. Also third party payers lobby for increased government regulatory control (20). To date, the legal and administrative controversy has centered around the authority of state agencies to regulate insurance rates, reimbursement schedules, and hospital expenditures. There are also questions regarding conflict between state and federal policy (20).

The bargaining process becomes multiparty rather than the traditional bipartite process in private enterprise bargaining. More frequently references are made to the "phantom" or the "ghost" at the health care bargaining table referring to a third party payer--someone not sitting at the bargaining table, but having the final authority either to pass or reimburse costs arising from contract negotiations (4).

Nonprofit hospitals view themselves as caught between three competing pressures: (1) union insistence on economic improvements for health care employees, (2) third party payer pressure to hold down cost increases, and (3) social demands for quality health care.

Management, labor and neutrals alike grow more concerned with the role and influence of the third party payers. In a speech, Mr. Nicholas Finandis of the Federal Mediation and Conciliation Services, states there are three problems that appear at the end of the bargaining table:

1. The degree of authority of the their party payee
2. What role, if any, should there be given while contract negotiations are taking place?
3. The dilemma facing Boards of Inquiry wherein recommendations are made which in many cases must be implemented or approved by a state authority (16, p. 1).

Expanding on these concerns, Rossman, American Hospital Association, described four categories of cost control mechanisms--the more the cost control, the greater the degree of authority of the third party payee. The categories are:

1. "Reasonable" costs are reimbursed after comparing with like area facilities. This has the least amount of control over the parties.
2. This stage includes state review procedures whereby insurance companies periodically review their costs and make health care institutions justify costs and charges.

3. This complex category requires the third party payee and health care facility to negotiate a prospective reimbursement rate. The projected labor cost then becomes hospitals' ceiling and unions' floor in collective bargaining.

4. This most severe category gives the state health review commission the final authority to review all charges and rates of reimbursement (40, p. 64).

Difficulties do emerge with the last two categories. Some critics feel the advocates of rate regulation and prospective reimbursement are in "effect trying to administer a wage control program but aren't honest enough to admit it" (3, p. A1). Most participants at a Symposium on Labor Relations conducted by the American Hospital Association agreed that "prospective reimbursement along with the bargaining process will result in a conflict that will be resolved only when the issues of controlling hospital costs and keeping medical services available are balanced" (3, p. A1).

Edward A. Meisser, Vice-President of Finance for St. Lukes Hospital Center in New York City said a hospital can go beyond the projected labor cost factor only if:

1. It is willing to suffer a financial penalty from the collective bargaining process
2. It maneuvers the union and third party payee into negotiations with each other

3. It cuts service to absorb the excess demands

4. It lets a strike test the financial ability of the hospital and the union (3, p. A2).

Meisser said that the costs of a strike must be compared to the costs of giving into the demands by the union. He recommended a hospital should follow these steps in the mediation process:

1. Support the original projected labor cost factor with economic evidence

2. Maneuver the reimbursement regulators to support the wage determination before the mediators

3. Present to the mediator the financial implications of a strike or service cutback on the hospital, its patients, and the community,

4. Remain in discussions so the reimbursers, unions, and mediators do not agree on matters that are unacceptable to the hospital, and

5. Assure both the mediator and third party payer that any recommendations on cost pass through above the original wage projection will be reasonable (3, p. A2).

The members of the National Health Care Labor Management Advisory Committee were adamant in their views that the third party payer did not belong at the bargaining table, but they held varying views on how much attention should be given to where the money comes from in an attempt of a settlement (30).

Anthony Weinlein, representing the Service Employees, has noted there is a difference between intervention by private companies and government agencies (30).

Finandis succinctly put the dilemmas in perspective by stating:

In any event bargainers in the health care industry, public or private, cannot escape the fact that governmental third party payers are going to have more and more control over how much money goes into the health care system, with even less certainty as to how much they are willing to reimburse the health care facilities (16, p. 7).

Third Party Payers and Third Party Neutrals

Boards of Inquiry are charged with the responsibility of issuing a written report complete with findings of fact and the Boards' recommendations. The objective of these recommendations is to achieve a prompt, peaceful and just settlement of the dispute (16). Finandis asks what is the relationship to the just settlement when it exceeds the percentage level approved by the state or if health care cost increases are inflexible, even frozen (16).

One fact finder stated: "In this case, the fact finder is fully cognizant of the reimbursement problem, but he cannot permit the third party payers to control what he believes to be an appropriate settlement and an effective date" (3, p. A1).

Perhaps the most powerful example of the conflict that exists was in the eleven day strike between members of District 1199 and the League of Voluntary Hospitals and Homes

of New York. In the past, New York state had permitted "pass through" rate increases as a result of labor settlements in the rates it paid Medicaid and Blue Cross. During the negotiations the state's role changed dramatically and the new hard line approach was "no pass through settlement" as a result of the rise in the cost of living (4, p. 74). A fact finders report called for a one time cost of living adjustment of approximately 6 per cent. The League turned down the recommendation saying the hospitals did not have the money and would not receive any from the state.

During the strike that followed, the New York governor's office even talked about cutbacks in existing reimbursements if there was no progress made (4, p. 74). This was increased external involvement. Finally, an arbitrator, Ms. Gottnick, was appointed. In issuing her award, she said: "The state has blunted and made ineffective," the wage recommendation of the federal fact finding panel. She quoted Davidoff, Division of Health Care Cost Control, New York State Department of Health: "If you, as arbitrators, grant a pay increase through binding arbitration it is irrelevant to the health department. The Health Department is not going to honor any rate appeals predicated on negotiated salary increases" (4, p. 77).

Ms. Gootnick's decision granted the League cost savings in the training and benefit funds enabling it to pay a one-time 4.5 per cent increase. She recognized the short term

and shortcomings of her award saying, "the solutions that must ultimately be found are long term ones that involve the reorganization of the health care delivery system in New York City and State" (4, p. 77).

Reactions were varied, as could be expected. Leon Davis, union president, predicted a massive strike in 1978 when the current contract expires. He did not believe the arbitrator should have considered primarily the hospitals ability to pay. Even though he accepted the Leagues poor fiscal plight, he questioned the origin of the deficits and the way the funds were actually spent, feeling that the workers should not have to suffer from poor managerial decision making (4, p. 78).

William Abelow, Executive Director for the League, felt the award was justified, "by the plight of the hospitals." He states, "This is the first decision that really recognized where public funds come from and how they are controlled" (4, p. 78). Abelow also made reference to the fact the state controls either directly or indirectly affect approximately 55 per cent of the money going into New York hospitals (4, p. 78).

Kevin Cahill, M. D., the governor's special assistant for Health Affairs states:

The system of resolving labor disputes by upping reimbursement rates is gone. We hope both sides understand that the state will no longer be a passive party. Our effort in the future will be to sustain all the leverage we can in all segments of the health industry to eradicate inefficiency (4, p. 77).

In 1974, Basil A. Paterson, Chairman of tripartite arbitration panel convened in accordance with Section 21 of the New York Labor Law, noted:

The problem of reimbursement to the institutions for the increased costs that will be incurred as a result of this award is one of the most difficult that the panel has had to face. Whether or not one accepts at face value the League contention that 'the bulk of League members, indeed the bulk of voluntary hospitals in this area, are at or near insolvency,' there can be little question of their inability to meet the costs of the increases and benefits herein awarded out of their present resources. The need is all too clear. Indeed, Section 716 makes it explicit that 'economic factors of the respective parties which are relevant to the arbitration decision' are entitled to be considered.

It is the considered opinion of the panel that what is required in this instance is intensive efforts to assure that the cash flow from third parties is expedited so that the institutions are able within a reasonable period to meet their obligations for the ensuing contract period. This panel will not consider its job done by the issuance of an award, but will exert every possible effort to persuade whatever state, city, or institutional agency is involved to ensure that required payments are authorized and implemented (33, p. 10).

Hopefully the restructuring that is taking place in the health care industry will lend itself to better health care delivery, and concern for rising costs. Collective bargaining must continue as a free process between the parties if it is to be a successful vehicle for problem solutions.

Labor Costs in Health Care

The Council on Wage and Price Stability states that even though hospital pay rates have increased at a higher rate than

other sectors of the economy, they are responsible for only a small part of the staggering increase in the cost of health care today. In the report, "The Rapid Rise of Hospital Costs," Fieldstein states that the increase of a day in the hospital since 1950 has been by 1,000 per cent, but 75 per cent of that increase has been due to a rise of "inputs per patient day--more hospital personnel and more services--and only 25 per cent is due to higher prices for these inputs" (15, p. 15).

The average earnings, per hospital employee, rose by 237 per cent from 1955 to 1975, while average earnings of private nonfarm production workers rose only 142 per cent. In several cases, the hospital employees were attempting to "catch up" from very low average wages common on the health care industry. Labor costs have actually been a declining fraction of total cost per patient day; 53 per cent in 1975 compared to 62 per cent in 1955, according to the council's report (15).

The report offers several ideas on the rapid increases in hospital wage rates. One idea relates to the increased employment of 4.6 per cent in hospitals compared to national employment rate increasing at 1.5 per cent a year from 1955 to 1975.

Another idea is the need to increase wages to attract specialized workers. Yet the Bureau of Labor Statistics shows wage rates for individual hospital occupations have

risen at least as rapidly as the overall earnings of the employees themselves. This indicates lower skilled employees, for which hospitals are not the major industry of employment, are receiving substantial wage increases. Specialized personnel wages often are higher than those based on the competition of supply and demand. The council report indicates there may have been a spin-off effect and the use of "relative wage scales" may have given clerical and housekeeping workers greater increases than they would have otherwise sustained. The report also addressed the increased role of hospital workers and unions and indicates that the impact of potential union activity "may be at least as important as unionization itself" (15, p. 17).

The Council states that even if hospital wages had not risen any faster than the average wage for all private non-farm production workers the 1,000 per cent increase in hospital costs would have been only 1 per cent lower (15.

Union Impact on Hospital Wages

Fottler completed a comprehensive study on the union impact on hospital wages (19). These data were collected from surveys conducted by the Bureau of Labor Statistics in twenty-one standard metropolitan areas for the years 1966, 1969, and 1972. The results are very interesting; however, it is unfortunate that information was not available to study the impact after the Taft Hartley amendments.

In order to examine the data empirically, Fottler established two hypotheses:

1. Unionization has a significant impact on wage rates of nonprofessional hospital personnel.
2. The union impact on wages is greater in private hospitals than in public hospitals (19, p. 346).

The dependent variable was the weighted average of weekly wages for six nonprofessional occupations: nursing aides, porters, maids, kitchen helpers, surgical technicians, and dishwashers (19, p. 346). The independent variables used were unionization (per cent of new professional hospital employees in each city covered by a collective bargaining agreement), cost of living, the proportion of women in non-professional hospital occupations, a concentration ratio, and a federal ratio (19, p. 346). The concentration ratio is defined as the percentage of total hospital employment in a given city accounted for by the eight largest hospitals (excluding federal hospitals), and the federal ratio is the percentage of total hospital (including federal) employment in each city accounted for by federal hospitals (19, p. 347).

Fottler calculated the means and standard deviations for all variables for the three years studied. The proportion of unionized employees and the proportion of women vary between private and public hospitals. The cost of living, the concentration ratio, and federal ratio vary over time, but not between private and public institutions, since these data apply to a given city. The data indicate that

nonprofessional wages have been higher in public hospitals. Over a period of time the public hospital wages were higher, but the differences grew smaller. In 1955 the difference was \$12.10; in 1969 and 1972 the difference was \$10.60. During those times a much more rapid growth of public hospital unionization was occurring. Perhaps then the wage impact of unions on public hospitals was not substantial.

During the six year period of the study, few changes in numbers of hospitals occurred, thus the concentration ratio and the federal ratio remained about the same throughout. The standard deviation was high; Fottler believes this indicates that unionization is highly concentrated in a few cities. The proportion of women employees has shown a tendency to decline but is still higher in the lower paying private hospitals. There has been a real increase in wages over the six years (19, p. 348).

Fottler presents the results of his calculation for private and public hospitals in Table XXXX. In each year the relationship of unionization and nonprofessional wage rates is significantly and positively correlated. In 1972 each 1 per cent increase in proportion to nonprofessional employees covered by collective bargaining contracts was associated with a 29 cent increase (Method One) or a 16 cent increase (Method Two) in weekly wages (19, p. 350). Average nonprofessional weekly wages in 1972 were approximately \$4.80 to \$8.70 higher than they would have been

TABLE XXXX

REGRESSION RESULTS FOR HYPOTHESIZED DETERMINANTS OF WEEKLY
EARNINGS OF NONPROFESSIONAL EMPLOYEES IN PRIVATE AND
PUBLIC HOSPITALS FOR 1966, 1969, and 1972

(t Values in Parentheses)

Independent Variables	Private Hospitals		Public Hospitals			
	1966	1969	1972	1966	1969	1972
U: Proportion of non-professional employees covered by collective bargaining contracts	.179 (8.69)***	.136 (2.69)***	.190 (3.41)***	.143 (1.49)*	.102 (1.66)*	.097 (0.62)
L: Cost-of-living standard	.018 (7.18)***	.014 (4.23)***	.009 (1.48)*	.016 (1.65)*	.037 (5.48)***	.018 (1.18)
CR: Concentration ratio	-.030 (-0.77)	-.056 (-1.11)	-.280 (-2.53)***	-.412 (-2.25)**	.071 (0.53)	-.307 (-0.90)
FR: Federal ratio	-.077 (-1.18)	-.090 (-1.40)	.108 (0.58)	.378 (1.40)	-.154 (-1.68)*	-.114 (-0.23)
P: Proportion of women	.012 (0.09)	-.405 (-2.37)	-.641 (-2.05)**	.404 (1.22)	-.161 (-0.61)	-.186 (-0.51)
n: Number of cities in sample	21	22	23	18	19	18

TABLE XXXX--Continued

Independent Variables	Private Hospitals			Public Hospitals		
	1966	1969	1972	1966	1969	1972
C: Constant	-49.60	17.78	101.09	-38.27	-160.56	5.58
R ² : Coefficient of determination	.952	.858	.860	.690	.823	.551
S.E.E.: Standard error of estimate	2.30	4.11	6.09	8.04	7.56	14.96

***Significant at .01 level.

**Significant at .05 level.

*Significant at .10 level.

Source: Fottler, Myron D., "Union Impact on Hospital Wages," Industrial and Labor Relations Review, 30, No. 3, April, 1977, 353.

without unionization. The union impact appears to be between 4.5 and 8.2 per cent, thus making the average weekly wage \$106. This would have been \$97 to \$101 without a union (19, p. 350).

Another significant variable presented by Fottler is the cost of living standard. Each dollar increase in the cost of living was associated with a 2 cent increase in 1966 and 1969 and a 1 cent increase in 1972 (19, p. 350). The example is given that if the mean cost of living standard was \$7,415 in 1972, hospitals with a cost of living standard of \$8,000 would pay their employees about \$6 more per week than the average of \$106.

A high concentration rate is associated with lower wage rates for nonprofessional hospital employees. In 1972 the average concentration ratio was 64 per cent. Each 1 per cent increase in the ratio was associated with a 27 to 30 cent drop in wages (19, p. 350). If the concentration ratio were 75 per cent, then the 11 per cent difference would equal \$2.97 to \$3.30 less per week than the average of \$105 or approximately \$103. This supports Fottler's position that hospitals often act as monopsonists.

A survey by Yett of large metropolitan hospitals found that fourteen out of fifteen had a well developed "wage stabilization" program, including informal agreements to limit wage rates and competition for labor between hospitals (19, p. 352). The nonprofessional worker possesses little training

specifically related to hospitals, but must be unable or unwilling to find alternative employment otherwise this monopsony power could not be utilized.

Since Rosen has indicated that blacks, females, and the less educated benefit from unions to a greater extent than white, anglo saxon, protestant, males; the overrepresentation of these groups among nonprofessional hospital employees has significance (19, p. 343). Hospitals paying lower wages may have difficulty attracting males to the jobs. Also the lack of mobility among females may keep wages depressed (19, p. 352).

Regression results in Table XXXX are given for the public and private hospital categories. The relationship between unionization and wages is more significant in the private hospitals. Fottler's study states that in each of the three years examined, each 1 per cent increase in unionization was associated with an increase in weekly wage of 14 to 19 cents in the private hospitals compared to 10 to 14 cents in public hospitals (19, p. 352). This equals \$5.60 to \$7.60 per week in private hospitals and \$4.00 to \$5.60 in public hospitals. In 1972, nonunion wages would have been \$95 (instead of \$103) in private hospitals and \$109 (instead of \$113) in public hospitals (19, p. 352).

The union impact while statistically significant was not high in dollar amounts. For hospitals in the aggregate

in 1972 the dollar amount was \$240-\$435 per employee. This equaled a 4.5 and 8.2 percentage impact on wages that year. Wages of nonprofessional personnel account for 23 per cent of total hospital costs so the union impact appears to be somewhere around 1-2 per cent. Thus, unionization did not seem to be a major contributing factor in the increasing health care costs (19, p. 355).

Hospital Cost Containment Act of 1977

The concern for higher and higher medical costs prompted the introduction of President Carter's proposal to put a "cap" on hospital payments. The Hospital Cost Containment Act of 1977 (HR 6575, S1391) was introduced in the House on April 25, 1977 by Representative Dan Rostenkowski (D-Illinois) and Paul Rogers (D-Florida); on April 26, 1977 Senator Edward Kennedy (D-Massachusetts) introduced the bill to the Senate.

Opposition to the bill by the American Hospital Association was voiced by AHA President, Alex McMahon. He stated the legislation would "prevent hospitals from increasing their services to patients and would require some . . . hospitals . . . to cut back existing services. The real victims would be sick and injured people" (23, p. 80). The only thing that the President's bill would accomplish, McMahon said, "is the reduction of health care to the American people" (23, p. 80).

The legislation itself is divided into two main sections: Title I would establish a formula for limiting increases in

total inpatient revenues from all sources; Title II would provide for a national limit, not to exceed \$2.5 billion, on hospital capital expenditures.

Title I, the cap portion of the bill, is intended to be a "transitional cost containment program," to remain in adoption till a permanent system evolves (23, p. 80). Title II is intended to be permanent. It would require the HEW Secretary to establish an annual hospital capital expenditure limit not to exceed \$2.5 billion (HEW estimates a present amount of close to \$5 billion per year) (23).

There is a great amount of opposition against this bill. Donald Newkirk, president of Ohio Hospital Association, said that the proposal "isn't cost containment, it's care containment" (23, p. 80). Frank Gentry, president of the Kansas Hospital Association agreed, saying that the Carter proposal be renamed the "Hospital Service Containment Act of 1977" (23, p. 80). Pressure will certainly continue in the forthcoming Congressional hearings.

CHAPTER BIBLIOGRAPHY

1. ABA Conference on Labor and Health Care 95 LRR 21 (May 9, 1977).
2. "AHA Research Capsule--No. 6," Hospitals, 46 (April 1, 1972), 213-216.
3. "AHA Symposium Discusses Collective Bargaining at Hospitals," White Collar Report, No. 953 (July 11, 1975), A-1 to A-4.
4. "AHA Urges Broad No Solicitation/No Distribution Rules," Hospitals (January, 1976), 16-17.
5. Brody, Paul E. and Joseph Stamm, "Statistics Tell a Tale of Two Strikes," Hospitals, 52 (January 1, 1978), 57-60.
6. Bureau of Labor Statistics.
7. "California Nurses End Strike," Personnel Management, VI, No. 1 (July 8, 1974), 8.
8. "Collective Bargaining Highlights," Personnel Management, VI, No. 18 (March 3, 1975), 7.
9. "Collective Bargaining: What is Negotiable," American Journal of Nursing, 69, No. 9 (September, 1969), 1892-1895.
10. Conta, Lionne, "What Happens at the Bargaining Table?" American Journal of Nursing, 59 (October, 1959), 54-56.
11. Craen, Rance, "Hospitals Tough on Benefits," Modern Health, 6, No. 4 (October, 1976), 20.
12. "Delegates Discuss Organizing Drives," White Collar Report, No. 976 (12-19-75), A-1 to A-4.
13. Elkouri, Frank and Edna Asper Elkouri, How Arbitration Works, Bureau of National Affairs, Inc., Washington, D. C., 1974.
14. Federal Mediation and Conciliation Service, National Seminar, New Orleans, November 5-12, 1975.

15. Feldstein, Martin, "The Rapid Rise of Hospital Costs," Council on Wage and Price Stability, Washington, D. C., January, 1977, pp. 15-17.
16. Finandis, Nicholas, transcript of speech made at FMCS Seminar, New Orleans, Louisiana, November 6, 1975, pp. 1-7.
17. Fleishmann, Raymond, "Living with a Contract," Hospitals, 47 (November 16, 1973), 51-54.
18. Follker, David A., "Preparations for a Potential Strike," Hospitals, 47 (September 16, 1973), 51-54.
19. Fottler, Myron D., "Union Impact on Hospital Wages," Industrial and Labor Relations Review, 30, No. 3 (April, 1977), 342-355.
20. Gibson, Robert H. and Marjorie Smith Mueller, "National Health Expenditures, Fiscal Year 1976," Social Security Bulletin, 40 (April, 1977), 1-40.
21. "Health Care Employees Ratify Agreement Between John Hopkins Hospital, District 1199," White Collar Report, No. 1026 (December 10, 1976).
22. "Hospital Administrator Assesses Impact of 1974 NLRA Amendments," White Collar Report, No. 929 (January 24, 1975), A-1 to A-2.
23. "Hospital Cost Containment Act," Hospitals, 51 (October, 1977), 80.
24. "Hospitals Face the Knife," Business Week, 2448 (September 6, 1976), 68-69.
25. "Hospital Walkout Ends but Threat Still Stands," Dallas Morning News, April 17, 1977, 26A.
26. Juris, Hervey, "Employee Discipline No Longer Management Prerogative Only," Hospitals, 51 (May 1, 1977), 69-74.
27. Juris, Hervey, "Labor Agreements in the Hospital Industry: A Study of Collective Bargaining Outputs," Labor Law Journal (August, 1977), 504-511.
28. Juris, Hervey and Joseph Rossmann, Charles Maxey, Gail Bentivegna, "Nationwide Survey Shows Growth in Union Contracts," Hospitals, 51 (March 16, 1977), 72-76.

29. Kline, Sheldon N., "Strike Benefits of National Unions," Monthly Labor Review, 98 (March, 1975), 17-23.
30. "Labor Relations Update," Hospitals, 50 (January 1, 1976), 34-37.
31. "Labor Relations Update," Hospitals, 51 (October 16, 1977), 46.
32. "Labor Relations Update," Hospitals, 52 (January 1, 1978), 42.
33. League of Voluntary Hospitals and Homes of New York and District 1199, National Union of Hospital and Health Care Employees, RWDSU, AFL-CIO; Before Basil A. Paterson, Chairman, Interview Opinion and Award, June 28, 1974, p. 10.
34. Miller, Ronald L., "Anticipate Questions, Seek Answers for Adept Labor Relations Efforts," Hospitals, 50 (July 1, 1976), 50-54.
35. NLRB vs. Massachusetts Nurses Association 95 LRRM 2852.
36. Phillips, Donald F., "New Demands of Nurses," Hospitals, 48 (September 16, 1973), 51-54.
37. "Quality Not Negotiable," editorial in Hospitals, 48 (October 16, 1974), 43.
38. Richardson, Reed C., Collective Bargaining by Objectives Englewood Cliffs, N. J., Prentice Hall, 1977.
39. Roberts, Harold S., Roberts' Dictionary of Industrial Relations, Washington, D. C., National Affairs, Inc., 1974.
40. Rossman, Joseph, "One Year Under Taft-Hartley," Hospitals, 49 (December 16, 1975), 64-68.
41. Rothenberg, I. Herbert and Steven B. Silverman, Labor Unions: How to Avert Them, Elkins Park, Pennsylvania, Management Relations, Inc., 1973.
42. "Service Employees Win Big Unit in Washington," AFL-CIO News Service, June 26, 1975.
43. Shershen, Michael and W. Randy Boxx, "Building Positive Union Management Relations," Personnel Journal, 64, No. 6 (June, 1975).

44. Singleton, Barry, "Negotiating a Collective Bargaining Agreement," Hospital Progress (October, 1975), 57-80.
45. "Social Security Bulletin," Department of Health Education and Welfare, Government Printing Office, Washington, D. C., February, 1977.
46. Spirn, Steven, "Negotiation and Coexisting with a Union," Hospital Progress (October, 1975), 54-57.
47. Tanner, Lucretia, "Research Project: 1974 Amendments Effect on Health Care," Research Department, Federal Mediation and Conciliation Service (1977), 354-369.
48. Van Cleve, William J., "Collective Bargaining in the Health Care Industry," Journal of the American Dietetic Association, 61 (December, 1972), 633-635.
49. Weiner, Edward W., "Hospitals and Unions Come to Grips," Texas Hospitals, 30 (March, 1975), 12-13.

CHAPTER VIII

UNFAIR LABOR PRACTICES

The National Labor Relations Board has two basic duties: to ensure fair and representative elections, and to prevent or remedy unfair labor practices. This latter duty is clearly defined in Section 10 of the Taft-Hartley Act which states:

Section 10(a). The Board is empowered, as hereinafter provided, to prevent any person from engaging in any unfair labor practice (listed in Section 8) affecting commerce (36).

Section 8(a) has designated five unfair labor practices that an employer should not commit. Section 8(b) states the unfair labor practices prohibited by labor organizations or its agents. These activities are prohibited and if violations occur the Board can determine appropriate remedies. The Board may not act to prevent or remedy unfair labor practices unless a complaint has been filed with the Board. Unfair labor practice charges can be filed by an employer, employee, labor organization or any other person. The Regional office of the Board where the alleged violation occurred is the location where the charges are filed. The Board then has a limited time in which to notify the party of the complaint and establish a hearing. Unfair labor practices are statutory wrongs. They are not crimes; they are most like common law torts, the invasion of publicly declared rights (12).

Special Provisions for the Health
Care Institutions

Congress felt the unique and actual services provided by health care institutions merited special consideration and special provisions. Much testimony was directed to this fact; for example, the Ohio Hospital Association stated the public's right to health care is above the right of employers to regulate union activity and the right of employees to engage in concerted activity (30).

Other testimonials reflected little alarm. Representative Thompson expressed the view that the unions involved in the hospital industry are extraordinarily responsible and have invariably not engaged in strike activity unless adequate care for patients was guaranteed (37). He concluded: "So there is really nothing but an illusory danger that the medical support needed by so many citizens would be deprived . . ." (37, p. 4588). The predominant view was that the essential nature of health care functions required efforts designed to minimize the likelihood of disrupted patient services and provide for continuity of patient care. The view was that of Senator Dominick who quoted at length newspaper articles pointing out the need to provide speedy solutions to impasses between labor and management in health care and even had his personal views appended to the Senate report (8).

The final Congressional Committee Reports then reflected the concern, made special provisions a reality, and stated that the NLRB should give "special attention" and "priority" to unfair labor practice charges in the health care situation, "CONSISTENT with existing statutory priority requirements for particular classes of cases" (35, p. 15). The Committee noted the existence of priority case treatments by the Board under Section 10(1) of the Taft-Hartley, involving charges filed under Section 8(b)(4) (secondary picketing), Section 8(b)(7) (recognitional picketing) and Section 8(e) (hot cargo agreements), as well as three existing priority directions under Section 10(m). Additionally the Congressional Committees enunciated the policy that appropriate related resources be developed to insure the requisite priority to health care institutions problems or disruptions (35, p. 15).

Effect on NLRB Caseload

After the 1967 Medical Center (21) decision when the NLRB asserted jurisdiction over proprietary hospitals, unfair labor practice charges were few. Between July, 1970 and April, 1973, less than thirty-six decisions were rendered by the Board involving hospitals, nursing homes or extended care facilities (40). The same 8(a) and (b) unfair labor practice provisions applied to health care as to other industry. The same criteria and tests were also applied.

At the time of the amendment unfair labor practice charges represented 2 per cent of the total NLRB caseload. After the 1974 amendments became effective, the number of unfair labor practice charges increased significantly. By 1976, the unfair labor practice charges had increased to 5 per cent. Table XLI indicates the changes in unfair labor practice charges and a comparison of the health care industry with all NLRB cases (24).

TABLE XLI
A COMPARISON OF ALL NLRB AND HEALTH CARE
UNFAIR LABOR PRACTICE CASES

	Fiscal Year		
	1974	1975	1976
<u>Unfair Labor Practices</u>			
All NLRB Cases	27,726	31,253	34,509
Health Care Cases	549	1,423	1,721
<u>All Charges Against Employers</u>			
All NLRB Cases	17,978	20,311	23,496
Health Care Cases	445	1,210	1,404
<u>Percent of Charges Against Employers</u>			
All NLRB Cases	64.8%	65.0%	58.1%
Health Care Cases	81.1%	85.0%	81.6%

Source: NLRB Annual Reports, 39th, 40th, 41st, Washington, D. C., Government Printing Office (1974, 1975, 1976).

The actual number of cases in health care increased 159 per cent from 549 in the 1974 fiscal year to 1,423 in the 1975 fiscal year. From 1974 to 1976 there was an increase of 213 per cent, equaling 1,721 cases. This can be compared to the 25 per cent increase for all industries (24).

General Counsel Guidelines

After the amendment's passage, the General Counsel of the NLRB announced the following priority schedule:

1. Initial consideration must be given to statutory priorities found in Sections 10(1) and (m) of the Act. Therefore health care charges arising out of the provisions outlined in those sections will receive attention before new priority cases.
2. As between nonhealth care and health care cases both of which involve charges warranting priority under Section 10(1) or (m) the health care charge will receive priority.
3. As between nonhealth care and health care cases neither of which involve charges warranting priority, the health care cases will be handled first (25, p. 1).

Health Care Unfair Labor Practices Cases

Section 8(a) designates the unfair labor practices for an employer and Section 8(b) for a labor organization. The cases which were heard in the two years following the amendment are discussed below. Violations of subsections of Section 8 are often interrelated. In presenting the discussion on the cases only those decisions that specifically apply to each section will be discussed.

Section 8(a)(1)

Section 8(a)(1) states, "It shall be an unfair labor practice for an employer to interfere with, restrain, or coerce employees in the exercise of the rights guaranteed in Section 7" (36).

Hospital No. Solicitation, No Distribution Rules.--The board at all times seeks to balance the rights of the individual employee with the rights of the employer to do business. The health care industry has unique characteristics that have required the Board to reconcile health care concerns with previous standards. General rules which prohibit employees from soliciting or distributing literature on company property by employees during nonworking time are presumed invalid. But a no solicitation rule when an employee is working is presumed to be valid for the purposes of maintaining production and discipline. A rule which prohibits solicitation or distribution by nonemployee union organizers is presumed valid unless the employee discriminates against the union by allowing other types of solicitation and distribution (29).

The health care industry has contended that due to its unique features it deserved special treatment allowing promulgation and enforcement of broad no-solicitation rules. This is not without precedent, because in May Department Stores Company (2) the Board made an exception for retail stores by

allowing them to ban all solicitation during working and nonworking hours, in public areas of the store, in order to avoid customer confusion. In health care enterprises, the Board has determined that a hospital may prohibit solicitation even on nonworking time in strictly patient care areas such as patient's rooms, X-ray, therapy, and operating rooms. These restrictions would be presumed invalid if this were extended to patient and visitor access areas, such as cafeterias and lounges. The Board observed that in patient care areas solicitation might be unsettling to those requiring quiet and peace of mind. However, patients who are well enough to frequent access areas would not be critically upset by union solicitation. Therefore, some irritation to these patients cannot outweigh the rights to the employees to discuss or solicit union representation. In St. John's Hospital and School of Nursing (31) the full Board found a violation of 8(a)(1) the employer rules which prohibited solicitation "during working time or in working areas of the hospital, or in any area to which patients and visitors have access."

In Lutheran Hospital of Milwaukee (18), the Board held a broad no solicitation rule was a violation of 8(a)(1) when it permitted union solicitation only in nonpublic and non-patient areas of the hospital. This rule eliminated solicitation in areas even remotely associated with patient care.

The mere presence of the visiting public could not be construed as an exceptional circumstance needed to further restrict employee's rights. In Lutheran Hospital, the employer offered to clarify the ambiguities in the rule upon employee request. This was not accepted because it would require a disclosure of the sympathies of the inquirer and employees have the privilege of not disclosing such information to their employer.

However in Tri-County Medical Center, Incorporated (38) the Board allowed the employer to clarify a rule which barred solicitations during "working hours." Prohibition during "working time" is valid because this connotes time actually spent in job performance, whereas "working hours" indicates business hours which include employee "free time" such as breaks and lunch. In Tri-County Medical the phrase working hours was explained to all employees to mean they could engage in solicitation and distribution, before and after their shifts, and during lunch and coffee breaks.

Another hospital no solicitation rule was found unlawful in St. Peter's Medical Center. The employer prohibited solicitation "for any reason," the express purpose being to "protect the employee from any solicitor of products, literature, services, bill collectors, insurance salesmen, etc." (33, p. 742). This rule was found unlawfully broad in its scope as it exceeded patient care areas and even though no reference was made to "union" solicitations the broad language

was susceptible to that interpretation. Also the Board regarded as irrelevant the fact the rule existed prior to the Health Care Amendments and consequent Board jurisdiction.

In Barnes Hospital, the Board stated that:

It requires more than a mere change of mind within the personnel director, the posting of four notices on some of the bulletin boards setting out the perfectly proper rule, to make clear in the minds of the employee group that they are in fact free to exercise the statutory prerogative of self-organization in a lawful manner (2, p. 126).

The hospital had between 3,000 and 4,000 employees, each of which had been given a fifty page handbook of rules and regulations. The preamendment rule was stated in these handbooks and it was felt the four notices would not compensate for the handbook statement.

The issue of no distribution, no solicitation has recently moved to the courts. The Circuit Court of Appeals for the District of Columbia refused to enforce a National Labor Relations Board Order invalidating the hospital's ban on solicitation or distribution of literature. Stating special circumstances are involved in running a hospital, the court upheld a Baylor University Medical Center (4) ban on union solicitation by employees in its corridors and cafeterias. The NLRB had said Baylor could prohibit union solicitation at all times within immediate patient care areas, but the ban could not be extended to corridors, cafeterias, and vending machine areas. Judge MacKinnor disagreed:

The situation in Baylor involves unique circumstances which justify a broad proscription on solicitation and distribution. . . .

The importance of prevention of crowding and disruption in the hospital corridors cannot be seriously debated (3).

Employees can engage in union soliciting in any area outside the hospital: lawns, gardens, parking lots, etc.

The U. S. Supreme Court has agreed to review Beth Israel Hospital vs. NLRB (5), a no distribution, no solicitation case. The court will decide if the hospital unlawfully prohibited union solicitation and the distribution of union literature in its cafeteria and coffee shop on grounds that the activities impinged upon patient care. The hospital argues that the "table hopping" and arguments about the union might "offend and upset patients and visitors" (5, p. 193). The First Circuit Court of Boston disagreed, finding the hospital's action unlawful.

The status of this issue then is still changing. The basic concerns seem to be: (1) no solicitation--no distribution during working hours no matter what the area; (2) a no solicitation--no distribution covering nonworking time in actual patient care areas; and (3) a no solicitation--no distribution rule covering nonworking time in a nonpatient area.

Section 8(g)

Included in the 1974 amendments was a new unfair labor practice section pertaining specifically to health care

institutions. The provision was developed under the auspices of Under Secretary of Labor Richard F. Schubert (34). He engineered the compromise between the American Hospital Association and the labor unions. The AHA had wanted a sixty day cooling off period, thirty day notice of a strike or lockout, a strike vote to be conducted by FMCS, a ten day strike notice of the time the job action was to commence (1); the union leaders did not want any special procedures in the law.

Section 8(g) states:

A labor organization before engaging in any strike, picketing, or other concerted refusal to work at any health care institution shall, not less than ten days prior to such action, notify the institution in writing and the Federal Mediation and Conciliation Service of that intention, except that in the case of bargaining for an initial agreement following certification or recognition the notice required by this subsection shall not be given until the expiration of the period specified in clause (B) of the last sentence of Section 8(d) of the Act. The notice shall state the date and time that such action will commence. The notice, once given, may be extended by the written agreement of both parties (36).

The Congressional intent is that violation of the 8(g) notice requirement will constitute an unfair labor practice separate and distinct from those presently existing. The paramount objective of the notice requirements is to allow the institutions to prepare for "continuity of patient care." The Senate Committee's report states:

In the Committees deliberations on this measure, it was recognized that the needs of patients in health care institutions required special consideration in the Act including a provision requiring the hospital to have sufficient notice of any strike or picketing to

allow for appropriate arrangements to be made for the continuance of patient care in the event of a work stoppage (35, p. 5).

If the union does not begin such activity when specified in the notice at least twelve hours additional notice must be given prior to the commencement of the activity. The House and Senate Committee expected activity to begin with seventy-two hours of the time set forth in the notice and if not, a new ten day notice must be offered (9, p. 270).

If a strike is called and abandoned, the rule should be to file a new notice before the activity is recommended. However, if the circumstances led to the conclusion the activity might be renewed, no new notice is required if recommenced within seventy-two hours of the beginning of the inactivity. Repeatedly serving such ten day notices upon the employer is to be construed as constituting evidence of a refusal to bargain in good faith by the labor organization (9).

It will be noted that the language of 8 (g) deals with "any" picketing, strikes, etc. The legislative history indicates:

This subsection applies not only to bargaining strikes or pickets but also . . . (a) examples, . . . to recognition strikes, area standard strikes, secondary strikes, jurisdictional strikes and the like (7, p. 6941).

Section 8 (g) applies only to labor organizations. Consequently activities of employers are not prohibited by the section (for example lockouts). Also, according to the General

Counsel's guidelines; "The 8 (g) notice requirements would probably also apply if a health care institution becomes so enmeshed in a dispute as to become an 'ally' of a struck employer" (28, p. 1).

Section 8 (g) is significantly linked with Section 8 (d) as amended by providing

. . . any employee who engages in a strike within any notice period specified in the subsection, or who engages in any strike within the appropriate period specified in subsection (g) of this section shall lose his status as an employee of the employer engaged in the particular labor dispute for the purpose of Sections 8, 9, and 10 of this Act, as amended . . . (27).

The first three cases to be decided by the Board involving the interplay of Section (d) and Section (g) were Lein-Steenberg (17), Mercy Hospital of Laredo (22), and Casey and Glass, Incorporated (6).

Lein-Steenberg is a joint venture engaged as a general contractor to expand and renovate Martin Memorial Hospital. Lein-Steenberg subcontracted with employer Taylor, a non-union mechanical and plumbing contractor. There were three gates, one of which was reserved for Taylor. The union had a dispute with Taylor and began picketing with signs which stated:

Notice to the public, Don Taylor Mechanical, Inc. lowers our standards. We have no dispute with any employee. This is not intended to stop work or deliveries. UA Local Union 630 (17, p. 155).

Notice had not been given to Martin Memorial or the Federal Mediation and Conciliation Service. The majority of

the Board (Murphy, Kennedy, and Penello) found that picketing Taylor at the Martin Memorial jobsite without first giving the required notices violated Section 8 (g) of the Act. The majority based the opinion on their conclusion of Congressional intent and literal reading of Section 8 (g). They concluded that "any strike or picketing on the premises of a health care institution, even primary reserved gate picketing directed at a subcontractor, is proscribed in the absence of proper notices" (17, p. 155). The majority also felt if the picketing were exempt because it did not disrupt hospital services then it might set a "troublesome precedent" requiring a case by case analysis. They felt Congress viewed any strike or picketing at the premises of a health care institution as "constituting sufficient potential for disruption of medical care to require notice to the institution and to the Federal Mediation and Conciliation Service" (17, p. 155).

Finally, the majority did not feel this would impose any undue burden or hardship on labor organizations. They felt convinced of the ability of labor to provide proper and timely notice and that as awareness of the obligation to do so occurs, this will become a "pro forma" procedure as notice of contract terminations are now (17).

Members Fanning and Jenkins dissented for several reasons. One the decisions of the three cases are significant due to setting a precedent. Also, they felt the cases raised some

doubts, since one was based on a stipulated record and the other on General Counsel's motion for summary judgment, they were decided without a hearing. In Lein-Steenberg there was concern about the picketing being on or off the hospital premises. The dissenters feel there are two flaws in the majority opinion. First, the majority felt a literal view was taken. The majority assumed the word "at" was associated with the word "work." The dissenters also disagreed with the majority that they were following Congressional intent. The dissenters felt the legislative history clearly indicated that Section 8 (g) was to apply only to action directed at a health care institution. In their discussion the suggestions of Under Secretary of Labor Schubert's testimony in August, 1973, were quoted. His recommendations included: "In addition a ten day strike notice would be required before a union could go on strike 'against' a private health facility . . ." (34, p. 1). The majority felt if Congress had wanted to use the word "against" it would have done so.

Another matter that bothered the dissenters was the seeming inconsistency they felt resulted from dividing Section 8 (g) into three parts. First, any labor organization must file a ten day notice before picketing "at" any health care institution. The second part, the initial bargaining exception, is limited to labor organizations representing health care

employees. Finally, the third part applies once again to all labor organizations. The dissenters felt this interpretation was incorrect and inconsistent (17).

Member Jenkins further dissented by stating construction work within hospital grounds is not necessarily hospital work and should not be entitled to the additional protection the Act provides to hospitals (17).

Mercy Hospital of Laredo.--In Mercy Hospital of Laredo (22) the situation was similar to that of Lein-Steenberg. The hospital and a glass company, Casey and Glass, Incorporated filed charges against Laborers International, citing 8 (g) unfair labor practices. The glass company was engaged in a construction job at the hospital and the union picketed the glass company on the hospital premises. The union did not give ten days written notice to the hospital or to the Federal Mediation and Conciliation Service.

The majority adhered to its position in Lein-Steenberg and concluded the union, by picketing a construction contractor on the premises of the hospital without giving the proper notice as required by Section 8 (g), violated that position of the Act. Members Fanning and Jenkins again dissented per Lein-Steenberg and emphasized the union took all possible action to clarify that it did not have any dispute with the hospital and to minimize any effect on the hospital (22).

Casey and Glass, Incorporated.--Casey and Glass, Incorporated (6) is a general contractor of a construction project at Mercy Hospital of Laredo. No individuals observed a picket line established by Laborers' International Union at the reserved gate used by the employees at the hospital premises. In the related case, Mercy Hospital of Laredo, the Board found the union violated Section 8 (g) of the Act because they did not give ten days notice to the hospital and the Federal Mediation Service. Under Section 8 (d) employees who engage in a strike in violation of Section 8 (g) lose their status as employees. Therefore, since the employees lost their status as employees they were ineligible to vote in an election conducted under Section 9 (c) of the Act. The dissenters, Fanning and Jenkins, would direct the opening and counting of the challenged ballots of the strikers (6).

St. Joseph's Hospital of Marsh Field, Incorporated.--The International Brotherhood of Electrical Workers, Local 3881, violated Section 8 (g) of the Act when it picketed a contractor, Hoffman Company, at a reserved gate without first giving ten days notice to the hospital and FMCS. For the reasons set forth in Lein-Steenberg and Mercy Hospital of Laredo, the Board found the union violated the act. The Board ordered the union to cease and desist from picketing without giving the required notice (32).

In 1977, the U. S. Seventh Circuit Court of Appeals reversed the Board's decision (13). The court determined the amendments were not intended to affect employees other than those of a health care institution. In holding that the contractor's union was not required to serve a Section 8 (g) notice, the court noted that employees other than those of the health facility do not increase the danger of health care delivery disruptions. The picketing that took place in these cases would be proper in any other industry. In reversing the NLRB, the court felt the literal interpretation undermined the rights of non-health care workers. This case is currently on appeal (13).

Sympathy Picketing: First Health Care Corporation.--The Service Employees International Union represents the service and maintenance employees at First Healthcare (10). Upon the expiration of its contract, they gave proper notice to strike to the health care facility and to the Federal Mediation Service.

Thirteen days after the strike had begun four officers of District 1199, National Union of Hospital Healthcare Employees, joined the picket line in sympathy and picketed for one and one-half hours. They did not represent any workers at the facility. The Board determined:

. . . a union wishing to join or support picketing of a health care institution must give its own ten day notice of intention to do so to the institution and the FMCS. When a union with no unit at the

institution sent four officers to join a picket line that had been lawfully established by another union. It did so unlawfully, even though the four only walked on the line one and one-half hours and their presence did not change the character of the strike or create any increased economic pressure on the institution (10, p. 212).

Pre Amendment Strike: Methodist Hospital of Kentucky, Incorporated.--Methodist Hospital of Kentucky (23) was charged with violating Section 8(a)(3) of the Act by refusing to reinstate strikers of the Communication Workers of America. The hospital felt it had no obligation to do so because they felt the union had failed to give proper ten day strike notice.

The strike began in June, 1972, and continued until October, 1974, almost two months after the Health care Amendment, including Section 8(g), became effective.

The Board felt the union did not have to stop a strike that existed prior to the effective date of the amendments, give a ten day advance notice, and then recommence the strike. The notice provision was established to allow ten days notice "before" any strike so the institutions could make arrangements for continuing of patient care.

The strike had begun prior to the effective date of the amendments, therefore the health care institution already possessed actual notice and continuity of patient care could be further provided with requiring additional notice (23).

Unorganized Employees: Walker Methodist Residence and Health Care Center, Incorporated.--In the Walker Methodist case (41), the Board ruled that Section 8 (g) applies only to labor organizations and not to unorganized workers who strike without a labor organization. Two nurses' aides were terminated when they engaged in a thirty minute work stoppage. They had failed to give the ten day notice. The Board ordered them reinstated which represented a change from their previous position. In the General Counsel guidelines the reasoning was that employees acting without a labor organization or in derogation of a representative have no fewer obligations nor no greater rights than those of a labor organization (41).

Strike Threat: Greater Pennsylvania Avenue Nursing Center, Incorporated.--According to legislative history the NLRB concluded that Section 8 (g) notice requirements did not apply to threats of a strike in the Greater Pennsylvania case (11).

Informational Picketing: United Hospitals of Newark.--The NLRB held that informational picketing without giving a ten day notice is a violation of 8 (g). The Board found:

1. the informational demonstration constituted picketing, despite the unions contention that the demonstration had a purpose only to inform the public and was more akin to handbilling than picketing;

2. it is immaterial that the picketing did not result in work stoppage or other disruption of delivery of health services, since section 8 (g) applies to all forms of picketing, not simply to those which involve a work stoppage;
3. the ten day notice requirement is not an impermissible restraint on the constitutionally protected right of free speech (39, p. 67).

Thus the Board ruled that peaceful information picketing is illegal unless a ten day notice has been filed with the employer and FMCS (39).

Summary of 8 (g) Cases.--From these initial cases it appears the Board is adhering quite literally to the requirements of the ten day notice that must be given by any labor organization that engages in picketing, strikes, or other refusal to work "at" any health care institution. This notice must be given to the institution and to the Federal Mediation and Conciliation Service. From Lein-Steenberg and Mercy Hospital the understanding becomes that this applies whether or not it is the hospital itself that is being picketed. Courts have reversed this decision and it is currently on appeal. Failure to adhere to this notice requirement might result in a loss of employee status under Section 8 (d) as in Casey Glass.

Exceptions to 8 (g) Requirements

Unfair Labor Practices.--Even though the adherence to the 8 (g) notice requirements is to be interpreted very strictly,

the legislative history indicates two areas of exception. The first of these situations relates to the employee's committing a serious or flagrant unfair labor practice. Mastro Plastics Corporation vs. NLRB (19) resulted in the United States Supreme Court holding that the notice period of Section 8 (d) did not apply to strikes that protest unfair labor practices, but only to economic strikes (those that set out to terminate or modify a contract). The notice requirement for health care institutions would be excused only where the actions of the employees would be of the magnitude of the unfair labor practices encountered in Mastro Plastics.

Abuse of the Waiting Period.--The other exception relates to activities during the 8 (g) notice period. Congress indicated during the ten day period the notified health care institution:

. . . should remain free to take whatever action is necessary to maintain health care, but not use the ten day period to undermine the bargaining relationship that would otherwise exist. For example, the employer would not be free to bring in large numbers of supervisory help, nurses, staff and other personnel from other facilities for replacement purposes. It would clearly be free to receive supplies but it would not be free to take extraordinary steps to stock up on ordinary supplies for an unduly extended period. While not necessarily a violation of the Act, violation of these principles would serve to release the Labor organization from its obligations not to engage in economic action during the course of the ten day notice period (35, p. 15).

Difficulties emerge from the problems in defining what are "appropriate arrangements" and what activities are

"undermining the bargaining relationship." Congress also recognized that work stoppages in certain areas, such as rural areas, might have an increased effect on patient care. The Committee Reports indicate that those employers should have greater leeway in making advance preparation "to alleviate the effects of a scarcity of alternative local resources" (35, p. 15).

The General Counsel interprets the Congressional comments to pose the test that where the employer's acts exceed what is essential to the health and life maintenance of the patients, and instead reinforce the employer's ability to endure the economic pressure applied by the union, the ten day notice requirement is violated. According to the Counsel's report:

Relevant circumstances would include the number of replacements being interviewed and/or hired, the permanency of the replacements, the number and type of supplies being ordered, the nature of the patients' illnesses, and the willingness of the union to permit the passage of supplies and personnel through its picket lines (25, p. 1).

Incidence of 8 (g) Notices.--In fiscal year 1975, the NLRB received 60 cases involving violations of 8 (g). With 25 cases closed, 14 were settled before issuance of a complaint, 9 were withdrawn, and 2 dismissed (24). In fiscal year 1976, 92 cases closed with 42 settled informally, 11 withdrawals, and 17 dismissed (24). It appears that the unions are trying in good faith to comply with 8 (g) requirements.

Subject Matter of Bargaining: 8(a)(5)
and 8(b)(3)

Unfair labor practice charges over refusals to bargain have emerged with items unique to health care situations. The chief issue appears to be whether certain matters related to patient care constitutes mandatory subjects for bargaining, or instead are reserved solely to management rights. This question prevails mostly with professional employees.

One case decided by the Board held that interest arbitration is not a mandatory subject of bargaining. The union claimed that because of the special nature of the health care industry it could insist to the point of impasse on the inclusion of the clause. The U. S. Court of Appeals for The First Circuit upheld the Board stating the special nature of health care did not warrant a judicial exception. Interest arbitration has no more direct impact on terms and conditions of employment in the health care industry than in any other industry (16).

Summary

Unfair labor practice charges have increased considerably after the 1974 amendments. Initially the charges have been related to 8(a)(1) violations. These violations primarily relate to organizing activities and particular concern has been in the "no distribution no solicitation" rules. The

other major area of unfair labor practice cases have been in the new provision 8(g) which requires a ten day notice before a strike or picketing. Since this is a new provision several aspects have had to receive Board attention and interpretation, especially requirements for nonhospital employee picketing.

It is expected that as the amendments remain in effect and the Board decisions establish precedence, the number of charges in the above categories will diminish as a per cent of the health care cases. As more health care facilities are organized other unfair labor practice charges will occur more frequently, such as 8(a)(5) and 8(b)(5) charges on refusal to bargain. Board rulings and court decisions are establishing the future for labor relations in the health care industry.

CHAPTER BIBLIOGRAPHY

1. American Hospital Association, Testimony before the Senate Subcommittee on Labor, July 31, 1973.
2. Barnes Hospital 217 NLRB 126 (1976).
3. "Baylor's Union Bid Ban Upheld," Dallas Morning News,
4. Baylor University Medical Center, 225 NLRB 102 (1976) of 76-1940, (D. C. Cir., 1978).
5. Beth Israel Hospital vs. NLRB (81 LC 13, 193, CCH 16, 773).
6. Casey and Glass, Incorporated, 219 NLRB 689 (1975).
7. 120 Congressional Record, 6941, May 2, 1974, Taft.
8. Senator Dominick, Senate Report No. 93-766, 93rd Congress, Second Session 39 (1974).
9. Fehely, Lawrence, "Health Care Institutions," Ohio State Labor Law Journal, 36 (1975), 235-298.
10. First Health Care Corporation, 222 NLRB 212 (1976).
11. Greater Pennsylvania Avenue Nursing Center, Incorporated, 94 LRRM 1083 (1976).
12. Guidebook to Labor Relations, Chicago, Illinois, Commerce Clearing House, 1975, pp. 114-122.
13. Hoffman Company 94 LRRM 2536 CA 7 (1977) denying enforcement of NLRB 90 LRRM 1390 (1975).
14. "Hospital No Solicitation No Distribution Rules," Commerce Clearing House, 909 (July 16, 1976), 15, 261-15, 263.
15. House Representatives Report No. 1051, 93rd Congress, Second Session, 6 (1974).
16. "Interest Arbitration Held Nonmandatory Bargaining Item in Health Care Sector," Daily Labor Report (July 13, 1977), A-1.

17. Lein-Steenberg 219 NLRB 153; 219 NLRB 155 (1975, 1976).
18. Lutheran Hospital of Milwaukee, CCH 16, 890 (1976).
19. Mastro Plastics Corporation vs. NLRB, 102 NLRB 51, 350 U. S. 270 (1956).
20. May Department Stores vs. NLRB, 326, U. S. 276 (1945).
21. Medical Center Hospital, 168 NLRB 52 (1967).
22. Mercy Hospital of Laredo, 89 LRRM 1777 (1975).
23. Methodist Hospital of Kentucky, Incorporated, 221 NLRB 87, CCH 15, 383 (1976).
24. NLRB Annual Reports, 39th, 40th, 41st, Washington, D. C., Government Printing Office (1974, 1975, and 1976).
25. NLRB General Counsel, "Guidelines for Handling Unfair Labor Practice Cases Arising Under the 1974 Nonprofit Hospitals Amendments to the Act," Memorandum 74-49, Washington, D. C., August 20, 1974.
26. "NLRB General Counsel's Monthly Report on Health Care Institution Cases," Washington, D. C. (December 21, 1974), 1-18.
27. "NLRB General Counsel's Monthly Report on Health Care Institution Cases," Washington, D. C. (January 24, 1975), 1-9.
28. "NLRB General Counsel's Monthly Report on Health Care Institution Cases," Washington, D. C. (February 24, 1975), 1-9.
29. "NLRB General Counsel's Monthly Report on Health Care Institution Cases," Washington, D. C. (March 27, 1975), 1-13.
30. Ohio Hospital Association, Testimony in hearings on S794 before the Subcommittee on Labor, 93rd Congress, First Session (August 2, 1973).
31. St. John's Hospital and School of Nursing 222 NLRB 182 (1976).
32. St. Joseph's Hospital of Marsh Field, Incorporated, 224 NLRB 47 (1976).

33. St. Peter's Medical Center, CCH 16, 742 (1975).
34. Schubert, Richard F., Under Secretary of Labor, U. S. Department of Labor, Testimony Before the Senate Subcommittee on Labor, August 2, 1973.
35. Senate Report No. 766, 93rd Congress, Second Session, 5 (1974).
36. Taft-Hartley Act, 1947, as amended 1974.
37. Representative Thompson, 120 Congressional Record 4588 (May 30, 1974).
38. Tri-County Medical Center, Incorporated, 222 NLRB 174 (1976).
39. United Hospitals of Newark, 232 NLRB 67 (1977).
40. Vladeck, Stephen C., "History of Labor Relations in Health Care Facilities Prior to the Health Care Amendments," Proceedings from Retail Clerks Attorneys Conference (September, 1976).
41. Walker Methodist Residence and Health Care Center, Incorporated, 227 NLRB 238 (1977).

CHAPTER IX

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

The 1974 health care amendments to the Taft-Hartley Act have affected many individuals and institutions. A longitudinal evaluation would require a longer passage of time in order to isolate specific trends; however, it is possible now to determine certain impacts and problem areas of the legislation.

The Taft-Hartley Amendment

Public Law 93-360 passed by the 93rd Congress on July 26, 1974, became effective August 25, 1974. This amendment to the Taft-Hartley Act provides coverage to health care institutions which are defined in Section 2 (14) as any "hospital, convalescent hospital, health maintenance organization, health clinic, nursing home, extended care facility, or other institutions devoted to the care of sick, infirm, or aged person. . . ." Federal, state, and municipal hospitals are exempt as are administrative employees in the health care industry.

Rather than merely extending the same provisions that exist for employees already covered by the National Labor Relations Act, Congress enacted special features for the health care industry:

1. A 90-day notice by the employer or labor organization is required on contract renewals or modifications. (A 60-day notice is required for other industries covered under the NLRA.)
2. The Federal Mediation and Conciliation Service (FMCS) must be notified 60 days prior to the termination or expiration of an existing contract in contrast to 30 days for other industries.
3. A written notice must be given by the labor organization to the health care institution and to the FMCS 10 days prior to engaging in any picketing, strike, or other concerted refusal to work. (There are no strike or picketing notice provisions in the NLRA for other industries. In July, 1975, the five-member NLRB ruled that section 8 (g) on strike prohibition also applied to a union picketing a contractor enlarging a hospital.)
4. Prior to the expiration of the notification periods on renewal and initial contracts, and at the discretion of the director of the FMCS, an impartial Board of Inquiry (BOI) could be established to investigate a labor-management dispute and to make a written report of its findings of fact. This process would only apply when the director of the FMCS makes the judgment that a threatened or actual work stoppage would substantially interrupt the delivery of health care to the locality concerned. (No such provisions exist for other industries under the NLRA except for the power given to the President of the United States during a dispute he deems to be a national emergency.)
5. A new section 19 was added which holds an employee of a health care institution who is a member of a bona fide religion, body, or sect which historically has held conscientious objections to participation or support of labor organizations will not be required to join or financially support any labor organization as a condition of employment. However, such employees may be required in lieu of periodic dues and initiation fees, to pay sums equal to such dues and initiation fees to a nonreligious charitable fund exempt from taxation under section 501 (c) (3) of the Internal Revenue Code.

Congressional Intent

Although they do not have the impact of legislative amendments, there were also several important provisions in the Senate Committee reports that reflected the sense and intent of Congress to lessen major disruptions in the health care industry:

1. Avoid the fragmentation of bargaining units in health care institutions;
2. Establish a system to give priority handling to cases involving health care institutions;
3. Allow certain transfers of patients and exchange of services from a struck or threatened health care institution to another without jeopardy of secondary strikes or boycotts against the assisting institution; and
4. Reaffirm the existing definitions of supervisors among professional employees in health care institutions.

The amendments and the committee reports formed the framework for the future of the health care labor relations environment.

National Labor Relations Board
and Health Care

Jurisdictional Standards

The National Labor Relations Board decided to continue jurisdiction over the previously covered proprietary facilities and to establish jurisdiction over nonprofit health care facilities, including charitable institutions. The Board

excludes government owned hospitals, unless operated autonomously by a private employer.

The NLRB established a \$100,000 gross revenue standard for nursing homes, visiting nurses associations, and related facilities; and extended the \$250,000 standard that previously applied to proprietary hospitals to nonprofit hospitals.

Bargaining Unit Determinations

The determination of appropriate units in health care facilities is often a crucial factor in organizing because the work force is extremely diverse. The size of the unit particularly has had a direct impact on the success or failure of union organizational drives.

A bargaining unit must consist of two or more employees who share common employment interests and conditions and may reasonably be grouped together for purposes of collective bargaining. A significant factor in determining the appropriate unit is the community of interests concept. A community of interests is generally considered as common skills, wages and working conditions. Interwoven in the determination of a common community of interests are the factors of geographical location, functional integration, employee interchange, and administrative territory.

The NLRB has attempted to follow the congressional mandate against proliferation of bargaining units by placing a special significance on the higher degree of integration of

operations performed throughout a health care facility. In the eight decisions handed down May 5, 1975, the Board established guidelines for bargaining unit determinations in private health care industry.

The health care bargaining unit guidelines are:

1. Registered nurses are entitled to join a bargaining unit separate from other professional employees.
2. Licensed practical nurses belong in units of technical employees, and technical employees are entitled to a bargaining unit separate from service and maintenance employees.
3. Business office clerical employees may join a separate unit, but hospital ward clerical workers should be part of the service and maintenance employee bargaining units.
4. In keeping with congressional intent, the Board turned down a separate unit for telephone switchboard operators, stationary engineers who maintain boilers and perform maintenance chores; and refused to establish a unit of "patient care" employees consisting of nursing assistants, occupational and recreational therapists, and ward secretaries.

Since the Board works by case law rather than regulation, there are some conditions that have warranted special "appropriate unit" patterns. When variations of the bargaining units do occur, however, the Board gives careful consideration to prevent proliferation of units.

Union Organizing in Health Care Facilities

The expected surge in union efforts to organize the employees of nonprofit hospitals has taken place. Based on NLRB statistics for representation elections and FMCS caseload

statistics for initial contract situations, the data shows the union "win rate" for elections is about 60 per cent of all units sought compared with the all U. S. industry rate of 48 per cent. The latest NLRB report indicated that 1,659 representation elections were filed with the Board.

Virtually every known union can be found in the health care field. There are five unions that contain the bulk of hospital union membership and these were active prior to the health care amendments. The unions are the American Federation of Government Employees (AFGE), the American Federation of State, County, and Municipal Employees (AFSCME), the Service Employees International Union (SEIU), the Retail, Wholesale and Department Stores Union--1199 (RWDSU), and the American Nurses Association (ANA). In the nonprofit non-governmental sector, RWDSU and SEIU are the two largest and most active representing about 40 per cent of the total organization. The Service Employees International Union is the largest union of health care workers representing approximately 200,000 health care workers in the United States. The absence of one singular large hospital union has made the industry a target for any union desiring increased membership.

Nurses usually are active in state units affiliated with the American Nurses Association. The leading state nurses associations have been California, Minnesota, New York, Oregon, and Washington. Nurses at times have been included in other bargaining units and as such may be found in the Retail Clerks

Union and the Teamsters Union. ANA has 35 per cent of its members covered by contracts.

Election activity has been concentrated in the Northeast and California, yet activity has been widespread geographically as elections have been held in forty states, District of Columbia and Puerto Rico. Organizing has basically taken place in areas where bargaining is an accepted event, although some areas that are not heavily organized in the private sector are experiencing union efforts.

Hospitals used to employ substantially unskilled labor. Advances in technology have resulted in the need for higher skilled personnel who demand higher wages and greater participation in decision making processes. Health care employees have been organizing facilities for many years, but the passage of the amendment giving them the protection of Taft-Hartley Act was the impetus for increased union activity.

The Role of the Federal Mediation and Conciliation Service in Health

The health care amendments of the National Labor Relations Act mandate the Federal Mediation and Conciliation Service to utilize mediation and board of inquiry procedures where the parties are unable to resolve their differences through their own resources.

Notification Procedures

The notice requirements for the health care industry differ from other private sector industries. Notification

procedures have been extended in order to minimize work stoppages in the health care industry.

Section 8(d) has been modified for health care institutions as follows:

- (A) The notice of Section 8(d)(1) shall be ninety days; notice of Section 8(d)(3) shall be sixty days; and the contract period of Section 8(d)(4) shall be ninety days.
- (B) Where the bargaining is for an initial agreement following certification or recognition, at least thirty days' notice of the existence of a dispute shall be given by the labor organization to the agencies set forth in Section 8(d)(3).

The contract, therefore, must remain in full force and effect without strike or lockout, for a period of ninety days (instead of sixty days) after the notice of termination or modification is given, or until the expiration date of the contract, whichever occurs later.

In cases of initial contracts a new provision, Section 8(d)(B), requires a labor organization in a health care institution to give at least thirty days' written notice to FMCS when a dispute arises, following certification or recognition. The ten-day notice provision of Section 8(g) is subsequent to this thirty-day notification, thereby creating a forty-day minimum period before a strike or picketing could lawfully begin. The loss of employee status provision would also apply during the forty-day period.

Due to mandatory involvement under the amendment the Federal Mediation and Conciliation caseload has increased

substantially. Approximately 1,600 cases per year have been added to the caseload. Hospital negotiations represent about 50 per cent of the total health care caseload, but represent 70 per cent of the total number of employees. Nursing homes account for about 30 per cent but represented only 15 per cent of the employees. Other health care disputes covered convalescent hospitals, health maintenance organizations, and other health care facilities.

Fact Finding and Boards of Inquiry

Notice requirements, time restrictions and mandatory mediation are not the only provisions applicable to the Federal Mediation Service in the Act. Section 213 was added to provide another mechanism to aid collective bargaining. If the Director of FMCS concludes that strike or lockout activity will substantially interrupt the delivery of health care in the locality concerned, a Board of Inquiry will be established.

The Board of Inquiry is designed to provide fact finding in an attempt to avoid health care strikes. The neutral can investigate the dispute and issue a report with recommendations. The Board must make a written report within fifteen days after its establishment citing the facts and recommendations for a prompt, peaceful, and just settlement of the dispute. The parties may not change their status quo during the Board of Inquiry interim.

Criteria for Boards of Inquiry members includes competency in fact finding, mediation, arbitration, and experience in the health care field. As of May, 1977, the Federal Mediation Service's total caseload equaled 3,949 cases and in these, 134 Boards of Inquiry had been appointed. Board procedure has been used in less than 5 per cent of all bargaining situations.

The larger institutions require more Board appointments. Generally, union chief negotiators more frequently favor having a Board appointed than management, although the difference is not great. The mechanism is seen by the parties as helpful, although the timing requirements have created problems.

There have been fifteen strikes in which Boards had been appointed. The strike rate in the health care industry is about 4 or 5 per cent. From August 25, 1974, to December 31, 1976, there were 129 strikes which occurred out of 2,585 health care bargaining situations. Twenty-seven days is the average duration of the strikes.

The FMCS has had a greatly increased caseload and other responsibilities to fulfill their roles in carrying out the provision of the health care amendments. The organization has had to gain expertise, then share it with others. It is anticipated the caseload will continue to increase. The issues surrounding Boards of Inquiry will have to be resolved regarding timing and written findings. Despite the new

requirements, the FMCS made a smooth transition into extensive involvement in the health care industry.

Unfair Labor Practices

After the 1974 amendments became effective, the number of unfair labor practice cases involving health care facilities increased significantly. In 1976, unfair labor practices in health care represented 5 per cent of the total NLRB caseload.

Ten Day Strike Notice

To provide continuity of patient care, Congress added a new unfair labor practice provision (Section 8(g) prohibiting a labor organization from engaging in a strike or picketing without first giving a ten-day written notice. If a labor organization engages in an action in violation of the strike notice requirements, this would constitute an unfair labor practice. Furthermore, the failure to give the required notice could be subject to a Section 10(j) injunction. While the total number of 8(g) notices is unclear, in 65 per cent of all Board of Inquiry situations a strike notice had been given, but a strike occurred in only 13 per cent of the cases.

Solicitation and Distribution Rules

In general, solicitation and distribution rules relate to union organizing efforts. An employer with a broad policy

prohibiting employees from soliciting union support or distributing union literature in all areas of a facility may be found guilty of an unfair labor practice in violation of Section (8)(a)(1) of the National Labor Relations Act, resulting in the setting aside of an election which the union lost.

The Board's traditional position has been that an employer may not lawfully adopt a rule prohibiting employee solicitation of union support during nonworking time, or prevent the distribution of union literature during nonworking time in nonwork areas, absent special circumstances. The hospitals' position is that because of their unique status in providing services to the ill and the infirm, a special rule should be applicable to such institutions that would permit them to prohibit solicitation and distribution by employees on their nonwork time in all areas to which the public and patients have access.

Subject Matter of Bargaining

Unfair labor practices issues under the health care amendments also relate to refusal to bargain under Section 8(a)(5) and 8(b)(3). The chief issues concern matters related to patient care and whether these constitute mandatory subjects of bargaining, or instead are reserved solely to management rights. This question is addressed frequently by professional employees.

Board rules and court decisions are having profound impact on some of the unions who are finding it necessary to accommodate by changing internal policies, seeking legislative amendments, or forming alliances.

Contract Developments

Basically, most of the contracts in health care are similar to all industry. The duration of contracts is shorter and the contracts often contain clauses related to training time, joint committees, and patient care issues. These items are particularly important among professional associations.

Initial contracts are traditionally more difficult to negotiate. This appears to be a major hurdle in health care where approximately 30 per cent of the bargaining involves initial contracts.

Third Party Payers

The third party payer issue exists in New York State, Maryland, New Jersey, and nine other states with cost containment authority. Bargaining is generally extended three to six months, settlement size is smaller, and bargaining may be perfunctory. As cost containment becomes more of an issue the impact on the traditional bargaining relationship will be seen.

Conclusions

The major conclusion of this study is that the amendment of the National Labor Relations Act as stated in Public Law No. 93-360 did have a significant impact on labor management relations in the health care industry.

Hypothesis I

Hypothesis I stated there would be a substantial increase in the number of election petitions filed with the National Labor Relations Board and a corresponding increase in the number of elections conducted by the National Labor Relations Board in the health care industry.

The two years prior to the passage of the amendment show 404 petitions and 414 petitions for representation being filed in 1972 and 1973 respectively. The numbers increases substantially in 1975 to 1,451 and in 1976 the figure was 1,138. In the two years prior to the amendment the total representation elections held by the NLRB were around 250 per year. In 1975 this increased to 579, and in 1976 the figure rose to 710 representation elections in the health care industry.

Hypothesis II

Hypothesis II stated there would be an increase in the number of cases submitted to the National Labor Relations Board related to bargaining unit determination; professional health care associations would plea for separate bargaining units.

The problem of bargaining and determination in health care is still of concern to the Board. Due to the Congressional mandate to avoid proliferation of bargaining units, the Board waited to make a determination until the Mercy Hospital and Barnett cases were determined on May 5, 1975. The Board had prior to the amendment used individual guidelines and determined cases on an individual basis. The new guidelines for health care bargaining units established five separate units of which registered nurses are the only group of professionals entitled to an individual unit. Several professional groups have disagreed with the guidelines established by the Board and many cases are pending.

Hypothesis III

Hypothesis III stated that there would be a significant increase in the number of unfair labor practice charges filed with the National Labor Relations Board in the health care industry.

Between July, 1970 and August, 1973, less than thirty-six decisions were rendered by the Board involving unfair labor practices charges in hospitals, nursery homes, or extended care facilities. By the time of the amendment's passage, health care unfair labor practice charges represented 2 per cent of the total NLRB caseload. This increased to 5 per cent by 1976. The actual number of cases increased 159 per cent from 549 in the 1974 fiscal year to

1,423 in the 1975 fiscal year. From 1974 to 1976, there was an increase of 213 per cent, equaling 1,721 cases. This can be compared to the 25 per cent increase for all industries.

Hypothesis IV

Hypothesis IV stated there would be substantial activity by the Federal Mediation and Conciliation Service in assisting the parties in contract negotiations.

The FMCS had participated in only 140 health care cases totally at the time the amendment became effective. In the two years following the amendment, the cumulative total had reached almost 3,000 cases and by May, 1977, almost 4,000 cases.

Boards of Inquiry are appointed by FMCS to assist in impasse resolutions. From August 25, 1974 to May 1, 1977, 134 Boards of Inquiry and special fact finders had been appointed.

Due to the special provisions of the law such as mandatory mediation and increased notification time units, a high caseload is expected to continue.

Recommendations

Although this study was designed to offer an overview of collective bargaining prior to the passage of the 1974 amendments, and provide a statement of the impact in the

subsequent years, continued research will be required. The first year following enactments of the amendments provided the initial adjustment period during which agencies administering the law and the parties to whom the legislation is directed sought to test its intent. This initial period occurred quite noticeably during the first year of the health care amendments, although additional forms of exploration into the act's intent and union accommodations were observed in the subsequent two years.

This study provides a basis on which to judge the impact of the amendments five to ten years hence. When collective bargaining in the health care industry completes its initial phase, one might expect: (1) NLRB questions to be less frequent, (2) a decline in the rate of organizing, (3) parties encountered at the bargaining table to be more experienced with collective bargaining, (4) issues to be more clearly defined, and (5) greater willingness to form associations for bargaining.

In addition to a longitudinal follow-up, further research should be undertaken in a number of topics which were excluded from this study. One area requiring further investigation involves the interrelationship between public and private institutions bargaining in a geographic area. Another area omitted from this study, but one that requires exploration, is the role of the American Hospital Association, its state

affiliates and other health care management associations and their role in the bargaining process, pre- and post 1974. It would also be valuable for the practitioner to know researchers' objective findings on the impact of a strike on patient care. Almost all research has been confined to a study of hospitals, and while this study covers all types of health care facilities, special attention should be devoted to the state of bargaining in nursing homes. These are only a few of the important areas of research to be considered for the future.

In retrospect, the first years have been eventful, National Labor Relations Board and court cases, administrative decisions, increased organizing activities, internal union changes and appointments of Boards of Inquiry are the primary developments to surface. In addition, a new discipline, industrial relations in the health care industry, new publications with an orientation to developments in the field, a surge of seminars, workshops, consultant services as well as research, have emerged to focus on bargaining in the health care industry. Hopefully, this activity will improve the collective bargaining process and compress the initial adjustment period.

BIBLIOGRAPHY

Books

- Aboduly, John E., The NLRB and the Appropriate Bargaining Unit, Philadelphia, Wharton School of Finance and Commerce, 1971.
- Alutto, Joseph A., "The Professional Association and Collective Bargaining: The Case of the American Nurses Association," Administering Health Systems Issues and Perspectives, Chicago, Aldine, 1971.
- American Hospital Association, Taft-Hartley Amendments: Implications for the Health Care Field. Report of a Symposium, Chicago, 1976.
- American Arbitration Association and Federal Mediation and Conciliation Service, Proceedings from the AHA and FMCS Conference, New York, June 10-11, 1975.
- American Nurses Association, Facts about Nursing, 74-75, Kansas City, Mo., American Nurses Association, 1976.
- _____, Facts about Nursing, 72-73, Kansas City, Mo., American Nurses Association, 1976.
- _____, House of Delegates Reports, 1974-1976, 50th Convention, Kansas City, Mo., American Nurses Association, 1976.
- _____, House of Delegates Reports, 1972-1974, 49th Convention, Kansas City, Mo., American Nurses Association, 1974.
- _____, Summary Proceedings ANA House of Delegates, 48th Convention, April 30-May 5, 1972, Kansas City, Mo., American Nurses Association, 1974.
- Anderson, Arvid, "The Structure of Public Sector Collective Bargaining," in Public Workers and Public Unions, edited by Sam Zagoria, Englewood Cliffs, N. J., Prentice-Hall, Inc., 1972.

- Bader, Albert X., "The Present Labor Law Status of Non-Profit Institutions," Proceedings of New York University 19th Annual Conference on Labor, edited by Thomas G. S. Christensen, Washington, D. C., Bureau of National Affairs, Inc., 1966.
- Baderschneider, Earl R. and Paul F. Miller, Labor Arbitration in Health Care, Holliswood, N. Y., Spectrum Publications, Inc., 1976.
- Berk, Selvester E., Hospital Economics, Lexington, Ma., D. C. Heath and Co., 1972.
- Berkeley, A. Elliot and Ann Barnes, eds., Labor Relations in Hospitals and Health Care Facilities, Washington, D. C., Bureau of National Affairs, Inc., 1976.
- Boyer, John M., Carl L. Westerhaus and John H. Goggeshall, Employee Relations and Collective Bargaining in Health Care Facilities, St. Louis, Mo., The C. V. Mosby Co., 1975.
- Burliny, Temple, The Give and Take in Hospitals: A Study of Human Organization in Hospitals, New York, G. P. Putnam and Sons, 1956.
- Coser, Rose, "Alienation of the Social Structure: A Case Analysis of a Hospital," The Hospital in Modern Society, New York, Macmillan, 1963.
- Durbin, Richard L. and W. Herbert Springall, Organization and Administration of Health Care: Theory, Practice, Environment, St. Louis, Mo., C. V. Mosby Co., 1969.
- Epstein, Richard L. "Labor Relations in Hospitals and Health Care Facilities before the National Labor Relations Act Amendments: Proprietary versus Nonprofit Hospitals," Proceedings: Labor Relations in Hospitals and Health Care Facilities, Washington, D. C., Bureau of National Affairs, 1976.
- Elkouri, Frank and Edna Asper Elkouri, How Arbitration Works, Washington, D. C., Bureau of National Affairs, 1974.
- Feldstein, Martin S., "The Medical Economy," Life and Death in Medicine, San Francisco, W. H. Freeman and Co., 1973.
- Flanagan, Lyndia, ed., One Strong Voice: The Story of the American Nurses Association, Kansas City, Mo., The Lowell Press, 1976.

- Gamm, Sara, Toward Collective Bargaining in Non-Profit Hospitals: Impact of New York Law, Bulletin 60, Ithaca, N. Y., Cornell University, New York State School of Industrial and Labor Relations, 1968.
- Golodner, Jack, "Collective Bargaining in Voluntary Non-Profit Institutions," Collective Bargaining Today, Proceedings of the Collective Bargaining Forum, Washington, D. C., Bureau of National Affairs, 1970.
- Harrington, Michael, The Retail Clerks, New York, John Wiley, Inc., 1962.
- Hepner, James O., John M. Boyer and Carl L. Westerhaus, Personnel Administration and Labor Relations in Health Care Facilities, St. Louis, C. V. Mosby Co., 1969.
- Hepton, Estelle, Battle for the Hospitals: A Study of Unionization in Non-Profit Hospitals, Bulletin 49, Ithaca, N. Y., Cornell University, New York State School of Industrial and Labor Relations, 1963.
- Industrial Relations Research Association, Proceedings of the 19th Annual Winter Meeting, San Francisco, 1966.
- _____, Proceedings of the 21st Annual Winter Meeting, Chicago, 1968.
- _____, Proceedings of the 22nd Annual Winter Meeting, New York, 1969.
- _____, Proceedings of the Annual Spring Meeting, Tucson, Arizona, 1977.
- Killingsworth, Charles C., State Labor Relations Act: A Study of Public Policy, Chicago, The University of Chicago Press, 1948.
- Kobs, Dennis R., A Guide to Employer-Employee Relations, St. Louis, Catholic Hospital Association, 1974.
- Knatt, Andria S., ed., Labor Relations Law Problems in Hospitals and the Health Care Industry, Washington, D. C., American Bar Association, 1977.
- Laudicina, Susan S., Prospective Reimbursement for Hospitals: A Guide for Policymakers, New York, Department of Public Affairs, Community Service Society of New York, 1976.
- Law, Sylvia, Blue Cross: What Went Wrong?, New Haven, Ct., Yale University Press, 1976.

- Metz, Harold W., Labor Policy of the Federal Government, Washington, D. C., The Brookings Institution, 1945.
- Metzger, Norman and Dennis D. Pointer, Labor-Management Relations in the Health Service Industry: Theory and Practice, Washington, D. C., Science and Health Publications, 1972.
- Miller, Ronald U. and others, The Impact of Collective Bargaining in Hospitals: A Three State Study, Madison, Wi., Industrial Relations Research Institute, University of Wisconsin, 1977.
- Millis, Harry A. and Emily Clark Brown, From the Wagner Act to Taft-Hartley: A Study of National Labor Policy and Labor Relations, Chicago, University of Chicago Press, 1950.
- Pinsky, David and others, Labor Relations in Connecticut Health Institutions, Bridgeport, Ct., Labor Education Center, University of Connecticut, 1973.
- Pointer, Dennis Dale, Unionization Collective Bargaining and the Non-Profit Hospital, Iowa City, Iowa, Center of Labor and Management, College of Business Administration, The University of Iowa, 1969.
- Rehmus, Charles M., Fact Finding and the Public Interest, An Occasional Paper from the Institute of Public Employment, Ithaca, N. Y., New York State School of Industrial and Labor Relations, Cornell University, 1974.
- Rosmann, Joseph, Implications of Third-Party Cost Control Efforts for the Collective Bargaining Process in the Hospital Industry, Chicago, Department of Employee Relations and Training, American Hospital Association, 1976.
- Rothman, William S., A Bibliography of Collective Bargaining in Hospitals and Related Facilities, 1959-1968, Ann Arbor, Mi., The University of Michigan-Wayne State University, 1970.
- _____, A Bibliography of Collective Bargaining in Hospitals and Related Facilities, 1969-1971, Ann Arbor, Mi., The University of Michigan-Wayne State University, 1972.
- _____, A Bibliography of Collective Bargaining in Hospitals and Related Facilities, 1972-1974, Ithaca, N. Y., New York State School of Industrial and Labor Relations, Cornell University, 1976.

- Royal Commission Report on Compulsory Arbitration in Disputes Affecting Hospital and their Employees, Ontario, 1964.
- RWDSU, AFL-CIO, Proceedings of the 11th Constitutional Convention, Bal Harbour, Florida, 1970.
- _____, Proceedings of the 12th Constitutional Convention, Bal Harbour, Florida, 1974.
- Somer, Anne R., Hospital Regulations: The Dilemma of Public Policy, Princeton, N. J., Industrial Relations Section, Princeton University, 1969.
- Somer, Herman M. And Anne R. Somer, Doctors, Patients, and Health Insurance, Washington, D. C., The Brookings Institute, 1970.
- Southwestern Legal Foundation, Labor Law Developments 1977, Proceedings of 23rd Annual Institute on Labor Law, New York, Matthew Bender, 1977.
- _____, Labor Law Development 1976, Proceedings of the 22nd Annual Institute on Labor, New York, Matthew Bender, 1976.
- Stark, Arthur, "Fact Finding in Labor Disputes," New York University Fifth Annual Conference on Labor, New York, Matthew Bender Co., 1952.
- Steiber, J. W., Ten Years of the Minnesota Labor Relations Act, Minneapolis, University of Minnesota Press, 1949.
- Vladeck, Judith, "Collective Bargaining in Voluntary Hospitals and Other Non-Profit Operations," Proceedings of New York University 19th Annual Conference on Labor, Washington, D. C., Bureau of National Affairs, Inc., 1966.
- Vladeck, Stephen C., "History of Labor Relations in Health Care Facilities Prior to the Health Care Amendments to the NLRA in 1974," presented at the Retail Clerks Attorneys Conference, September, 1976.
- Vosloo, William B., Collective Bargaining in the United States Civil Service, Chicago, Public Personnel Association, 1961.
- Weaver, Jerry L., Conflict and Control in Health Care Administration, Beverly Hills, California, Sage Publications, Inc., 1975.

Werther, William B., Jr. and Carol A. Lockhart, Labor Relations in the Health Professions: The Basis of Power. The Means of Change, Boston, Little, Brown and Co., Inc., 1976.

Wolfbein, Seymour, Emerging Sectors of Collective Bargaining, Morristown, N. J., General Learning Press, 1970.

Zubkoff, Michael, ed., Health: A Victim or Cause of Inflation?, New York, Neale Watson Academic Publications, Inc., 1976.

Articles

Abelow, William J. and Norman Metzger, "Multi-Employer Bargaining for Health Care Institutions," Employee Relations Law Journal, 1 (Winter, 1976), 395-397.

"Active CAP Program by State," Bedside Nurse (October, 1970), 7.

"Administrative Judge Upsets Hospital Solicitation Ban," Health Labor Relations Report, 1 (November 29, 1976), 2-3.

AFL-CIO Spokesman Urges Nonprofit Hospital Law," Service Employees, 33 (November, 1973), 4.

AFL-CIO, Teamsters Team Up to Organize Chicago Hospital Employees," Hospitals, 40 (November 16, 1966), 19.

"AHA Urges Prompt Dismissal of Pharmacy Petitions for Separate Bargaining Unit Representation," Hospitals (May, 1976), 16-18.

"AHA Urges Broad No-Solicitation/No Distribution Rules," Hospitals (January, 1976), 16-17.

"AHA Research Capsules--No. 6," Hospitals, 46 (April 1, 1972), 216-218.

Allen, A. D., "Systems View of Labor Negotiations," Personnel Journal, L (February, 1971), 103-114.

"Ambulance Drivers Union Cancels Strike Following Intervention by Mediators," The Modern Hospital, 50 (May, 1938).

"The ANA: Can a Professional Association be a Trade Union, Too?" Hospitals, XLVIII (September 1, 1974), 103-115.

- "The ANA Economic Security Program," American Journal of Nursing, 47 (February, 1947), 70-73.
- "Anti-Labor Amendment Threatens Hospital Bill," Service Employees, 34 (July, 1974), 11.
- "Appeals Court Waters Down NLRB Solicitation Rule," Health Labor Relations Report, 1 (May 16, 1977), 6-7.
- Applebaum, Alan L., "The Meaning of the New York Strike," Hospitals, XLIX (April 16, 1975), 17.
- _____, "Third Party Payers Gain Most from Arbitrated Labor Dispute," Hospitals, 50 (November 16, 1976), 72-76.
- "Arbitration Board Gives Seattle Hospitals Fair Deal in Settling Labor Controversy," The Modern Hospital, 49 (November, 1937), 106.
- Arnold, Pam and Jim Loveless, "ANA in Action: Implications of Economic and General Welfare Program, Past, Present, Future," The American Nurse (November, 1974), 11-14.
- Ashman, Maude Lanis, "I Lived Through a Strike," The Modern Hospital, 51 (November, 1938), 94-96.
- "Ask Union Rights in Hospitals," Service Employees, 32 (September, 1972), 3.
- Bachmeyer, Arthur C., "Looking at Labor Unions," The Modern Hospital, 49 (August, 1973), 51-53, 77.
- Baird, William M., "Barriers to Collective Bargaining in Registered Nursing," Labor Law Journal (January, 1969), 42-46.
- "Bargaining Rights for House Staff Gain Momentum in Congress," Health Labor Relations Report, 1 (April 18, 1977), 1-3.
- "Bargaining Rights Upheld," PNHA Update, 1 (October 15, 1976), 1.
- Bernstein, Arthur H., "Hospitals and Labor Laws," Hospitals, 47 (December 1, 1973), 110-112.
- Bice, Michael O., "Building a Data Base," Hospitals, 48 (June, 1974), 77-80.

- "Bill Placing Nonprofit Hospitals Under the Taft-Hartley Act, sent to the President by House," Daily Labor Report (July 11, 1974), A13-A15.
- Billington, Glenn E., "Hospitals, Unions, and Strikes," Cleveland-Marshall Law Review, 48 (January, 1969), 70-81.
- "Birth of a District," 1199 News (June, 1977), 5.
- "Bitter Strike Brings 22.8 Percent Boost for California Nurses Over Three Years," Health Labor Relations Report, 1 (September 19, 1977), 5.
- "BNA Survey on Organizing of Health Care Institutions (and Comment)," Daily Labor Report (May 14, 1975), D1-D8.
- "Board Panel Includes RN's, Nurse Practitioners in Bargaining Unit," White Collar Report, BNA, No. 973 (November 28, 1975).
- "Brennan Endorses Bill Covering Employees of Nonprofit Hospitals," Daily Labor Report (February 7, 1974), A3-A4.
- Brody, Paul E. and Jordon London, "How Costly is a Strike?" Hospitals, XLIX (September 16, 1975), 53-55.
- "Brooklyn Strike Brings Pact for 642 Nurses," Health Labor Relations Report, 1 (September 19, 1977), 6.
- Bruner, Ray, "Toledo Plan: Supported by Hospitals and Labor," The Modern Hospital, 93 (July, 1959), 76-77.
- Burton, John F., Jr., "Local Government Bargaining and Management Structure," Industrial Relations, 2 (May, 1972), 123-140.
- "California Nurses' Contract Gives 22.8 Percent Boost," Health Labor Relations Report, 1 (September 19, 1977), 5.
- Carlson, Duane R., "Minnesota's Pioneer Hospital Labor Act: Model or Mistake?" Modern Hospital, 104 (May, 1965), 106-110.
- Chamot, Dennis, "Professional Employees Turn to Unions," Harvard Business Review, LIV (May-June, 1976), 119-127.
- Cherkasky, Martin, "Why We Signed a Union Agreement," The Modern Hospital, 93 (1959), 69-70.
- "Chicago Hospitals Ask Legal Opinion on Strikes," The Modern Hospital, 49 (October, 1937), 118.

- Christopher, W., "Hospitals and Unions Come to Grips," Hospital Topics (May, 1974), 21.
- Clark, Groner M., "The Unionization of Hospital Professionals," Personnel, XLVII (July-August, 1970), 40-46.
- Clark, Russell J. and Annette Auld, "The Hospitals and Collective Bargaining," Hospitals, 24 (June, 1950), 37-43.
- Cleland, Virginia, "Taft-Hartley Amended: Implications for Nursing--The Professional Model," American Journal of Nursing, 75 (February, 1975), 288-292.
- Cobler, Sharon, "Nurses to Discuss Standards, Politics," Dallas Morning News, August 15, 1975.
- Coleman, Francis T. and Louis Sperling, "NLRB Unit Determinations Expanding," Hospital Progress, LVII (August, 1976), 43-46, 66.
- "Collective Bargaining Law for Nurses Passed by Oregon State Legislature," The Modern Hospital, 97 (October, 1961), 162.
- "Collective Bargaining: What is Negotiable?" American Journal of Nursing, 69 (September, 1969), 1892-1895.
- "Comments of General President Turner on April 6, 1976 at the 30th IOUE Convention," The International Engineers (June, 1976), 56-57.
- "Compromise Bill on NLRA Coverage of Nonprofit Hospital Employees Offered," Daily Labor Report (March 4, 1974), A9-A10.
- "Connecticut Nurses Association Withdraws from NLRB Election at Psychiatric Hospital," White Collar Report (October 8, 1976), A4-A5.
- "Connecticut Nurses Reported Defecting from Association," Health Labor Relations Report, 1 (November 15, 1976), 4.
- "Contract Negotiations Reviewed," Oregon Nurse Association (November, 1975), 4.
- Contuzzi, Peter J., "The Role of the President in National Emergency Disputes," ILR Research, 13 (May, 1967), 13-14.
- "County Employees Vote to Join SEIU," AFL-CIO News (June 1, 1974), 8.

- "Court Overturns NLRB Bargaining Decision," Health Labor Relations Report, 1 (November 15, 1976), 6-7.
- "Court Reverses NLRB Against Nurses Union," The Evening Sun, Baltimore (September 9, 1977), 3.
- "Court Rules Health Workers Have Legal Right to Strike," Health Labor Relations Report, 1 (October 3, 1977), 8.
- "Court Rules Pennsylvania Interns and Residents are Students, Not Public Employees Under PERA," Government Employee Relations Report (December 2, 1974), B1-B2.
- "Court Strikes Down Hospital's Ban on Union Organizing Activity," Health Labor Relations Report, 1 (October 31, 1977), 1-2.
- Crain, Rance, "Hospitals Tough on Benefits," Modern Health Care, VI (October, 1975), 20.
- Crispo, John, "Collective Bargaining and the Professions," Canadian Hospital, 40 (June, 1963), 47-49.
- Cruikshank, Nelson H., "The Case for Unionization of Hospital Workers," The Modern Hospital, 93 (July, 1959), 71-72.
- Davis, Karen, "Theories of Hospital Inflation: Some Empirical Evidence," Journal of Human Resources, 8, No. 2 (Spring, 1973), 181-201.
- Davis, Leon J., "Local 1199: Union Power Plus Soul Power," New Physician, XX (May, 1971), 312-317.
- "A Decision to Act," Editorial, Bedside Nurse (September/October, 1969), 37.
- "Denial of Bargaining Rights Spurs Court Test by House Physicians," Health Labor Relations Report, 1 (March 21, 1977), 4.
- "Divided NLRB Reiterates View Precluding Housestaff Bargaining," White Collar Report (June 3, 1977), A4.
- Doane, Joseph C., "Personnel Relations," Hospitals 11 (September, 1937), 15-19.
- "Doctors, Nurses, Teachers--Why More are Joining Unions," U.S. News and World Report (November 10, 1975), 61-62.
- Dowling, William L., "Perspective Reimbursement of Hospitals," Inquiry, 9 (September, 1974).

- Dunlap, Karen, "Alternative Techniques: Mediation-Arbitration: Reaction from Rank and File," Monthly Labor Report, 96 (September, 1973), 65-66.
- "Effects of Unionization Stir Concern," American Medical News, XVII (August 26, 1974), 1.
- Emanuel, William J., "Hospital Policy: Professional Associations as Unions," Hospital Progress, LVII (January, 1976), 51-56.
- _____, "Nonprofit Hospitals and the NLRA Exemption," Hospital Progress, 54 (January, 1973), 69.
- "The Employees Demands," The Modern Hospital, 49 (November, 1937), 41.
- "The Employees Unions," The Modern Hospital, 49 (November, 1937), 124.
- Engel, G. V. and M. L. Schulman, "Relationship of Unionization to Professionalism in Medicine," Journal of Medical Education, LI (February, 1976), 132-134.
- Epstein, Richard L., "Employee Relations," Hospitals, XLIX (April 1, 1975), 75-77.
- _____, and Bruce Stickler, "The Nurse as a Professional and a Unionist," Hospitals, L (January 16, 1976), 44-48.
- "Era of Medical Unionism Dawning," Hospital Progress (June, 1976), 32.
- "Exemption of Nonprofit Hospitals Employees from the National Labor Relations Act: A Violation of Equal Protection," Iowa Law Review, 57 (December, 1971), 412-443.
- "Extension of Taft-Hartley Act to Nonprofit Hospitals Predicted," Daily Labor Report (February 7, 1974), A3-A4.
- Falberg, W. C., "Resisting Union Organizing Attempts," Hospital Topics, L (January, 1972), 30.
- Fanning, John H., "Address to New York University's 29th Annual Conference on Labor," Daily Labor Report (May 21, 1976), D1-D5.
- Farwell, Raymond F., "The Hospital's Side of a Hospital Strike," The Modern Hospital, 93 (July, 1959), 63-68.

- "Federal Court Gives State Jurisdiction Over Interns,"
Health Labor Relations Report, 1 (February 7, 1977),
2-5.
- "Federal Court Reverses NLRB in Hospital Construction Case,"
Health Labor Relations Report, 1 (February 21, 1977),
2-3.
- Feheley, Lawrence F. and Joseph M. Millious, "New Developments
in the Law Concerning Labor Relations in Health Care In-
stitutions: Will Treatment on the Operating Table be
Dominated by Pressures at the Bargaining Table?" Ohio
Bar, 47 (November 18, 1974), 1411-1436.
- Feldstein, Martin S., "Hospital Cost Inflation," The American
Economic Review, 61 (December, 1971).
- Finandis, Nicholas, "Address to New York University's 29th
Annual Conference on Labor," Daily Labor Report (May 21,
1976), D5-D7.
- Flath, Carl I., "Hospitals and the Labor Movement," Southern
Hospitals (July, 1960), 24-30.
- Fleishman, Raymond, "Living with a Contract," Hospitals, XLVII
(November 16, 1973), 51-54.
- Foley, Margaret, "Nursing News and Notes: Collective Bar-
gaining Law for Nurses Passed," Hospital Progress, 42
(July, 1961), 12.
- Folkes, David A. and S. David Promriose, "Preparations for a
Potential Strike," Hospitals, XLVII (September 16, 1973),
51-55.
- Fottler, Myron D., "The Union Impact on Hospital Wages,"
Industrial and Labor Relations Review, 30 (April, 1977),
342-345.
- Freeman, John R., "You Can Too Learn To Live with Unions,"
The Modern Hospital, 103 (November, 1964), 95.
- French, Wendell L. and Richard Robinson, "Collective Bar-
gaining by Nurses and Other Professionals: Anomaly or
Trend?" Labor Law Journal (October, 1960), 903-910, 944.
- Gambs, John S., "Hospitals and the Unions," Survey Graphic,
26 (August, 1937), 435-439.

- Gershenfield, Walter J., "Organization and Bargaining in Hospitals," Monthly Labor Review, 91 (July, 1968), 51-52.
- Gibson, Robert and Marjorie Smith Mueller, "National Health Expenditures, Fiscal Year 1976," Social Security Bulletin, 40 (April, 1977), 3-22.
- Gillingham, J. B., "Collective Bargaining and Professional Ethics," American Journal of Nursing, 50 (April, 1950), 214-216.
- "Goals and Trends in the Unionization of Health Professionals," Hospital Progress, LIII (February, 1972), 40-43.
- Goodfellow, Matthew, "If You Aren't Listening to Your Employees, You May be Asking for a Union," Modern Hospital, CXIII (October, 1969), 88-90.
- Gordon, Murray A., "Hospital Housestaff Collective Bargaining," Employee Relations Law Journal, 1 (Winter, 1976), 418-438.
- Gotbaum, Victor, "Influence of the Labor Movement on Hospital Affairs," Hospitals, 44 (January, 1970), 72-76.
- Gottlieb, Sanford, "How Unions are Doing in Hospitals Campaigns," The Modern Hospital, 94 (March, 1960), 109-111, 164.
- Grant, R. A., "Professional vs. Administration," Canadian Hospital (July, 1973), 22-23.
- Hacker, Bruce, "Organizational Systems for Change Offer an Alternative to Unions," Hospitals (December, 1976), 1, 45.
- Hague, J. E., "AMA Does An About-Face on Collective Bargaining," Hospital Medical Staff, V (February, 1976), 28-31.
- Hare, Arthur, "Hospitals and Unions in Harmony," Modern Hospital, (February, 1943), 74.
- Hart, Joseph K., "Economic Security for Nurses," American Journal of Nursing, 38 (April, 1938), 391-395.
- _____, "Drift--Conflict--or Education," American Journal of Nursing, 38 (May, 1938), 544-548.
- Health/Labor-Management Services, Inc., Health/Labor Management Report, Vol.2, No. 9, 1974.

- Henderson, Laura, "Hospitals vs. Unions," Dallas Times Herald (November 13, 1974), 1.
- Hobart, Christine L., "Collective Bargaining with Professionals: Conflict, Containment or Accommodation?" Health Care Management Review, 1 (Spring, 1976), 7-16.
- Holloway, Sally T., "Health Professionals and Collective Action," Employee Relations Law Journal, 1 (Winter, 1976), 410-417.
- "Honolulu Nurses End Nineteen Day Strike," Hospitals (March, 1976), 1, 23.
- "Hospitals and Labor Unions," Hospitals, 11 (August, 1937), 75.
- "Hospitals and Organized Labor," Hospitals, 11 (May, 1937), 71.
- "Hospital Bill Approved by Senate Committee is Introduced in House," Daily Labor Report (March 22, 1974), A8-A9.
- "Hospitals Face the Knife," Business Week (September 6, 1976), 68-69.
- "Hospital-Labor Troubles Are Renewed in Some Sections: Months on the Whole is Quiet," The Modern Hospital, 49 (December, 1937), 110.
- "Hospital Law Enacted," Service Employees, 43 (August, 1974), 6-7.
- "Hospital Law In Effect: SEIU Honored for Its Role," Service Employees, 34 (September, 1974), 3.
- "Hospital Organizing: Special Report," BNA Bulletin to Management, No. 1318 (May 15, 1975), 1-8.
- "Hotline," Texas Nursing (January, 1975), 4; (February, 1975), 3, 4; (March, 1975), 23, 27; (April, 1975), 5; (May, 1975), 3, 4; (June, 1975), 3, 4, 5.
- "House Passes Measures Putting Nonprofit Hospitals Under NLRA," Daily Labor Report (May 31, 1974), A15-A20.
- "House Staff Are Students, Not Employees," National Labor Relations Board Rules, Hospitals, 1 (April 16, 1976), 17.

- "Housestaff Association Sues to Overturn NLRB's Denial of Bargaining Rights," Health Labor Relations Report, 1 (March 21, 1977), 4.
- "House-Staff Bargaining Again Rejected by NLRB," Health Labor Relations Reports, 1 (June 13, 1977), 2-3.
- Hurd, Richard W., "Equilibrium Vacancies in a Labor Market Dominated by Nonprofit Firms: The 'Shortage' of Nurses," The Review of Economics and Statistics, 55, No. 2 (May, 1973), 234-240.
- Hyatt, James C., "Organizing Workers in Nonprofit Hospitals Begins: More Likely to Boost Wage Costs," The Wall Street Journal (July 29, 1974), 22.
- "If a Hospital Strike Occurs," American Journal of Nursing (March, 1960), 344-347.
- Iglehart, John K., "Senator Taft 'Vetoes' Taft-Hartley Amendment," Hospital Progress, 53 (October, 1972), 21.
- Imberman, H. A., "Communications: An Effective Weapon Against Unionization," Hospital Progress, LIV (December, 1973), 54-57.
- "Industrial Relations Research Association, Proceedings of the 1977 Annual Spring Meeting," Labor Law Journal, 28.
- "Industrial Union Precedents Spread to Health Care Industry," Hospital Practice, X (August, 1975), 111-114.
- Jacox, Ada K., "Who Defines and Controls Nursing Practice?" American Journal of Nursing, 69, No. 5 (May, 1969), 977-982.
- "Joint Explanatory Statement of the Committee of Conference on Nonprofit Hospital Bill Alter Two House Amendments," Daily Labor Report (June 26, 1974), A16-A18.
- Judge, Diane, "The New Nurse: A Sense of Duty and Destiny," Modern Healthcare, 2, No. 4 (October, 1974), 21-28.
- Juris, Hervey, "Employee Discipline No Longer Management Prerogative Only," Hospitals, 51 (May 1, 1977), 69-74.
- _____, "Labor Agreements in the Hospital Industry: A Study of Collective Bargaining Outputs," Labor Law Journal (August, 1977), 504-511.

- _____, Joseph Rossman, Charley Maxey, and Gail Betivegna, "Nationwide Survey Shows Growth in Union Contracts," Hospitals, 51 (March 16, 1977), 72-76.
- Kagel, Sam, "Alternative Techniques: Combining Mediation and Arbitration," Monthly Labor Review, 96 (September, 1973), 62-63.
- "Kaiser Hospital Technicians Give Local 1092 A-1 Rating," Retail Clerks Advocate (April, 1976), 10-11.
- "The Keewanee Story," American Journal of Nursing, 63 (October, 1961), 74-79.
- Kessler, Harold D., "Guidelines for Resolving Labor Disputes," Hospital Progress, 51 (September, 1970), 52-55.
- King, Sheldon, "Disaster Plan Guides Services During Hospital Strike," Hospitals, XLI (May 16, 1967), 68.
- Kochan, Thomas A., "A Theory of Multilateral Collective Bargaining in City Government," Industrial Relations Review, 27 (July, 1974).
- Kochery, David R. and George Strauss, "The Nonprofit Hospital and the Union," Buffalo Law Review, 9 (Winter, 1960), 255-282.
- Kralewski, John E., "Collective Bargaining Among Professional Employees," Hospital Administration, 19 (Summer, 1974), 30-41.
- Krinsky, Edward B., "Problems of Discipline and Discharge," Hospitals, XLVIII (May 16, 1974), 48-50.
- Kruger, Daniel H., "The Appropriate Bargaining Unit for Professional Nurses," Labor Law Journal, 19 (January, 1968), 3-11.
- _____, "Bargaining and the Nursing Profession," Monthly Labor Review, 84 (July, 1961), 669-703.
- _____, "Labor Relations Update," Hospitals, 49 (February, 1975), 18, 18a.
- _____, "Labor Relations Update," Hospitals, 49 (July, 1975), 18, 19.
- _____, "Labor Relations Update," Hospitals, 49 (August, 1975), 31.

- _____, "Labor Relations Update," Hospitals, 50
(January, 1976), 34-37.
- _____, "Labor Relations Update," Hospitals, 50
(February, 1976), 40.
- _____, "Labor Relations Update," Hospitals, 50
(March, 1976), 37-39.
- _____, "Labor Relations Update," Hospitals, 50
(April, 1976), 38.
- _____, "Labor Relations Update," Hospitals, 50
(May, 1976), 45-47.
- _____, "Labor Relations Update," Hospitals, 50
(June, 1976), 39, 40.
- _____, "Labor Relations Update," Hospitals, 50
(July, 1976), 34, 36.
- _____, "Labor Relations Update," Hospitals, 50
(August, 1976), 48.
- _____, "Labor Relations Update," Hospitals, 50
(September, 1976), 46, 50.
- _____, "Labor Relations Update," Hospitals, 50
(October, 1976), 64.
- "Law Changes May Be South on Timing of Inquiry Boards,"
Health Labor Relations Reports, 1 (November 14, 1977),
1-2.
- "Lee, Vincent, "46 More Nurses at Charity Hospital Agree to
Strike," The Times-Picayune, (August 13, 1975), 1.
- Lewis, Howard, "Wave of Union Organizing will Follow Break in
the Taft-Hartley Dam," Modern Health Care, 1 (May, 1974),
25-32.
- Link, M. G., "Professional Labor Organization: New York City,"
American Journal of Hospital Pharmacy, XXVII (March,
1970), 221-222.
- "Long on Funds--Short on Personnel," American Journal of
Nursing, 42 (July, 1943), 617-618.
- McCormick, William, "Labor Relations in Hospitals," American
Journal of Nursing, LXX (December, 1970), 2607.

McKelvey, Jean T., "Fact Finding in Public Employment Disputes: Promise or Illusions?" Industrial and Labor Relations Review, 22 (July, 1969), 530-543.

McLennan, Kenneth and Michael Moskow, "Multilateral Bargaining of Public Employees," Monthly Labor Review (April, 1969), 58-60.

"Maintenance Workers Walkout; Leave Hospital 'Cold' at Eight Above," The Modern Hospital, 50 (January, 1938), 108.

Matlack, D. R., "Coping with the Unionization of Health Professionals," Hospital Progress, LIII (March, 1972), 32.

"Meet the Divisions: A New Advocate Feature," Retail Clerks Advocate (August-September, 1976), 4.

"Meet the RCIA's Professional Division," Retail Clerks Advocate, 77 (June-July, 1974), 18-19.

Metzger, Norman, "Association Bargaining: The Dilemma of the Organized Hospital," Hospital Management (April, 1968), 68-76.

_____, "Collective Bargaining and the Professional Employee," Hospital Management, CXI (April, 1971), 10-11.

_____, "Compulsory Arbitration Stifles Negotiations," Hospital Progress, 51 (May, 1970), 96-104.

_____, "The Arbitration Procedure--Part One," Hospitals, XLVIII (April 16, 1974), 47-49.

_____, "The Arbitration Procedure--Part Two," Hospitals, XLVIII (May 1, 1974), 45-48.

_____, "The Case Against Compulsory Arbitration of Hospital Labor Disputes," Hospitals, 41 (January 1, 1967), 42-45.

_____, "NLRB Boards of Inquiry have been Used Sparingly," Hospitals, L (July 1, 1976), 55-57.

Miller, Jon D. and Stephen M. Shortell, "Hospitals Unionization: A Study of the Trends," Hospitals, 43 (August 16, 1969), 67-72.

- Miller, Ronald L., "Anticipate Questions, Seek Answers for Adept Labor Relations Efforts," Hospitals, L (July 1, 1976), 50-54.
- _____, "Development and Structure of Collective Bargaining among Registered Nurses," Part II of Two Parts, Personnel Journal (March, 1971), 218-225.
- _____, "Development and Structure of Collective Bargaining among Registered Nurses," Personnel Journal (February, 1971), 135.
- _____, "The Hospital-Union Relationship, Part I," Hospital-JAHA, 45 (May 1, 1971), 49-54.
- _____, "The Hospital-Union Relationship, Part II," Hospitals, 45 (May 16, 1971), 54.
- Monat, J. S., "Determination of Bargaining Power," Personnel Journal, L (July, 1971), 513-520.
- "More Than 800 Attended the 1974 Seminars," Retail Clerks Advocate, 77 (October, 1974), 2-6.
- Morgan, K. R., "Nationwide Doctor Strike? It's Unthinkable!," Medical Economics, LIII (January 12, 1976), 90.
- Munger, Mary D., "ANA Program to Promote Collective Bargaining," Hospital Topics (May, 1974), 23-24.
- Nash, Al, "Hospital Values, Conflicts and Supervisory Practices," Personnel Journal, 52 (December, 1973), 1056.
- _____, "Hospital's Value System and the Union," Hospital Administration, 19 (Fall, 1974), 49-64.
- _____, "Labor Management Conflict and Change in a Hospital," Hospital and Health Services Administration (Spring, 1976).
- "Nation's Hospitals Face Union Drive," The Modern Hospital, 93 (July, 1959), 61-62.
- "National Hospital Union Executive Board Examines Organization and Finances," 1199 News, 11 (June, 1976), 6.
- "New International Representatives Get Overview of RICA Activity," Advocate, 79 (March, 1976), 6.
- "New Support for Hospital Bargaining Rights," Service Employees, 32 (March, 1973), 3.

- "New York Court Rules Against Strikes in Hospitals," Hospitals, 11 (October, 1937), 22.
- "New York Hospital Labor Bill Passes: Similar Acts Considered in Four States," The Modern Hospital, 104 (May, 1965), 25.
- "New York Hospitals Survive a Strike," Medical World News, XIV (December, 1973), 35-36.
- "NFLPN's CAP Program," Bedside Nurse (October, 1970), 6.
- "NLRB Denies Minnesota's Request that Board Cede Jurisdiction Over Private Hospitals," Daily Labor Report (August 15, 1975), A10-A11.
- "NLRB Excludes Physicians from Professional Unit," Health Labor Relations Report, 1 (July 11, 1977), 4-5.
- "NLRB General Counsel Guidelines for Handling Unfair Labor Practice Cases Arising Under the 1974 Nonprofit Hospital Amendments to the Act," Daily Labor Report (August 23, 1974), D1-D14.
- "NLRB Ruling Keeps Interns, Residents Under Federal Law," Health Labor Relations Report, 1 (November 29, 1976), 1-2.
- "NLRB Seeks Federal Court Ban on House Staff Bargaining," Health Labor Relations Report, 1 (December 13, 1976), 4.
- "NLRB Sets Bargaining Unit Guidelines for Nonprofit Hospitals, Nursing Homes," The Wall Street Journal (May 8, 1975), 8.
- "No-Solicitation Rules of Hospitals Found Too Restrictive," Health Labor Relations Report, 1 (October 26, 1976), 10.
- "No Unionization," Hospital Management, 75 (May, 1953), 80-81.
- Noie, Nancy, "Doctors Move Beyond Medicine," Hospitals, 50 (April 1, 1976), 69-72.
- "Nonprofit Hospital Bill Nearing Enactment," Service Employees, 33 (June, 1974), 3.
- Northrup, Herbert R., "Collective Bargaining and the Professions," American Journal of Nursing, 48 (March, 1948), 141-144.
- _____, "Fact Finding in Labor Disputes: The States Experience," Industrial and Labor Relations Review, 17 (October, 1963), 114-134.

- "Nurse Membership in Unions," Editorial, American Journal of Nursing (July, 1937), 766-767.
- "Nurse on Rhode Island Staff to Help Build 1199 RN Guild," 1199 News (February, 1977), 20.
- "Nurses Association Join Unions," RWDSU Record (January, 1976), 4.
- "Nurses' Strikes," American Journal of Nursing, 12 (October, 1911), 2.
- "Nurses Strike Seattle Hospitals," Hospitals (September, 1976), 1, 18.
- "Nurses Strike Six Honolulu Hospitals," Hospitals (February, 1976), 16-21.
- "Nurses' Unions?" American Journal of Nursing, 36 (November, 1936), 1122-1123.
- "Nursing Home Employees Organize!," Retail Clerks Advocate, 77 (March, 1974), 11-15.
- "Nurse Strike is Still Likely," The States Item--New Orleans, (August 12, 1975), A-10.
- "N. Y. Strike Ends; Terms Include Worker Representation but not Union Recognition," The Modern Hospital, 93 (July, 1959), 60.
- "N. Y. Union Opens Drive to Collect Strike Fund," Health Labor Relations Reports 1 (February 21, 1977), 1-2.
- "O. R. Nurse--Betwixt Union and Management," Hospitals, 48 (May 1, 1974), 77-81.
- "Organizing Material Prepared by Council of AFL-CIO Unions for Professional Employees," White Collar Report (June 10, 1977), D1-D7.
- Osterhaus, Leo B., "The Effect of Unions on Hospital Management," Hospital Progress, 48 (June, 1967), 90.
- _____, "Patterns of Union-Management Relationship, Part I," Hospital Progress, 48 (June, 1967), 68-73.
- _____, "Factors Stimulating and Inhibiting Unions, Part II," Hospital Progress, 48 (July, 1967), 76-80.

- _____, "Survey of Ten Policies and Practices in Four Metropolitan Areas, Part III," Hospital Progress, 48 (August, 1967), 90-95, 128-130.
- _____, "Recommendations and Conclusions, Part IV," Hospital Progress, 48 (September, 1967), 72-78.
- _____, "Union-Management Relations in 30 Hospitals Change Little in Three Years," Hospital Progress, 49 (October, 1968), 72-77.
- Oswald, Rudy, "A Voice for Hospital Workers," American Federationist (January, 1975), 14-17.
- Parker, Hyman, "The Laws Governing Labor-Management Relations in Michigan Hospitals," Labor Law Journal, 12 (October, 1961), 174-175.
- "Pennsylvania Supreme Court Overturns Prior Ruling, Finds Interns and Residents are Not Public Employees," Government Employees Relations Report (July 26, 1976), B1-B3.
- Petty, Roy, "After Four Years, PHNA Looking More Like a Trade Union," American Medical News (May 10, 1976), 3.
- "Pharmacists Affiliate To RCIA," Retail Clerks Advocate, 77 (November, 1975), 10.
- Phillips, Donald F., "The California Physician's Strike," Hospitals, 49 (August, 1975), 49-52.
- _____, "Cook County Hospital: Politics and Power Plays," Hospitals, 50 (March, 1976), 101-103.
- _____, "Taft-Hartley: What to Expect," Hospitals, 48 (July 1, 1974), 18a-18d.
- "Physicians Sue to Gain Employee Status," PNHA Update, 2 (April 1, 1977), 3.
- "The Plight of Nonprofit Hospital Employees," The Laborer (November, 1973), 9.
- Pointer, Dennis Dale, "Hospital Labor Relations Legislation: An Examination and Critique of Public Policy," Hospital Progress (January, 1973), 71-76.
- _____, "Catholic Hospitals' Dual Nature Complicates Labor Relations Strategy," Hospital Progress (February, 1976), 58.

- _____, "Hospitals and Professionals--A Changing Relationship," Hospitals, 50 (October 16, 1976), 117-121.
- _____, "The Labor Law Status of Health Care Facilities Part I: The Wagner Act," Hospital Progress, 51 (September, 1970), 44-47.
- _____, "The Labor Law Status of Health Care Facilities Part 2: The Taft-Hartley and Landrum-Griffin Acts," Hospital Progress, 51 (October, 1970), 83-86.
- _____, "The Labor Law Status of Health Care Facilities Part 3: Proprietary Hospitals, Nursing Homes, and State and Federal Government Hospitals," Hospital Progress, 51 (November, 1970), 72-75.
- _____, "The Federal Labor Law Status of the Health Care Delivery Industry," Labor Law Journal, 22 (May, 1971), 278-286.
- _____, "Toward A National Hospital Labor Relations Policy: An Examination of Legislative Exemption," Labor Law Journal, 23 (April, 1972), 238-248.
- _____, "How the 1974 Taft-Hartley Amendments will Affect Health Care Facilities--Part 1," Hospital Progress, 55 (October, 1974), 68-70.
- _____, "How the 1974 Taft-Hartley Amendments will Affect Health Care Facilities--Part 2," Hospital Progress, 55 (November, 1974), 58-61.
- _____, "Prospects for Removing the Taft-Hartley Exemption," Hospital Progress, 55 (March, 1974), 43-45.
- _____, "The 1974 Health Care Amendments to the National Relations Act," Labor Law Journal, 26 (June, 1975), 350-359.
- _____ and Harry Graham, "Recognition, Negotiation and Work Stoppages in Hospitals," Monthly Labor Review, XLIV (May, 1971), 54-58.
- Polland, Harry, "Alternative Techniques; Mediation-Arbitration: A Trade Union View," Monthly Labor Review, 96 (September, 1973), 63-65.
- President Signs into Law Bill Bringing Nonprofit Hospitals Under Taft-Hartley," Daily Labor Report (July 29, 1974), A1-A5.

- "Preventive Medicine in Employer Relations," Hospitals, 48 (May 1, 1974), 80.
- Prindle, Janice, "New York's \$3 Billion Medicaid Boondoggle," Empire State Report, 2 (July, 1976), 33.
- "Proliferation of Bargaining Units Seen as Major HLRB Issue," Health Labor Relations Reports, 1 (January 24, 1977), 4-5.
- Rakich, Jonathan S., "Hospital Unionization: Causes and Effects," Hospital Administration, 18 (Winter, 1973), 7-18.
- Raskin, A. H., "A Union with a Soul," New York Times, (March 22, 1970), 24.
- Rayburn, J. Michael, "Professionalism and Pharmacy Unionism," Journal of the American Pharmacy Association, 40 (October, 1971), 541-543.
- "Report Filed on Nonprofit Hospital Bill: Senate Vote Possible During Week of July 8," Daily Labor Report (July 5, 1974), A8-A9, D1-D2.
- "Retail Clerks Union Launches Drive to Sign Up Health Professionals," Health Labor Relations Reports, 1 (March 7, 1977), 3-4.
- Rice, R. Q., "Analysis of the Hospital as an Economic Organism," Modern Hospital (April, 1966).
- Robinson, A. Selden, "Collective Bargaining in the Technical and Professional Fields," Personnel Journal, 55 (June, 1976), 278-281.
- Rogen, Peter G., "Private Nonprofit Hospitals: A Viable Alternative to the Strikes," Hospital Administration (Spring, 1974), 22-25.
- Rosen, Sherwin, "Trade Union Power, Threat Effects, and the Extent of Organization," Review of Economics and Statistics, 36, No. 2 (April, 1969), 186-196.
- Rosasco, Louise C., "Collective Bargaining: What's A Director of Nursing to Do?" Hospitals, 48 (September 16, 1974), 79-113.
- Rosmann, Joseph, "One Year Under the Taft-Hartley," Hospitals, 49 (December, 1975), 64-68.

- Rothman, William and William A. Himmelsback, Jr., "Study of Michigan Contracts," Hospitals, 44 (December 16, 1971), 67-71.
- "RWDSU President Supports Merger with RCIU and Meatcutters," Retail Clerks Advocate, 80 (August/September, 1977), 26.
- Sammons, James H., "American Medical Association Explains Negotiation Department," Hospitals, 50 (May 16, 1976), 113-115.
- Sanders, Paul H., "Some Comments on Labor Dispute Settlement Processes," Vanderbilt Law Review, 27 (January, 1974), 5-22.
- Scarce, James and Lucretia Dewey Tanner, "Health Care Bargaining: The FMCS Experience," Labor Law Journal, 27 (July, 1976), 387-398.
- Schorr, Thelma M., "They'd Better Believe," American Journal of Nursing, 74, No. 8 (August, 1974), 1415.
- Schulte, Eugene J., "Union Organization in Catholic Hospitals," The Catholic Lawyer, 21 (Autumn, 1975), 332-338.
- Schutt, Barbara G., "The ANA Economic Security Program--What It Is and Why," American Journal of Nursing, 58 (April, 1958), 520-524.
- _____, "Collective Action or Professional Security," American Journal of Nursing, 73, No. 11 (November, 1973), 1946-1951.
- _____, "Excelsior," American Journal of Nursing, 69, No. 5 (May, 1969), 728.
- _____, "Images and Values," American Journal of Nursing, 65, No. 1 (January, 1965), 424.
- Scott, William C., "Shall Professional Nurses Associations Become Collective Bargaining Agents for Their Members?" American Journal of Nursing, 44 (March, 1944), 231-232.
- _____, Elizabeth K. Porter, and Donald Smith, "The Long Shadow," American Journal of Nursing, 66 (March, 1966), 542-544.
- _____, and Donald W. Smith, "The Taft-Hartley Act and the Nurse," American Journal of Nursing, 56 (December, 1956), 1556-1558.

- "Seattle Hospitals, Nurses Settle Two Month Strike," Modern Healthcare, 6 (October, 1976), 15, 16.
- "Second Circuit Bars Interns and Residents from Pursuing Right Before State Board," White Collar Report (September 30, 1977), A1-A2, C-1.
- Seidman, Joel, "Nurses and Collective Bargaining," Industrial and Labor Relations Review, 23 (April, 1970), 342-343.
- "SEIU International Hospital Conference," Service Employees, 33 (February, 1974), 5-8.
- "SEIU Tells Senate Committee: Hospitals Workers Must Have Bargaining Rights," Service Employees, 33 (September, 1973), 4.
- "Senate Approves Conference Report Putting Nonprofit Hospitals Under Taft-Hartley," Daily Labor Report (July 10, 1974), A9-A11.
- "Senate Committee O.K.'s Hospital Bargaining Bill," Service Employees, 33 (April, 1974), 7.
- "Senate Conference Chosen for Nonprofit Hospital Bill," Daily Labor Report (June 14, 1974), A6.
- "Senate Labor Committee Approves Bill Putting Hospitala Employees Under NLRA," Daily Labor Report (March 10, 1974), A14.
- "Senator Taft Vetoes Taft-Hartley Amendment," Hospital Progress, 53 (October, 1972), 21.
- Shepard, Ira M., "Health Care Institution Amendments to the National Labor Relations Act: An Analysis," American Journal of Law and Medicine, 1 (1975), 41-53.
- Sheppard, Harold L. and Audrey P. Sheppard, "Paternalism in Employer-Employee Relationships," American Journal of Nursing, 51 (January, 1951), 16-18.
- Sherman, Fredrick E. and Dennis B. Black, "The Labor Board and the Private Nonprofit Employer: A Critical Examination of the Board's Worthy Cause Exemption," Harvard Law Review, 83 (1969-1970), 1323-1351.
- Sherwin, Michael J. and W. Randy Boxx, "Building Positive Union-Management Relations," Personnel Journal, 54 (June, 1975), 326-331.

- Shinn, J., "How Local 1199 Wins Over Hospitals: Soul Power, Black Power, and \$120.76 a Week," Modern Hospital (January, 1971), 39-42.
- Shister, J., "The Direction of Unionism 1947-1967: Thrust or Drift?" Industrial and Labor Relations Review, 20 (1967), 578-601.
- Shultz, George P., "The Massachusetts Choice of Procedures Approach to Emergency Disputes," Industrial and Labor Relations Review, 10 (April, 1957), 359-373.
- Sieling, Mark, "Private Hospitals Hearing Wage Levels in State, Local Government Hospitals," Monthly Labor Review (May, 1977), 46-47.
- "Signing Up Relations Reports," Health Labor Relations Reports, 1 (February 21, 1977), 10.
- "Special Report: Hospital Bargaining Seminar," BNA Union Labor Report (July 10, 1975), 1-4.
- "Special Report: Collective Action and Health Care Professionals," White Collar Report (June 10, 1977), C1-C4.
- "Spotlight on the Central Division," Retail Clerks Advocate, 80 (February-March, 1977), 22.
- "Spotlight on the Northwestern Division," Retail Clerks Advocate, 77 (June-July, 1974), 20-23.
- Stieber, Jack and Benjamin W. Wolkinson, "Fact Finding Viewed by Fact Finders: The Michigan Experience," Labor Law Journal, 28 (February, 1977), 89-101.
- "Strike at Charity Hospital Prohibited by Injunction," The Modern Hospital, 49 (September, 1937), 101.
- "Strikes by Physicians--Editorial," The Journal of the American Medical Association, 235 (February 16, 1976), 756.
- Stumpf, Grace L., "Labor Relations among Professional Groups," Journal of the American Dietetic Association, 65 (August, 1974), 138-142.
- "Summary of Rate Review Activity," Hospitals (September 7, 1975), 65-70.

- "Survey of 1976 NLRB Elections Results Shows Unions Winning Record Number of White Collar Votes," White Collar Report (April 15, 1977), B1-B6.
- "Temple Health Professionals Affiliate with Union," Health Labor Relations Reports (November 15, 1976), 5-6.
- Terenzio, Joseph V., "What Every Administrator Should Know-- and Do--About Labor Relations," Hospitals, 38 (August, 1964), 43.
- Thompson, J. W., "Industrial Relations Strike Planning," Personnel Journal, 49 (January, 1970), 57-60.
- "Top RCIA Leaders Stress Organizing," Advocate, 79 (May, 1976), 5.
- "Two Bills Die: Hospital and Union Rights, Minimum Wage Dead," Service Employees, 32 (November, 1972), 9.
- "Under The Law, Is A Threat the Same as A Strike?" Health Labor Relations Reports, 1 (October 26, 1976), 6-8.
- "Union Membership? No!"--Editorial, American Journal of Nursing, 38 (May, 1938), 573-574.
- "Unionization of Hospitals Employees in Minnesota May Set National Pattern," Minnesota Medicine (May, 1959), 607-610.
- "University Interns, Residents are Entitled to Bargain, Nebraska Supreme Court Rules," Government Employee Relations Reports (August 15, 1977), 10-12.
- Van Cleve, William J., "Collective Bargaining in the Health Care Industry," Journal of American Dietetic Association, 61 (December, 1972), 633-636.
- Vernon, Richard G., "Labor Relations in the Health Care Field Under the 1974 Amendments to the National Labor Relations Act: An Overview and Analysis," Northwestern University Law Review, 70 (March-April, 1975), 202-219.
- "Voluntary Hospitals Face Unionization in Cleveland," Modern Hospital, 100 (May, 1963), 21.
- "Wage-Price Council says Rising Wages are Small Factor in Hospital Cost Inflation," Daily Labor Report (January 20, 1977), A9-A10.

Weimer, Edward W., "Hospitals and Unions Come to Grips," Texas Hospitals 30 (March, 1975), 12-13.

"WLB Approves Salary Standards of California State Nurses' Association," American Journal of Nursing, 43 (October, 1943), 951.

"Washington, D.C., Physicians Ask Recognition as Union," Health Labor Relations Reports, 1 (November 14, 1977), 4-5.

Weismann, Esther, "Nonprofit Hospital and Labor Unions," Cleveland-Marshall Law Review, 8 (September, 1959), 482-491.

Wendorf, Carl E., "State Hospital Associations Initiate Lawsuits for Cost Reimbursement for Medicaid Services," Hospitals, 51 (February 1, 1977), 55-58.

"We Need You In the Lobby, H.R. 2222 Introduced by Rep. Thompson," PNHA Update, 2 (February 5, 1977), 1.

"What State Associations Did in 1945," American Journal of Nursing, 33 (July, 1946), 322.

Wood, Donald, "They Live and Learn with Unions," Modern Hospital, 93 (July, 1959), 73-74.

Zimmerman, Anne, "Taft-Hartley Amended: Implications for Nursing--The Industrial Model," American Journal of Nursing, 75 (February, 1975), 284-292.

Government Documents

Advisory Committee on Intergovernmental Relations--Labor Management Policies for State and Local Governments, Washington, D.C., Government Printing Office, 1969.

National Labor Relations Board, A Layman's Guide to Basic Law under the National Labor Relations Act, Washington, D.C., U. S. Government Printing Office, 1971.

93 Daily Congressional Index, Washington, D.C., Government Printing Office, May 12, 1947.

U.S. Congress, House of Representatives, Committee on Education and Labor, Extension of NLRA to Nonprofit Hospital Employees, Hearings Before the Special Subcommittee on Labor on H.R. 11357, 92nd Congress, 1st and 2nd sessions, 1972.

- _____, Extensions of NLRA to Nonprofit Hospital Employees, Hearings Before the Special Subcommittee on Labor on H.R. 1236, 93rd Congress, 1st Session, 1973.
- _____, Hospital Housestaff as Professional Employees, Hearings Before the Subcommittee on Labor-Management Relations, on H.R. 15842, 94th Congress, 2nd Session, 1976.
- _____, House Report No. 92-1252, 92nd Congress, 2nd Session, July 27, 1972.
- _____, House Report No. 93-1051, 93rd Congress, 2nd Session, 1974.
- _____, Oversight Hearings on the National Labor Relations Board, Hearings Before the Subcommittee on Labor-Management Relations, 94th Congress, 1st Session, 1975.
- _____, Oversight Hearings on the National Labor Relations Act, Hearings Before the Subcommittee on Labor-Management Relations on H.R. 8408, H.R. 8409, H.R. 8410, and H.R. 12822, 94th Congress, 2nd Session, 1976.
- U.S. Congress, Senate, Committee on Labor and Public Welfare, Coverage of Nonprofit Hospitals Under National Labor Relations Act, 1972 Hearings Before the Subcommittee on Labor on H.R. 11357, 92nd Congress, 2nd Session, 1972.
- _____, Coverage of Nonprofit Hospitals Under the National Labor Relations Act, 1972 Hearings Before the Subcommittee on Labor on S.794, S.2292, 93rd Congress, 1st Session, 1973.
- _____, Legislative History of the Coverage of Non-profit Hospitals Under the National Labor Relations Act, 1974, Public Law 93-360 (S.3203) prepared by the special Subcommittee on Labor on Report No. 93-766, Public Law 93-360 (S.3203), 93rd Congress, 2nd Session, November, 1974.
- _____, Nomination, Hearings Before the Committee on Labor and Public Welfare on James F. Scearce, of Virginia, to be Director, Federal Mediation and Conciliation Service, 94th Congress, 2nd Session, 1976.
- _____, Report No. 93-766, 93rd Congress, 2nd Session, 1974.

U.S. Department of Labor, Bureau of Labor Statistics, Director of National Unions and Employee Associations, 1975, BLS Bulletin 1937.

_____, Industry Wage Survey: Hospitals, August 1975-January 1976, BLS Bulletin 1949.

_____, Industry Wage Survey: Hospitals, August 1972, BLS Bulletin 1829.

_____, Industry Wage Survey: Hospitals, March 1969, BLS Bulletin 1688.

_____, Industry Wage Survey: Hospitals, July 1966, BLS Bulletin 1553.

_____, Industry Wage Survey: Nursing Homes and Related Facilities, May 1976, BLS Bulletin 1964.

_____, Industry Wage Survey: Nursing Homes and Related Facilities, May 1973, BLS Bulletin 1855.

_____, Industry Wage Survey: Nursing Homes and Related Facilities, September 1969, BLS Bulletin 1638.

U.S. National Labor Relations Board, General Counsel's Memorandum 74-79, "Guidelines for Handling Unfair Labor Practice Cases Arising Under the 1974 Nonprofit Hospital Amendments to the Act," August 20, 1974.

_____, General Counsel's Monthly Report on Health Care Institutions Cases, December 21, 1974; January 24, 1975; February 24, 1975; March 26, 1975; April 30, 1975; May 29, 1975; July 31, 1975; and October 3, 1975.

Wisconsin Employment Relations Commission, Thirty-Third Annual Report, July 1, 1970-June 30, 1971; Thirty-Fourth Annual Report, July 1, 1971-June 30, 1972; Thirty-Fifth Annual Report, July 1, 1972-June 30, 1973.

NLRB Decisions

Albert Einstein College of Medicine of Yeshiva University, 226, NLRB 185 (1976).

Alexian Brothers Hospital, 219 NLRB 179 (1975).

Allegheny General Hospital, 216 NLRB 168 (1975).

- Alta Bates Hospital, 226 NLRB 65 (1976).
- Alton Memorial Hospital, 218 NLRB 149 (1975).
- American Care Center d/b/a Gold Leaf Convalescent Home, 220 NLRB 44 (1975).
- American Hospital Management Corp. d/b/a Mad River Community Hospital, 220 NLRB 58 (1975) supplementing 219 NLRB 4.
- American Nurses Association and ANA Economic and General Welfare, No. 17RC 7758 NLRB (1975).
- Anaheim Memorial Hospital, 277 (NLRB 25 (1976)).
- Anne Arundel General Hospital, 217 NLRB 148 (1975).
- Anne Arundel General Hospital, 221 NLRB 39 (1975).
- Barnes Hospital, 217 NLRB 126 (1975).
- Barnes Hospital, 224 NLRB 83 (1976).
- Baptist Medical Center-Princeton, 216 NLRB 110 (1975).
- Baptist Hospital, Inc., 223 NLRB 34 (1976).
- Baptist Memorial Hospital, 244 NLRB 52 (1976).
- Baptist Memorial Hospital, 225 NLRB 69 (1976).
- Baptist Memorial Hospital, Inc., 225 NLRB 165 (1976), 344 appeal Docketed No. 76-1675 (6th Cir., 1976).
- Barnert Memorial Hospital Center, 217 NLRB 132 (1975).
- Bay Medical Center, Inc., 218 NLRB 100 (1975).
- Bay Medical Center, Inc., 224 NLRB 14 (1976).
- Baylor University Medical Center, 225 NLRB 102 (1976), appeal No. 76-1940, (C.D. Cir. 1978).
- Bellaire General Hospital, Inc., 203 NLRB 151, (1973).
- Beth Israel Hospital and Geriatric Center, 219 NLRB 93 (1975).
- Beth Israel Hospital, 223 NLRB 118 (1976), appeal Docketed No. 76-1318, (1st Cir., 1976).
- Beth Israel Hospital, 223 NLRB 188 (1976).

Beverly Farm Foundation, 218 NLRB 194 (1975) supplementing 215 NLRB 73.

Beverly Farm Foundation, Inc., 225 NLRB 70 (1976).

Bio-Medical Applications of San Diego, Inc., 216 NLRB 115 (1975).

Bishop Randall Hospital, 217 NLRB 185 (1975), DC WYO (1975) revised U.S. Court of Appeals, Tenth Circuit 523 F 2d. 845 1975.

Brattleboro Memorial Hospital, Inc., 226 NLRB 148 (1976).

Buffalo General Hospital, 218 NLRB 167 (1975).

Buffalo General Hospital, 224 NLRB 17 (1976).

Butte Medical Properties, 168 NLRB 266 (1967).

Camden-Clarke Memorial Hospital, 221 NLRB 160 (1975).

Carle Clinic Association, 192 NLRB 60 (1971).

Casey and Glass, Inc., 219 NLRB 689 (1975).

Cedar-Sinai Medical Center, 223 NLRB 57 (1976, motion for reconsideration denied in 224 NLRB 90 (1976).

Central Dispensary and Emergency Hospital vs. NLRB, 44 NLRB 533 (1942) aff'd 145, F. 2d., 852, 853, D.C. Circuit 1944, cert. denied, 342 U.S. 847 (1945).

Central General Hospital, 223 NLRB 27 (1976).

Century City Hospital, 219 NLRB 6 (1975).

Charles Circle Clinic, 215 NLRB 84 (1975).

Chicago Lighthouse for The Blind, 225 NLRB 46 (1976).

Chicago School and Workshop for the Retarded, 225 NLRB 172 (1976).

Children's Baptist Home of Southern California, 215 NLRB 44 (1974); 215 NLRB 45 (1974).

Children's Village, Inc., 186 NLRB 953 (1971).

Children's Hospital of Pittsburgh, 222 NLRB 90 (1976).

Clarion Osteopathic Community Hospital, 219 NLRB 41 (1975).
Clark County Medical Health Center, 225 NLRB 105 (1976).
Clear Lake Hospital, 223 NLRB 1 (1976).
Clermont Nursing and Convalescent Home, 223 NLRB 3 (1976).
Crittenton Hospital, 220 NLRB 173 (1975).
Colonial Haven Nursing Home, Inc., 218 NLRB 137 (1975).
Community Hospitals of Roanoke, 220 NLRB 50 (1975).
Community Medical Properties, Ltd., 218 NLRB 98 (1975).
Consolidated Vultee Aircraft Corp., 56 NLRB 1785 (1944).
Dalewood Rehabilitation Hospital, Inc., d/b/a Golden State
Habilitation Convalescent Center, 224 NLRB 197 (1976).
Deaconess Hospital of Buffalo, 226 NLRB 164 (1976).
Diversified Health Services, 180 NLRB 461 (1969).
Doctors Hospital, 217 NLRB 87 (1975).
Doctors Hospital of Modesto, Inc., 193 NLRB 833 (1971).
Dominican Santa Cruz Hospital, 218 NLRB 182 (1975).
Drexel Homes, 182 NLRB 151 (1970).
Driftwood Convalescent Hospital, 217 NLRB 183 (1975).
Duke University and AFSCME, 194 NLRB 30 (1971).
Duke University, 217 NLRB 136 (1975).
Duke Univeristy, 194 NLRB 31 (1971).
East Oakland Community Health Alliance, Inc., 218 NLRB 193
(1975).
Eskaton American River Health Care Center, 225 NLRB 97 (1976).
Extendicare of West Virginia, 203 NLRB 170 (1973).
Family Doctor Medical Group, 226 NLRB 22 (1976).
First Healthcare Corporation, 222 NLRB 212 (1976).

- Flatbush Healthcare Corporation, 126 NLRB 144 (1960).
- Fort Tyron Nursing Home, 223 NLRB 96 (1976).
- Four-Seasons Nursing Home Center, 208 NLRB 50 (1974).
- General Electric Co., Kaedlec Hospital, 89 NLRB 1247 (1950).
- Gloria's Manor Home for Adults, 225 NLRB 156 (1976).
- Gnaden Huetten Memorial Hospital, 219 NLRB 79 (1975).
- Gold Leaf Convalescent Home, 220 NLRB 44 (1975).
- Greater Bakersfield Memorial Hospital, 226 NLRB 143 (1976).
- Greater Pennsylvania Avenue Nursing Center, Inc., 227 NLRB 26 (1976).
- Green Oak Manor, 215 NLRB 112 (1974).
- Grey Nuns of the Sacred Heart, 221 NLRB 201 (1975).
- Guyan Valley Hospital, Inc., 198 NLRB 28 (1972).
- Haven Manor Health Related Facility, 226 NLRB 50 (1976).
- Heights Hospital, 221 NLRB 81 (1975).
- Highland Acres Extend-A-Care Center, 222 NLRB 114 (1976).
- Hill Road Convalescent Hospital, Inc., 217 NLRB 77 (1975).
- Holyoke Nursing Home, Inc., 219 NLRB 163 (1975).
- Hospital and Health Care Employees, District 1199 (Parkway Pavilion Healthcare), 222 NLRB 15 (1976).
- Hospital Hato Tejas (P.R.), 111 NLRB 155 (1955).
- Huntington Hospital, Inc., 227 NLRB 44 (1976).
- Illinois Extended Care Convalescent Center, 220 NLRB 167 (1975).
- International Paper Co., 172 NLRB 100 (1968).
- Jack L. Williams, DDS, 219 NLRB 21 (1975).
- Jewish Center for the Aged, 220 NLRB 21 (1975).

- Jewish Hospital of Cincinnati, 223 NLRB 91 (1976).
- Jewish Hospital of Brooklyn vs. John Doe, 252 Appel. 581, 300 N.Y., (1937).
- Jewish Orphan Homes of Southern California, 191 NLRB 11 (1971).
- Kaiser Foundation Health Plan of Oregon, 225 NLRB 50 (1976).
- Kaiser Foundation Hospital, et. al., 210 NLRB 142 (1974).
- Kaiser Foundation Hospital, 219 NLRB 78 (1975).
- Kaiser Foundation Hospital, 219 NLRB 22 (1975).
- Kaiser Foundation Hospital, Inc., 223 NLRB 51 (1976).
- Kalamazoo Paper Box Corp., 136 NLRB 134 (1962).
- Kanawha Valley Memorial Hospital, Inc., 218 NLRB 135 (1975).
- Kansas City General Hospital and Medical Center, Inc., 225 NLRB 14 (1976); revised 225 NLRB 14 (1976).
- Kansas City College of Osteopathic Medicine, 220 NLRB 36 (1975).
- Kennecott Copper Corp., 99 NLRB 748 (1952).
- Kentfield Medical Hospital, 219 NLRB 32 (1975).
- Klein's Golden Manor, 214 NLRB 121 (1974).
- Lakeshore Manor, Inc., 225 NLRB 126 (1976).
- Lansing General Hospital, 220 NLRB 1 (1975).
- Lauderdale Lakes General Hospital, 227 NLRB 198 (1977).
- Leisure Hills Health Centers, 203 NLRB 46 (1973).
- Lenox Hill Hospitals, 225 NLRB 181 (1976).
- Leonard Hospital, 220 NLRB 158 (1975).
- Les Suburban Hospital, 224 NLRB 100 (1976).
- Levine Hospital of Hayward, Inc., 219 NLRB 81 (1975).
- Long Island College Hospital, 228 NLRB 13 (1977).

Loyola University Medical Center, 194 NLRB 30 (1971).

Lutheran Association for Retarded Children, D/b/a Home of Guiding Hands, 218 NLRB 195 (1975).

Lutheran Hospital of Milwaukee, 225 NLRB 36 (1976).

Lutheran Welfare Service of Illinois, 216 NLRB 96 (1975).

Lydia E. Hall Hospital, 227 NLRB 85 (1976).

Mad River Community Hospital, 219 NLRB 4 (1975).

Madison General Hospital Association, 218 NLRB 150 (1975).

Malcom X Center for Mental Health, Inc., 222 NLRB 147 (1976).

Mallincrodt Chemical Works, 162 NLRB 387 (1966).

Maple Shade Nursing Home, Inc., 223 NLRB 216 (1976).

Marquette General Hospital, 216 NLRB 44 (1975).

Marquette General Hospital, Inc., 218 NLRB 105 (1975).

Mason Clinic, 221 NLRB 66 (1975).

Massachusetts Nurses Association and Lawrence General Hospital, 225 NLRB 91 (1976).

May Department Stores Co., vs. NLRB, 326 U.S. 276 (1945).

McKeesport Hospital, 220 NLRB 180 (1975).

Medical Arts Hospital of Cudahy, Inc., 219 NLRB 215 (1975).

Medical Arts Hospital of Houston, Inc., 221 NLRB 170 (1975).

Medical Center Hospital, 168 NLRB 52 (1967).

Meharry Medical College, 219 NLRB 57 (1975).

Memorial Clinic, Ltd., 220 NLRB 217 (1975).

Memorial Hospital of Roxborough, 217 NLRB 99 (1975).

Memorial Hospital of Roxborough, 220 NLRB 73 (1975).

Mendeno Hospital, 219 NLRB 991 (1975).

Menninger Foundation, 219 NLRB 144 (1975).

Mental Health Center of Boulder County, Inc., 222 NLRB 146 (1976).

Mental Health Services Eire County South East Corp., 220 NLRB 18 (1975).

Mercy Center for Health Care Services, 227 NLRB 265 (1977).

Mercy Hospital, 220 NLRB 145 (1975).

Mercy Hospital, Inc., 217 NLRB 765 (1975).

Mercy Hospital of Laredo, 219 NLRB 154 (1975).

Mercy Hospital of Sacramento, Inc., 217 NLRB 131 (1975).

Mercy Hospital of Sacramento, Inc., 224 NLRB 58 (1976).

Mercy-Memorial Hospital Corp., 221 NLRB 1 (1975).

Mercy-Memorial Hospital Corp., 224 NLRB 11 (1976).

Methodist Hospital of Kentucky, Inc., 221 NLRB 87 (1975).

Methodist Hospital of Sacramento, Inc., 223 NLRB 186 (1976).

Metropolitan Hospital, 223 NLRB 35 (1976).

Mile Square Health Center, Inc., 223 NLRB 201 (1976).

Milwaukee Psychiatric Hospital, 219 NLRB 166 (1975).

Ming Quong Children's Center, 210 NLRB 125 (1974).

Misericordia Hospital Medical Center, 224 NLRB 126 (1976).

Mon Valley United Health Services, Inc., 227 NLRB 114 (1977).

Mon-Youth Community Mental Health and Mental Retardation Services, Inc., 227 NLRB 172 (1977).

Morristown-Hamblen Hospital Assn., 226 NLRB 13 (1976).

Mt. Airy Psychiatric Center, 217 NLRB 137 (1975).

Mountain Manor Nursing Home, 204 NLRB 71 (1973).

Multi-Medical Convalescent and Nursing Center of Towson, 225 NLRB 56 (1976).

- National Jewish Hospital and Research Center, 226 NLRB 198 (1976).
- National Medical Hospitals, Inc., d/b/a, Chico Community Memorial Hospital, 215 NLRB 155 (1974).
- Nebraska Methodist Hospital, 218 NLRB 99 (1975).
- Nebraska Methodist Hospital, 222 NLRB 1 (1976).
- New Fern Resorium, Co., 175 NLRB 142 (1971).
- Newington Children's Hospital, 217 NLRB 134 (1975).
- Newton-Wellesly Hospital, 219 NLRB 80 (1975).
- NLRB vs. Delaware-New Jersey Ferry Co., 128 F.2d 130 (3rd Cir., 1942).
- NLRB vs. IBEW Local 388, 548 F. 2d. 704, (7th Cir., 1977).
- NLRB vs. Kostel Corp., 440 3d 341 (7th Cir., 1971).
- Noble Hospital, 218 NLRB 221 (1975).
- North Memorial Medical Center, 224 NLRB 28 (1976).
- Oak Ridge Hospital of United Methodist Church, 220 NLRB 9 (1975).
- Oakwood Hospital Corp., 219 NLRB 120 (1975).
- Oshner Clinic, 192 NLRB 55 (1971).
- Otis Hospital, Inc., 219 NLRB 55 (1975).
- Otis Hospital, Inc., 222 NLRB 47 (1976).
- Otis Hospital, Inc., 227 NLRB 11 (1976).
- Otis Hospital, Inc., 226 NLRB 211 (1976).
- Pacific Medical Center, 20-RC-12379 (1974).
- Pacific Medical Center, 20-RC-12871 (1975).
- Paul Kimball Hospital, Inc., 224 NLRB 48 (1976).
- Pawating Hospital Assn., 222 NLRB 106 (1976).
- Pennisula Hospital Center, 219 NLRB 21 (1975).

- Phelps Dodge Corp., 98 NLRB 726 (1952).
- Pinecrest Convalescent Home, CCH NLRB 16,891 (1976).
- Pittsburgh Plate Glass vs. NLRB, 313 U.S. 146 (1940).
- Pontiac Osteopathic Hospital, 227 NLRB 235 (1977).
- Presbyterian Medical Center, 218 NLRB 192 (1975).
- Presbyterian Medical Center, 227 NLRB 135 (1977).
- Rhode Island Catholic Orphan Asylum d/b/a St. Aloysius Home,
224 NLRB 70 (1976).
- River Manor Health Related Facility, 224 NLRB 38 (1976).
- Riverside Hospital, 222 NLRB 149 (1976).
- Riverside Methodist Hospital, 223 NLRB 158 (1976).
- Riviera Manor Nursing Home, 220 NLRB 23 (1975).
- Rock Hill Convalescent Center, 226 NLRB 133 (1976).
- Rockridge Medical Care Center, 221 NLRB 119 (1975).
- Rockville Nursing Center, 193 NLRB 149 (1971).
- Rosewood, Inc., 185 NLRB 193 (1970).
- Sacramento Medical Foundation Blood Bank, 220 NLRB 156 (1975).
- Sacred Heart General Hospital, 219 NLRB 111 (1975).
- Saddleback Community Hospital, 223 NLRB 45 (1976).
- St. Anthony Center, 220 NLRB 139 (1975).
- St. Catherine's Hospital of Dominican Sisters of Kenosha, Wisconsin, 217 NLRB 133 (1975).
- St. Clare's Hospital and Health Center, 223 NLRB 163 (1976).
- St. Clare's Hospital and Health Center, 229 NLRB 158 (1977).
- St. Claude General Hospital, 219 NLRB 116 (1975).
- St. Christopher's Hospital for Children, 223 NLRB (1976).
- St. Elizabeth's Hospital of Boston, 220 NLRB 61 (1975).

- St. Francis Hospital, 219 NLRB 72 (1975).
- St. Francis Hospital-Medical Center, 223 NLRB 213 (1976).
- St. John's Hospital and School of Nursing, Inc., 222 NLRB 182 (1976); Appeal Docketed No. 76-1130, (10th Cir., 1976).
- St. Joseph Home for Children, Inc., 224 NLRB 187 (1976).
- St. Joseph's Hospital, 221 NLRB 213 (1975).
- St. Joseph Hospital, 228 NLRB 23 (1977).
- St. Joseph Hospital of Marshfield, Inc. (Electrical Workers, IBEW, Local 388), 220 NLRB 98 (1975).
- St. Joseph Hospital and Medical Center, 219 NLRB 161 (1975).
- St. Luke's Episcopal Hospital, 222 NLRB 109 (1976).
- St. Luke's General Hospital, 220 NLRB 86 (1975).
- St. Luke's Hospital Center, 221 NLRB 217 (1976).
- St. Mary's Hospital, Inc., 220 NLRB 92 (1975).
- St. Patrick's Hospital, 225 NLRB 110 (1976).
- St. Peter's Medical Center, 223 NLRB 140 (1976).
- St. Rose de Lima Hospital, Inc., 223 NLRB 224 (1976).
- St. Vincent's Hospital, 223 NLRB 98 (1976).
- St. Vincent's Hospital, 227 NLRB 70 (1976).
- San Jose Hospital and Health Center, Inc., 228 NLRB 6 (1977).
- Seaview Manor Home for Adults, 222 NLRB 94 (1976).
- Seton Medical Center, 221 NLRB 4 (1975).
- Shadecrest Health Care Center, 228 NLRB 135 (1977).
- Sheffield Corp., NLRB 49 LRRM 1265 (1961).
- Sherewood Enterprises, Inc., 175 NLRB 354 (1969).
- Shorewood Manor Nursing Home and Rehabilitation Center, 217 NLRB 55
- Shrewsbury Nursing Home, Inc., 227 NLRB 10 (1976).

- Shriner's Hospital for Crippled Children, 217 NLRB 138 (1975).
- Sinai Hospital of Detroit, Inc., 226 NLRB 61 (1976).
- Sierra Vista Hospital, Inc., 225 NLRB 115 (1976).
- Sierra Vista Hospital, Inc., 229 NLRB 35 (1977).
- Sisters of Charity of Province, St. Agnatus Province d/b/a St. Patrick's Hospital, 225 NLRB 110 (1976).
- Sisters of St. Joseph's Peace, 217 NLRB 135 (1975).
- Sadat, Inc., 218 NLRB 202 (1975).
- Society of New York Hospital vs. Hanson, 185 Misc. 93759, NYSS 2d. 91 (1945).
- Southwest Louisiana Hospital Association, 226 NLRB 136 (1976).
- Southwest Louisians Hospital Association d/b/a Lake Charles Memorial Hospital, 226 NLRB 136 (1976).
- Soyosset General Hospital, 190 NLRB 59 (1971).
- Standard Oil Co., 80 NLRB 1022 (1948).
- Stoddard-Quirk Manufacturing Co., 138 NLRB 615 (1962).
- Summit Nursing and Convalescent Homes, Inc., 196 NLRB 110 (1972).
- Sun Harbor Manor, 228 NLRB 118 (1977).
- Sunset Nursing Homes d/b/a North Miami Convalescent Home, 224 NLRB 176 (1976).
- Sutter Community Hospital of Sacramento, Inc., 227 NLRB 18 (1976).
- Sweetwater Hospital Association, 219 NLRB 142 (1975).
- Taylor Hospital, 218 NLRB 179 (1975).
- Terry Industries of Oregon, NLRB 89 LRRM 1045 (1975).
- Toledo District Nurse Association, 216 NLRB 130 (1975).
- Tri-County Medical Center, Inc., 222 NLRB 174 (1976).
- Trinity Lutheran Hospital, 218 NLRB 34 (1975).

- Trinity Memorial Hospital of Cudahy, Inc., 219 NLRB 63 (1975).
- Trumbull Memorial Hospital, 218 NLRB 122 (1975).
- Trustees of Columbia University vs. Herzog, 269 Appel. 24 (1945).
- Tuschak/Jacobson, Inc. t/a Franklin Convalescent Center, 223 NLRB 197 (1976).
- United Hospitals of Newark, 232 NLRB 67 (1977).
- University of Chicago Hospitals and Clinics, 223 NLRB 154 (1976).
- University Nursing Home, 168 NLRB 263 (1967).
- Valley Hospital, Ltd., 220 NLRB 216 (1975).
- Valley Hospital, Ltd., 221 NLRB 210 (1975).
- Valley Hospital, Ltd., 222 NLRB 102 (1976).
- Valley Hospital, Ltd., 226 NLRB 41 (1976).
- Vancouver Memorial Hospital, 219 NLRB 15 (1975).
- Victor Valley Hospital, 220 NLRB 149 (1975).
- Victor Valley Hospital, 227 NLRB 84 (1976).
- Von Solbrig Hospital, Inc., 189 NLRB 46 (1971).
- Walker Methodist Residence and Health Care Center, Inc., 227 NLRB 238 (1977).
- Washington Manor Nursing Center (North), 211 NLRB 24 (1974).
- Washington Manor Nursing Center (South), 211 NLRB 23 (1974).
- Wavecrest Home for Adults, 217 NLRB 47 (1975).
- Wayne Memorial Hospital Association, 217 NLRB 1015 (1975).
- Wayne State University, 226 NLRB 168 (1976).
- Westchester Corp., 124 NLRB 194 (1959).
- West Suburban Hospital, 224 NLRB 100 (1976).
- West Suburban Hospital, 227 NLRB 206 (1977).

- Westbrook Park Nursing Home, 219 NLRB 188 (1975).
- Western Medical Enterprises d/b/a Driftwood Convalescent Hospital, 217 NLRB 183 (1975).
- Western Pennsylvania vs. Lichter, 340 Pa. 382 11A 2d. 206 (1941).
- Westside Hospital, 218 NLRB 16 (1975).
- William W. Backus Hospital, 220 NLRB 107 (1975).
- Wing Memorial Hospital Association, 217 NLRB 172 (1975).
- Woodlawn Park Hospital, 205 NLRB 144 (1974).
- Yale-New Haven Hospital, 214 NLRB 34 (1974).
- Yale-New Haven Hospital, 219 NLRB 37 (1975).
- Young World, 216 NLRB 97 (1975).
- Youngstown Hospital Association, South Unit, 222 NLRB 93 (1976).
- Youngstown Osteopathic Hospital Association, 216 NLRB 136 (1975).

Theses, Dissertations and Grant Reports

- Ahmuty, Alice L., "The Development of the Michigan Nurses Association's Economic Security Program," Master's Thesis, Michigan State University, 1968.
- Anderson, Sulgrove Larry, "A Social Analysis of Bargaining between Hospital and Registered Professional Nurses," Master's Thesis, University of Iowa, June, 1967.
- Bailey, Jack C., "A Comparative Study of the Employment Conditions of Nurses," Master's Thesis, George Washington University, 1965.
- Baird, William M., "Collective Bargaining by Registered Nurses," Ph.D. Dissertation, Ohio State University, 1968.
- Baltch, Philip R., "Unions in Hospitals," Master's Thesis, Xavier University, April, 1968.

- Bristow, Charles L., "A Descriptive and Explanatory Analysis of Unionization and Its Effect on Costs, Employees Compensation and Compensation Programs in The Voluntary Not-for-Profit Hospital," Master's Thesis, University of Alabama, 1972.
- Brothers, Patrick E., "Collective Bargaining by Nurses under the American Nurses' Association's Economic Security Program: An Historical and Empirical Description," Master's Thesis, University of Iowa, January, 1972.
- Brown, Stephen Joseph, "The History and Development of Unions and Collective Bargaining in Hospitals in the United States," Master's Thesis, University of Iowa, August, 1969.
- Chandrasekharan, K., "An Exploration of a Viable Process of Collective Bargaining in Nonprofit Hospital Minimizing the Strike Potential," Ph.D. Dissertation, University of Tennessee, December, 1972.
- Crimen, John Chase, "Organization of Nongovernment Hospital Employees by the AFL-Cio: 1950-1959," MBA Thesis, George Washington University, June, 1960.
- Day, Sister M. Celesta, "The Hospitals Organization During Union Activity: A Comparison of Three Factors of Organization in Thirty New York City Hospitals as They Related to Union Activities," Master's Thesis, George Washington University, May, 1956.
- Franklin, Stephen H., "Fringe Benefits, Hospitals, and Unions," Master's Thesis, University of Iowa, June, 1968.
- Genzburg, Susan I., "Nonprofessional Hospital Workers: Unions, Wages, and Labor Market Problems," Master's Thesis, University of California, Berkely, January, 1964.
- Ginsburg, H., "Wages Differentials In Hospitals, 1956-1963; A Study Emphasizing the Wages of Nurses and Unskilled Workers in Nonprofit Hospitals," Ph.D. Dissertation, New School for Social Research, 1967.
- Hacker, John Joseph, "Militant Actions by Nurses in Collective Bargaining in Voluntary Not-for-Profit Hospitals: An Exploratory Analysis," Master's Thesis, University of Iowa, December, 1973.

- Harnett, George D., "A Comparative Survey of Selected Personnel Activities between those Acute General, Non-Profit Hospitals with and Those without Bargaining Units," Master's Thesis, George Washington University, 1965.
- Hynes, Michael W., "A Measurement of the Responsiveness of the American Hospital Association to a Selected Sample of its Personal Membership," Master's Thesis, Pace University, January, 1976.
- Kelleher, Veronica, "A Study of Multi-Employer Bargaining in the Voluntary Hospitals in New York City as Conducted by the Multi-Employer Association, the League of Voluntary Hospitals and Homes," Master's Thesis, Pace University, January, 1976.
- Larkins, Eddie L., "A Study of Grievances, 1971-1973, University Hospital, Ann Arbor, Michigan," Master's Thesis, University of Michigan, 1974.
- Leick, Sister Marybelle, "The Study of Collective Bargaining in Minnesota and California Hospitals," Master's Thesis, George Washington University, 1957.
- McCormick, William, Jr., "Labor Relations and Labor Costs in Hospitals," Ph.D. Dissertation, Case Western Reserve University, June, 1968.
- Menichette, Adrian J., "A Study of Labor Unions: Their Impact on the Voluntary Non-Profit Hospital," Master's Thesis, Xavier University, May, 1969.
- Nash, Abraham, "Labor-Management Conflict in a Voluntary Hospital," Ph.D. Dissertation, New York University, June, 1972.
- Pointer, Dennis D., "Employee Organization In Health Care Facilities: An Exploratory Analysis and Evaluation," Ph.D. Dissertation, University of Iowa, 1971.
- Raymond, Samuel, "A Comparison of Personnel Policies in Unionized and Nonunion Hospitals," Master's Thesis, George Washington University, March, 1965.
- Richmond, Charles A., "The Nature of Hospital Unions: An Evaluation of the Movement and Management's Reaction to It," Master's Thesis, Temple University, April, 1971.

Schmidt, Leo G., "A Survey of Collective Bargaining in Hospitals: An Analysis of Labor Agreements with Voluntary Non-Profit Hospitals," Master's Thesis, State University of Iowa, June, 1963.

Shaffer, Dale Eugene, "Collective Bargaining in Hospitals," Master's Thesis, Ohio State University, 1956.

Vinci, Louis J., "Unionization of Health Care Facilities in South Florida," Master's Thesis, George Washington University, 1970.

Miscellaneous

American Nurses Association, Commission of Economic and General Welfare, "A Care for Registered Nurses," Pamphlet, American Nurses Association, 1975.

_____, "ANA's Economic and General Welfare Program: Organizing the Local Unit," Pamphlet, American Nurses Association, 1975.

_____, "ANA's Economic and General Welfare Program: Philosophy, Goals, Policies, Positions," Pamphlet, American Nurses Association, 1975.

_____, "Dynamics of the Local Unit," Pamphlet, American Nurses Association, no date.

_____, Memo from EGGW Department, to EGGW Staff, Requesting Basic Program Changes of New Executive Order, dated 3-14-75.

_____, "ANA's Guidelines for the Individual Nurse Contract," American Nurses Association, Kansas City, Missouri, 5-23-74, pp. 1-12.

_____, "So You're Interested in Economic and General Welfare," Pamphlet, Economic and General Welfare Department, American Nurses Association, Kansas City, Missouri.

Boydston, Patty, Texas Nurses Association, Interview, September 18, 1976.

Cainstraight, John, Federal Mediation and Conciliation Service, Assistant Director of Arbitration Services, Interview, April 18, 1976.

Connerton, Robert, General Counsel, Laborers International, Interview, May 6, 1977.

Doranz, Jeffery, Associate Counsel, Senate Subcommittee on Labor, "Legislative History of Health Care Amendments to the Taft-Hartley Act," December 12, 1974.

Emanuel, William, Interview, April 27, 1977.

Executive Office of the President Council on Wage and Price Stability, The Problem of Rising Health Care Costs, Staff Report, April, 1976.

Finandis, Nicholas A., Deputy Director, Office of Mediation Services, Federal Mediation and Conciliation Service, Interview, December 21, 1976.

Fishgold, Herbert, Former General Counsel, Federal Mediation and Conciliation Service, Interview, December 14, 1976.

Gamm, Sara, "Toward Collective Bargaining in Nonprofit Hospitals: Impact of New York Law," Bulletin No. 60 (Ithaca, New York State School of Industrial Relations, Cornell University, 1968).

Gershenfeld, Walter J., "Emerging Sectors of Collective Bargaining; Labor Relations in Hospitals," Mimeograph, March 28, 1968.

Guy, Vincent L., Federal Mediation and Conciliation Service, Interview, April 11, 1976.

Hogan, Austin, Legislative Representative, American Hospital Association, Interview, May 9, 1977.

Holloway, Sally and Joan Wallace, "Dispute Resolution in the Health Care Industry," Speech presented at Conference on Contemporary Arbitration Problems, October 24, 1974, Dallas.

King, Roger, Interview, April 27, 1977.

League of Voluntary Hospitals and Homes of New York and District 1199, National Union of Hospitals and Health Care Employees, AFL-CIO, Arbitration Award, Margery Gootnick, Arbitrator, September 10, 1976.

League of Voluntary Hospitals and Homes of New York and District 1199, RWDSU, AFL-CIO, Before Basil A. Paterson, Chairman, Interim Opinion and Award, June 28, 1974.

Murphy, Richard, Legislative Director, SEIU, Interview, April 18, 1977.

Oswald, Rudy, Research Director, AFL-CIO, Interview, September 15, 1976.

Perry, Richard, Director of Professional Employees Division, RCIA, Interview, June 20, 1977.

Preli, Sorine A., Assistant Director of Administration for Budget and Financial Management, Federal Mediation and Conciliation Service, Interview, April 17, 1977.

Searce, James F., Former National Director, Federal Mediation and Conciliation Service, Interview, October 8, 1976.

Schultz, Lawrence, Director, Office of Arbitration, Federal Mediation and Conciliation Service, Interview, December 22, 1976.

_____, SPIDR Conference, October, 1976.

Tyler, Rea, Assistant Executive Director, Physicians National Housestaff Association, Interview, September 19, 1977.

Usery, William, Former Secretary of Labor, Interview, July 1, 1976.