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COVERAGE OF NONPROFIT HOSPITALS UNDER  
NATIONAL LABOR RELATIONS ACT, 1972

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HEARINGS  
BEFORE THE  
SUBCOMMITTEE ON LABOR  
OF THE  
COMMITTEE ON  
LABOR AND PUBLIC WELFARE  
UNITED STATES SENATE  
NINETY-SECOND CONGRESS

SECOND SESSION

ON

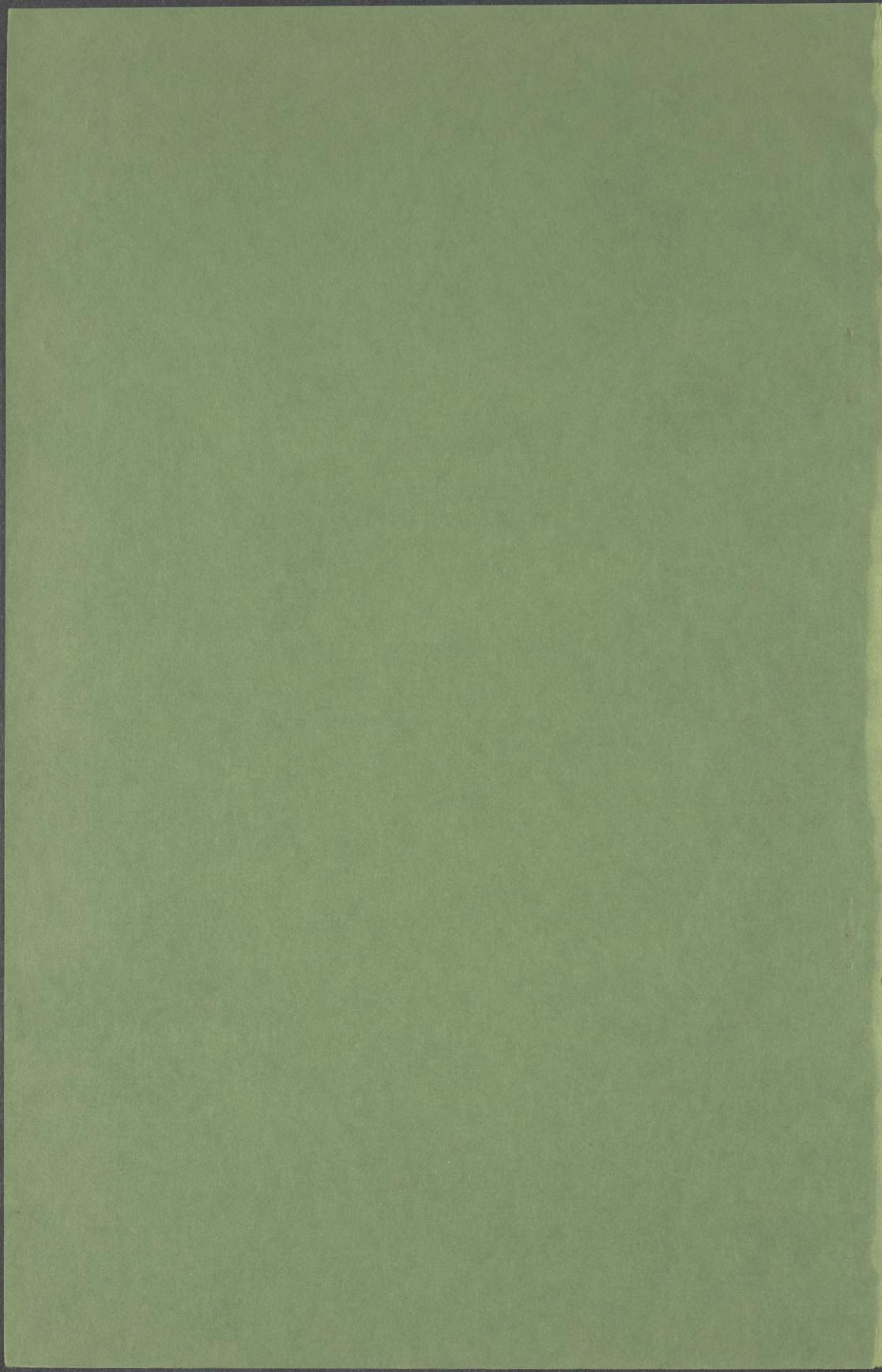
H.R. 11357

TO AMEND THE NATIONAL LABOR RELATIONS ACT TO EXTEND  
ITS COVERAGE AND PROTECTION TO EMPLOYEES OF NON-  
PROFIT HOSPITALS AND FOR OTHER PURPOSES

AUGUST 16 AND SEPTEMBER 6, 1972



Printed for the use of the  
Committee on Labor and Public Welfare



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NATIONAL LABOR RELATIONS ACT, 1972

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WASHINGTON : 1972

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# CONTENTS

## CHRONOLOGICAL LIST OF WITNESSES

WEDNESDAY, AUGUST 16, 1972

	Page
Hardy, George, international president, Service Employees International Union, AFL-CIO, accompanied by Michael McDermott, assistant to the president, local 399, Los Angeles, Calif., and executive board member; Timothy Twomey, secretary-treasurer, Local 250, San Francisco, Calif., and vice president, SEIU; Harry Kurshenbaum, organizing director, Local 73, Chicago, Ill.; Leo Geffner, counsel; Lester Asher, counsel; Richard Murphy, legislative representative.....	1
Metcalf, Hon. Lee, a U.S. Senator from the State of Montana.....	10
Munger, Mary, R.N., vice chairman, Commission of Economic and General Welfare, American Nurses Association; accompanied by Alice L. Ahmuty, R.N., director; Anthony Battore, M.D., executive secretary, Committee of Interns and Residents, New York; and Michael Horowitz, attorney.....	11
Battore, Anthony, M.D., executive secretary, Committee of Interns and Residents, New York, N.Y.....	29
Hitt, David H., chief operating officer, Baylor University Medical Center Dallas, Tex., accompanied by William J. Emanuel, labor attorney, and member, special committee, American Hospital Association of Labor Relations and Personnel Management; and Dr. Leo J. Gehrig, M.D., acting director, American Hospital Association Service Bureau, Washington, D.C.....	31
Alderson, Frederick K., vice president and director of legislative liaison, National Right To Work Committee.....	37
Fields, Ogden W., former executive secretary, National Labor Relations Board.....	44
Albert, Alfred, Deputy Solicitor, Department of Labor.....	70
Gibbons, Myles J., counsel, Hospital Association of Pennsylvania, accompanied by Leon A. Cord, director, management and fiscal affairs; and John F. Wick, public affairs director, Hospital Association of Pennsylvania.....	71
Painter, John, association administrator, Providence Hospital, Washington, D.C.; accompanied by Robert J. Smith, Morgan, Lewis & Bockius; and Robert J. Hickey, counsel for Providence Hospital.....	112

WEDNESDAY, SEPTEMBER 6, 1972

Pomrinse, David S., M.D., director, the Mount Sinai Hospital of New York; accompanied by Robert Kaufman, counsel, Greater New York Hospital Association; and Richard Epstein, counsel, Hospital Association of New York State.....	138
Whelan, William M., executive director, California Hospital Association, William J. Emanuel, Esq., counsel, California Hospital Association; Thomas M. Vogt, counsel, Minnesota Hospital Association; O. Ray Hurst, executive director, Texas Hospital Association; Robert E. Debacker, executive director, Louisiana Hospital Association; a panel.....	149
Newcomer, James D., vice president, Ohio Hospital Association; accompanied by Jerry N. Ranschoff and Richard V. Whelan, Jr.; George H. Yeckel, executive director, Missouri Hospital Association; accompanied by Clifton L. Elliot, attorney; Marc Ihm, president, Iowa Hospital Association; accompanied by Donald W. Dunn, executive vice president; a panel.....	210

## STATEMENTS

	Page
Albert, Alfred, Deputy Solicitor, Department of Labor.....	70
Alderson, Frederick K., vice president and director of legislative liaison, National Right To Work Committee.....	37
Prepared statement.....	38
Battore, Anthony, M.D., executive secretary, Committee of Interns and Residents, New York, N.Y.....	29
Bromberg, Michael D., director, Washington Bureau, and Samuel A. Weems, chairman, Legislative Committee, Federation of American Hospitals, Washington, D.C., prepared statement (with exhibits)....	308
Catholic Hospital Association, St. Louis, Mo., prepared statement.....	348
Communications Workers of America, Washington, D.C., prepared state- ment.....	255
DeBacker, Robert E., associate administrator of Schumpert Memorial Hospital, Shreveport, La., prepared statement.....	200
Fields, Ogden W., former executive secretary, National Labor Relations Board.....	44
Prepared statement.....	49
Gibbons, Myles J., counsel, Hospital Association of Pennsylvania, ac- companied by Leon A. Cord, director, management and fiscal affairs; and John F. Wick, public affairs director, Hospital Association of Pennsylvania.....	71
Prepared statement (with attachment).....	75
Hardy, George, international president, Service Employees International Union, AFL-CIO; accompanied by Michael McDermott, assistant to the president, Local 399, Los Angeles, Calif., and executive board member; Timothy Twomey, secretary-treasurer, Local 250, San Fran- cisco, Calif., and vice president, SEIU; Harry Kurshenbaum, organizing director, Local 73, Chicago, Ill.; Leo Geffner, counsel; Lester Asher, counsel; Richard Murphy, legislative representative.....	1
Hitt, David H., chief operating officer, Baylor University Medical Center, Dallas, Tex.; accompanied by William J. Emanuel, labor attorney, and member, special committee, American Hospital Association of Labor Relations and personnel management; and Dr. Leo J. Gehrig, M.D., acting director, American Hospital Association Service Bureau, Washington, D.C.....	31
Hurst, Ray O., executive vice president, Texas Hospital Association, pre- pared statement.....	206
Ihm, Marc, president, Iowa Hospital Association, prepared statement....	243
Massachusetts Labor Relations and Federal Jurisdiction, prepared state- ment.....	131
Metcalf, Hon. Lee, a U.S. Senator from the State of Montana.....	10
Munger, Mary, R.N., vice chairman, Commission of Economic and General Welfare, American Nurses Association; accompanied by Alice L. Ah- muty, R.N., director; Anthony Battore, M.D., executive secretary, Committee of Interns and Residents, New York; and Michael Hor- witz, attorney.....	11
Prepared statement.....	13
Newcomber, James D., vice president, Ohio Hospital Association; ac- companied by Jerry N. Ransohoff and Richard V. Whelan, Jr.; George H. Yeckel, executive director, Missouri Hospital Association; ac- companied by Clifton L. Elliot, attorney; Marc Ihm, president, Iowa Hospital Association; accompanied by Donald W. Dunn, executive vice president; a panel.....	210
Prepared statement.....	214
Painter, John, association administrator, Providence Hospital, Washing- ton, D.C.; accompanied by Robert J. Smith, Morgan, Lewis & Bockius; and Robert J. Hickey, counsel for Providence Hospital.....	112
Pomrinse, David S., M.D., director, the Mount Sinai Hospital of New York; accompanied by Robert Kaufman, counsel, Greater New York Hospital Association; and Richard Epstein, counsel, Hospital Associa- tion of New York State.....	138
Sister Rosa, administrator, Providence Hospital, Washington, D.C., pre- pared statement.....	122

Vogt, Thomas M., a lawyer representing the Minnesota Hospital Association, prepared statement.....	Page 153
Whelan, Richard V., Jr., partner, law firm of Thompson, Hine, & Flory, Cleveland, Ohio, prepared statement.....	229
Whelan, William M., executive director, California Hospital Association, William J. Emanuel, Esq., counsel, California Hospital Association; Thomas M. Vogt, counsel, Minnesota Hospital Association; O. Ray Hurst, executive director, Texas Hospital Association; Robert E. Debacker, executive director, Louisiana Hospital Association; a panel.....	149
Prepared statement (with enclosures).....	160
Wilson, Henry T., legislative director, Federal-Public Service Division, Labourers International Union of North America on behalf of Peter Fosco, general president, prepared statement.....	319

#### ADDITIONAL INFORMATION

##### Articles, publications, etc.:

<i>Federal v. State Coverage of Hospital Labor Relations</i> , as viewed by the Hospital Association of New York State; prepared by Harris, Beach & Wilcox.....	129
---	-----

##### Communications to:

Cooper, Hon. John Sherman, a U.S. Senator from the State of Kentucky, from Women's Auxiliary, Methodist Evangelical Hospital, Louisville, Ky., September 19, 1972.....	340
Church, Hon. Frank, a U.S. Senator from the State of Idaho, from: Boyd, L. Clay, administrator, Gritman Memorial Hospital, Moscow, Idaho, August 15, 1972 (telegram).....	368
Brenich, James, Bonner General Hospital, Bonners Ferry, Idaho, August 16, 1972 (telegram).....	369
Felder, Leon C., administrator, St. Benedict's Hospital, Inc., Jerome, Idaho, August 16, 1972.....	363
Gilbertson, E. E., administrator, St. Lukes Hospital, Boise, Idaho, August 15 (telegram).....	367
Harris, Hannah, superintendent, Oneida Hospital, Malad, Idaho, August 15, 1972 (telegram).....	366
Reed, E. Lynn, administrator, Bingham Memorial Hospital, Blackfoot, Idaho, August 15, 1972 (telegram).....	365
Schongalia, William, administrator, St. Mary's Hospital, Cottonwood, Idaho, August 15, 1972 (telegram).....	364
Sister Helen Frances, administrator, St. Joseph's Hospital, Lewiston, Idaho, August 15, 1972 (telegram).....	365
Sister Mary Martina, St. Anthony Community Hospital, Pocatello, Idaho, August 15, 1972 (telegram).....	368
Sister Justine Marie, administrator, St. Alphonsus Hospital, Boise, Idaho, August 15, 1972 (telegram).....	367
States, Newton H., Walter Knox Memorial Hospital, Emmett, Idaho, August 16, 1972 (telegram).....	364
Williams, Dick, Elks Rehabilitation Center, Boise, Idaho, August 15, 1972 (telegram).....	366
Feder, Gerald, counsel, Labor Subcommittee, from J. D. Norris, president, Private Clinics and Hospitals Association of Texas, Stephenville, Tex., September 1, 1972 (with enclosures).....	353
Williams, Hon. Harrison A., Jr., a U.S. Senator from the State of New Jersey, from:	
Abelow, William J., executive director and counsel, League of Voluntary Hospitals, New York, N.Y., August 24, 1972.....	352
Beirne, Joseph A., president, Communications Workers of America, Washington, D.C., August 18, 1972.....	349
Bromberg, Michael D., director, Washington Bureau, Federation of American Hospitals, September 5, 1972 (with enclosures).....	306, 334
Bucher, William M., executive vice president and director, Hospital Council of the National Capital Area, Inc., September 6, 1972 (with attachment).....	271
Davis, Hilton, general manager, Chamber of Commerce of the United States, September 6, 1972.....	265

## VI

Doolan, Thomas B., president, Association of Hospital Personnel Administrators of Greater New York, Lenox Hill Station, N. Y., September 6, 1972 (with enclosure)-----	Page 295
Elder, Harmon L., Washington representative, Southern States Industrial Council, August 24, 1972 (with attachments)-----	276
Fitzsimmons, Frank E., general president, International Brotherhood of Teamsters, Washington, D.C., August 16, 1972-----	360
Hargreaves, (Mrs.) Anne G., president, Massachusetts Nurses Association, Boston, Mass., August 14, 1972 (with enclosure)-----	357
Harrah, Ivan O., executive director, South Florida Hospital Association, Miami, Fla., August 23, 1972-----	330
Johnson, Robert, president, Local No. 4, Service Employee's International Union, Chicago, Ill., August 11, 1972-----	356
Kraus, Sister Irene, D.C., president, the Catholic Hospital Association, St. Louis, Mo., August 25, 1972 (with enclosure)-----	345
Link, E. R., Jr., executive director, American Osteopathic Hospital Association, Park Ridge, Ill., August 25, 1972-----	361
Monahan, Jack F., Jr., executive vice president, Florida Hospital Association, Orlando, Fla., August 24, 1972 (with enclosure)-----	304
Ottley, Peter, president, Local No. 144, Hotel, Hospital, Nursing Home and Allied Health Services Union, New York, N.Y., August 14, 1972-----	355
Rogness, Stephen, Minnesota Hospital Association, Minneapolis, Minn., August 30, 1972-----	350
Rose, David E., administrator, Clear Lake Hospital, Webster, Tex., September 1, 1972-----	343
Sangster, Tom R., assistant director, Colorado Hospital Association, Denver, Colo., August 30, 1972-----	338
Schmidt, Etta B., executive director, National Federation of Licensed Practical Nurses Inc., August 4, 1972-----	260
Sister Mary Lucille, president, St. Patrick Hospital of Lake Charles, Lake Charles, La., August 23, 1972-----	328
Sister Rosa, administrator, Providence Hospital, Washington D.C., September 5, 1972 (with enclosure)-----	121
Stratton, J. D., director of governmental relations, Louisiana Hospital Association, New Orleans, La.-----	351
Vandervort, L. M. administrator, St. Luke's Hospital, Milwaukee, Wis., August 24, 1972-----	331
Vannozzi, Ralph E., administrator, the Bridgeton Hospital, Bridgeton, N.J., September 5, 1972-----	332
Von Ehren, Warren R., executive director, Wisconsin Hospital Association, Madison, Wis., August 25, 1972-----	337

## COVERAGE OF NONPROFIT HOSPITALS UNDER NATIONAL LABOR RELATIONS ACT, 1972

WEDNESDAY, AUGUST 16, 1972

U.S. SENATE,  
SUBCOMMITTEE ON LABOR OF THE  
COMMITTEE ON LABOR AND PUBLIC WELFARE,  
*Washington D.C.*

The subcommittee met at 10:10 a.m. in room 4232, New Senate Office Building, Senator Harrison A. Williams, presiding.

Present: Senators Williams and Taft.

Committee staff present: Gerald Feder, counsel, Donald Elisburg, associate counsel, and Eugene Mittelman, minority counsel.

The CHAIRMAN. The subcommittee will come to order.

We are meeting to consider H.R. 11357 which passed the House of Representatives last week by a vote of 285 to 95. This is a simple bill designed to bring some basic equity to a large class of workers excluded from the protections of the Federal labor management laws by the 1947 amendments; employees of private nonprofit hospitals. Under current law, employees of proprietary hospitals, both proprietary and private nonprofit nursing homes, and educational institutions are covered. This bill would bring equal treatment to both labor and management at these hospitals.

We have a long witness list. We'll begin with Mr. George Hardy, president of the Service Employees International Union. Mr. Hardy, would you introduce your colleagues?

**STATEMENT OF GEORGE HARDY, INTERNATIONAL PRESIDENT, SERVICE EMPLOYEES INTERNATIONAL UNION, AFL-CIO, ACCOMPANIED BY MICHAEL McDERMOTT, ASSISTANT TO THE PRESIDENT, LOCAL 399, LOS ANGELES, CALIF., AND EXECUTIVE BOARD MEMBER; TIMOTHY TWOMEY, SECRETARY-TREASURER, LOCAL 250, SAN FRANCISCO, CALIF., AND VICE PRESIDENT, SEIU; HARRY KURSHENBAUM, ORGANIZING DIRECTOR, LOCAL 73, CHICAGO, ILL.; LEO GEFFNER, COUNSEL; LESTER ASHER, COUNSEL; RICHARD MURPHY, LEGISLATIVE DIRECTOR**

Mr. HARDY. If I may, on my extreme right is Richard Murphy, our legislative director; then Leo Geffner, counsel; Lester Asher, counsel.

To my left is Mike McDermott, assistant to the president, Local 399, Los Angeles, Calif., and executive board member; Timothy Twomey, secretary-treasury, Local 250, San Francisco, Calif.; and Harry Kurshenbaum, from the city of Chicago.

The CHAIRMAN. Senator Cranston has asked me to express his welcome, Mr. McDermott and Mr. Twomey. He wanted to be here but could not. We appreciate your help in this legislation.

Mr. HARDY. Thank you, Senator.

I appreciate the opportunity to speak to you today with regard to H.R. 11357.

Mr. Chairman, I am George Hardy, international president of Service Employees International Union, AFL-CIO. We represent a half-million members in the service industries.

Among our members, we represent more than 125,000 workers in the health-care field. These workers and many thousands of other workers are told that despite the fact that the employees of almost every other nonprofit institution are covered by the National Labor Relations Act, including nonprofit nursing homes and employees of nonprofit colleges, these workers in nonprofit hospitals cannot use the National Labor Relations Board procedures.

The bill before your committee, H.R. 11357, merely deletes this exclusion.

Employers of nonprofit hospital employees are not required by law to recognize or bargain with organizations such as Service Employees International Union representing such employees.

In many instances, hospitals have voluntarily chosen to recognize and bargain with a union. When the hospital employers refuse, however, employees are often forced to strike; not for better wages or conditions or fringe benefits, but merely to obtain recognition. If the bill before us becomes law, employers, employees, and all others involved, will benefit therefrom.

We have experienced many recognition strikes in attempting to represent the workers in nonprofit hospitals. We have succeeded in gaining recognition as the result of many strikes; and sometimes, it takes a very long time.

In Cleveland a few years ago, our local union organized the 450 workers at Saint Luke's Methodist Hospital. We then asked the hospital to recognize us as the legitimate representative of these workers.

The hospital administrator refused to sit down with us. When we strike a hospital in a case such as this, we advertise to all patients and doctors and everybody involved prior to the strike that there is going to be a strike. We did this at Saint Luke's Methodist Hospital.

If necessary, we even furnish ambulances to remove any patients that should be moved out of the hospital. When we are forced to strike, we don't say, "All right, we will strike you tomorrow morning," but we give ample notice and generally put a sign in front of the hospital giving the information exactly when the strike will take place.

We were finally forced to strike Saint Luke's for recognition and this strike lasted 11 months.

Finally, at the end of the 11 months, Mayor Stokes promised passage of a collective bargaining ordinance for nonprofit hospitals; and Saint Luke's finally recognized our local union.

We also had another strike for recognition in 1969 that lasted 33 months. This one was at Ingleside Hospital in Cleveland. There were strikes for recognition at the famous Cedars of Lebanon Hospital in

Los Angeles, the Wesley Memorial Hospital in Chicago, and at many other hospitals.

It seems to me that it is a simple matter of justice that the employees of nonprofit hospitals should be permitted to use the protections of the National Labor Relations Act.

Hospital employees should no longer be denied the same legal rights as employees in other industries.

Coverage under the provisions of the National Labor Relations Act would provide a peaceful method for employees to obtain recognition from their employer.

As you know, the Secretary of Labor, James Hodgson, said in a letter to Chairman Perkins of the House Education and Labor Committee on July 19, 1972:

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 confrontations.

The exemption has not prevented organization when employees have wished to organize. H.R. 11357 will eliminate the major cause for strikes affecting hospitals that take place on grounds of failure to grant recognition.

We urge your committee to report this bill favorably.

Our counsel now has a few words concerning a possible technical amendment that you might wish to make in regard to the definition of "supervisor" and the problems it creates for registered nurses, interns, residents, et cetera.

We are not opposed to this technical amendment as long as chances for the bill's passage are not damaged.

Mr. ASHER. My name is Lester Asher of Chicago. I understand the problem of supervisor has come up here on the Senate side; nothing in connection with this problem was raised before the House committee. We are most anxious to have this bill passed, if possible; because we realize that the organization of hospital workers is a matter of great importance.

There are many strikes, because we have no ground rules. With respect to the supervisor problem, we neither favor nor oppose it. We just would like to get something out as quickly as possible.

But overall, it seems to me that the Labor Board would be able to handle this problem of supervisors most adequately.

This is not the only area where you have close questions as to who are supervisors, and close questions as to the work that they do and how to handle them.

I fear a little, if you open up the statute with respect to the issue of interns or nurses or classifications of that kind, you will be deluged with requests for similar exemptions for other occupations, where the lines of supervision are extremely close.

One of the difficulties in this field is that titles are not controlling. A title in one hospital is different than a title in another hospital; and an intern in one hospital would certainly not be a supervisor; in another hospital he might be.

A nurse in one hospital might be a supervisor and in another hospital she might not be.

So I feel that overall, it would be best for the Labor Board to handle this problem on a case-by-case basis, as it has very successfully throughout all of the facets of our industrial life.

Mr. HARDY. May I introduce next, Senator, Mike McDermott, Local 399, Hospital Workers in Los Angeles.

Mr. McDERMOTT. Senator Williams and Senator Taft, I would like to thank you for the opportunity to appear before you today.

I would like to state that in 1967, the NLRB extended the rights and protections of the National Labor Relations Act to employees of proprietary hospitals, by assuming jurisdiction over the proprietary hospital industry. These rights and protections enjoyed by workers in proprietary hospitals are not enjoyed by workers in nonprofit hospitals.

H.R. 11357 is designed to extend the protection of the National Labor Relations Act to employees of nonprofit hospitals. A great inequity has existed for 25 years.

On December 13, 1971, hearings were held in Los Angeles by the House of Representatives Special Subcommittee on Labor on H.R. 11357. Rev. John Simmons, the administrator of the Pacoima Memorial Lutheran Hospital, in his testimony in support of H.R. 11357, stated:

The difference between a profit and a nonprofit hospital is only in the distribution of any profits generated by the hospital. He went on to say, "Consequently, if all hospitals are to serve the public health care needs, they must be governed by a public policy which is evenhanded."

Tax dollars have been given to build most nonprofit community hospitals under Hill Burton Medicare and Medicaid pay for hospital care services rendered to citizens. This is tax money. Therefore, public policy, under Taft Hartley, should apply equally to profit and nonprofit hospitals.

I call the committee's attention to the distinction between nonprofit and proprietary hospitals. The only difference is the type of ownership and tax loopholes. The service to the community is the basic purpose of both proprietary and nonprofit hospitals and they perform this service in near identical fashion:

The proprietary hospital has a board of directors controlling operations of the hospital.

The nonprofit hospital has a board of directors controlling operations of the hospital.

The proprietary hospital belongs to an employers' association (Southern California Hospital Council.)

The proprietary hospital employs registered nurses, licensed vocational nurses, nurses aides, orderlies, licensed technicians, dietary, housekeeping and maintenance employees. The nonprofit hospital employees have the identical classifications of employees.

Senator TAFT. Are public hospitals members of that association? Are county hospitals members?

Mr. HARDY. No.

They get a wage survey called Griffin-Hagen which is given to county hospitals.

Senator TAFT. In my community, they are all members of the same hospital association.

Mr. HARDY. I do not think under State law, that they can belong to these associations. But they do exchange wage information. They

make a wage survey, and it is turned over to the county for their personnel office.

Mr. GEFNER. Senator, in Los Angeles County, the county hospital—it is determined under the prevailing wage ordinance or charter so that prevailing salaries in the community then become almost automatically the prevailing wages in the county and in the public hospitals.

Senator TAFT. I did not mean to interrupt. Go ahead, please.

Mr. McDERMOTT. The proprietary hospital required verification of medical insurance from incoming patients.

The nonprofit hospital required verification of medical insurance from incoming patients.

The charges from semiprivate rooms and intensive care are the same for both proprietary and nonprofit hospitals.

There are two basic distinctions that can be made between proprietary and nonprofit hospitals:

Employees working for a proprietary hospital are covered by the act and are under the jurisdiction of the National Labor Relations Board.

Employees of nonprofit hospitals are specifically exempted from the act and held outside the jurisdiction of the National Labor Relations Board.

Proprietary hospitals pay taxes on their income. Nonprofit hospitals do not pay taxes on their income.

For many years, the Queen of Angels Hospital functioned as a nonprofit hospital and as such, its employees were precluded from the opportunity to gain union representation through the office of the NLRB.

Recently, it was sold and became a proprietary hospital. Within a few weeks thereafter, the employees of the hospital flocked to the union requesting representation. By the fortune of a sale, these employees were enfranchised with rights hitherto denied them. By what rationalization should the rights and responsibilities of both the employers and the employees be shifted because of a mere shift in the type of ownership?

There have also been instances of proprietary hospitals becoming nonprofit hospitals. This can happen without any visible signs. The employees may not even be aware of this change in status. The patients in the beds would not be aware. There would be no change in any function, service, or cost to the patients. The only difference would be a nondiscernible change in the type of ownership.

In recent years, workers of numerous nonprofit hospitals throughout the southern California area have approached local 399 requesting representation:

Pomona Valley Community Hospital, Intercommunity Hospital, St. Bernadines Hospital, San Pedro Community Hospital, San Bernardino Community Hospital, St. Johns Hospital, Daniel Freeman Hospital, Ingleside Mental Hospital, to mention only a few.

In each instance the union notified the hospital that it represented a majority of the employees. In every instance the hospital either ignored the request for recognition or informed us quite candidly that they were not legally obligated to recognize the union or to consent to an election.

We were confronted with only two options: to abandon the employees, or to strike. One hospital stated that it did not doubt that the union represented a majority of its employees, but under no circumstances would it recognize the union or consent to an election.

There have been hospital strikes in southern California and, except for one hospital, the issue was recognition. We recognize a hospital is vital to the community. In each instance of a strike, the union notified the Department of Public Health that a strike was imminent.

Relatives of patients were notified of the coming strike so there would be ample opportunity to transfer patients to other hospitals. The union even offered to pay ambulance charges so that patients could be moved.

All our collective bargaining agreements contain a grievance procedure, including binding arbitration and a no-strike clause. Unfortunately, recognition of the seriousness of a strike does not resolve the issue.

Resolution can only be found through extensions of the Board's jurisdiction to nonprofit hospitals.

No one is looking for an advantage. The employees of nonprofit hospitals are merely looking for equal treatment and an equal opportunity.

Employees of nonprofit hospitals should no longer be excluded from the act.

It is the cornerstone of our system of industrial democracy. It provides a meaningful alternative to the strike for nonprofit hospital employees who want union representation and, most important, it works.

Mr. HARDY. May I call on Mr. Twomey of San Francisco.

Mr. TWOMEY. Senator Williams and Senator Taft, I am Tim Twomey, secretary-treasurer of local 250 of the San Francisco Bay area. Our union was founded in 1936, and for 31 years, it functioned without protection of any law.

We have today over 20,000 members. We represent workers in all nonprofit hospitals in San Francisco except one, and that is a Chinese hospital in the Chinese ghetto.

The local was founded in 1936, and the impetus of it was the general upheaval that San Francisco, the general strife, the feelings of solidarity among the workers, and also the terrific support and solidarity of all the unions.

In the early days, recognition was gained by heading the picket lines and by the backing of all the unions.

For example, in 1952, we had to strike Notre Dame Hospital for 6 months. Finally, the labor council ruled that all services would be cut off, the stationery, uniforms, inform the hospital they were closing down the boilers.

Within a few days, as soon as the threat was put down, the hospital did agree to recognize us, to sit down and bargain collectively.

We bargained, for example, for 11 hospitals which are members of an association; namely, the affiliate. Another association, Employer Association, of 12 hospitals, four in San Francisco, the remainder in east bay, cities of Berkeley, Oakland, Alameda, and San Leandro, as well as the Keyser Foundation Hospital, and so on, employing over 4,000 of our members. These hospitals stretching from Sacramento to San

Jose, 12 other hospitals are represented individually, but basically follow the pattern that is set.

Our experience has been that strikes have occurred over the issue of recognition. We have come many times close to strikes over bargaining, as part of the bargaining process.

For example, in 1969, we did apply for strike sanction, and we did get ready to strike and Mayor Alioto intervened and mediated the dispute, and I might mention our members got 66 cents an hour increase.

So we are quite sophisticated. The hospitals are quite sophisticated. We realize our responsibility to the community, that we have always appealed to the community for their help and for their support, and realizing our obligation to the community to settle our differences short of a strike.

We represent the workers employed in San Francisco County Hospital where we also have bargaining rights. We are the collective bargaining agent for the employees of Alameda County Hospital, and I might relate one incident on the strike that happened.

This was actually not connected with local 250 nor any other labor organization. It was at Stanford University.

A few years previous, we had been beaten in the election. The election was conducted by the State Conciliation Service.

The law in California does not allow for any unfair labor practices in the conduct of the election. If this had been conducted under Federal standards, the election would have been thrown out.

Stanford University pulled every unfair labor practice in the book. But they lived to regret it. A few years later they were faced with an ad hoc union which called themselves the Revolutionary Black Workers Caucus, and they wanted to sit down, as part of the bargaining process, they wanted to start talking about who they were going to hire as managers. The university refused, and in the process, the committee decided that they were going to stay in the administrator's office.

The police were called; a fire was started and something like \$25,000 worth of damage was done.

It has been happening across the country that because of Federal policy, that draft resisters are, instead of getting jail sentences, in community service. There are many hospitals where draft resisters have gone in.

If hospitals continue with this procedure, I can see there are going to be more instances of revolutionaries and others without any recourse or law to go through.

We are a responsible labor organization. We can be sued. An ad hoc revolutionary committee, who knows who they are? They are here today and gone tomorrow. But the whole point is that we are not asking for you to give us the opportunity to organize these workers. Our union existed for 31 years without any protection. I might mention that the labor movement existed long before the Wagner Act.

What we are asking is that we have orderly legal procedures to determine that do we represent the people. We are asking a fair chance in nonprofit hospitals, that we take our chances through the elective

process. Let the workers decide whether they want a union to represent them or not. If they do not, if they do not choose us, then of course we go away and maybe try later.

Thank you.

Mr. HARDY. The next representative is Harry Kurshenbaum, local 73, Chicago, Ill.

Mr. KURSHENBAUM. Thank you, Senator, for inviting us. I think we reflect in Chicago our experience in the hospital drive started 5 years ago, and I think we can almost add up the turmoil in terms of senseless waste.

Five years ago, we started covering the Chicago area as a union in seeking recognition rights. Since that time, in broad statistics, one-third of the hospitals that we approached, we have had strikes for recognition.

The question was not a contract. We have never had a strike for a contract. Recognition in two-thirds of the hospitals was gained with pure brinksmanship. And I want to point out the fact that in that brinksmanship, which sometimes took from 6 to 9 months, in order to obtain an election, the kind of turmoil, the kind of confusion that existed both between our organization and management and the employees, left some of the hospitals almost helpless.

We are in a situation now that to us really represents an excruciating experience. There are many hundreds of workers in Children's Memorial Hospital in Chicago, who want to be represented by us. The hospital said they will never, over their dead body, allow us to have any kind of an election.

We, ourselves, do not care to enforce a recognition procedure, because of the children. Therefore, employees are utterly helpless in that situation because of our feeling of the kind of reaction that would happen to the children in that hospital as patients being almost involved in a conflict.

Presently, we have had two strikes in 1 month, and the strikes themselves were almost really a kind of a senseless situation, where the issue was simply the question: can we have an election? And the hospitals said, "No."

Looking at the waste in this last month in both those situations, they could have been overcome by some orderly procedure.

The hospital workers in Chicago say how can the Federal Government give recognition in the Veterans' Administration hospitals that we represent, and have members in and not give it to us? Why is there such an imbalance?

The State tries to enter the picture and act as mediator, and they are helpless in trying to bring both parties together.

We feel that and think that as unions we have learned a tremendous responsibility in our relationship with hospitals because of the patient factor.

We think that we can eliminate so much of the turmoil that exists in Chicago today and that people can get a kind of responsiveness to resolve their problems of contractual conditions through grievance procedures, and the contract itself, if the Government sets up the standards such as jurisdiction under the National Labor Relations Act. I think that our people in Chicago are desirous, there is no question that they are desirous, that we impart this feeling to you.

We, at present, in the 6 years have organized 27 hospitals out of 80 hospitals in the immediate Chicago area.

Again, as I pointed out, every one of those situations were fraught with turmoil, and it should be eliminated. The communities feel it should be eliminated.

The newspapers feel it should be eliminated. The hospitals say go to the Labor Board when they know darned well the Labor Board does not have jurisdiction.

Then we come back and point out that the Board does not have jurisdiction—they laugh in our faces. The cynicism is really overwhelming on their part. We feel that this is an opportunity to do something to bring some kind of sanity into the hospital field so that nonprofit workers can have some kind of channels in which to indicate the desires of whether they want to go up or down for a labor union to represent them.

Thank you.

Mr. HARDY. I would like to conclude with Leo Geffner, our counsel from the west coast.

Mr. GEFFNER. Just one or two comments.

Mr. McDermott commented on the basic unfairness of the present status of the law, and the example of the Queen of Angles Hospital in Los Angeles.

The Queen of Angels was a nonprofit hospital where employees did not have the rights under the National Labor Relations Act, and the hospital was sold, and it became a proprietary hospital.

Then the same employees overnight did have basic NLRB rights for representation election. As far as the community was concerned, there was no difference in the hospital; the same services, the same facilities, the same staff, the same number of employees, and in fact the same employees themselves.

The problem is also unfair and discriminatory on the other side of the coin.

For many years the Labor Board did not assert jurisdiction over proprietary hospitals. The service employees organized the nonprofessional employees of a hospital in northern California and used that case hospital as an effort to convince the Board to reverse its prior policy.

The service employees filed a petition, and we had numerous hearings, and the Board deliberated for many, many months and eventually reversed its prior policy on a showing that the proprietary hospital was clearly involved in interstate commerce and did have a national impact because of the introduction of medicare and because of the heavy influence of national insurance carriers that carry a substantial coverage of medical costs.

After the Board asserted jurisdiction under the California law, the group of doctors that owned the medical center in northern California obtained a nonprofit hospital charter and the hospital after this long litigation became a nonprofit hospital and then did not come under the National Labor Relations Board even though this long litigation had involved that very same hospital.

So the same employees, nonprofessional employees that had filed this petition, obtained recognition in early 1966 after a year and a half of litigation, just simply because there was a change in title,

then did not have any bargaining or representation rights on the NLRB.

The hospital remained the same hospital, same doctors, same staff, same employees, although technically it was a nonprofit hospital.

One further point. There is a tendency at least in California for small proprietary hospitals to shift to a nonprofit status. What occurs is that the method of distributing income of proprietary hospital changes form and the hospital becomes nonprofit in name only and the profits are attained through the device of higher administrative salaries, special facility treatment where physicians have previously had stock in a hospital and other gimmicks, such as high rents under leases, leased for the holder of the physical holder.

So that this technical difference of nonprofit or proprietary has had a severe impact on employees because of the status of the law has ended up in this unfair discriminatory position.

The question of supervisors, Mr. Asher discussed; we have had numerous problems in terms of these, defining a unit and in the sense that the Board is taking jurisdiction over proprietary hospitals and nursing homes and nonprofit convalescent homes.

We realize it is a problem, particularly in the nursing department, because of the function of the professional, in terms of a nurse performing professional duties separate from administrative duties.

And so if an amendment is in order concerning this question of supervisors in the nonprofit hospitals, Mr. Asher and I would be happy to meet with counsel of the committee and work on language, if we are so requested.

The CHAIRMAN. Thank you very much.

Mr. HARDY. Those are our presentations.

The CHAIRMAN. I have no questions. Thank you very much.

Senator Metcalf, we welcome you. I know you want to introduce our next witness, so I will say nothing further other than to welcome you back to this committee.

#### STATEMENT OF HON. LEE METCALF, A U.S. SENATOR FROM THE STATE OF MONTANA

Senator METCALF. Thank you very much, Mr. Chairman.

It is a real privilege to come back to the committee and have the opportunity to present one of Montana's most respected and distinguished citizens.

Mrs. Mary Munger, who is going to be your witness, has been a representative and executive director of the Montana Nurses' Association for 16 years.

She was the lobbying representative for the Montana Nurses' Association when we passed the 1967 Montana bargaining law for registered nurses and licensed practical nurses.

As a result of her activities, that became known in the legislation as the blue-eyed nurses' law and she more than anyone else is responsible for that bargaining law, blue-eyed nursing law, and she well deserves it.

After the law went into effect, she participated in her capacity as executive director. She is a skilled professional nurse; she is an experienced executive in the nurses' association and she has participated in bargaining in the nurses' association.

She is very well respected and experienced witness to appear before this committee, and I am proud, and I know Senator Mansfield would be equally proud were he able to be here, to present Mary Munger as a witness before your committee.

The CHAIRMAN. We appreciate very much that introduction.

Mary Munger, we are looking forward to your statement. Let us hope you are as effective here as you were there.

**STATEMENT OF MARY MUNGER, R.N., VICE CHAIRMAN, COMMISSION ON ECONOMIC AND GENERAL WELFARE, AMERICAN NURSES ASSOCIATION; ACCOMPANIED BY ALICE L. AHMUTY, R.N., DIRECTOR; ANTHONY BATTORE, M.D., EXECUTIVE SECRETARY, COMMITTEE OF INTERNS AND RESIDENTS, NEW YORK; AND MICHAEL HOROWITZ, ATTORNEY**

Mrs. MUNGER. I am Mary Munger; I am vice chairman of the Commission on Economic and General Welfare of the American Nurses' Association.

I am here to present testimony on H.R. 11357 for the ANA. I would like to introduce at this time Alice Ahmuty, who is the executive director of our economic and general welfare department.

The other people who are at the table will be introducing themselves.

Senator, I do have a statement and have submitted it. It is a rather lengthy statement of testimony regarding this legislation, and I would like to have it submitted in total for the record. I just have a brief summary that I would like to follow today.

The CHAIRMAN. We appreciate that and your full statement will be made a part of the record and inserted at the end of your testimony and we will be glad to have your summary.

Mrs. MUNGER. The American Nurses' Association has supported the amendment to the National Labor Relations Act for several years to extend coverage to the employees of nonprofit hospitals. We have a long record of this kind of support.

The ANA believes that the protection of the right to organize and bargain should be extended to all health-care employees, professionals, and nonprofessionals.

As you probably know, the ANA supports collective bargaining as the means by which professionals as well as nonprofessionals will be able to influence not only the standard of employment where they work, but also to participate in the discussions about nursing practice standards.

We believe this would be the most effective means to do this.

The ANA is concerned, however, as was pointed out by the gentlemen who preceded us about the determination of the appropriate bargaining unit should the NLRA be extended to cover nonprofit hospitals.

In the determination of the appropriate bargaining unit the problem arises out of strict interpretation of the term "supervisor" as defined in section 2(11) of the NLRA, when applied to the work of a professional nurse.

By law—and this is by State statute—nursing practice act, patient care supervision, as principal duty of the registered nurse, but this does not mean that the registered nurse controls the work of others

in a bureaucratic sense. It rather means that registered nurse shares her professional knowledge with other members of the nursing team in determining the best way to meet patient need.

By legal definition of nursing practice, the registered nurse is required to assume responsibility for exercising independent judgment and discretion in relation to patient care needs, a responsibility which is at the very core of the nurse's professional status under the NLRA.

It would make no sense and would defy Congress' express intention that registered nurses be accorded rights as professionals under the act to hold that the act of patient care supervision, which goes toward registered nurses' professional status, are also—have the effect of making her a supervisor under the act.

There is a need to differentiate between the exercise of independent judgment as part of the work of a highly skilled occupation directed toward quality patient care and in the exercise of independent judgment for purposes of personnel administration.

It is no exaggeration to say that proper regard for this distinction is vital for the protection of professional employees' rights under the NLRA.

Within the authority structure authorized health care services, professionals have unique status and responsibility. The right of health care professionals to bargain, of which registered nurses constitute the largest single body, approximately 486,000 in this country in all categories of hospitals, require special protection in the law.

We have on this point had conferences with representatives of organized labor as well as with the gentlemen who are here representing the interns and resident physicians, and we have agreed on the need to change the definition of supervisor in NLRA to accommodate to the uniqueness of the professionals under the act.

The report on H.R. 11357, the House report, is not sufficiently clear on its legislative intent when it states on page 5 of the report that nurses with only nominal supervisory duties should not be considered as supervisors.

As one of the gentlemen earlier stated, job titles really do not apply the kind of authority that the title might imply, and there is a need then to look at what the nurse is actually doing, rather than by making a judgment about her supervisory responsibilities on the basis of the title.

The bargaining rights of registered nurses and other professionals may be jeopardized unless there is a change in section 211 of the NLRA. The ANA, therefore, suggests that 211 of the NLRA be amended to qualify the definition of supervisor as it relates to the responsibility of nurses and other professionals for patient care.

In the testimony, in the full text of the testimony, this issue is dealt with primarily in much greater length, Senator, so I will not go into it any further here.

The CHAIRMAN. Thank you very much.

(The prepared statement of Mary Munger follows:)

## AMERICAN NURSES' ASSOCIATION

## STATEMENT ON

H.R. 11357

to the

Subcommittee on Labor  
of the Committee on Labor and Public Welfare  
of the U. S. Senate

by  
Mary Munger, R.N.

August 16, 1972

I am Mary Munger, R.N., Vice Chairman of the Commission on Economic and General Welfare of the American Nurses' Association. Accompanying me is Alice L. Ahmuty, Director of our Economic and General Welfare Department. The Association is the professional organization of registered nurses in the United States. It has constituent associations in all fifty states, the District of Columbia, Guam and the Virgin Islands.

As the Association representing the largest group of professionals providing health care to the American public, the American Nurses' Association welcomes this opportunity to present its views and comments on this proposed amendment to the National Labor Relations Act, which seeks to extend its coverage and protection to employees of nonprofit hospitals.

The American Nurses' Association has long supported such an amendment. We believe the present exemption of hospitals has hindered harmonious employer-employee relations in the hospital field.

The right of all health care employees to organize and bargain should be protected in Federal law. In extending protection, it is essential that Federal legislation recognize and accommodate to the basic character of the health care industry in the United States today. Hospitals have evolved their own distinctive form of organization for their professional staff. Organizationally, the hospital is a mix of two authority systems: the bureaucratic and the professional. The nature of hospital organization is elaborated upon in Appendix I.

#### Professional Authority and Supervision

Within the authority structures of organized health care services, professionals have unique status and responsibilities. The right to bargain of health care professionals, of which registered nurses constitutes the largest single body, requires special protection in law. The bargaining rights of registered nurses and other professionals may be jeopardized unless the definition of supervisor is qualified.

The problem arises out of a strict interpretation of the term "supervisor" as defined in Section 2(11) of the NLRA, when applied to the work of a professional nurse. The term as originally defined was intended for application to the business or industrial setting, where a supervisor exercises considerable amount of authority to control and direct the work of others. This is not true for the work of nurses, or for that matter, work of all professional employees. Every nurse while practicing her profession exercises her own independent judgment. Legally,

every nurse is responsible for her own acts. Even a doctor's order cannot immunize the nurse from such responsibility or from suit by an injured patient. The nurse supervisor may advise and assist other nurses in their practice, but she cannot "direct" their practice. In view of this peculiarity of the nursing profession, any mechanistic interpretation of the term "supervisor" as is normally relevant and valid in the business or industrial parlance would result in the exclusion of a large number of practicing nurses from the coverage of NLRA.

The health team providing the actual care to the patients within the unit may consist of several types of personnel -- the nursing aide, the practical nurse and the registered nurse. The registered nurse, as the professional and the most educated of this group, provides the direction for the care of the patient. In this sense, the senior nurse or head nurse or the nurse "in charge" of the nursing care unit or of a group of patients, functions as a patient care coordinator: determining the patient's needs, determining who among the staff shall care for the patient, and providing the advice and consultation needed by less prepared or less experienced team members. The nurse utilizes professional judgment in providing direct care to patients and in evaluating whether good and adequate patient 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 patient care can go on despite the shifts in personnel.

Almost all nurses exercise independent judgment and professional authority to direct other employees. Few, however, possess the "bureaucratic" authority envisioned in the NLRA definition of "supervisor" -- to

effectively recommend hiring, firing, promotion and discharge. In nursing, the term "supervisor" should be limited to those registered nurses who truly and substantially possess and exercise such authority over other registered nurses. In present-day hospitals, such true supervisors are typically limited to the director of nursing and her immediate assistants and associates.

Whatever transitory or limited authority nurses have over other employees is often not "supervisory," but rather a manifestation of their professional role in the nursing care of patients. A registered nurse who leads subprofessional employees should not be considered a supervisor any more than a physician should be considered a supervisor because nurses respond to his directions, or an attorney should be considered a supervisor because a secretarial staff is available to work with him.

New forms of organization are developed and tried in response to the problems posed by the rising demand for health care and the shortage of skilled personnel. Hospitals and nurses should be free to cooperate in experiments with newer structures without endangering the status of the professional association as the representative of nurses. Where labor boards accept the "trappings" of supervision as "supervision," employers are encouraged to encumber their registered nurse employees with whatever regalia it takes to remove the employer from the obligation to bargain.

Registered nurses satisfy the definition of "professional" employee under the National Labor Relations Act and under a number of state statutes. Under laws with a supervisory exclusion, the right of registered nurses to organize and bargain collectively can be disastrously

diluted unless labor laws recognize their community of interest and the nature of the professional authority they exercise over others on the nursing team.

The Massachusetts Labor Relations Commission has included in bargaining units all registered nurses, except directors and assistant directors of nursing service, and almost eight years of experience with that unit determination has confirmed its wisdom. While the Massachusetts Labor Relations Law contained no express provision excluding supervisors from the bargaining unit, the Massachusetts Commission considered the matter just the same, and concluded that the supervisors and head nurses do not possess the indicia of supervisory employees in any relatively greater degree than a general duty nurse who, by virtue of her training and experience as a registered nurse, is also required to exercise independent professional judgment. Thus, in the Quincy City Hospital and the University Hospital cases, (Nos. CR 2951 and 2963, 1965) the Massachusetts State Labor Relations Commission ruled that nursing supervisors and head nurses were to be included in the bargaining unit.

Whatever the rules for determining the supervisory status of non-professionals, great caution must be exercised in applying those rules to professionals in order to avoid confusing the requisite judgment and discretion of professionals with the directional responsibilities of supervisors and thereby depriving the former of rights Congress intended they have. While registered nurses in the exercise of their professional responsibilities give direction and assistance to other nursing personnel such as LPN's and aides, they do not exercise true supervisory responsi-

bilities. Registered nurses must exercise independent judgment in making decisions in regard to patient care but only routine and minimal authority with respect to personnel matters. The fact that, as professionals, they routinely lead the work of less skilled employees does not make them supervisors within the Act. It is important that the responsibility of registered nurses to exercise independent judgment in supervising patient care not be confused with the question of personnel supervision under the Act. By law, patient care supervision is a principal duty of the registered nurse.

By legal definition of nursing practice in state's nursing practice acts, the registered nurse is required to assume responsibility for exercising independent judgment and discretion in relation to patient care needs, a responsibility which is at the very core of the nurse's professional status under the Act. It would make no sense, and would defy Congress's expressed intention that registered nurses were to be accorded rights as professionals under the Act, to hold that the fact of patient care supervision which goes towards the registered nurses professional status, also had the effect of making her a supervisor under the Act. There is need to differentiate between the exercise of independent judgment as a part of the work of a highly skilled calling and for quality patient care, and the exercise of independent judgment for purposes of personnel administration. It is no exaggeration to say that proper regard for this distinction is vital for the protection of professional employees rights under the Act.

#### Proposed Amendment to Section 2(11)

Special note was made in the House Report on H.R. 11357 of the special problems faced by nurses. The Report states:

"The ANA urged that industrial concepts of 'supervisor' not be carried over into the hospital industry, possibly

leading to the exclusion of head nurses or charge nurses from bargaining units. These nurses are presently included in bargaining units in some states. Your committee's intent in extending NLRA coverage to nonprofit hospitals is that nurses as well as all other hospital employees enjoy the rights guaranteed to other employees covered by the Act, and it is your committee's view that nurses with only nominal supervisory duties should not be considered as 'supervisors' within the meaning of the National Labor Relations Act." (p.5)

While we appreciate the recognition of nurses special problems, this statement of legislative intent is not sufficient. Manifestations of professional authority and responsibility in the nursing care of patients are supervisory functions entirely different from that of industrial supervisory functions.

Congress has recognized in the past unique problems of special industries in the NLRA. For instance, Sections 8(e) and 8(f) accommodate to the special needs of the clothing and apparel industry and the construction industry. Special accommodation needs to be made in the law which clearly recognizes the distinction between professional authority of registered nurses and "bureaucratic" authority within the hospital setting. Therefore, the ANA suggests that Section 2(11), the definition of the term "supervisor," be amended to qualify that definition as it relates to professional registered nurse authority and responsibilities. A registered nurse should not be deemed a supervisor when exercising independent professional judgment.

The ANA supports the removal of Section 2(2) from the NLRA because it brings a level of protection to hospital workers sorely needed. We ask, however, that you give particular attention to the state arrangements that have grown up in the vacuum created by the exception. We strongly urge that the proposed amendment to Section 2(11) of NLRA qualifying the term "supervisor" in regard to registered nurses be favorably acted upon.

Thank you, Mr. Chairman. The ANA appreciates the opportunity you have given us to appear before you today.

## Appendix I

The Nature of Hospital Organization

Most businesses are organized along bureaucratic lines: there is an hierarchic authority structure in which persons in the top-ranked positions have authority to direct the activities of those below them. In contrast, the professional model is characterized by autonomy and self-determination:

"...members of the occupation are self-regulating and have control of their functions in the work situation. Because of the specialized nature of the knowledge, only members of the profession are recognized as competent to define and control functions."

In health care facilities, these two administrative systems co-exist.<sup>2</sup>  
In hospitals, for example:

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- 1 Ada K. Jacox, "Who Defines and Controls Nursing Practice?," American Journal of Nursing, May 1969.
  - 2 From the remarks of Temple Burling, M.D., to the 1960 ANA Economic Security Conference. Published by ANA in "Addresses on Trends Affecting the ANA Economic Security Program." At that time, Dr. Burling was a professor of industrial and labor relations at Cornell University and a member of the American Medical Association, the American Psychiatric Association and the American Orthopsychiatric Association.

"....the hospital administrator must facilitate communication and coordination of activities among the professional groups and enable the different professional groups to coordinate their varied and specialized functions in such a way that the patient will benefit to the maximum extent.

"....the professional worker tends to turn to his profession and his professional organization for the sanctions and directives for carrying out his task. As a result, in hospitals, or any organization in which a large proportion of the workers are professional people, the administration has diminished responsibility and authority to direct and regulate the activities of the workers. For example, the administrator cannot order members of a professional group to behave in ways that are contrary to their professional ethics."

Thus, in the hospital, the authority of the administrator as chief executive is limited. "His authority extends to, but not beyond, the heads of the various departments which...typically have, as their responsibility and authority, a more or less independent and distinct organizational sub-<sup>3</sup>division within the hospital."

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<sup>3</sup> Hans O. Mauksch, "The Organizational Context of Nursing Practice," in Fred David, ed., The Nursing Profession, John Wiley and Sons, Inc., New York, 1966.

This organizational model mixing two authority systems has proved perfectly valid. However, it is not the model with which labor boards customarily deal, nor is it the model upon which regulations developed for bureaucratically structured industry can be successfully imposed without accommodation. This organizational context for nursing influences the relationship of the nurse to everyone else in the health care facility -- to the physician, to other nurses, to nonprofessionals and to the employer.

Hospitals are complex organizations providing the services of many different occupational groups, both professional and nonprofessional. Yet, all these groups within the hospital structure work to one end, the care of the patient. Within the organizational structure of the hospital are a number of different departments. Hans O. Mauksch, a leading sociologist studying this field, points out that unlike industry where the organizational structure is that of a "tree:"<sup>4</sup>

"The organizational scheme of the hospital resembles a comb, rather than a tree. While the administrator is the chief executive, his authority extends, to but not beyond, the heads of the various departments which are horizontally aligned, and typically have, as their responsibility and authority, a more or less independent and distinct organizational subdivision within the hospital. Any direct influence of the administrator is, incidentally, most evident in those departments which either do not have a professional identity or do not extend into the area of direct patient care....

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4 *Ibid.* pp. 114, 116.

"The departments of the hospital vary in size and complexity, and by this criterion alone they can be considered to have various degrees of importance. The department of nursing is most generally the largest one and includes the most involved suborganizational structure...."

The department of nursing is the one which has the most direct and consistent contact with the patient. It is the one that, no matter the organizational structure of the institution, is always staffed on a 7-day a week, 24 hour a day basis.

The structure of this department usually has a director of nursing, nurse supervisors, so-called "head nurses," staff or general duty nurses, practical nurses, nursing aides, orderlies, and attendants. Also, there are often ward maids, ward secretaries, and the like. The head nurse is the senior nurse within a patient care unit structure within the department. In more complex structures, there may be within the patient care unit so-called "charge nurses," team leaders, nurse clinical specialists, and ward managers. However, it can be seen that the professional person staffing this department is the registered nurse. The registered nurse is the professional worker who is "assigned to the patients' care unit and remains there while all other workers come and go. This implies that she is charged with the totality and continuity of the patients' care."<sup>5</sup>

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5 Mauksch, H. O.; "Nursing Dilemmas in the Organization of Patient Care," in Buiiough and Buiiough, eds., *Issues in Nursing*, Springer Publishing Co., Inc., New York, 1966, p. 129.

Other sociologists cite this role of the registered nurse within the modern hospital structure:<sup>6</sup>

"One of the social conditions which has contributed to the emergence of nurses as leaders is the fact that they are often in the middle of communication networks about patients in the modern hospital. Physicians, technicians, dietitians, social workers, families and friends of patients typically come and go through the day. But it is the nurse who spends most time directly where the patients stay...."

"The nurse also stands at the communication center between hospital and medical lines of authority. She is usually familiar with hospital rules and procedures so she can interpret them to physicians who appear infrequently or briefly in her section. She performs a similar function for aidés, orderlies and floor secretaries, interpreting medical information for them so they can work effectively in the hospital...."

Thus, all registered nurses within the hospital, regardless of position title, at some time or other perform the function of interpreting hospital policy and instructing those with lesser qualifications. Furthermore, each

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6 Mumford and Skipper, *Sociology In Hospital Care*, Harper and Row, New York, 1967, pp. 93-94.)

registered nurse is legally responsible for her own acts. In carrying out her duties as a professional, regardless of position title, she must exercise independent judgment in interpreting medical directives and caring for the patients for whom she is responsible.

Since, in today's hospital, the health team providing the actual care to the patients within the unit may consist of several types of personnel -- the nursing aide, the practical nurse, and the registered nurse -- it becomes the responsibility of the registered nurse, the professional and most educated of this group, to provide the direction for the care of the patient within the nursing unit. In this sense, the senior nurse, or the nurse "in charge" of the unit or a group of patients, becomes a patient care coordinator. This person, in determining a patient's needs, can determine who among the staff or the unit shall care for the patient and provide the advice and consultation needed by the less prepared or less experienced member of the team within the unit. She needs to utilize her professional judgment in evaluating whether good and adequate care is being given, 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 the shifts in personnel. Because of the 7-day, 24 hour operation within a patient care unit, several registered nurses within the unit may perform some facet of this operation at times. Conversely, the registered nurse "in charge" also functions largely in the capacity of providing direct professional care to the patient.

When dealing with a professional group one needs to look at the profession as a whole. One of the characteristics of a profession is its community of interest. The members of a profession are bound by a "sense of identity;"

they share common values, and have a common language peculiar to the profession and only partially understood by outsiders.<sup>7</sup> In determining the appropriate bargaining unit for a group of registered nurses care needs to be taken that this community of interest not be severed or fractionalized by equating fine distinctions in role or responsibility with traditional industrial concepts of "supervisor." Basically, the role of the professional nurse within the hospital structure is that of administering, planning and organizing nursing care. As one nursing leader has put it "Rank, as such, is nonexistent within the team membership or within the total organization of the nursing service."<sup>8</sup>

The basic concern of all registered nurses is the patient and the real determinant of who does what is the nursing needs of the patient and the diagnosis and prescription of the physician.

A professional must utilize his unique skill and education within the bureaucratic structure in which he finds himself. While in some few situations today and more frequently in yesterday's world one would find the role of the registered nurse that of both developing the nursing care plan for a patient and completely carrying it out, this is not the case in most hospitals today. Today we find a number of subprofessional categories carrying some of the functions involved in the care of the

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7 Goode, William J., "Community Within A Community: The Professions," American Sociological Review, Vol. 22, April, 1957.

8 Lambertsen, Eleanor, Nursing Team Organization and Functioning, Bureau of Publications, Teachers College, Columbia University, 1953, p. 13.

patient. Thus, the exigencies of the modern system of the delivery of health care place the registered nurse to a certain extent in a coordinating, directing, and teaching role as well as one of administering direct care. The complexity of the modern hospital requires a certain pyramiding of nurse positions to handle the various aspects of this role. One of the nurse leaders in an article describing the release of this person from having to develop time and vacation assignments for individuals has indicated that the "most vital role" of the head nurse is that of "nursing care management."<sup>9</sup> The professional responsibility of all registered nurses and the goal toward which their education is directed is that of providing quality care regardless of position within the structure. The degree of responsibility of a particular registered nurse for the organization of this care may be of greater or lesser dimension, but all registered nurses working within a patient care unit carry some aspect of this responsibility in exercising their professional judgment of the type of care which a patient requires. This does not make them supervisors within Section 2(11) of the Act, since all of them are bedside (or operating room, etc.) nurses, engaged primarily in direct care to the patients, with any other functions sporadic and incidental thereto. All of the registered nurses within the unit have and must have a colleague relationship with the other to achieve the goals of quality care for the patients within the unit. This mutuality of interest and concerns should be maintained in all aspects of the working relationship.

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<sup>9</sup> Stryker, Ruth P., "A Staffing Secretary Releases Nursing Time," American Journal of Nursing, Vol. 66, No. 11, November 1966, pp. 2478.

Mr. BATTORE. My name is Dr. Anthony Battore. I am executive secretary of the committee of interns and residents. I am accompanied by our counsel, Mr. Michael Horowitz.

We are here also to offer testimony about H.R. 11357, and our belief that it needs to be amended, specifically as nurses indicated, to clarify the position as to whether or not so-called supervisory personnel can join under the National Labor Relations Act.

Technically, we believe that interns and residents and nurses and related personnel should be related to more elaborate presentation of the type of amendment. Briefly let me state about what the committee is and my own qualifications.

I trained at Downstate Medical Center in New York City, graduated in 1966, and since then trained in California, San Francisco.

The area of study which I have undertaken is predominantly labor relations matters as it relates to interns and residents.

The committee of interns and residents represents approximately 5,000 household interns and residents and clinical fellows at about 22 hospitals in the New York City area. It has been in existence since 1958.

**STATEMENT OF ANTHONY BATTORE, M.D., EXECUTIVE SECRETARY,  
COMMITTEE OF INTERNS AND RESIDENTS, NEW YORK, N.Y.**

There are two aspects to H.R. 11357, which I think are essential with regard to interns and residents.

No. 1 is the ethical thing, to prevent strikes by hospital employees. This can be done through providing a framework for collective bargaining.

The second thing is humanistic aspect, to provide a situation, where house officers can have a humane type of training. There have been many instances where house officers have tried to effect improvements in their working conditions.

One such example is job action held in 1967 at Boston City Hospital. At that time, the wife of one of the officers was interviewed in the newspapers.

He had been working for 20 years in various schools. He was \$10,000 in debt and the family qualified for food stamps at that time. The wife made a quote which I think is relevant. "I think if the fellows were able to make a decent living during this period, they would not be so conscious afterward. My husband is really an idealist, but sometimes when he is working over the bills, he will say something like, 'Oh, boy, wait until I have some money.'"

I think it is very important that young physicians be given the same rights as other hospital workers, and that a framework be presented which would prevent the possibility of strike for recognition by a group of house officers, who would see porters and other groups forming unions, but would be told they are so-called supervisory personnel.

The CHAIRMAN. Mr. Horowitz.

Mr. HOROWITZ. I am going to be as brief as I can. I think it might be somewhat significant to note the scope of intern and resident responsibilities. We are talking of some 50,000 young physicians in this country, who in the main bear the principle immediate health treatment responsibility at the hospitals of this country, particularly in major urban areas.

Some 18 to 20 percent of the practicing physicians dispensing health care in this country are young and not so young interns and residents.

The committee of interns and residents, in our sense, it is reflective of the prototype health staff officer, just under 30 years old, is married, and has a fraction less than a child and is some \$8,000 or \$10,000 in debt.

We have had in the committee of interns and residents various collective bargaining agreements, fixed salaries for interns and residents, and I might indicate, Senator, that one of our witnesses at a proceeding was Margaret Mead, who is a physician herself, and perhaps the principal academic expert and otherwise on problems, generation gaps, in this country and elsewhere.

She described a problem with interns and residents as one of the most potentially explosive situations in this country.

In this country, we are not talking about schools, Senator. We are talking about family physicians for the sick poor, salaries of \$4,000, \$5,000, and \$6,000 a year, working 100 hours a week, and who are told by hospitals that they have no right to form organizations to better their own circumstances.

Now, there is going to be a lot of testimony, and I have read the statements about the strike, the problem of strikes.

I think H.R. 11357 is mandated legislation, precisely in order to avoid strikes, because there is no way of holding down that explosive mix on circumstances where they have no alternative between confrontation on the one hand and submission on the other.

That is a terrible choice, which is proposed in the absence of meaningful legislation.

I can tell you just yesterday I received a call from some interns and residents in New York. I cannot mention the hospital at this point, in fact, because the protection afforded to interns and residents who undertake these kinds of efforts is such that they feel particularly exposed. But the need for that right of organization, meaningful statute, just is created precisely to avoid the kind of strikes which one can almost guarantee will take place, particularly if you are talking about people who are not very distance from campus settings themselves, where they have been in situations where confrontations have been used.

One can hardly describe a more dangerous mix, and it is the absence of legislation which provides them that alternative, which provides and moves the door for this situation, that creates the problem.

I want to comment on what Dr. Battore and Mrs. Munger said with regard to some technical modifications of the statute.

I cannot believe that there is anyone in the Senate or otherwise who would wish to decertify existing units of interns and residents in some communities. They are involved in various phases of bargaining in New York, in Minnesota; it is beginning to form in Pennsylvania; and there are some other States.

There are some very real risks attendant to the supervisory definition, in the legislative history and the House report, as it will indicate, for insufficient protection to those interns as well as those nurses.

May I say parenthetically, and here I claim limited expertise of being counsel to the New York State Nurses Association, as much as 30 percent of the nurses are involved in positions which might be in jeopardy in terms of collective bargaining if a rigid application of section 211, supervisors exclusion, were applied, and that could be

of extraordinary impact, of causing the very kind of recognition strikes which H.R. 11357 is meant to avoid.

So that we testify, and with some having dealt with this situation of seeing interns and residents not only in New York City, but elsewhere, feeling themselves in a situation of very difficult circumstance, committed not to training, undertake any kind of efforts, but in no position of having alternatives, and there is no legal recourse available to them.

So this Congress must pass, and pass pretty quickly, some legislation which provides a meaningful way for these people to solve their problems.

In terms of New York, over a course of a 20-year period, the salaries have gone from \$70 a month to something around \$12,000 a year.

Not only that, it has been voting membership on medical boards from these young physicians in hospitals through collective bargaining.

All of these things have taken place without confrontation within the context of the law, and it is precisely that which has to be preserved if 11357 is passed by permitting all residents to engage in bargaining.

I want to indicate, Senator, that I regard NLRB—would necessarily hold that interns and residents are supervisors, and I would say, however, from reading the decisions that the risk is substantial and enormous, and that some technical clarification is clearly needed if we are to avoid that decertification and the recognition strike.

I will just impose on your time, because I know there are additional witnesses coming, and I have read some of the statements, but we take no back seat to any of the witnesses in our parlance in strikes, in our desire to have a peaceable setting in hospitals. I heard the testimony of the gentleman from Chicago, and I can tell you from my own experience, that the difficulty of strikes—well, it is precisely that which is going to happen increasingly unless professionals who are now engaged in bargaining are permitted to continue to do so and unless hospital employees in States where there is no such ability to do so, are not; so that we do not—this is in the strike legislation, most fundamental.

Thank you very much.

The CHAIRMAN. Thank you very much.

It is very persuasive testimony. We appreciate your statement and your help in formulating this legislation.

Mr. HOROWITZ. Thank you.

The CHAIRMAN. Mr. David H. Hitt, chief operating officer, Baylor University Medical Center is the next witness.

**STATEMENT OF DAVID H. HITT, CHIEF OPERATING OFFICER, BAYLOR UNIVERSITY MEDICAL CENTER, DALLAS, TEX., ACCOMPANIED BY WILLIAM J. EMANUEL, LABOR ATTORNEY, AND MEMBER, SPECIAL COMMITTEE, AMERICAN HOSPITAL ASSOCIATION OF LABOR RELATIONS AND PERSONNEL MANAGEMENT; AND LEO J. GEHRIG, M.D., ACTING DIRECTOR, AMERICAN HOSPITAL ASSOCIATION SERVICE BUREAU, WASHINGTON, D.C.**

Mr. HITT. Mr. Chairman, I am David H. Hitt, chief operating officer of the Baylor University Medical Center, in Dallas, Tex.

The CHAIRMAN. You are not a medical doctor, are you?

Mr. HITT. Pardon me?

The CHAIRMAN. Are you a medical doctor?

Mr. HITT. No; I am not.

With me are William J. Emanuel, a labor attorney from Los Angeles, Calif., who is a member of a special committee of the American Hospital Association on labor relations and personnel matters, and Dr. Leo J. Gehrig, who is acting director of the American Hospital Association's Washington Service Bureau.

I am here to testify on behalf of the American Hospital Association, which is an association of some 7,000 hospitals located throughout the United States.

I have a brief statement, and I would like to read it, if I may.

The American Hospital Association strongly opposes H.R. 11357, which would remove from the National Labor Relations Act the current exemption for nonprofit hospitals.

Our opposition to the bill is based on our sincere belief that the provisions of the National Labor Relations Act should be not applied to hospitals or other health-care institutions because the basic elements in the collective bargaining process under the National Labor Relations Act; that is, strikes, picketing, and work stoppages, should not be tolerated in the life and death situation faced daily by hospitals.

We believe that it is clearly not in the interest of the American public to legislatively authorize such activities for general application in the environment where seriously ill persons must be treated. Certainly, hospital services are from society's standpoint at least as essential as fire protection and police protection, and must be available without any interruption.

In recognizing why hospitals and other health-care institutions should not be subject to the National Labor Relations Act, it is necessary to understand the essential nature of health-care services to a community.

Health care institutions really have no true analogy in industry. Health care institutions do not manufacture or sell products. Rather, they deal in the preservation of human life and the restoration of human functions.

The primary purpose of such institutions is the delivery of patient care services and, in providing these vital community services, often under emergency conditions, health-care institutions depend on the close coordination of many different professional, skilled, semiskilled, and unskilled workers.

In delivering patient care services, health care institutions are wholly dependent on their employees. In community hospitals across the country today there are almost three employees for each inpatient. The fundamental needs of sick persons cannot be met by machines.

Thus, around-the-clock availability of health care personnel working closely together as a team is an absolute requirement for health-care institutions to meet their responsibilities to patients and the community. Any interruption, interference, or delay in patient care services would result in increased morbidity or loss of life.

And if I can say parenthetically here—it is not in the report—that we are not just talking about the difficulty after you have got a strike and you are told to move the patient. We are talking about the weeks of anxiety among employees before a strike as well as those

who remain on the job during a strike, and then the animosity that might be present after a strike.

The CHAIRMAN. An economic strike or a recognition strike?

Mr. HITT. Either kind of strike, from the standpoint of the patient, is reflected in the same manner.

The report of the House Committee on Education and Labor on H.R. 11357 states that the American Hospital Association opposed passage of this bill but that "its New York and Massachusetts State Associations favored its passage."

We wish to point out to the committee that these two State associations recognize the serious deficiencies of the National Labor Relations Act as applied to hospitals which we are presenting in our testimony.

H.R. 11357 would amend the National Labor Relations Act by removing the current exemption of nonprofit hospitals from the provisions of that act.

The implications of such action must be carefully evaluated in light of the effects of applying the provisions of the act to the hospital field.

In two basic areas, the act is seriously deficient and inappropriate for applications to the health care field.

The first involves strikes, picketing, and impasses. The second pertains to the fragmentation and proliferation of bargaining units. Both of these areas have serious implications in regard to interference and interruption of patient care services.

Now, to discuss strikes, picketing, and impasses.

There are two different, distinct aspects to the problem of strikes, picketing, and impasses.

The first deals with work stoppages and picketing in situations not involving an impasse in collective bargaining.

Under the National Labor Relations Act, unions are permitted to engage in recognition strikes and recognition picketing.

For example, an institution in San Diego, that is covered under the National Labor Relations Act, recently went through an entire election campaign surrounded by a recognition picket line even though the union was granted a secret ballot election by the National Labor Relations Board.

Apart from recognition strikes and picketing, the National Labor Relations Act does not provide adequate protection from secondary boycotts and secondary picketing.

Moreover, when related to patient care, an additional deficiency is the National Labor Relations Board's inability to respond rapidly enough when a union violates the act's prohibitions against secondary boycotts, jurisdictional strikes, picketing and the like.

Because, under the act, an employer cannot obtain an injunction against illegal strikes or picketing from a Federal or State court, delays of 2 weeks or more are common while awaiting action by the National Labor Relations Board to obtain injunctive relief in the courts. In the meantime, the hospital's patients must suffer from the effects of these illegal activities.

The second aspect involves impasses in collective bargaining negotiations which in turn may lead to strikes and picketing.

I would like to say again parenthetically here, the problem to date has been heavily in the recognition area; but it is absolutely inevitable that if enough contracts are arrived at this will result in impasse type of proceedings becoming predominant in this field. It is only a matter of where we are in the history of labor relations in the hospital field that says that recognition strikes are dominant.

The act has no provision for effectively resolving such impasses. The association believes that the problem of bargaining impasses in health care institutions must be resolved because strikes in such institutions are intolerable.

This committee should carefully weigh the serious implications for the public of work stoppages in the health care field whether occurring in a single institution or on a widespread basis.

Those who support coverage of all health care institutions under the National Labor Relations Act argue that the problems of strikes and work stoppages in health-care institutions have not really materialized where coverage already exists.

They cite as an example the National Labor Relations Board's jurisdiction over investor-owned health care institutions.

There have been instances of strikes in such institutions and we would further point out that there has been very limited experience in this area in that the extension of jurisdiction over these institutions is relatively recent.

If collective bargaining were to become more widespread in the hospital field as a consequence of enactment of H.R. 11357, the potential for more strikes and for strikes involving all hospitals in a broad geographic area would clearly exist.

And, parenthetically again, I don't know what you do with patients if all of the hospitals in an area are hit with a strike.

#### FRAGMENTATION OF BARGAINING UNITS

The National Labor Relations Act also fails to deal adequately with the problem of multiple bargaining units within a health-care institution.

There are over 100 separate occupational classifications in the health care field with an overwhelming percentage of these classifications being critical to the efficient operation of hospitals.

The health care institutions of this country would face major difficulties in attempting to provide coordinated patient care services if forced to bargain separately with many different employee groups within an institution.

More and more of the allied health professional groups have been obtaining licensure through State legislation. This problem of fragmentation has reached such a magnitude that this Association, as well as others, including the American Medical Association, the American Nurses' Association, and the U.S. Department of Health, Education, and Welfare, have called for a national moratorium on licensure of additional categories of health care personnel.

Under the provisions of the National Labor Relations Act, employees of health care institutions would be further fragmented into numerous small bargaining units.

The National Labor Relations Board, for example, has already recognized separate bargaining units for pharmacists, laboratory technologists, registered nurses, and licensed practical or licensed vocational nurses.

Additional bargaining units can be projected for many other professional and paraprofessional groups as well as for the many crafts which are vital to the functioning of health care institutions such as engineers, carpenters, plumbers, electricians, and maintenance workers.

This proliferation of bargaining units within an institution would have the following adverse effects:

First, any one of these many bargaining units, even a very small bargaining unit within the institution, could close down the entire facility because of the general practice of all bargaining units to respect the picketing efforts of others.

As an example, a small unit of four stationary engineers could effectively disrupt the total operations of a hospital by establishing a picket line that would be honored by other employees.

Second, the existence of numerous bargaining units could lead to many jurisdictional disputes. Rigid craft lines could be imposed on hospitals, similar to those that exist in the construction industry.

These rigid craft lines create problems both because of overlapping responsibilities as well as interference with patient care when employees refuse to perform tasks outside of those defined by their bargaining unit.

This would seriously impair efforts to provide efficient, coordinated and high quality patient care services.

Third, the various bargaining units within the health-care institution would each fiercely compete for the most favorable wages, hours, and working conditions. Such continuing competition would interfere with the necessary team work which is critical in providing quality patient services.

Fourth, dealing with many bargaining units in a hospital would result in an excessive and unnecessary cost in terms of administrative and legal time and expense.

It is difficult to justify these additional costs, which must of course be borne by the patient, at a time when vigorous efforts are being directed by hospitals and by the Government at controlling rising health care costs.

In conclusion, Mr. Chairman, we reiterate our strong belief that enactment of H.R. 11357 which would subject nonprofit hospitals to the provisions of the National Labor Relations Act, with all of its significant limitations and shortcomings as it applies to the health field, would seriously impair the delivery of patient care services and would not be in the best interest of the public. We urge the committee to reject this bill.

We thank you for the opportunity of presenting the views of the American Hospital Association to the committee.

I wonder if I could say just one additional word.

The issue has been raised that within the groups that are striving for recognition, that their choice is submission or conflict, that they either submit to not being recognized, or—

We would submit that because of the public pressures on a hospital to maintain service in spite of whatever demands might be made, and our own concern for patients, that this would be our choice, once the union is recognized, that our choice would be submission to whatever demands have been made, essentially, or conflict.

The CHAIRMAN. Are you sure you want to put that on the public record?

Mr. HITT. This is the nature of the concern that faces the hospital field that it has to maintain a continuity of service.

The CHAIRMAN. Let me ask you this: do you see a qualitative difference between the situations of an employee in a profit hospital and a nonprofit hospital?

Mr. HITT. No, sir; I do not.

The CHAIRMAN. Now, is there anything else in conclusion gentlemen?

Dr. GEHRIG. Senator, if I may, I think Mr. Hitt hit very closely on the real concerns that must center on the patient; and I think that the problem of stoppages and impasses that are related to the bargaining unit again brings out the fact that hospital people, physicians and others, must show a first concern for the patient.

I would like to add another thought here, and that is, as was just indicated, the vulnerability of health care institutions to demands to which many institutions will have to accede. This is going to be reflected also in costs. As you know, hospitals are under tremendous pressure, both by our own efforts and those of our Government, to control hospital costs.

I predict that with this sort of action, we are going to see further inflation in hospital costs. In the past increased costs have been reflected in increasing salaries, which we are pleased to have been able to give, but nonetheless, while salaries of hospital employees have been improved during this period, we are in between—by Government and public—because of increasing hospital costs—costs which are related to personnel salaries, to the tune of about 60 percent.

Mr. HITT. Senator, from your reaction to what I said, maybe you misunderstood the point I was trying to make.

The point I was trying to make is that we who are responsible for delivering hospital services and working out whatever arrangements are necessary, will be under such great pressure at the time of a threat of a strike, that we will—we would have to give in to demands that under other circumstances might be resisted, or considered completely out of the question.

Our ability to resist these comes from the nature and the purpose of hospitals and the public pressures for services, as well as from our own concerns for the patient. We cannot back off of bargaining as though we were bargaining over just dollars.

Thank you very much.

The CHAIRMAN. Thank you very much.

Mr. Frederick K. Alderson, vice president and director of Legislative Liaison of the National Right to Work Committee.

I have read your paper, Mr. Alderson, if you want to just summarize it; I am the only one that happens to be here; so if you want to simplify it for yourself, it is all right with me.

STATEMENT OF FREDERICK K. ALDERSON, VICE PRESIDENT AND  
DIRECTOR OF LEGISLATIVE LIAISON, NATIONAL RIGHT TO WORK  
COMMITTEE

Mr. ALDERSON. I would be very happy to do that, Mr. Chairman; and I will submit the whole statement for the record at the end of my testimony.

The National Right to Work Committee is a single-purpose citizens organization dedicated to the principle that union membership should be voluntary, not compulsory.

Our principal concern today is not with the broad aspects of the bill, H.R. 11357, but with one vital facet: the impact it would have in extending to hospital employees that provision of the National Labor Relations Act which sanctions compulsory unionism.

This provision of the NLRA is objectionable to the overwhelming majority of the American people. Their attitude is reflected by the findings of a recent nationwide public opinion survey.

When H.R. 11357 was reported out, it was argued that this legislation, and I quote, "will result in greater labor stability by largely eliminating the recognition strike by providing access to the election procedures of the NLRB."

Witnesses today have also mentioned this.

The supporters of this bill however seem to be unfamiliar with the impact of the existing law which authorizes the forced unionization of workers. Recent history indicates clearly that much industrial unrest has been generated by disputes between union officials and employers over the issue of compulsory unionism.

AFL-CIO President George Meany himself, during an appearance before a House subcommittee several years ago, acknowledged this fact by saying, "Disputes over union security have been a frequent cause of industrial strife."

The Bureau of Labor Statistics published fiscal data which tended to confirm Mr. Meany's statement.

Mr. Chairman, with bills now pending in Congress that would extend the horizons of compulsory unionism to embrace farmworkers and the millions of employees in the public sector, we feel the enactment of this legislation, which you are considering today, could set a very dangerous precedent. It could serve to intensify the demands of officials of public employee unions for the same extraordinary privileges now granted union officials in the private sector. And we submit that the Nation would be on the road to ruin when and if Congress should legalize the forced unionization of agricultural and public employees.

In conclusion, Mr. Chairman, if it should be decided to report favorably this bill to the Senate for consideration, we strongly urge this committee to include a provision that would guarantee to employees of nonprofit hospitals freedom of choice with respect to union membership.

Such a provision would most certainly be hailed by rank and file workers throughout the country as a hallmark decision—a decision breaking with the current Federal policy which forces employees in the private sector to pay money to a labor organization in order to hold a job.

Thank you very much.

The CHAIRMAN. Thank you very much.

(The prepared statement of Mr. Alderson follows:)

A COALITION OF EMPLOYEES AND EMPLOYERS



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## NATIONAL RIGHT TO WORK COMMITTEE

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Statement of

Frederick K. Alderson  
Vice President and Director of Legislative Liaison  
National Right to Work Committee

before

Subcommittee on Labor  
Committee on Labor and Public Welfare  
United States Senate

August 16, 1972

*"Americans Must Have the Right But Not Be Compelled to Join Labor Unions"*

Mr. Chairman and Members of the Subcommittee:

I am Frederick K. Alderson, Vice President and Director of Legislative Liaison of the National Right to Work Committee. We sincerely thank you for this opportunity to present our views on the subject of amending the National Labor Relations Act to extend its coverage to employees of non-profit hospitals.

The National Right to Work Committee is a single-purpose citizens organization dedicated to the principle that union membership should be voluntary, not compulsory. We believe it is wrong for any individual to be denied employment for his refusal or failure to pay money to a labor union. Our members and supporters represent a cross-section of individuals from all walks of life -- professional people; rank and file wage earners, both union and non-union; businessmen; and others.

During floor debate in the House of Representatives on H. R. 11357, the bill you are considering today, it was emphasized by several members that there is no longer any basis to treat non-profit hospitals any differently than other organizations or institutions that engage in interstate commerce. Our Committee agrees that there should not be discrimination in such matters; however, we seriously question the wisdom of bringing over 1,000,000 hospital employees under a law that has serious defects.

Like most Americans, we are anxious to see that every working man and woman has the greatest possible opportunity to utilize his talents to the maximum extent of his ability and to be appropriately compensated. We think that the right to organize and bargain collectively can be an important tool for the employee in achieving justice. But, Mr. Chairman, our Committee does not believe that the National Labor Relations Act, our country's labor policy, has served the best interests of our wage earners.

This policy, under which the nation has operated for some 40 years, is the subject of widespread debate today. Many believe that the National Labor Relations Act grants, at the expense of the employee, broad privileges to the

Page 2

organizers of labor unions. Therefore, there are grounds for questioning the premise that the public interest is served by using the power of the Federal government to help organize labor unions.

Our principal concern today, however, is not with the broad question of public policy, but with one vital facet of it -- that provision in the National Labor Relations Act that sanctions compulsory unionism. This provision, which requires an individual to pay tribute to a labor official in order to hold a job, is objectionable to an overwhelming majority of the American people. Their attitude is reflected by the findings of a recent nationwide public opinion survey conducted just prior to this year's National Democratic Party Convention by the Opinion Research Corporation of Princeton, New Jersey. Each of the survey respondents was asked the following question: "Do you think the platform of your political party (of the presidential candidate you vote for) should or should not have a statement that says each person has the right to get and hold any job whether or not that person belongs to a labor union."

According to the survey results, 73 percent of all Republican voters believe their party's platform should contain such a statement. This viewpoint is shared by 68 percent of the Independents and 65 percent of the Democrats. It is also supported by 72 percent of all voters between the ages of 18 and 29, 65 percent of the voters whose annual family income is under \$5,000, 56 percent of all non-white voters, and 58 percent of union families.

When H. R. 11357 was before the House, it was argued that this legislation "will result in greater labor stability by largely eliminating the recognition strike by providing access to the election procedures of the NLRB...."

The sponsors of this bill, however, seem to be unfamiliar with the impact of the existing law which authorizes the forced unionization of workers. Recent history indicates clearly that much industrial unrest has been generated by

Page 3

disputes between union officials and employers over the issue of compulsory unionism. AFL-CIO president George Meany himself, during an appearance before a House Subcommittee several years ago, acknowledged this fact by saying, "Disputes over union security have been a frequent cause of industrial strife." You understand of course that "union security" is Mr. Meany's euphemism for "compulsory unionism."

Bureau of Labor Statistics confirm Mr. Meany's statement. According to data released earlier this year by the Bureau, in states without Right to Work laws, much more time (.41% of working time in those states as opposed to .26% in Right to Work states) was lost in 1970 through work stoppages due to strike action. The number of man hours lost in the same year in non-Right to Work states totalled 57,268,000; in Right to Work states, 9,124,000.

In its present form, the National Labor Relations Act guarantees grief for employees and employers alike. One of its provisions compels employers to bargain with union negotiators over the question of compulsory unionism. An employer who refuses to do so, will be adjudged guilty of an "unfair labor practice" by the National Labor Relations Board, whose orders are enforceable in the nation's courts. The existing law permits an employer to be held in contempt of court if he refuses to bargain with respect to forced unionization of his employees.

The law explicitly prohibits an employer from paying bribes to union officials out of his own pocket to gain labor peace, but the law encourages the payment of such bribes so long as the money comes from the pockets of his employees. The authorization of compulsory unionism thus puts pressure on an employer to do indirectly what he cannot do directly without risking prosecution by the Justice Department. The law encourages the employer to buy labor peace by requiring his

Page 4

employees to pay money to union officials in the form of dues, fees and assessments.

Perhaps the greatest abuse that results from the compulsory unionism provision in the National Labor Relations Act is the use, by union officials, of compulsory union dues for partisan political purposes. This not only robs wage earners of their political freedom, but it undermines our representative form of government.

Mr. Chairman, with bills now pending in Congress that would expand the horizons of compulsory unionism to embrace farm workers and the millions of employees in the public sector, we feel the enactment of this legislation which you are considering today could set a very dangerous precedent. It could serve to intensify the demands of officials of public employee unions for the same extraordinary privileges now granted union officials in the private sector. And, we submit that the Nation would be on the road to ruin when and if Congress should legalize the forced unionization of agricultural and public employees.

It is worth noting, we believe, that in 1970 when the quasi-independent Postal Service was established, the Administration's Postal Reorganization bill would have authorized the forced unionization of postal employees. But, you will recall that Congress elected to amend that bill so as to guarantee postal employees freedom of choice.

In conclusion, Mr. Chairman, if it should be decided to report favorably this bill to the Senate for consideration, we strongly urge this Committee to include a provision that would guarantee to employees of non-profit hospitals freedom of choice with respect to union membership. Such a provision would most certainly be hailed by rank and file workers throughout the country as a hallmark decision -- a decision breaking with the current Federal policy which forces employees to pay money to a labor organization in order to hold a job.

Page 5

We appeal to you not to force upon nearly 1.5 million hospital employees, a policy which experience tells us is not in the best interest of the employer, the employee, or the country as a whole.

The CHAIRMAN. Mr. Ogden Fields, former Executive Director of the National Labor Relations Board.

Mr. Fields, we appreciate your being here.

**STATEMENT OF OGDEN W. FIELDS, FORMER EXECUTIVE SECRETARY, NATIONAL LABOR RELATIONS BOARD**

Mr. Fields. Thank you very much, Mr. Chairman.

I have a prepared statement for the record and I will discuss the most pertinent parts.

The CHAIRMAN. Very good.

Mr. FIELDS. Mr. Chairman, my name is Ogden W. Fields. Two months ago, I retired after 31 years of service with the National Labor Relations Board.

Since 1948, I worked as the assistant or associate executive secretary, and for the past 12 years, I served as executive secretary to the board.

I was glad to be invited by your committee to testify today on this bill.

I received your invitation on Monday, and I had hoped I would have had more time to prepare for this; but I think I can throw some light on the administrative and practical aspects of this amendment.

This long-overdue amendment would remove the discriminatory exemption of nonprofit hospital workers and permit them to enjoy the protection and benefits of the National Labor Relations Act, as well as to assume its responsibilities.

The hospitals would also enjoy the protection, benefits, and responsibilities the act accords to employers.

Perhaps I can best assist this committee if I concern myself with the administrative or practical aspects of this amendment and be available for any questions you may have.

The desirability and justification of this amendment is too well established for repetition.

From November 1967, when the Board first asserted jurisdiction over proprietary hospitals and nursing homes to June 1972, it has conducted 712 elections, involving approximately 40,000 of these employes with its customary promptness and efficiency.

For the past 2 years it has averaged 200 of these elections a year. If the exemption is removed, I see no reason why the Board cannot handle with equal speed and expertise nonprofit hospitals.

During fiscal year 1968, the first year of its experience with profit hospitals and nursing homes, it held 80 such elections. Only four of these elections were directed by the Board itself. Twenty-seven were directed after hearing by regional directors, and 49 were held by consent of the parties.

Once the Board set the dollar volume standard for asserting jurisdiction and made some initial determinations of appropriate units, the regional directors and employers and unions were able to take it from there.

Thus, even during the first year, 60 percent of the elections were held by consent of the parties. This average percent has continued substantially to the present and is about the same percent as that applicable to all 8,000 elections held every year by the Board, 80 percent of which are held by consent.

The Board's experience with profit hospitals and both profit and nonprofit nursing homes should be no different for nonprofit hospitals. Once the Board sets the guidelines for jurisdiction and appropriate units, employers and union will soon agree to consent elections in about 80 percent of the cases, and the regional directors will direct elections in 17 percent, leaving only 3 percent of the cases involving refinements of unit and other problems to the Board.

The Board itself now has to order elections in only 3 percent of the profit hospitals and nursing home cases.

Thus it is apparent that most of the work involved in holding consent elections and directing elections will devolve upon the Board's 31 regional offices just as these offices handle the great bulk of unfair labor practices. Once the basic guidelines are established the number of election cases rising to the Board itself can be absorbed although, of course, it will add further to its ever-increasing caseload. The caseload problem of the Board members themselves is not in representation or election cases, thanks to the 1959 Landrum-Griffin amendments to the act which permitted the Board to delegate so much of this work to its regional directors. This saved the life of the Board during the last decade. The Board's problem is with the staggering and increasing load of formal unfair labor practice decisions that the members cannot delegate. This has been described in a speech I gave last September in San Francisco entitled "40,000 Cases." A copy of this speech will be furnished the committee. This proved to be conservative for a little over 41,000 cases were filed in fiscal 1972.

With regard to setting a standard for asserting jurisdiction over nonprofit hospitals, the Board could set it after hearing and after requesting briefs *amici curiae* from interested organizations and associations as it did in the 1967 proprietary hospital case where it set a standard of \$250,000 gross revenue per year.

Alternatively, the Board could adopt the rulemaking procedures of section 4 of the Administrative Procedures Act, to arrive at a jurisdictional standard as it did for private colleges and universities and as it may do soon in the horseracing and dogracing industries.

Whether by case or rulemaking, interested organizations, in addition to immediate parties, will have an opportunity to advise the Board as to appropriate jurisdictional standards.

In discussing the authority of the Board under section 10(a) of the act to cede jurisdiction to States, the House committee report states that despite such authority, and I quote, "the Board has not chosen to cede jurisdiction in any case."

That is not quite the story. It was not a matter of the Board not choosing to cede. As a practical matter, no State has asked the Board to cede jurisdiction to it for any kind of cases, let alone nonprofit hospitals.

I recall that many, many years ago, the Board had some correspondence with the State of New York and the territory of Puerto Rico relative to the possible ceding of jurisdiction in certain types of cases. Nothing came of it, however, because neither New York nor Puerto Rico had a labor statute with provisions consistent with corresponding provisions in the Federal act.

The Board concluded from its analysis of section 10(a) that it was not enough to simply provide for elections. Employees had to be protected in their right to organize or to refrain from union activity.

Likewise, if a union was certified as exclusive representative not only as was the employer required to bargain in good faith but the union was also required to bargain in good faith.

In short, the State or territorial statute must provide provisions comparable to sections 8(a) and 8(b) of the act; namely, provision against unfair labor practices by union as well as by employers. Neither the New York nor Puerto Rico statutes made any provision for union unfair labor practices.

Likewise, none of the other 48 States had a statute consistent with Taft-Hartley and none asked the Board for any cession of jurisdiction.

So after 25 years none of the 50 States have taken the labor legislation steps necessary to any cession of jurisdiction. I think the great majority of Board members over the years would have been happy to cede jurisdiction to States could they have done so. The States did not make this possible.

The CHAIRMAN. Are you going on to another point now, Mr. Fields?

Mr. FIELDS. Just the—

The CHAIRMAN. On that one point—the individual views on the House report. Have you evaluated that with regard to the fears or where it described the minority—the individual views have any substance, or not?

Mr. FIELDS. I don't think so; because I think in the Board's experience that it has not been the experience since 1957, with profit hospitals and nursing homes, the Board developed an expertise that will permit them to handle most of those problems.

Much of the experience the Board has had in resolving issues and developing guidelines for profit hospitals would be helpful in handling nonprofit hospitals.

I list a number of cases, and then I go on to say, these cases illustrate the growth of experience, the development of policy guidelines and experience in the profit hospital and medical field which will facilitate its handling of nonprofit medical institutions.

Unexpected problems or issues now to the Board's experience will, of course, arise. Likewise, the field of labor-management relations is dynamic and ever changing; but I have complete confidence in the flexibility and resourcefulness of the Board and its exceptional staff to cope with any uncertainties that may arise. It has proven this many times in the past 37 years.

It is for the Congress to determine whether to extend the act or to cover nonprofit hospital workers. If this be done, experience teaches that the Board can find workable solutions for the problems anticipated and for those not yet foreseen.

Mr. Chairman, I would like now to just address myself to a few of the points raised by the American Hospital Association.

Now, they are concerned with recognition strikes and picketing for recognition. But apparently their oral testimony ignores the provisions of the Taft-Hartley Act proposing expedited elections where unions are picketing for recognition. This involves section 8(b)7, the provision for expedited elections.

So the act calls it an unfair labor practice to picket for recognition unless a petition for election is filed within a reasonable time and normally within 30 days.

Now, what is a reasonable time depends upon the product or service.

For example, if you have a perishable product; for example, the work in a fruit or vegetable cannery, what would be reasonable there would not be reasonable in a furniture factory.

So that under those circumstances the Board can currently hold an election, waiting 30 days and without a hearing.

In the event the union should lose that election, they would be enjoined from continuing to picket. That is the entire pattern to take care of the picketing for recognition problem that the Hospital Association favors.

As to the ways to lift an injunction, again one of the grounds for getting a very prompt injunction is the extent of the irreparability of the damage. And if you have a strawberry packing plant, the judge recognizes and the Board recognizes the importance of the resumption of work and an injunction is very promptly taken care of.

I would very much approve that our Federal judges and certainly our Board personnel would, in hospital situations be concerned for medical care, the life and death aspects of hospital administration, so that the judges would beat the week-record that the gentleman referred to; it can be done faster than that.

Secondly, the problem of fragmentation of units.

As you know, the basic unit of the Board in the original case was all professional employees—and I spell it out in detail in my paper. And that was largely based upon a stipulation by—and I might say that now 80 percent of all elections involving hospitals and nursing homes, the units are agreed upon by the parties. So I do not expect the degree of fragmentation that the gentleman from the American Hospital Association quoted.

Basically speaking, there are three units of all nonprofessionals, office, clericals, and then the professional employees, under law, they are not included with nonprofessional workers unless they choose to do so in a separate question.

As to jurisdictional tensions and fears, the Board resolved these jurisdictional claims between the unions under its procedures to do so. Presently, the unions can fight it because they—the provisions of the Board.

If they are brought under the Board, the Board would dissolve these jurisdictional disputes.

And I might say that unions may compete for the best contract; each union is trying to outdo the other. Mr. Chairman, we are now in the age of coordinated—and there is more cooperation between unions today; there is more joint bargaining than there has been up to this time.

One last point. I would like to mention some of the statistics that Senator Taft raised this morning.

Basically, there are approximately 7,200 non—7,200 hospitals in the country. And, rounding out the figure, approximately 3,700 are nonprofit, or 52 percent; profit, 900 hospitals, or 13 percent. And the remaining 35 percent are publicly owned hospitals—State, county, urban, suburban, et cetera.

Now, the approximate breakdown I have is that there are approximately 1,500,000 in nonprofit hospitals, because they are the largest hospitals. The public, including State, local, and Federal, approximately 1 million. With the proprietary it amounted to approximately 100,000—or, 100,000 employees. That is the breakdown as I have it, and it is based on Annual Hospital Guide of 1971, published by the National Hospitals Association, of Chicago, Ill.

The CHAIRMAN. Do you have a copy of that document?

Mr. FIELDS. It is in pencil form, Senator, but it is broken down; but I can make this available to you.

The CHAIRMAN. Yes; I wish you would. Senator Taft was concerned appropriately himself; as a matter of fact, he was going to have some additional hearings to get that information; this perhaps will make it unnecessary to have another hearing on that.

Mr. FIELDS. And I might say that the—

The CHAIRMAN. That will be very, very helpful.

Mr. FIELDS. Surely.

The CHAIRMAN. Thank you very much.

Mr. FIELDS. I might add that in the House report, there is a paper by A. R. Summers of Princeton University, that contains this information.

The CHAIRMAN. If we had that paper it would certainly help our committee.

Thank you very much. Excellent statement.

Mr. FIELDS. Not at all.

(The prepared statement of Mr. Fields and the requested information subsequently supplied for the record follow:)

STATEMENT OF OGDEN W. FIELDS  
BEFORE THE SENATE COMMITTEE ON LABOR AND PUBLIC WELFARE

AUGUST 17, 1972

EXEMPTION OF NONPROFIT HOSPITALS UNDER NLRA

Mr. Chairman, my name is Ogden W. Fields. Two months ago I retired after 31 years of service with the National Labor Relations Board. Since 1948 I worked as the Assistant or Associate Executive Secretary and for the past 12 years I served as Executive Secretary to the Board.

I was glad to be invited by your Committee to testify today on this bill. This long overdue amendment would remove the discriminatory exemption of nonprofit hospital workers and permit them to enjoy the protection and benefits of the National Labor Relations Act and its responsibilities.

The hospitals would also enjoy the protection, benefits and responsibilities the Act accords to employers.

Perhaps I can best assist this Committee if I concern myself with the administrative or practical aspects of this amendment and be available for any questions you may have. The desirability and justification of this amendment is too well established for repetition.

From November 1967, when the Board first asserted jurisdiction over proprietary hospitals <sup>1/</sup> and nursing homes <sup>2/</sup> to June 1972, it has conducted 712 elections

<sup>1/</sup> Butte Medical Properties, d/b/a Medical Center Hospital, 168 NLRB 266 (1967)

<sup>2/</sup> University Nursing Home, 168 NLRB 263 (1967)

-2-

involving approximately 40,000 of these employees with its customary promptness and efficiency. For the past two years it has averaged 200 of these elections a year. If the exemption is removed, I see no reason why the Board cannot handle with equal speed and expertise nonprofit hospitals.

For the past several years the Board conducted about 8000 secret ballot elections a year to determine whether or not employees wish to be represented by a union for purposes of collective bargaining. Year in and year out about 6400 or 80% of these elections were agreed upon by the employer and union. The remaining 20% are directed after hearing by the Regional Director, subject to review by the Board, or by the Board itself.

During fiscal year 1968, the first year of its experience with profit hospitals and nursing homes, it held 80 such elections. Only 4 of these elections were directed by the Board itself. 27 were directed after hearing by Regional Directors and 49 were held by consent of the parties. Once the Board set the dollar volume standard for asserting jurisdiction and made some initial determinations of appropriate units, the Regional Directors and employers and unions were able to take it from there. Thus even during the first year 60% of the elections held were by agreement of the parties. The next year 80% of the elections were held by consent of the parties. This average percentage has continued substantially to the present and is about the same percent as that applicable to all 8000 elections held every year by the Board -- 80% by consent.

The Board's experience with profit hospitals and both profit and nonprofit nursing homes should be no different for nonprofit hospitals. Once the Board sets the guidelines for jurisdiction and appropriate units, employers and union will soon agree

-3-

to consent elections in about 80% of the cases and the Regional Directors will direct elections in 17% leaving only 3% of the cases involving refinements of unit and other problems to the Board. The Board itself now has to order elections in only 3% of the for profit hospitals and nursing home cases 3/.

Thus it is apparent that most of the work involved in holding consent elections and directing elections will devolve upon the Board's 31 Regional Offices just as these offices handle the great bulk of unfair labor practices. Once the basic guidelines are established the number of election cases rising to the Board itself can be absorbed although, of course, it will add further to its ever increasing case load. The case load problem of the Board Members themselves is not in representation or election cases, thanks to the 1959 Landrum-Griffin amendments to the Act which permitted the Board to delegate so much of this work to its Regional Directors. This saved the life of the Board during the last decade. The Board's problem is with the staggering and increasing load of formal unfair labor practice decisions that the members cannot delegate. This has been described in a speech I gave last September in San Francisco entitled "40,000 Cases." A copy of this speech will be furnished the Committee. This proved to be conservative for a little over 41,000 cases were filed in fiscal 1972.

With regard to setting a standard for asserting jurisdiction over nonprofit hospitals, the Board could set it after hearing and after requesting briefs amici curiae from interested organizations and associations as it did in the

3/ From 1967 through fiscal 1971, of 516 elections held the Board itself only had to direct elections in 18 cases or about 3%.

-4-

1967 proprietary hospital case where it set a standard of \$250,000 gross revenue per year. Alternatively the Board could adopt the rule-making procedures of Section 4 of the Administrative Procedures Act <sup>4/</sup> to arrive at a jurisdictional standard as it did for private colleges and universities and as it may do soon in the horse and dog racing industries.

Whether by case or rule-making, interested organizations, in addition to immediate parties, will have an opportunity to advise the Board as to appropriate jurisdictional standards.

In discussing the authority of the Board under Section 10(a) of the Act to cede jurisdiction to states, the House Committee Report states that despite such authority "...the Board has not chosen to cede jurisdiction in any cases."

That is not quite the story. It was not a matter of the Board not choosing to cede. As a practical matter no state has asked the Board to cede jurisdiction to it for any kind of cases, let alone nonprofit hospitals. I recall that many, many years ago, the Board had some correspondence with the State of New York and the Territory of Puerto Rico relative to the possible ceding of jurisdiction in certain types of cases. Nothing came of it, however, because neither New York nor Puerto Rico had a labor statute with provisions consistent with corresponding provisions of the Federal Act. The Board concluded from its analysis of Section 10(a) that it was not enough to simply provide for elections. Employees had to be protected in their right to organize or to refrain from union activity. Likewise, if a union was certified as exclusive representative not only was the employer required to bargain in good faith but the union was also required to

<sup>4/</sup> (60 STAT 238: 5 U.S.C. Sec. 553)

bargain in good faith. In short, the State or Territorial statute must provide provisions comparable to Sections 8(a) and 8(b) of the Act, namely, provision against unfair labor practices by union as well as employers. Neither the New York nor Puerto Rico statutes made any provision for union unfair labor practices.

Likewise, none of the other 48 states had a statute consistent with Taft-Hartley and none asked the Board for any cession of jurisdiction. So after 25 years none of the 50 states have taken the labor legislation steps necessary to any cession of jurisdiction. I think the great majority of Board Members over the years would have been happy to cede jurisdiction to states could they have done so. The states did not make this possible.

Much of the experience the Board has had in resolving issues and developing guidelines for profit hospitals would be helpful in handling nonprofit hospitals. In its initial nonprofit hospital case,<sup>5/</sup> the Board found the appropriate unit to be "All nonprofessional employees of the Employer at its Oroville, California, location including cooks, tray girls, maids, janitors, storekeepers, maintenance employees, grounds keepers, orderlies, nurses' aides, surgical aides, surgical technicians, surgical licensed vocational nurses, licensed vocational nurses, and laboratory helpers, but excluding physicians, registered nurses, medical technologists, and other professional employees, office clerical employees, head cook, chief housekeeper, chief engineer, and other supervisors as defined in the Act." In later cases the Board found appropriate separate units of unrepresented hospital pharmacists and hospital technicians and clerical employees,<sup>6/</sup> dietary, maintenance, laundry and housekeeping departments,<sup>7/</sup> visiting registered

<sup>5/</sup> Butte Medical Properties, supra

<sup>6/</sup> Syosset General Hospital, 190 NLRB No. 59

<sup>7/</sup> St. Joseph Infirmary, 194 NLRB No. 31 .

-6-

nurses and public health nurses, <sup>8/</sup> and admission clerks, receptionists and social directors were held to be office clerical employees and excluded from a nursing home unit.<sup>9/</sup> The Board found licensed practical nurses to be non-supervisory. Licensed practical nurses were included in nursing home employees unit.<sup>10/</sup> Jurisdiction was asserted over a profit clinic furnishing professional, para-professional, and clinical laboratory technologists to perform services for nonprofit hospitals.<sup>11/</sup> In other case, the Board did not assert jurisdiction over eight doctors engaging in group practice finding it to be essentially local in character and that it had no substantial impact on commerce.<sup>12/</sup> On the other hand it asserted jurisdiction over a large urban medical clinic.<sup>13/</sup>

The above cases illustrate the growth of expertise -- the development of policy, guidelines and experience in the profit hospital and medical field which will facilitate its handling of nonprofit medical institutions. Unexpected problems or issues new to the Board's experience will, of course, arise. Likewise, the field of labor-management relations is dynamic and ever changing; but I have complete confidence in the flexibility and resourcefulness of the Board and its exceptional staff to cope with any uncertainties that may arise. It has proven this many times in the past 37 years. It is for the Congress to determine whether to extend the Act to cover nonprofit hospital workers. If this be done, experience teaches that the Board can find workable solutions for the problems anticipated and for those not yet foreseen.

<sup>8/</sup> Visiting Nurse Association, Inc., 188 NLRB No. 21

<sup>9/</sup> Riviera Manor Nursing Home 186 No. 113

<sup>10/</sup> Jackson Manor Nursing Home, supra

<sup>11/</sup> The Permanente Medical Group 187 NLRB No. 143

<sup>12/</sup> Alameda Medical Group 196 NLRB No. 57

<sup>13/</sup> Ochsner Clinic 196 NLRB No. 4

Address  
Before the Labor-Management-NLRB Conference  
San Francisco, California - September 24, 1971  
Ogden W. Fields, Executive Secretary, NLRB

"40,000 Cases"

The title of this paper is not a prediction. It is here. In our fiscal year ending June 30, 1971 we had estimated 35,000 but we actually received 37,000 cases. 1/ This year we estimate 40,192 and so far we are getting them.

For the first ten years of the Taft-Hartley Act we averaged 13,000 a year. 2/ Then from 1957 to 1962 the case load practically doubled. In five years it went from 13,000 to 25,000. Ten years later it is 40,000. 3/ This is phenomenal.

What is even a greater phenomenon is the fact that the Agency kept up with the load. Its case load tripled in 15 years yet it did not fall apart. It did not become swamped. In fact it improved. Last year it handled more cases with less help and in less time. And this was achieved with substantially the same basic machinery--the same statutory procedures. We could do this because we have a superb field organization--31 Regional Offices and their satellites. We do this because the Regions handle over 95 percent of the work. Year in and year out 95 percent of the

1/ 23,770 unfair labor practice charges and 13,422 representation cases or a total of 37,212.

2/ An average of 5000 charges and 8000 petitions.

3/ 25,825 charges and 14,367 petitions. In addition we expect a few hundred postal service cases.

- 2 -

charges filed are either withdrawn, dismissed or settled informally-- without litigation. The remaining 5 percent are litigated. In representation cases the field offices handle an even higher percentage. They dispose of 99 percent of all petitions filed either by withdrawal, dismissal, elections by agreement or by direction after hearing. Out of 13,000 petitions filed last year the Regions transferred less than 100 cases to the Board for initial decision or less than one percent. And not only do our field offices handle over 90 percent of the cases but they do it fast. Four out of five unfair labor practice cases are disposed of within a median of 45 days. Our field offices also conduct 6000 consent elections every year within 45 days and direct elections after hearing in 2000 cases within a median of 50 days. In addition every Regional Office runs a graduate college for labor lawyers and supplies talent to labor and management, private law firms, EEOC, the Department of Labor, and now the Postal Service!

Our Regional Offices are also highly accurate in their judgments. When a Regional Director says a violation has occurred he is proved to be right well over 90 percent of the times if you add up the settlements and the litigated cases in which he is affirmed by Trial Examiner, Board, and the courts. I must add that this is made easier by the large number of clear violations of the Act which our expert Field Examiners do not miss.

Now when a Regional Office grows too big we can divide it up. There is no statutory limitation on the number of Regional Offices so we can keep up with the case load in the field by adding

- 3 -

offices and personnel. Likewise we can add more Trial Examiners and lawyers in Washington to read records and write opinions and enforcement briefs.

We cannot, however, increase the number of decision-makers. The Act only allows us four members and a chairman.

So the problem of 40,000 cases is not the total case load for you can expand staff to meet it.

The problem is the work load at the top. Chairman Miller made the point so effectively before the House Labor Subcommittee last May when he said that in 1938 the three-man Wagner Act Board handed down a total of 33 unfair labor practice decisions. 4/ The present Board hands down more decisions than that every two weeks!

Nor can the Board change the statutory provisions that govern its basic procedures. Legislation is necessary. The need to redesign the machinery to reduce the Board's workload has long been understood. Congress recognized and dealt with part of the problem in the 1959 Landrum-Griffith amendments when it authorized the Board to delegate to Regional Directors decision-making authority in representation cases. This saved the Board's life. It would have been almost impossible in the last decade for the Board to have doubled its decisions in complaint cases 5/ and still write

4/ Statement before the Special Subcommittee on Labor of the Committee on Education and Labor, (Thompson Subcommittee) U.S. House of Representatives. May 26, 1971. (H. R. 7152.)

5/ In 1961 the Board issued 415 unfair labor practice decisions. In 1971 it issued 836.

- 4 -

at least 2000 representation decisions every year. And I must say that management and labor and the Board agree that such delegation to Regional Directors has worked quite successfully.

In 1961 the President asked the Congress to make the Board an appellate body by delegating to Trial Examiners authority to make final decisions.

As you recall, this was Reorganization Plan 5 which was voted down by the House of Representatives.

In my opinion, Plan 5 was defeated because it delegated final authority to Trial Examiners (subject, of course, to discretionary or appellate review by the Board). Congress just refused to deprive the right of respondents to full de novo review by Presidential appointees confirmed by the Senate.

But the Board did not give up hope. For the next 10 years the need for relief was frequently raised but almost always the only solution suggested by the Board was a Plan 5--final decision by Trial Examiners with appellate review by the Board. And in the meantime the decisional burden upon the Chairman and Board Members has become steadily heavier.

The labor relations family recognizes that the Board Members carry a crushing load. I think it important, nevertheless, to give you all the hard facts today so you may fully realize the extent of the load it carries. In 1961, the year Plan 5 was sought, the Board issued 415 unfair labor practice decisions, and rulings on jurisdictional disputes. In 1971 the Board doubled that by issuing 836.

- 5 -

Although unfair labor practice decisions have become the measure of the Board's work that is only part of it. Last year the Board also issued 423 written decisions in representation cases and ruled on 666 Requests for Review of Regional Directors Decisions Directing Elections or Rulings on Objections to Elections and/or Challenged Ballots. In addition there were 151 rulings on appeals from administrative dismissal. This amounts to 1240 decisions or rulings in representation cases. And don't forget a few hundred rulings on a great number and variety of motions. There were also more than a hundred enforcement or certiorari matters in addition to injunctions, contempt, special litigation, etc. In addition, there are now oral arguments, speeches, and problems of budget and personnel ceilings. In addition, the Postal Service is now our customer. And the Board is expected to turn out 913 complaint decisions in 1972 and 1008 in 1973 with everything else proportional.

This awesome case load has only been met because the Chairmen and Board Members are gifted with decisiveness and great capacity for work. But, however great their capacity, this pace cannot keep up. At our average rate of increase for the past 3 years we will go from 40,000 cases to 50,000 by 1976. A 20 percent increase or 10,000 more cases, would mean that the Board would have to issue over 1200 complaint and 1500 representation decisions or rulings a year or 225 a month or 50 a week or 10 a day. No one, least of all the Board, would want that for no

- 6 -

one would think the Board Members could possibly give his case the reasonable consideration it deserves. 6/

So something has to give. The question is: What?

What new scheme will Congress adopt to handle the new volume? I am speaking only for myself, of course, and not for the Board. I am convinced that it will not be any Plan 5. 7/  
In my opinion Congress will not delegate final authority in labor cases to civil service appointees, however competent and impartial they are shown to be. I repeat, Congress thinks that in the controversial field of labor law every aggrieved party is entitled, indeed has a right, to de novo review by Presidential appointees.

For several years I have thought the most practical scheme to reduce the national Board's work load would be to create 5 Regional Boards composed of 3 members each, who would be appointed by the President with confirmation by the Senate. The five-man Board in Washington would be converted into a policy-making and appellate body for unfair labor practice cases as it is for representation cases. This plan is practical because it is politically feasible--and politically attractive.

6/ Even now some parties are apprehensive that their case does not receive the attention it deserves. I want to assure them that in spite of the magnitude of the Board's work load that I have detailed, the work is done--the records and pleadings are read--there is still due process--even an excess. Everyone gets a full shake. That is because so many attorneys get into every case at the Board. Three signatory Members and their Chief Counsels make 6, the staff attorney and his supervisor make 8 and 2 clearing Board Members and their counsel make 12. And you can add a few more for the important and novel full Board cases. With so many in the act it is rare indeed that an argument or fact does not reach the decision-makers--the Chairman and the Board Members.

7/ I also think the Chairman and some of his colleagues do not think any Plan 5 will be adopted by Congress, without regard to what they each may think about the merits of such plan today.

- 7 -

It will pass the Congress.

It will pass the Congress because it meets the Congressional objections to Plan 5.

It will not increase the authority of civil service appointees.

Greater finality will not be given to Trial Examiner's decision.

The plan meets the basic requirements of the House of Representatives. Every respondent continues to be assured full de novo review of his case. And the de novo review will be done by Presidential appointees confirmed by the Senate. It is also attractive because it means 15 more Presidential appointees, and I assume the bi-partisan character of the Board would be continued by tradition if not written into any new legislation. It also means the appointments would be geographically distributed over the United States. The Southern Regional Board Members would be Southerners and the Mid-West Board be Midwesterners, etc. which would add to its political attractiveness, inducing regional political support for the idea.

Regional Boards would add a step between the Trial Examiner and the National Board making it a 4-step structure for fully litigated cases. However, a Regional Board plan would remain a 3-step structure if the national Board is given the same status as the Circuit Courts of Appeal. Or a change could be made whereby a special Labor Court of Appeals would surplant present review by Circuit Courts of Appeal. Thus the national Board of special Labor Court would enforce the decisions of the Regional Boards and enforce its own decision where it granted appellate review of a Regional Board decision.

- 8 -

I think it practical and attractive to most practitioners before the Board because of the old saying "Better the devil you know than the devil you don't know." There would be little change in practice before the Board. Instead of de novo review of a Trial Examiner's Decision by a Panel of three Board Members in Washington, D.C., you will get de novo review by three members of a Regional Board. As our labor bar knows, about 90 percent of Board decisions are issued by 3-member panels. I grant, of course, that in all cases the two non-panel Members are given an opportunity to participate in every case if they wish. However, with Regional Boards, an aggrieved party could seek appellate review by the 5-man national Board in Washington.

The big objection to Regional Boards is the view that the addition of one more step or stage in an already over-structured decisional scheme would increase delay further. 8/ Chairman Miller in his informative and perceptive statement to the special House

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8/ From my experience I would not concede, until a trial proved otherwise, that it would increase delay in the whole caseload. It may delay policy making decision or other Regional Board cases that warrant appellate review by the National Board. But in the great majority of cases in which review is not sought or is denied by the National Board, it should save time. Consistently over the years about 65 percent of the Board's decisions are routine cases that are resolved by short form affirmance of the Trial Examiner's decision. Another 25 percent are Panel decisions that require some writing. Only about 10 percent are important enough to warrant determination and signatures by the full Board. Were the caseload divided among five Regional Boards, there should be little doubt that the bulk of the cases could be handled faster than they would by the single Board in Washington. And being relieved of most panel-type cases, the National Board would be able to decide the important policy cases transferred to it by Regional Boards or accepted for appellate review more promptly.

- 9 -

Labor Subcommittee last May pointed out the relationship of structure to delay. The basic time problem in the administration of the Act is the time it takes from the filing of a charge to the effective enforcement of an order remedying the unfair labor practice. Although promptness in processing within each step is of considerable importance, the number of steps in the process largely determine the time it takes to get an order of the Board enforced by the Circuit Court of Appeals. His use of steps to describe the judicial structure sharply points out that the way to save time if you are serious about delay is to reduce the number of steps from charge to enforcement. Of particular importance is that the first step be by decision-makers, as he calls them, for all the next steps up the judicial ladder would be appellate. This is only possible if all the decision makers in the vital first-step--and we need at least a hundred now--are Presidential appointees and this I do not think is feasible. However, I think an additional 15 Regional Board Members appointed by the President for second-step decision making would be feasible.

In discussing this subject with Chairman Miller, I find that he persists in his conviction that we must find a way to give enforceable effect to decisions at the first step, and he therefore has reservations about my suggestions in this connection. On the other hand, he has advised me, as he has said publicly, that he has an open mind on this subject, and would welcome any sound reform which would command the support of the industrial relations community and of the Congress.

Under our present structure, there are three basic steps for litigated cases: 1, the Trial Examiner's fact finding and recommendation; 2, the decision by the Board and; 3, enforcement by a Circuit Court of Appeals.

It now takes about a year for the first two steps--the Trial Examiner's recommendation and the Board's decision. The

- 10 -

third step, enforcement by the Circuit Court of Appeals, which is required by about half of the 800 Board decisions a year, takes at least another year. So its at least two years from charge to remedy in these cases, which is too long.

The Thompson Bill, H.R. 7152, which is essentially a Plan 5, is another 3-step structure.

Two-step bills have been introduced in the House of Representatives and referred to the Committee on the Judiciary which would replace the Board and the Trial Examiners with a 15-judge Labor Court which would have the same status as a Circuit Court of Appeals. 9/This court would appoint Commissioners to hear cases. The decision of the Commissioners would not be final but decisions of the Labor Court reviewing and enforcing the findings of the commissioners would be.

Senator Towers' bill, S. 1320, which would abolish the Board and turn the show over to Federal District Court judges, is a one-step bill.

Next week the tango.

I will not discuss these bills here for this paper is not a critique of alternative proposals. My purpose is to present the needs and advantages of Regional Boards to relieve the present Board. Whatever the restructure, the most important requirement in my opinion is to spread the decision-makers around the United States whether they be Regional Boards or a 15-man Labor Court divided into panels. Labor Court panels could convene every month to consider en banc cases. And the airlines and metroliners need the business.

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9/ H.R. 1277, H.R. 3247 and H.R. 5807.

- 11 -

I favor regionalization for several reasons.

It would bring National labor policy closer to States and people. Our national labor relations policy has been held up for 36 years by Federal bootstraps. Since its passage in 1947, the Taft-Hartley Act in Section 10(a) has provided for ceding jurisdiction to a State if it would pass a little Taft-Hartley Act, thus encouraging states to share in the administration of a federal labor policy. After 24 years there have been no takers among the 50 States. There are many reasons why the States have ducked assuming any responsibility such as the expense of little State Taft-Hartley Boards. But I venture to say that the main reason is that the national labor policy with Sections 7, 8(a), and 9, included in the package with 8(b), is too hot for the States or local governments to handle. So, I'm afraid, rather than go for federal-state cooperation, the States have said "Let the Federal Government do it" and "Let those guys in Washington take the heat."

Over the long haul there will be no real acceptance of collective bargaining as a desirable part of our economic life until it is accepted at the grass roots.

Regionalization by Boards or Courts would be a step in that direction. The National Board, so often friendless, could use the support of Regional Boards wrestling with the same problems.

A decision by 3 Presidentially appointed southerners, finding that a Southerner violated the Act would be more acceptable and meaningful than 3 yankees in Washington finding the same violations.

- 12 -

Regional Boards will be more attuned and responsive to labor relations needs and the impact and effect of national policy in their region than centralization in Washington permits. It will multiply the sources of expertness available to the National Board, making it more responsive to regional needs while still assuring uniform national policy where uniformity is paramount. It will add catalytic agents. 15 Presidential appointees will add 15 more catalytic agents to the industrial relations scene than we have now. We need them. Presidential appointment adds a degree of stature, freedom, and flexibility that career employees rarely can achieve. Regional Board Members can contribute to the administration of the Act by speaking, by closer contact with practitioners, by stimulating regional research, by observing the effectiveness and ramifications of policies, by communication with labor and management leaders in their respective regions and by exchanging ideas with other regional and national board members.

Regional Boards would accord with judicial experience, both Federal and State, in solving problems of expanding case loads of the highest tribunal by interposing intermediate courts of appeal between the lowest and the highest court. It also accords with our war time experience with War Labor and Wage stabilization Boards which were organized into 14 Regional Boards. So Regional Boards are not strangers in our history of industrial relations.

In his far reaching statement before the House Labor Subcommittee, Chairman Miller wisely suggests that any restructuring of the labor judiciary should consider the many facets of national labor policy being administered and adjudicated by independently isolated administrative and judicial bodies which induce a multiplicity

- 13 -

of litigation in different forums all arising from the same conduct. <sup>10/</sup> He suggests that now is the time to establish "some kind of consolidated or coordinated labor judiciary." It may well take several years for Congress to legislate the amendments, integration, and coordination of the many separate statutes that, added together, make up our national labor policies.

In the meantime, we could start with Regional Boards or Labor Courts that would solve the pressing needs of the National Labor Relations Board and serve as a basic structure upon which an effective coordinated labor judiciary can be built. It may be prudent to integrate the statutes gradually, perhaps starting with a merger of statutes concerned with discrimination, such as union activity or racial discrimination, for the techniques of investigation are so transferable and the pretexts so similar.

#### CONCLUSION

Now the obvious conclusion from all this is that the Board's machinery must be redesigned and soon. And the Board is asking for help. The Chairman has frequently and publicly invited labor and management to take this problem seriously and take joint initiative in constructive new design. He has publicly expressed his disappointment in their failure to date to do so. He continues to urge it. He is deadly serious about it.

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<sup>10/</sup> National labor policies mentioned for example, in addition to the NLRA, are those involving wages and hours, race, creed, color, sex, age, arbitration, public employees, etc.

- 14 -

I can only hope that this paper throws more light on the problem and stimulates more thought and debate on how to handle more than 40,000 cases.

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Testimony of Ogden W. Fields  
before Senate Labor and  
Public Welfare Committee

August 16, 1972

HOSPITAL DATA FOR 1970

	NUMBER OF HOSPITALS	PERCENT OF ALL HOSPITALS	NUMBER OF EMPLOYEES	PERCENT OF ALL EMPLOYEES	NUMBER OF BEDS	PERCENT OF TOTAL BEDS	TOTAL EXPEN- DITURES	PERCENT OF TOTAL EXPEN- DITURES
PROFIT	858	12.0%	105,580	4.2%	59,330	3.8%		
NON-PROFIT	3600	50.5%	1,427,012	56.2%	618,584	38.3%	\$14,558,853	57.0%
PUBLIC State, Local (Including Federal)	2665	37.4%	1,004,430	39.6%	937,893	58.0%		
TOTAL	7123	99.9%	2,537,112		1,615,771		\$25,555,880	

Source: Annual Hospital Guide, 1971  
Published by American Hospital Association  
Chicago, Illinois

The CHAIRMAN. Our next witness is Mr. Alfred Albert, Deputy Solicitor, Department of Labor.

Mr. Albert.

**STATEMENT OF ALFRED ALBERT, DEPUTY SOLICITOR,  
DEPARTMENT OF LABOR**

Mr. ALBERT. Mr. Chairman and members of the subcommittee, it is a pleasure to be with you this morning for this legislative doubleheader.

The bill now before the subcommittee, H.R. 11357, amends the National Labor Relations Act to include private, nonprofit hospitals—hospitals which have been outside NLRA since passage of the Taft-Hartley Act in 1947.

We agree with H.R. 11357 and believe the time has come to place private, nonprofit hospitals under the salutary provisions of the NLRA.

At the time Taft-Hartley was enacted, it was believed that nonprofit hospitals needed relief from the NLRA so they could continue to provide services to the poor.

Such hospitals, it was argued, were charitable institutions; they were not businesses, in the ordinary sense of the word, seeking to operate at a profit for their owners.

The dynamics of their employee relations, therefore, would lack certain of the tensions attendant to labor relations in standard "for profit" enterprises.

These arguments may have had some validity in the past. But much has happened since 1947 and the distinctions between private, nonprofit hospitals and other private hospitals have largely disappeared.

Labor problems are essentially similar in both situations. The same types of personnel are needed. Professional management is utilized.

Unions are organizing nonprofit hospitals at a growing rate, although it has not proceeded as smoothly as it would have with statutory guidelines.

The need for an equitable set of ground rules become clear. Without statutory procedures, the strenuous efforts at organization which are currently taking place have sometimes taken on aspects of political and social strife, disrupting both hospitals and communities.

I believe H.R. 11357, which removes the exclusion of private nonprofit hospitals from the section 2(2) definition of "employer" and has been passed by the House, is a proper method of solving these problems.

Private, nonprofit hospitals were, in fact, covered originally under the Wagner Act, in 1935. They were, in 1947, excluded by amendment, but after only a short debate and without, it appears, a clear understanding of the amendment's implications.

In 1947, it was thought that the NLRA would, in some way, hinder labor-management relations in these private, nonprofit hospitals. Today, we know the opposite is true. NLRA will not hinder labor relations, but will help them immeasurably.

As Secretary Hodgson has said, "It is far better that (labor-management problems) be resolved through the orderly procedures of the National Labor Relations Act than through bitter and wasteful confrontations."

Accordingly, we favor enactment of this bill.

Thank you.

The CHAIRMAN. Thank you very much. I have no questions.

Senator Taft.

Senator TAFT. Mr. Albert, what percentage of hospital employees are in nonprofit hospitals today?

Mr. ALBERT. I am afraid I could not give you an answer on that, Senator. We could try to produce it for the record.

Senator TAFT. How many hospital employees are there in the United States?

Mr. ALBERT. I could not give you an answer to that.

Senator TAFT. How many public hospital employees are there in the United States?

Mr. ALBERT. I would be happy to furnish this for the record.

Senator TAFT. What is the general ratio between public hospital employees and nonpublic hospital employees?

Mr. ALBERT. Personally, I could not answer all these questions; but I am sure we could furnish that information for the record.

Senator TAFT. I am kind of appalled, frankly, that you would come up and testify on a bill of this import without having the very basic facts upon which to base your conclusions.

Mr. ALBERT. I am sure we have those facts. I just do not happen to know them myself, and I do not have them available at the moment. But I am sure we can furnish them.

Senator TAFT. Can you have a witness up here who has some background in what the employment situation in hospitals is in the United States? Because obviously you do not—

Mr. ALBERT. We will do that; yes.

Mr. GRUNEWALD. Yes.

Senator TAFT. I do not have any further questions.

The CHAIRMAN. Thank you very much.

Next is Mr. Myles J. Gibbons, Jr., counsel for the Hospital Association of Pennsylvania.

Mr. Gibbons.

**STATEMENT OF MYLES J. GIBBONS, COUNSEL, HOSPITAL ASSOCIATION OF PENNSYLVANIA, ACCOMPANIED BY LEON A. CORD, DIRECTOR, MANAGEMENT AND FISCAL AFFAIRS; AND JOHN F. WICK, PUBLIC AFFAIRS DIRECTOR, HOSPITAL ASSOCIATION OF PENNSYLVANIA**

Mr. GIBBONS. Thank you, Senator Williams.

Before I proceed, let me introduce Mr. Leon A. Cord, the director of management and fiscal affairs to the Hospital Association of Pennsylvania; and Mr. John F. Wick, director of public affairs of the Hospital Association of Pennsylvania.

We have submitted a statement for the record, and we would appreciate it if it would be included in the record at the end of our testimony.

The CHAIRMAN. Surely.

Mr. GIBBONS. We have also submitted a copy of the Pennsylvania Public Employees Collective Bargaining Act for the record, and we

would appreciate if that would be included in the record, because we feel it is especially pertinent to the matters before this subcommittee.

Mr. GIBBONS. Before I proceed, let me give you a brief background of the Hospital Association of Pennsylvania.

The statewide association consisting of about 300 member hospitals and related health-care institutions includes not only nonprofit hospitals but also public hospitals and in addition, private hospitals, private profit hospitals.

In addition, we represent perhaps 300 other individuals who are members of the association.

In Pennsylvania, the statistics which the prior witness stated, would seem to be approximately correct. We have about 150,000 employees in hospitals in the State of Pennsylvania, of which about 15,000 are in public hospitals and another 5,000 are in private hospitals.

Now, in Pennsylvania, the experience that we have had with the private nonprofit—private profit hospitals under the Taft-Hartley amendment is very slight; the reason being that none of the profit hospitals in Pennsylvania are now organized under the National Labor Relations Act.

The important thing that I want to convey in my own presentation here—and I will have to not read the transcript of what I have already presented—is that Pennsylvania, about 2 years ago, was concerned with all the problems that have been presented here before this committee; they were concerned with the problems of organizational strikes not only among public employees, teachers, State employees, sanitation workers, but also among employees in the nonprofit hospitals.

As a result of this concern, a commission was formed; and this commission recommended legislation which eventually was enacted, and that is the Pennsylvania Public Employees Act.

This act covers not only public employees, but also covers those employees in charitable institutions, including the nonprofit hospitals of Pennsylvania. Thus far, we have had approximately 40 petitions for elections in Pennsylvania for nonprofit hospitals, some of which have obviously gone in favor of the unions which weren't interested in organizing and some which have gone the other way.

The act which Pennsylvania now is operating under for nonprofit hospitals is tailored very closely after the National Labor Relations Act. But it differs in a few very salient points. And those are the points that I hope to emphasize.

First of all, it differs in the machinery which is established for resolving bargaining impasses. Before we get to the impasse stage, of course, we have to have a union which is organized and certified. And as I indicated earlier, the Pennsylvania act follows the National Labor Relations Act very closely as far as that is concerned.

Probably the most significant alteration is what we do in our act, partially due to—of bargaining units within a particular employer. But aside from that, the right to organize, to hold elections, to have the Board determine what constitutes an appropriate unit, and certify units as the sole representative of employees, is very similar to the National Labor Relations Act.

And so we solved the problem in Pennsylvania with regard to the organizational strike, the recognition strike, which has occurred throughout the country and were occurring in Pennsylvania.

But once this unit is certified, then we go a little further than the National Labor Relations Act because we feel that we are involved here with a product and a service which is somewhat different than the production of widgets and the loss of profit that might occur during a strike or bargaining impasse.

We therefore have a very elaborate impasse-resolving procedure in this act.

It begins with mediation. Mediation is required after a specific time of bargaining; it is followed by private factfinding and public factfinding. This factfinding is partially binding in the Commonwealth of Pennsylvania, according to the parties involved.

After factfinding is made public, then we do provide and Pennsylvania I think was the second State in the Nation to provide it—a limited right to strike among public employees—and I believe Hawaii was the first by 2 months. The Pennsylvania law does allow a limited right to strike for public employees and employees of nonprofit hospitals, limited by whether or not the strike endangers or affects the public safety, health, or welfare.

Now, what does this mean as far as nonprofit hospitals are concerned?

Well, thus far, we have not had a strike in Pennsylvania involving nonprofit hospitals after approximately 2 years of operation under this act. This is not to say that there won't be a strike in the future.

We did have one strike that I am familiar with in a county nursing home which also came under this act. As a result of the provisions of this act, which provide for injunctive relief if safety, health, and welfare of the public is endangered, in the particular instance which I have cited, the county was able to go into court and get an injunction but, keep this in mind: An injunction does not have to bring a strike to a close; it can limit the amount of people who are on strike, or it can limit the effect of the strike.

In this particular situation, I am going to take some issue with some of the witnesses that preceded me in this particular situation. The union did not give the county any type of warning. It did not through any means of ambulance service or offer to supply minimal service. In this particular situation, the strike was called without warning, and very little, if any, service was provided. It was only because the Pennsylvania Public Employee Act did provide for a method of going into court and getting injunctive relief in a situation like that and that some relief was made available to this particular county nursing home.

It is this type of a situation which we are concerned will occur with the National Labor Relations Act. There is no protection under the National Labor Relations Act if the union, which as was testified here before the committee indicated, are deeply concerned with the welfare of patients and making sure that the public is not adversely affected.

If for some reason they are able to or are willing to go through with these good intentions, the hospital is more or less at the mercy of the particular union. It is for this reason that we do provide the injunctive relief where the public health, safety, and welfare is concerned in Pennsylvania.

I submit—and I think it is very important to take note of the fact, and I am going to repeat myself—that I don't think nonprofit hospitals, or any public body, should be put in the position of operating only if the good will and good intentions of the union are followed through. I think there has to be some procedure for protecting the public; and we have that procedure in the Pennsylvania Public Employee Act and I really submit that—and would hope—your subcommittee and the Senate and the Congress, would look at our experience in Pennsylvania, would see what we have done, and look at our strength in Pennsylvania. And if there is going to be legislation which covers nonprofit hospitals, that this legislation have the protections, contains all of the protections, that the Pennsylvania Public Employee Act contains.

That concludes my statement.

The CHAIRMAN. Thank you very much.

(The prepared statement and other information follows:)

STATEMENT  
OF  
HOSPITAL ASSOCIATION OF PENNSYLVANIA  
ON  
H.R. 11357  
BEFORE THE

SUB COMMITTEE OF THE  
SENATE COMMITTEE ON  
LABOR AND PUBLIC WELFARE

August 16, 1972

The Hospital Association of Pennsylvania appreciates the opportunity to appear before the Committee to express its views on H.R. 11357.

The Association opposes this bill primarily on two grounds:

- (1) that the matter should fall within the ambit of state control and/or
- (2) that labor management legislation as applied to hospitals should be treated differently than provided for by the National Labor Relations Act which is primarily geared to the private sector industry.

It should be understood that this Association does not oppose the proposition that bargaining rights be granted to employes of non-profit hospitals. In Pennsylvania, such hospitals are subject to operation of a statute which provides employes with the right to organize select representatives and bargain collectively through such representatives. A representative must be selected by an exercise of the democratic processes, the unit represented must be composed of members with a community of interest and the representation must be exclusive.

Bargaining is required on wages, hours and working conditions, but the employer is not required to bargain on

matters of policy or on matters which are inconsistent with state statutes.

Unfair practices similar to those set forth under the National Labor Relations Act are established for both employers, employes and their representatives. Good faith bargaining is required and in cases of impasse, mediation and fact-finding are utilized. If the latter fails to break the impasse, then the employes are entitled to strike for so long as the public health, safety or welfare is not endangered.

It is rather clear that non-profit hospitals are endowed with certain public service functions and for this reason are to a great extent regulated by the State. In fact, at this time, the Commonwealth of Pennsylvania has just finished hearings on regulations which will mandate the composition and structure of hospital boards.

The services which these hospitals perform are essential services which parallel those services of government. If these hospitals did not perform these vital health services, state government would of necessity be forced to so do in order to protect the health, safety and welfare. State governments, by and large, have already taken over mental health programs and institutions. From a purely objective standpoint non profit hospitals are now a tool of state government.

Since there is a close and continuing relationship between the state and these non profit institutions, the states are in the best position to establish standards applicable to the labor management relationship since this area is but one segment of the entire state-hospital inter-relationship.

Units have been organized in hospitals throughout the state, bargaining has taken place and agreements consummated. All of this within the parameters of the Pennsylvania Act which gives protection to and shows concern for the general public welfare.

The Association also is of the opinion that the proposed Act fails to take into consideration the fact that the National Labor Relations Act has been tailored to meet the problems which have arisen in the employer-employee relationship in the industrial segment of our economy. In the past, Congress recognized the fact that the Act should not be applicable to non profit hospitals and therefore created the exemption which this bill simply eliminates. Nothing has occurred since the exemption was created which has changed the character of the hospital as an employer and the exemption is just as valid today as it was then.

It is the extent to which the public interest is involved which makes the non profit hospital setting rather

unique. The employer-employee relationship in this context must begin with the fundamental promise that the public interest is paramount. It could hardly be maintained that the continued operation of a hospital or hospitals is not required. The continued operation of hospitals is essential to the health, safety and welfare of the public.

An act, therefore, which threatens the continuity of such operations threatens the overall public interest. The National Labor Relations Act is devoid of protections inasmuch as an unlimited right to strike exists thereunder with certain exceptions not applicable hereto.

The rather obvious purpose of the National Labor Relations Act was to create a balance at the bargaining table so that equitable agreements would result. However, where an imbalance exists this result is less likely to be accomplished. Since the right to strike a hospital is such a potent weapon because of the catastrophic impact, hospitals would be hard put to prevent employe unions from exercising complete control. It might be pointed out that hospitals would not have the balancing weapon of a lock out in their arsenals. What would a hospital serving three or four counties in the center of our Commonwealth do in the event of a strike? Ship patients out - refuse to take new patients - neither of which is practical and certainly not in the public interest.

Unions maintain they must have the right to strike. We question this because of our experience under the Pennsylvania Act. If there is to be an imbalance that imbalance must not be tipped toward the union or the hospital itself, but must be tipped in favor of the general public, health and safety. The standards established under the Pennsylvania statute are workable and with proper administration shall be effective.

Non profit hospitals do not have the secondary controls. In short, competition from the standpoint of increased business or increase in profits is not an element in their operations. The market place exercises no dampening or limiting influence on either the employer or the union.

Paramount at all times was the public welfare. Neither unions nor employer groups were entirely satisfied, but a workable statute did evolve.

We feel that a cursory examination of the Pennsylvania Act will show the inadequacy of the Bill before this Committee and certainly make apparent the necessity for additional thought and study before encompassing the hospitals within the framework of the National Labor Relations Act.

## THE GENERAL ASSEMBLY OF PENNSYLVANIA

## SENATE BILL

No. 1333

Session of  
1970INTRODUCED BY FRAME, LAMB, PIASECKI, SESLER, REIDMAN AND  
GERHART, MARCH 17, 1970

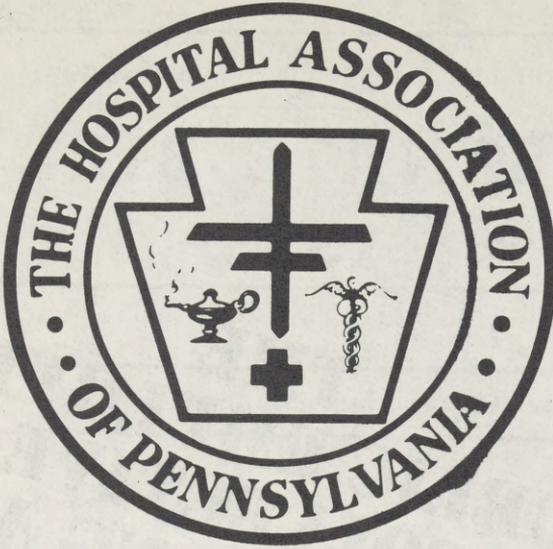
AS AMENDED ON SECOND CONSIDERATION, JUNE 11, 1970

**THE  
PUBLIC EMPLOYEES'  
COLLECTIVE  
BARGAINING ACT**

1 Establish rights in public employes to organize and bargain  
2 collectively through selected representatives; defining  
3 public employment of public employes; providing for  
4 organization of institutions of public employes; providing for  
5 mediation and fact-finding in case of collective bargaining  
6 impasses; providing arbitration for certain public employes  
7 for collective bargaining impasses; defining the scope of  
8 collective bargaining; establishing unfair employe and  
9 employe practices; prohibiting strikes for certain public  
10 employes; permitting strikes under limited conditions;  
11 providing penalties for violations; and establishing  
12 procedures for implementation.

## TABLE OF CONTENTS

13		
14	Article I.	Public Policy
15	Article II.	Short Title
16	Article III.	Definitions
17	Article IV.	Employe Rights
18	Article V.	Pennsylvania Labor Relations Board
19	Article VI.	Representation
20	Article VII.	Scope of Bargaining
21	Article VIII.	Collective Bargaining Impasse
22	Article IX.	Prepared by Collective Bargaining Agreement
23	Article X.	The Hospital Association of Pennsylvania Strikes



## THE BARGAINING BILL IN BRIEF

*The following brief synopsis of Act 195 (S-1333) was prepared for HAP by Attorney Thomas H. Lane, of Reed Smith Shaw & McClay, who authored the original legislation when he was Assistant Attorney General. The complete text of the bill as it was approved by the General Assembly begins on page 3. HAP will be providing more details on its provisions in the weeks ahead.*

Now that Senate Bill 1333 has become law, it is incumbent upon both employer and employee groups to know and understand its provisions so that viable working relations will be the rule in the future. The Act may be broken down into six general areas, each, of course, dependent upon the other. The first of these areas deals with "organization." We must keep in mind that even without the passage of this Act, employees had a constitutional right protected by the first and 14th Amendments to associate in whatever form they may choose.

This Act simply gives certain employees the right to bargain. Confidential employees, management level employees, clergymen, firemen and policemen are not covered by this Act. All other persons employed by the Commonwealth or its political subdivisions, or any nonprofit organization or institution, are included and entitled to the benefits provided therein.

The first difficulty that will be faced by employee-employer groups is determining the unit appropriate for bargaining purposes. We must keep in mind that membership in a union and membership in an appropriate unit are not the same. Unit determination will be made under guidelines established in the Act, the most important of which is that all members of the unit must have an "identifiable community of interest" which, in essence, means a similarity in wages, hours, and working conditions.

In the private sector, numerous criteria are involved, some of which I am sure will be utilized by the Pennsylvania Labor Board in its determinations in the public sector. First line supervisors will not be permitted in rank and file units, but they may be able to form their own separate homogeneous units. Employees above the first level of supervision will be considered management level employees and will not be covered by the Act. Guards at prisons and mental hospitals, employees necessary to the functioning of the courts, and persons employed to protect the property of the employer or safety of people on the employer's premises will be permitted to form their own separate homogeneous units but will not be allowed to be members of a unit including rank and file employees. One of the more difficult problems in this area will involve the determination of who is a supervisor. In analyzing the Act, we must look at the definition of the word "supervisor" in the disjunctive, so that even the "power to direct" could be sufficient to indicate supervisory status.

If an employer agrees with an employee representative that the unit is appropriate for bargaining purposes and voluntarily wants to recognize the representative, they may jointly petition the board for approval of the unit and request certification of the representative as the exclusive agent. If the employer does not choose to voluntarily recognize, then an election would be required,

provided that there is 30% or more showing interest. If this criteria is met, then an election can be conducted. If a majority of the votes cast in an election is for a specific representative, then the representative so elected would be exclusive. Dual representation is prohibited.

There is no doubt that elections will have to be conducted under "laboratory conditions" and that many of the rules utilized in the private sector will be utilized in the public sector. The 24-hour rule, locus rule, rules on misrepresentation, rules on solicitation and distribution are but a few.

The second major area deals with the "*scope of bargaining.*" This is extremely important since many employee groups want to encroach upon the policy-making decisions of employers. The purpose for rather specific structuring of the provisions of the Act bearing on bargaining was done to prevent the employees from becoming involved in these decisions. They will be entitled to bargain over wages, hours, and other terms and conditions of employment, but the employer shall not be required to bargain over matters of inherent managerial policy such as functions and programs, standards of service, overall budget, the utilization of technology, the organizational structure, and selection and direction of personnel. However, where any policy decision affects wages, hours, and working conditions, the employer will be required to engage in a process labelled "meet and discuss." This procedure would require the employer to sit down at reasonable times and discuss with the employe group such policy matters. The decisions of the employer, however, will be final.

It might be pointed out that it is an "unfair practice" for either employers or employees to refuse to comply with the requirements of "meet and discuss." If an employee group would not accept the determination of the employer as final, it would be guilty of an "unfair practice." First level supervisors will be permitted to engage in "meet and discuss" on matters which are deemed bargainable for other public employees. Maintenance of membership and checkoff are subjects of bargaining. The former would require an employee who has joined an organization to remain a member until the expiration of the contract so providing, with the proviso that during the last fifteen days of that contract he could resign.

Section 703 of the Act prohibits the parties from effecting or implementing a provision in an agreement if the provision would be in violation of, inconsistent with, or in conflict with any statute of the Commonwealth. This will undoubtedly create problems in the future, at least until court determinations are made in several areas.

The third area is the area dealing with the "*mechanics of bargaining.*" Both employers and employees are required to bargain in good faith. If they engage in bargaining for 21 days and an agreement is not reached, then they must call upon the Pennsylvania Bureau of Mediation. If, after mediation has been used for a period of 20 days, but an agreement has not been reached then the Pennsylvania Labor Board may in its discretion appoint a factfinding panel of one or three members. The Bureau of Mediation must notify the board after the 20 days, but in no event later than 130 days prior to the budget submission date of the impasse. Not more than 40 days after the Bureau of Mediation has notified the board, the recommendations and findings of the panel, if one is so

(continued on page 28)

The following reprint of SB 1333 — now Act No. 195 — is in the form in which it was finally passed by the General Assembly. Senate amendments are in CAPITAL LETTERS. The House made no changes.

The Governor signed the legislation on July 23, 1970. All provisions of the Act will be operational on October 21, 1970.

## TABLE OF CONTENTS

Article I.	Public Policy . . . . .	4
Article II.	Short Title . . . . .	5
Article III.	Definitions . . . . .	5
Article IV.	Employe Rights . . . . .	8
Article V.	Pennsylvania Labor Relations Board . . . . .	8
Article VI.	Representation . . . . .	8
Article VII.	Scope of Bargaining . . . . .	12
Article VIII.	Collective Bargaining Impasse . . . . .	13
Article IX.	Collective Bargaining Agreement . . . . .	15
Article X.	Strikes . . . . .	16
Article XI.	Picketing . . . . .	17
Article XII.	Unfair Practices . . . . .	18
Article XIII.	Prevention of Unfair Practices . . . . .	19
Article XIV.	Unfair Practices During Article VIII Procedures . . . . .	21
Article XV.	Judicial Review . . . . .	21
Article XVI.	Investigatory Powers . . . . .	23
Article XVII.	Employe Organizations . . . . .	25
Article XVIII.	Conflict of Interest . . . . .	26
Article XIX.	Penalties . . . . .	26
Article XX.	Savings Provisions . . . . .	26
Article XXI.	Separability . . . . .	27
Article XXII.	Repeals . . . . .	27
Article XXIII.	Effective Date . . . . .	28

*Changes from the original version of SB 1333 are shown in capital letters.*

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 THE GENERAL ASSEMBLY OF PENNSYLVANIA
 

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# SENATE BILL

No.

**1333**Session of  
1970

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 Introduced By Frame, Lamb, Piasecki, Sesler, Reibman And Gerhart,  
March 17, 1970
 

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 As amended on second consideration, July 13, 1970
 

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## AN ACT

Establishing rights in public employes to organize and bargain collectively through selected representatives; DEFINING PUBLIC EMPLOYES TO INCLUDE EMPLOYES OF NONPROFIT ORGANIZATIONS AND INSTITUTIONS; providing compulsory mediation and fact-finding, for collective bargaining impasses; providing arbitration for certain public employes for collective bargaining impasses; defining the scope of collective bargaining; establishing unfair employe and employer practices; prohibiting strikes for certain public employes; permitting strikes under limited conditions; providing penalties for violations; and establishing procedures for implementation.

The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

### ARTICLE I Public Policy

Section 101. The General Assembly of the Commonwealth of Pennsylvania declares that it is the public policy of this Commonwealth and the purpose of

this act to promote orderly and constructive relationships between all public employers and their employees subject, however, to the paramount right of the citizens of this Commonwealth to keep inviolate the guarantees for their health, safety and welfare. Unresolved disputes between the public employer and its employees are injurious to the public and the General Assembly is therefore aware that adequate means must be established for minimizing them and providing for their resolution. Within the limitations imposed upon the governmental processes by these rights of the public at large and recognizing that harmonious relationships are required between the public employer and its employees, the General Assembly has determined that the overall policy may best be accomplished by (1) granting to public employees the right to organize and choose freely their representatives; (2) requiring public employers to negotiate and bargain with employe organizations representing public employees and to enter into written agreements evidencing the result of such bargaining; and (3) establishing procedures to provide for the protection of the rights of the public employe, the public employer and the public at large.

## ARTICLE II

### Short Title

Section. 201. This act shall be known and may be cited as the "Public Employe Relations Act."

## ARTICLE III

### Definitions

Section 301. As used in this act:

(1) "Public employer" means the Commonwealth of Pennsylvania, its political subdivisions including school districts and any officer, board, commission, agency, authority, or other instrumentality thereof AND ANY NONPROFIT ORGANIZATION OR INSTITUTION AND ANY CHARITABLE, RELIGIOUS, SCIENTIFIC, LITERARY, RECREATIONAL, HEALTH, EDUCATIONAL OR WELFARE INSTITUTION RECEIVING GRANTS OR APPROPRIATIONS FROM LOCAL, STATE OR FEDERAL GOVERNMENTS but shall not include employers covered or presently subject to coverage under the act of June 1, 1937 (P. L. 1168), as amended, known as the "Pennsylvania Labor Relations Act," the act of July 5, 1935, Public Law 198, 74th Congress, as amended, known as the "National Labor Relations Act."

(2) "Public employe" or "employe" means any individual employed by a public employer but shall not include elected officials, appointees of the Governor with the advice and consent of the Senate as required by law, management level employes, confidential employes, CLERGYMEN OR

OTHER PERSONS IN A RELIGIOUS PROFESSION, EMPLOYEES OR PERSONNEL AT CHURCH OFFICES OR FACILITIES WHEN UTILIZED PRIMARILY FOR RELIGIOUS PURPOSES AND those employes covered under the act of June 24, 1968 (Act No. 111), entitled "An act specifically authorizing collective bargaining between policemen and firemen and their public employers; providing for arbitration in order to settle disputes, and requiring compliance with collective bargaining agreements and findings of ARBITRATORS."

(3) "Employee organization" means an organization of any kind, or any agency or employee representation committee or plan in which membership includes public employes, and which exists for the purpose, in whole or in part, of dealing with employers concerning grievances, employee-employer disputes, wages, rates of pay, hours of employment, or conditions of work but shall not include any organization which practices discrimination in membership because of race, color, creed, national origin or political affiliation.

(4) "Representative" means any individuals acting for public employers or employes and shall include employee organizations.

(5) "Board" means the Pennsylvania Labor Relations Board.

(6) "Supervisor" means any individual having authority in the interests of the employer to hire, transfer, suspend, layoff, recall, promote, discharge, assign, reward or discipline other employes or responsibly to direct them or adjust their grievances; or to a substantial degree effectively recommend such action, if in connection with the foregoing, the exercise of such authority is not merely routine or clerical in nature but calls for the use of independent judgment.

(7) "Professional employe" means any employe whose work: (i) is predominantly intellectual and varied in character; (ii) requires consistent exercise of discretion and judgment; (iii) requires knowledge of an advanced nature in the field of science or learning customarily acquired by specialized study in an institution of higher learning or its equivalent; and (iv) is of such character that the output or result accomplished cannot be standardized in relation to a given period of time.

(8) "Unfair practice" means any practice prohibited by Article XII of this act.

(9) "Strike" means concerted action in failing to report for duty, the wilful absence from one's position, the stoppage of work, slowdown, or the abstinence in whole or in part from the full, faithful and proper performance of the duties of employment for the purpose of inducing, influencing or coercing a change in

the conditions or compensation or the rights, privileges, or obligations of employment.

(10) "Person" includes an individual, public employer, public employe, authority, commission, legal representative, labor organization, employe organization, profit or nonprofit corporation, trustee, board or association.

(11) "Membership dues deduction" means the practice of a public employer to deduct from the wages of a public employe, with his written consent, an amount for the payment of his membership dues in an employe organization, which deduction is transmitted by the public employer to the employe organization.

(12) "Budget submission date" means the date by which under the law or practice a public employer's proposed budget, or budget containing proposed expenditures applicable to such public employer is submitted to the Legislature or other similar body for final action. For the purposes of this act, the budget submission date for the Commonwealth shall be February 1 of each year AND FOR A NONPROFIT ORGANIZATION OR INSTITUTION, THE LAST DAY OF ITS FISCAL YEAR.

(13) "Confidential employe" shall mean any employe who works: (i) in the personnel offices of a public employer and has access to information subject to use by the public employer in collective bargaining; or (ii) in a close continuing relationship with public officers or representatives associated with collective bargaining on behalf of the employer.

(14) "Wages" means hourly rates of pay, salaries or other forms of compensation for services rendered.

(15) "Commonwealth employe" means a public employe employed by the Commonwealth or any board, commission, agency, authority, or any other instrumentality thereof.

(16) "Management level employe" means any individual who is involved directly in the determination of policy or who responsibly directs the implementation thereof and shall include all employes above the first level of supervision.

(17) "Meet and discuss" means the obligation of a public employer upon request to meet at reasonable times and discuss recommendations submitted by representatives of public employes: Provided, That any decisions or determinations on matters so discussed shall remain with the public employer and be deemed final on any issue or issues raised.

(18) "Maintenance of membership" means that all employes who have joined an employe organization or who join the employe organization in the future must remain members for the duration of a collective bargaining agreement so providing with the proviso that any such employe or employes may resign from such employe organization during a period of fifteen days prior to the expiration of any such agreement.

(19) "First level of supervision" and "first level supervisor" means the lowest level at which an employe functions as a supervisor.

#### ARTICLE IV Employe Rights

Section 401. It shall be lawful for public employes to organize, form, join or assist in employe organizations or to engage in lawful concerted activities for the purpose of collective bargaining or other mutual aid and protection or to bargain collectively through representatives of their own free choice and such employes shall also have the right to refrain from any or all such activities, except as may be required pursuant to a maintenance of membership provision in a collective bargaining agreement.

#### ARTICLE V Pennsylvania Labor Relations Board

Section 501. The board shall exercise those powers and perform those duties which are specifically provided for in this act. These powers and duties shall be in addition to and exercised completely independent of any powers and duties specifically granted to it by other statutory enactments.

Section 502. The board shall have authority from time to time to make, amend and rescind such rules and regulations as may be necessary to carry out the provisions of this act. Such rules and regulations shall be effective upon publication in the manner which the board shall prescribe.

Section 503. The board shall establish after consulting representatives of employe organizations and of public employers, panels of qualified persons broadly representative of the public to be available to serve as members of fact-finding boards.

#### ARTICLE VI Representation

Section 601. Public employers may select representatives to act in their interest in any collective bargaining with representatives of public employes.

Section 602. (a) A public employer may recognize employe representatives for collective bargaining purposes, provided the parties jointly request certification by the board which shall issue such certification if it finds the unit appropriate.

(b) Any employe representatives in existence on JANUARY 1, 1970, shall so continue without the requirement of an election and certification until such time as a question concerning representation is appropriately raised under this act; or until the board would find the unit not to be appropriate after challenge by the public employer, a member of the unit or an employe organization. The appropriateness of the unit shall not be challenged until the expiration of any collective bargaining agreement in effect on the date of the passage of this act.

Section 603. (a) A public employe, a group of public employes or an employe organization may notify the public employer that thirty percent or more of the public employes in an appropriate unit desire to be exclusively represented for collective bargaining purposes by a designated representative and request the public employer to consent to an election.

(b) If the public employer consents, the public employe, group of public employes or employe organization whichever applicable may submit in a form and manner established by the board an election request. Such request shall include a description of the unit deemed to be appropriate. The basis upon which it was determined that thirty percent or more of the employes desired to be represented and a joinder by the public employer. The board may on the basis of the submissions order an election to be held or it may at its discretion investigate or conduct hearings to determine the validity of the matters contained in such submissions before determining whether or not an order should issue.

(c) If a public employer refuses to consent to an election, the party making the request may file a petition with the board alleging that thirty per cent or more of the public employes in an appropriate unit wish to be exclusively represented for collective bargaining purposes by a designated representative. The board shall send a copy of the petition to the public employer and provide for an appropriate hearing upon due notice. If it deems the allegations in the petition to be valid and the unit to be appropriate it shall order an election. If it finds to the contrary it may dismiss the petition or permit its amendment in accordance with procedures established by the board.

(d) If a public employer receives notification that thirty per cent or more of the public employes desire to be exclusively represented for collective bargaining purposes by a designated representative and the party giving notice does not

thereafter seek an election the public employer may file a petition for the same with the board. The board shall then follow the procedures as established for petitions filed under subsection (c) of this section.

Section 604. The board shall determine the appropriateness of a unit which shall be the public employer unit or a subdivision thereof. In determining the appropriateness of the unit, the board shall:

(1) Take into consideration but shall not be limited to the following: (i) public employes must have an identifiable community of interest, and (ii) the effects of over-fragmentization.

(2) Not decide that any unit is appropriate if such unit includes both professional and nonprofessional employes, unless a majority of such professional employes vote for inclusion in such unit.

(3) Not permit guards at prisons and mental hospitals, EMPLOYES DIRECTLY INVOLVED WITH AND NECESSARY TO THE FUNCTIONING OF THE COURTS OF THIS COMMONWEALTH, or any individual employed as a guard to enforce against employes and other persons, rules to protect property of the employer or to protect the safety of persons on the employer's premises to be included in any unit with other public employes, each may form separate homogenous employe organizations with the proviso that organizations of the latter designated employe group may not be affiliated with any other organization representing or including as members, persons outside of the organization's classification.

(4) Take into consideration that when the Commonwealth is the employer, it will be bargaining on a Statewide basis unless issues involve working conditions peculiar to a given governmental employment locale. This section, however, shall not be deemed to prohibit multi-unit bargaining.

(5) Not permit employes at the first level of supervision to be included with any other units of public employes but shall permit them to form their own separate homogenous units. IN DETERMINING SUPERVISORY STATUS THE BOARD MAY TAKE INTO CONSIDERATION THE EXTENT TO WHICH SUPERVISORY AND NONSUPERVISORY FUNCTIONS ARE PERFORMED.

Section 605. Representation elections shall be conducted by secret ballot at such times and places selected by the board subject to the following:

(1) The board shall give no less than ten days notice of the time and place of such election.

(2) The board shall establish rules and regulations concerning the conduct of any election including but not limited to regulations which would guarantee the secrecy of the ballot.

(3) A representative may not be certified unless it receives a majority of the valid ballots cast.

(4) The board shall include on the ballot a choice of "no representative."

(5) In an election where none of the choices on the ballot receives a majority, a run-off election shall be conducted, the ballot providing for a selection between the two choices or parties receiving the highest and the second highest number of ballots cast in the election.

(6) The board shall certify the results of said election within five working days after the final tally of votes if no charge is filed by any person alleging that an "unfair practice" existed in connection with said election. If the board has reason to believe that such allegations are valid, it shall set a time for hearing on the matter after due notice. Any such hearing shall be conducted within two weeks of the date of receipt of such charge. If the board determines that the outcome of the election was affected by the "unfair practice" charged or for any other "unfair practice" it may deem existed, it shall require corrective action and order a new election. If the board determines that no unfair practice existed or if it existed, did not affect the outcome of the election, it shall immediately certify the election results.

(7) (i) No election shall be conducted pursuant to this section in any appropriate bargaining unit within which in the preceding twelve-month period an election shall have been held nor during the term of any lawful collective bargaining agreement between a public employer and an employe representative. This restriction shall not apply to that period of time covered by any collective bargaining agreement which exceeds three years. For the purposes of this section, extensions of agreements shall not affect the expiration date of the original agreement.

(ii) Petitions for elections may be filed with the board not sooner than ninety days nor later than sixty days before the expiration date of any collective bargaining agreement or after the expiration date until such time as a new written agreement has been entered into. For the purposes of this section, extensions of agreements shall not affect the expiration date of the original agreement.

Section 606. Representatives selected by public employes in a unit appropriate for collective bargaining purposes shall be the exclusive

representative of all the employes in such unit to bargain on wages, hours, terms and conditions of employment: Provided, That any individual employe or a group of employes shall have the right at any time to present grievances to their employer and to have them adjusted without the intervention of the bargaining representative as long as the adjustment is not inconsistent with the terms of a collective bargaining contract then in effect: And, provided further, That the bargaining representative has been given an opportunity to be present at such adjustment.

Section 607. If there is a duly certified representative: (i) a public employe or a group of public employes may file a petition for decertification provided it is supported by a thirty per cent showing of interest, or (ii) a public employer alleging a good faith doubt of the majority status of said representative may file a petition in accordance with the rules and regulations established by the board, subject to the provisions of clause (7) of section 605.

## ARTICLE VII Scope of Bargaining

Section 701. Collective bargaining is the performance of the mutual obligation of the public employer and the representative of the public employes 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 but such obligation does not compel either party to agree to a proposal or require the making of a concession.

Section 702. Public employers shall not be required to bargain over matters of inherent managerial policy, which shall include but shall not be limited to such areas of discretion or policy as the functions and programs of the public employer, standards of services, its overall budget, utilization of technology, the organizational structure and selection and direction of personnel. Public employers, however, shall be required to meet and discuss on policy matters affecting wages, hours and terms and conditions of employment as well as the impact thereon upon request by public employe representatives.

Section 703. The parties to the collective bargaining process shall not effect or implement A PROVISION IN a collective bargaining agreement if the implementation of that PROVISION would be in violation of, or inconsistent with, or in conflict with any statute or statutes enacted by the General Assembly of the Commonwealth of Pennsylvania or the provisions of municipal home rule charters.

Section 704. Public employers shall not be required to bargain with units of first level supervisors or their representatives but shall be required to meet and discuss with FIRST LEVEL supervisors or their representatives, on matters deemed to be bargainable for other public employes covered by this act.

Section 705. Membership dues deductions and maintenance of membership are proper subjects of bargaining with the proviso that as to the latter, the payment of dues and assessments while members, may be the only requisite employment condition.

SECTION 706. NOTHING CONTAINED IN THIS ACT SHALL IMPAIR THE EMPLOYER'S RIGHT TO HIRE EMPLOYEES OR TO DISCHARGE EMPLOYEES FOR JUST CAUSE CONSISTENT WITH EXISTING LEGISLATION.

## ARTICLE VIII

### Collective Bargaining Impasse

Section 801. If after a reasonable period of negotiation, a dispute or impasse exists between the representatives of the public employer and the public employes, the parties may voluntarily submit to mediation but if no agreement is reached between the parties within twenty-one days after negotiations have commenced, but in no event later than one hundred fifty days prior to the "budget submission date," and mediation has not been utilized by the parties, both parties shall immediately, in writing, call in the service of the Pennsylvania Bureau of Mediation.

Section 802. Once mediation has commenced, it shall continue for so long as the parties have not reached an agreement. If, however, an agreement has not been reached within twenty days after mediation has commenced or in no event later than one hundred thirty days prior to the "budget submission date," the Bureau of Mediation shall notify the board of this fact. Upon receiving such notice the board MAY IN ITS DISCRETION APPOINT A FACT-FINDING PANEL WHICH PANEL MAY CONSIST OF EITHER ONE OR THREE MEMBERS. IF A PANEL IS so designated or selected IT shall hold hearings and take oral or written testimony and shall have subpoena power. If during this time the parties have not reached an agreement, the panel shall make findings of fact and recommendations:

(1) The findings of fact and recommendations shall be sent by registered mail to the board and to both parties not more than forty days after the Bureau of Mediation has notified the board as provided in the preceding paragraph.

(2) Not more than ten days after the findings and recommendations shall have been sent, the parties shall notify the board and each other whether or not they accept the recommendations of the fact-finding panel and if they do not, the panel shall publicize its findings of fact and recommendations.

(3) Not less than five days nor more than ten days after the publication of the findings of fact and recommendations, the parties shall again inform the board and each other whether or not they will accept the recommendations of the fact-finding panel.

(4) THE COMMONWEALTH SHALL PAY ONE-HALF THE COST OF THE FACT-FINDING PANEL; THE REMAINING ONE-HALF OF THE COST SHALL BE DIVIDED EQUALLY BETWEEN THE PARTIES. THE BOARD SHALL ESTABLISH RULES AND REGULATIONS UNDER WHICH PANELS SHALL OPERATE, INCLUDING, BUT NOT LIMITED TO, COMPENSATION FOR PANEL MEMBERS.

Section 803. If the representatives of either or both the public employes and the public employer refuse to submit to the procedures set forth in section 801 and 802 of this article, such refusal shall be deemed a refusal to bargain in good faith and unfair practice charges may be filed by the submitting party or the board may on its own, issue an unfair practice complaint and conduct such hearings and issue such orders as provided for in Article XIII.

Section 804. Nothing in this article shall prevent the parties from submitting impasses to voluntary binding arbitration with the proviso the decisions of the arbitrator which would require legislative enactment to be effective shall be considered advisory only.

Section 805. Notwithstanding any other provisions of this act where representatives of units of guards AT prisons or mental hospitals OR UNITS OF EMPLOYES DIRECTLY INVOLVED WITH AND NECESSARY TO THE FUNCTIONING OF THE COURTS OF THIS COMMONWEALTH have reached an impasse in collective bargaining and mediation as required in section 801 of this article has not resolved the dispute, the impasse shall be submitted to a panel of arbitrators whose decision shall be final and binding upon both parties with the proviso that the decisions of the arbitrators which would require legislative enactment to be effective shall be considered advisory only.

Section 806. Panels of arbitrators for bargaining units referred to in section 805 of this article shall be selected in the following manner:

(1) Each party shall select one member of the panel, the two so selected shall choose the third member.

(2) If the members so selected are unable to agree upon the third member within ten days from the date of their selection, the board shall submit the names of seven persons, each party shall alternately strike one name until one shall remain. The public employer shall strike the first name. The person so remaining shall be the third member AND CHAIRMAN.

Section 807. The costs of the arbitrators selected under the provisions of section 806 shall be paid by the Commonwealth under rules and regulations established by the board.

## ARTICLE IX

### Collective Bargaining Agreement

Section 901. Once an agreement is reached between the representatives of the public employes and the public employer, the agreement shall be reduced to writing and signed by the parties. Any provisions of the contract requiring legislative action will only be effective if such legislation is enacted.

Section 902. If the provisions of the constitution or bylaws of an employe organization requires ratification of a collective bargaining agreement by its membership, only those members who belong to the bargaining unit involved shall be entitled to vote on such ratification notwithstanding such provisions.

Section 903. Arbitration of disputes or grievances arising out of the interpretation of the provisions of a collective bargaining agreement is mandatory. The procedure to be adopted is a proper subject of bargaining with the proviso that the final step shall provide for a binding decision by an arbitrator or a tri-partite board of arbitrators as the parties may agree. Any decisions of the arbitrator or arbitrators requiring legislation will only be effective if such legislation is enacted:

(1) If the parties cannot voluntarily agree upon the selection of an arbitrator, the parties shall notify the Bureau of Mediation of their inability to do so. The Bureau of Mediation shall then submit to the parties the names of seven arbitrators. Each party shall alternately strike a name until one name remains. The public employer shall strike the first name. The person remaining shall be the arbitrator.

(2) The costs of arbitration shall be shared equally by the parties. Fees paid to arbitrators shall be based on a schedule established by the Bureau of Mediation.

Section 904. Any provision of any collective bargaining agreement in existence on January 1, 1970 which is inconsistent with any provision of this act

but not otherwise illegal shall continue valid until the expiration of such contract. The parties to such agreements may continue voluntarily to bargain on any such items after the expiration date of any such agreement and for so long as these items remain in any future agreement.

## ARTICLE X

### Strikes

Section 1001. Strikes by guards at prisons or mental hospitals, EMPLOYES DIRECTLY INVOLVED WITH AND NECESSARY TO THE FUNCTIONING OF THE COURTS OF THIS COMMONWEALTH are prohibited at any time. If a strike occurs the public employer shall forthwith initiate in the court of common pleas of the jurisdiction where the strike occurs, an action for appropriate equitable relief including but not limited to injunctions. If the strike involves Commonwealth employees, the chief legal officer of the public employer or the Attorney General where required by law shall institute an action for equitable relief, either in the court of common pleas of the jurisdiction where the strike has occurred or the Commonwealth Court.

Section 1002. Strikes by public employes during the pendency of collective bargaining procedures set forth in sections 801 and 802 of Article VIII are prohibited. In the event of a strike during this period the public employer shall forthwith initiate an action for the same relief and utilizing the same procedures required for prohibited strikes under section 1001.

Section 1003. If a strike by public employes occurs after the collective bargaining processes set forth in sections 801 and 802 of Article VIII of this act have been completely utilized and exhausted, it shall not be prohibited unless or until such a strike creates a clear and present danger or threat to the health, safety or welfare of the public. In such cases the public employer shall initiate, in the court of common pleas of the jurisdiction where such strike occurs, an action for equitable relief including but not limited to appropriate injunctions and shall be entitled to such relief if the court finds that the strike creates a clear and present danger or threat to the health, safety or welfare of the public. If the strike involves Commonwealth employees, the chief legal officer of the public employer or the Attorney General where required by law shall institute an action for equitable relief in the court of common pleas of the jurisdiction where the strike has occurred or the Commonwealth Court. Prior to the filing of any complaint in equity under the provisions of this section the moving party shall serve upon the defendant a copy of said complaint as provided for in the Pennsylvania Rules of Civil Procedure applicable to such actions. Hearings shall be required before relief is granted under this section and notices of the same shall be served in the manner required for the original process with a duty imposed upon the court to hold such hearings forthwith.

Section 1004. An unfair practice by a public employer shall not be a defense to a prohibited strike. Unfair practices by the employer during the collective bargaining processes shall receive priority by the board as set forth in Article XIV.

Section 1005. If a public employe refuses to comply with a lawful order of a court of competent jurisdiction issued for a violation of any of the provisions of this article the public employer shall initiate an action for contempt and if the public employe is adjudged guilty of such contempt, he shall be subject to suspension, demotion or discharge at the discretion of the public employer, provided the public employer has not exercised that discretion in violation of clauses (1), (2), (3) and (4) of subsection (a) of section 1201, Article XII.

Section 1006. No public employe shall be entitled to pay or compensation from the public employer for the period engaged in any strike.

Section 1007. In the event any public employe refuses to obey an order issued by a court of competent jurisdiction for a violation of the provisions of this article, the punishment for such contempt may be by fine or by imprisonment in the prison of the county where the court is sitting or both in the discretion of the court.

Section 1008. Where an employe organization wilfully disobeys a lawful order of a court of competent jurisdiction issued for a violation of the provisions of this article, the punishment for each day that such contempt persists may be by a fine fixed in the discretion of the court.

Section 1009. In fixing the amount of the fine or imprisonment for contempt, the court shall consider all the facts and circumstances directly related to the contempt including but not limited to (i) any unfair practices committed by the public employer during the collective bargaining processes; (ii) the extent of the wilful defiance or resistance to the court's order; (iii) the impact of the strike on the health, safety or welfare of the public, and (iv) the ability of the employe organization or the employe to pay the fine imposed.

Section 1010. Nothing in this article shall prevent the parties from voluntarily requesting the court for a diminution or suspension of any fines or penalties imposed. Any requests by employe representatives for such participation by the public employer shall be subject to the requirements of "meet and discuss."

## ARTICLE XI

### Picketing

Section 1101. Public employes, other than those engaged in a nonprohibited strike, who refuse to cross a picket line shall be deemed to be engaged in a

prohibited strike and shall be subject to the terms and conditions of Article X pertaining to prohibited strikes.

ARTICLE XII  
Unfair Practices

Section 1201. (a) Public employers, their agents or representatives are prohibited from:

(1) Interfering, restraining or coercing employes in the exercise of the rights guaranteed in Article IV of this act.

(2) Dominating or interfering with the formation, existence or administration of any employe organization.

(3) Discriminating in regard to hire or tenure of employment or any term or condition of employment to encourage or discourage membership in any employe organization.

(4) Discharging or otherwise discriminating against an employe because he has signed or filed an affidavit, petition or complaint or given any information or testimony under this act.

(5) Refusing to bargain collectively in good faith with an employe representative which is the exclusive representative of employes in an appropriate unit, including but not limited to the discussing of grievances with the exclusive representative.

(6) Refusing to reduce a collective bargaining agreement to writing and sign such agreement.

(7) Violating any of the rules and regulations established by the board regulating the conduct of representation elections.

(8) Refusing to comply with the provisions of an arbitration award deemed binding under section 903 of Article IX.

(9) Refusing to comply with the requirements of "meet and discuss."

(b) Employe organizations, their agents, or representatives, or public employes are prohibited from:

(1) Restraining or coercing employes in the exercise of the rights guaranteed in Article IV of this act.

(2) Restraining or coercing a public employer in the selection of his representative for the purposes of collective bargaining or the adjustment of grievances.

(3) Refusing to bargain collectively in good faith with a public employer, if they have been designated in accordance with the provisions of this act as the exclusive representative of employes in an appropriate unit.

(4) Violating any of the rules and regulations established by the board regulating the conduct of representation elections.

(5) Refusing to reduce a collective bargaining agreement to writing and sign such agreement.

(6) CALLING, INSTITUTING, MAINTAINING OR CONDUCTING A STRIKE OR BOYCOTT AGAINST ANY PUBLIC EMPLOYER OR PICKETING ANY PLACE OF BUSINESS OF A PUBLIC EMPLOYER ON ACCOUNT OF ANY JURISDICTIONAL CONTROVERSY.

(7) ENGAGING IN, OR INDUCING OR ENCOURAGING ANY INDIVIDUAL EMPLOYED BY ANY PERSON TO ENGAGE IN A STRIKE OR REFUSAL TO HANDLE GOODS OR PERFORM SERVICES; OR THREATENING, COERCING OR RESTRAINING ANY PERSON WHERE ANY OBJECT THEREOF IS TO (I) FORCE OR require any public employer to cease dealing or doing business with any other person or (ii) force or require a public employer to recognize for representation purposes an employe organization not certified by the board.

(8) Refusing to comply with the provisions of an arbitration award deemed binding under section 903 of Article IX.

(9) Refusing to comply with the requirements of "meet and discuss."

### ARTICLE XIII

#### Prevention of Unfair Practices

Section 1301. The board is empowered, as hereinafter provided, to prevent any person from engaging in any unfair practice listed in Article XII of this act. This power shall be exclusive and shall not be affected by any other means of adjustment or prevention that have been or may be established by agreement, law, or otherwise.

Section 1302. Whenever it is charged by any interested party that any person has engaged in or is engaging in any such unfair practice, the board, or

any member or designated agent thereof, shall have authority to issue and cause to be served upon such person a complaint, stating the charges in that respect, and containing a notice of hearing before the board, or any member or designated agent thereof, at a place therein fixed, not less than five days after the serving of said complaint. Any such complaint may be amended by the board, member or agent conducting the hearing at any time prior to the issuance of an order based thereon. The person so complained of shall have the right to file an answer to the original or amended complaint and to appear in person, or otherwise, to give testimony at the place and time set in the complaint. In the discretion of a member or agent conducting the hearing or of the board, any other person may be allowed to intervene in the said proceeding and to present testimony. In any such proceeding, the rules of evidence prevailing in courts of law or equity shall be followed but shall not be controlling.

Section 1303. Testimony shall be taken at the hearing and filed with the board. The board upon notice may take further testimony or hear argument. If, upon all the testimony taken, the board shall determine that any person named in the complaint has engaged in or is engaging in any such unfair practice, the board shall state its findings of fact, and issue and cause to be served on such person an order requiring such person to cease and desist from such unfair practice, and to take such reasonable affirmative action, including reinstatement of employes, discharged in violation of Article XII of this act, with or without back pay, as will effectuate the policies of this act. Such order may further require such person to make reasonable reports, from time to time, showing the extent to which the order has been complied with. If, upon all the testimony, the board shall be of the opinion that the person or persons named in the complaint has not engaged in or is not engaging in any such unfair practice, then the board shall make its findings of fact and shall issue an order dismissing the complaint. A copy of such findings of fact, conclusions of law, and order shall be mailed to all parties to the proceedings.

Section 1304. Until a transcript of the record in a case shall have been filed in a court as hereinafter provided, the board may at any time, upon reasonable notice, and in such manner as it shall deem proper, modify or set aside, in whole or in part, any finding or order made or issued by it: Provided, That any agreement made between an employer and a bona fide employe organization, and all the provisions thereof, shall be entitled to full force and effect unless the board specifically finds that these provisions involve the commission of an unfair practice within the meaning of Article XII of this act.

Section 1305. The proceedings before the board or before any of its examiners shall be conducted with speed and dispatch. No findings shall be made on the basis of evidence relating to acts which occurred prior to the original passage of this act.

Section 1306. All cases in which complaints are actually issued by the board, shall be prosecuted before the board or its examiner, or both, by the representatives of the employe organization or party filing the charge, and, in addition thereto or in lieu thereof if the Department of Justice sees fit, by a deputy attorney general especially assigned to this type of case. No examiner shall have any other position with the government of this State or of the United States or with the Pennsylvania Labor Relations Board while in the employ of the board.

#### ARTICLE XIV

##### Unfair Practices During Article VIII Procedures

Section 1401. Notwithstanding any of the provisions of Article XIII, the board upon the filing of a charge alleging the commission of an unfair labor practice committed during, or arising out of the collective bargaining procedures set forth in sections 801 and 802 of Article VIII of this act, shall be empowered to petition the court of competent jurisdiction for appropriate relief or restraining order.

Upon the filing of any such petition the board shall cause notice thereof to be served upon such person and thereupon the court shall have jurisdiction to grant to the board such temporary relief or restraining order as it deems just and proper.

#### ARTICLE XV

##### Judicial Review

Section 1501. The board shall except where an employe of the Commonwealth is involved have power to petition the court of common pleas of any county wherein the unfair practice in question occurred, or wherein any person charged with the commission of any unfair practice resides or transacts business, for the enforcement of such order and for appropriate temporary relief or restraining order, and shall certify and file in the court a transcript of the entire record in the proceeding, including the pleadings and testimony upon which such order was entered and the findings and order of the board. In the instance of the exception involving the said Commonwealth employes, the board shall file its petition in the Commonwealth Court. Upon such filing, the court shall cause notice thereof to be served upon such person, and thereupon shall have jurisdiction of the proceeding and of the question determined therein, and shall have power to grant such temporary relief, restraining or mandamus order as it deems just and proper or requisite to effectuate the policies of this act and to make and enter upon the pleadings, testimony, and proceedings set forth in such transcript a decree enforcing, modifying and enforcing as so modified, or setting aside, in whole or in part, the order of the board. The parties before the

court shall be the board, the person charged with the commission of any unfair labor practice, and may include the charging party. No objection that has not been urged before the board, its members or agents shall be considered by the court unless the failure or neglect to urge such objection shall be excused because of extraordinary circumstances. The findings of the board as to the facts, if supported by substantial and legally credible evidence, shall be conclusive. If either party shall apply to the court for leave to adduce additional evidence, and shall show to the satisfaction of the court, that such additional evidence is material, and that there were reasonable grounds for the failure to adduce such evidence at the hearing before the board, its members or agent, the court may order such additional evidence to be taken before the board, its members or agent, and to be made a part of the transcript. The board may modify its findings as to the facts or make new findings by reason of additional evidence so taken and filed, and it shall file such modified or new findings which, if supported by substantial and legally credible evidence, shall be conclusive, and shall file its recommendations, if any, for the modification or setting aside of its original order. The jurisdiction of the court of common pleas, or the Commonwealth Court, as the case may be, shall be exclusive within the limits of its jurisdiction, and its judgment and decree shall be final, except that the same shall be subject to review by the Supreme Court on appeal by the board or any party in interest, irrespective of the nature of the decree or judgment or the amount involved. Such appeal shall be taken within a period of thirty days from the date of court's order and otherwise prosecuted in the same manner and form and with the same effect as is provided in other cases of appeal to the Supreme Court, and the record so certified shall contain all that was before the court of common pleas or the Commonwealth Court, as the case may be.

Section 1502. Any person aggrieved by a final order of the board granting or denying, in whole or in part, the relief sought in any unfair practice case, or by an order certifying or refusing to certify a collective bargaining agent of employes in any representation case, may obtain a review of such order in the court of common pleas of any county where the unfair practice in question was alleged to have been engaged in, or wherein such person or employer in a representation case resides or transacts business, or in the instance of Commonwealth employes in the Commonwealth court, as the case may be, by filing in such court, within thirty days after the final order has been issued by the board, a written petition praying that the order of the board be modified or set aside. A copy of such petition shall be forthwith served upon the board, and the board shall file in the court a transcript of the entire record in the proceeding certified by the board, including the pleadings and testimony and order of the board. Upon such filing, the court shall proceed in the same manner as in the case of an application by the board under section 1501, and shall have the same exclusive jurisdiction to grant to the board such temporary relief,

restraining or mandamus order as it deems just and proper or requisite to effectuate the policies of this act, and in like manner to make and enter a decree enforcing, modifying, and enforcing as so modified, or setting aside, in whole or in part, the order of the board, and findings of the board as to the facts, if supported by substantial and legally credible evidence, shall in like manner be conclusive. The parties before the court shall be any person aggrieved by an order of the board, as aforesaid, and the board and any other party to the board proceeding. The jurisdiction of the court of common pleas, or the Commonwealth Court, as the case may be, shall be exclusive within the limits of its jurisdiction, and its judgment and decree shall be final, except that the same shall be subject to review of the Supreme Court on appeal by the person aggrieved, or the board, irrespective of the nature of the decree or judgment or the amount involved. Such appeal shall be taken within thirty days of the date of the court's order and otherwise prosecuted in the same manner and form, and with same effect, as is provided in other cases of appeal to the Supreme Court, and the record so certified shall contain all that was before the court of common pleas or the Commonwealth Court, as the case may be.

Section 1503. The commencement of proceedings under sections 1501 or 1502 of this article shall not, unless specially ordered by the court, operate as a stay of the board's order.

Section 1504. When granting appropriate temporary relief, a restraining or mandamus order or making and entering a decree enforcing, modifying, or enforcing as so modified, or setting aside, in whole or in part, an order of the board, as provided in this section, the jurisdiction of courts sitting in equity shall not be limited by acts pertaining to equity jurisdiction of courts. The act of June 2, 1937 (P. L. 1198), known as the "Labor Anti-Injunction Act," shall not be applicable to orders of the board, or to court orders enforcing orders of the board, or any provision of this act, or to violations of any order of the board, or of court orders enforcing orders of the board, or any provisions of this act.

Section 1505. Petitions filed under this act shall be heard expeditiously and, if possible, within ten days after they have been docketed. No petitions or charges involving questions arising under clause (2) of subsection (a) of section 1201 of Article XII shall relieve the board of determining any questions arising under sections 603, 604 and 605 of Article VI immediately, and in their regular and normal order, and the making of a certification thereon if such is warranted. No petition or charge shall be entertained which relates to acts which occurred or statements which were made more than four months prior to the filing of the petition or charge.

## ARTICLE XVI

### Investigatory Powers

Section 1601. For the purpose of all hearings and investigations which, in the opinion of the board, are necessary and proper for the exercise of the powers

vested in it by Article VI and Article XIII, and for the purpose of investigating and considering disputes, other than a question concerning the representation of employes, which it shall be the duty of the board to undertake whenever petitioned so to do by either an employe organization, an employer, or the representative of any unit of employes, the board shall have the investigatory powers granted in this article.

Section 1602. The board or its duly authorized agents shall at all reasonable times have access to, for the purpose of examination and the right to copy, any evidence of any person being investigated or proceeded against that relates to any matter under investigation or in question. Any member of the board shall have the power to issue subpoenas requiring the attendance and testimony of witnesses and the production of any evidence that relates to any matter under investigation or in question before the board, its members or agent conducting the hearing or investigation. Such subpoenas shall be issued as a matter of right upon the request of either party at any time during the pendency of a proceeding. Any member of the board, or any agent designated by the board for such purposes, may administer oaths and affirmations, examine witnesses, and receive evidence.

Section 1603. If any witness resides outside of the Commonwealth or through illness or other cause is unable to testify before the board or its members or agent conducting the hearing or investigation, his or her testimony or deposition may be taken within or without this Commonwealth, in such manner and in such forms as the board or its members or agent conducting the hearing, may by special or general rule prescribe.

Section 1604. In case of contumacy or refusal to obey a subpoena issued to any person except to any person representing the Commonwealth as an employer, when jurisdiction will be in the Commonwealth Court, the court of common pleas of any county within the jurisdiction of which the inquiry is carried on or within the jurisdiction of which said person guilty of contumacy or refusal to obey is found or resides or transacts business, upon application by the board, shall have jurisdiction to issue to such person an order requiring such person to appear before the board, its members or agent, there to produce evidence if so ordered, or there to give testimony touching the matter under investigation or in question, and any failure to obey such order of the courts may be punished by said court as a contempt thereof.

Section 1605. No person shall be excused from attending and testifying or from producing books, records, correspondence, documents or other evidence in obedience to the subpoena of the board on the ground that the testimony or evidence required of him may tend to incriminate him or subject him to a penalty or forfeiture, but no individual shall be prosecuted or subjected to any

penalty or forfeiture for, or on account of, any transaction, matter or thing concerning which he is compelled, after having claimed his privilege against self-incrimination, to testify or produce evidence, except that such individual so testifying shall not be exempt from prosecution and punishment for perjury committed in so testifying.

Section 1606. Complaints, orders and other process and papers of the board, its members or agent may be served, either personally or by registered mail or by telegraph or by leaving a copy thereof at the principal office or place of business of the person required to be served. The verified return by the individual so serving the same, setting forth the manner of such service, shall be proof of the same and the return post office receipt or telegraph receipt therefor when registered and mailed or telegraphed as aforesaid, shall be proof of service of the same. Witnesses summoned before the board, its members or agent shall be paid the same fees and mileage that are paid witnesses in the courts of this Commonwealth, and witnesses whose depositions are taken and the person taking the same shall severally be entitled to the same fees as are paid for like services in the courts of this Commonwealth.

Section 1607. All process of any court to which application may be made under this act may be served in the county wherein the defendant or other person required to be served resides or may be found.

## ARTICLE XVII Employe Organizations

Section 1701. No employe organization shall make any contribution OUT OF THE FUNDS OF THE EMPLOYE ORGANIZATION either directly or indirectly to any political party or organization or in support of any political candidate for public office.

The BOARD shall establish such rules and regulations as IT may find necessary to prevent the circumvention or evasion of the provisions of this section.

IF AN EMPLOYE ORGANIZATION HAS MADE CONTRIBUTIONS IN VIOLATION OF THIS SECTION IT SHALL FILE WITH THE BOARD A REPORT OR AFFIDAVIT EVIDENCING SUCH CONTRIBUTIONS WITHIN NINETY DAYS OF THE END OF ITS FISCAL YEAR. SUCH REPORT OR AFFIDAVIT SHALL BE SIGNED BY ITS PRESIDENT AND TREASURER OR CORRESPONDING PRINCIPALS.

Any employe organization which violates the provisions of this section or fails to file any required report or affidavit or files a false report or affidavit shall be subject to a fine of not more than two thousand dollars (\$2,000).

Any person who wilfully violates this section, or who makes a false statement knowing it to be false, or who knowingly fails to disclose a material fact shall be fined not more than one thousand dollars (\$1,000) or imprisoned for not more than thirty days or both. Each individual required to sign affidavits or reports under this section shall be personally responsible for filing such report or affidavit and for any statement contained therein he knows to be false.

NOTHING HEREIN SHALL BE DEEMED TO PROHIBIT VOLUNTARY CONTRIBUTIONS BY INDIVIDUALS TO POLITICAL PARTIES OR CANDIDATES.

#### ARTICLE XVIII Conflict of Interest

Section 1801. (a) NO person who is a member of the same local, State, national OR INTERNATIONAL organization as the employe organization with which the public employer is bargaining or who has an interest in the outcome of such bargaining which interest is in conflict with the interest of the public employer, shall participate on behalf of the public employer in the collective bargaining processes WITH THE PROVISIO THAT SUCH PERSON MAY, WHERE ENTITLED, VOTE ON THE RATIFICATION OF AN AGREEMENT.

(b) Any PERSON who violates subsection (a) of this section shall be immediately removed by the public employer from his role, if any, in the collective bargaining negotiations or in any matter in connection with such negotiations.

#### ARTICLE XIX Penalties

Section 1901. Any person who shall wilfully resist, prevent, impede or interfere with any member of the board, or any of its agents, in the performance of duties pursuant to this act, shall be guilty of a misdemeanor, and, upon conviction thereof, shall be sentenced to pay a fine of not more than five thousand dollars (\$5,000), or by imprisonment for not more than one year, or both.

#### ARTICLE XX Savings Provisions

Section 2001. The rights granted to certain public employes by the following acts or parts thereof shall not be repealed or diminished by this act:

(1) Section 24 of the act of August 14, 1963 (P.L. 984), known as the "Metropolitan Transportation Authorities Act of 1963."

(2) The act of November 27, 1967 (P.L. 628), entitled "An act protecting the rights of employes of existing transportation systems, which are acquired by cities of the third class or any authority thereof or certain joint authorities; requiring cities of the third class or any authority thereof or any such joint authority to enter into contracts with labor organizations acting for such employes, and providing for arbitration in case of disputes."

(3) Section 13.2 of the act of April 6, 1956 (P.L. 1414), known as the "Second Class County Port Authority Act."

Section 2002. This act shall not be construed to repeal the act of June 24, 1968 (Act No. 111), entitled "An act specifically authorizing collective bargaining between policemen and firemen and their public employers; providing for arbitration in order to settle disputes, and requiring compliance with collective bargaining agreements and findings of arbitrators."

Section 2003. Present provisions of an ordinance of the City of Philadelphia approved April 4, 1961, entitled "An Ordinance to authorize the Mayor to enter into an agreement with District Council 33, American Federation of State, County and Municipal Employes, A.F.L.-C.I.O., Philadelphia and vicinity regarding its representation of certain City Employes," which are inconsistent with the provisions of this act shall remain in full force and effect so long as the present provisions of that ordinance are valid and operative.

#### ARTICLE XXI

##### Separability

Section 2101. If any clause, sentence, paragraph or part of this act, or the application thereof to any person or circumstances, shall, for any reason, be adjudged by a court of competent jurisdiction to be invalid, such judgment shall not affect, impair or invalidate the remainder of this act and the application of such provision to other persons or circumstances, but shall be confined in its operation to the clause, sentence, paragraph, or part thereof, directly involved in the controversy in which such judgment shall have been rendered and to the person or circumstances involved. It is hereby declared to be the legislative intent that this act would have been adopted had such invalid provisions not been included.

#### ARTICLE XXII

##### Repeals

Section 2201. The act of June 30, 1947 (P.L. 1183), entitled "An act relating to strikes by public employes; prohibiting such strikes; providing that such employes by striking terminate their employment; providing for

reinstatement under certain conditions; providing for a grievance procedure; and providing for hearings before civil service and tenure authorities, and in certain cases before the Pennsylvania Labor Relations Board," is hereby repealed as to those public employes covered by the provisions of this act, and any penalties or other limitations currently in force or presently pending against any public employes, shall be deemed null and void.

### ARTICLE XXIII

#### Effective Date

Section 2301. This act shall take effect in ninety days, except that the provisions of Article V and the amnesty provisions of the repealer shall take effect immediately.

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(continued from page 2)

constituted, must be submitted to the parties. They will have ten days to accept or reject. If they are not accepted, then the findings are published. Not less than five nor more than ten days after the publication, the parties shall again inform the board whether they accept or reject the recommendations. The Commonwealth shall pay one-half the cost of the factfinding panel, the other half will be shared equally by the parties. Voluntary arbitration is permitted if the parties so agree.

The fourth area concerns itself with actions the parties can take after all of the bargaining procedures have been followed and an agreement is still not reached. Except for guards at prisons and mental hospitals and employees directly involved with or necessary to the functioning of the courts, all other employees shall have a limited right to strike. The limiting conditions are health, safety, or welfare. If employees strike, the employer shall have recourse to the courts for injunctive relief. Whether the health, safety, or welfare is affected is determined by the appropriate court upon the facts and circumstances presented to it. If the court issues an injunction and the injunction is not complied with, the court shall have the power to levy fines and impose jail sentences on the offending parties at its discretion. The employer, where the employee would be in contempt, could fire, discharge, transfer, demote, etc.

The fifth general area involves "*unfair practices*" which are set out in Article 12 of the Act. These establish certain general rules under which the employee-employer relation will function. It protects rights guaranteed employees by Article 4, i.e., the right to organize, select representatives, and bargain collectively in good faith. By the same token, activities of employees or their representatives are also restricted; restraining or coercing other employees, refusing to bargain in good faith, secondary boycotts, etc. The Unfair Practice Sections will probably be involved in more litigation than any other sections of the Act, since challenges to employee and employer activities will generally be based upon one of these prohibited practices.

The last general area deals with the "*procedures.*" Senate Bill 1333 had two companion pieces of legislation, one of which was to increase the size and salaries of the Pennsylvania Labor Board. This was voted down by the House of Representatives for reasons entirely unrelated to the problem at hand. New legislation will be introduced again when the General Assembly reconvenes. The Board will be primarily charged with the resolution of questions of representation, that is, the proper conduct of elections; the determination of appropriateness of units; and claims of unfair practices. All matters that come up before the Board will be subject to appeals to the courts by either party or any party which may be interested directly in the outcome of the Board's determination.

There are certain other general miscellaneous type provisions; one of which specifies that an employee who refuses to cross a picket line will be deemed to be engaged in prohibitive strike unless that employee was engaged in the strike which was permitted under the Act. Unfair employer practices shall not be deemed a defense to a prohibitive strike. There is also a "conflict of interests" provision which would prohibit a member of a local, state, national or international organization from representing the public employer in any collective bargaining negotiations. This is geared to eliminate self-dealing.

The above is simply a brief synopsis of the Act. The Act itself is rather extensive and there are shadings and nuances which attach to many of the provisions which will have to be studied and understood before engaging in the bargaining battle.

(The type used in this reprint of S-1333 was provided by the Pennsylvania School Board Association, Inc.)

The CHAIRMAN. We are obviously not getting into long dialogs that might be helpful, but we are getting late and the record is very complete.

John Painter.

**STATEMENT OF JOHN PAINTER, ASSOCIATE ADMINISTRATOR, PROVIDENCE HOSPITAL, WASHINGTON, D.C.; ACCOMPANIED BY ROBERT J. SMITH, MORGAN, LEWIS & BOCKIUS; AND ROBERT J. HICKEY, COUNSEL FOR PROVIDENCE HOSPITAL**

Mr. PAINTER. Mr. Chairman, my name is John Painter. I am president of the Association of Health Care Administrators for the National Capital area; I am associate administrator at Providence Hospital right here in the District of Columbia.

I am appearing on behalf of Sister Rosa, the administrator of Providence Hospital.

With me are Robert J. Hickey and Robert J. Smith, counsel for Providence Hospital.

The statement I am about to give represents the views of the following hospitals of the Metropolitan Washington area:

Columbia Hospital for Women, Doctors Hospital, Metropolitan Hospital, the Hospital for Sick Children, Fairfax Hospital, and Providence Hospital.

I and the cocounsel are prepared to answer any questions which members of this subcommittee might have regarding the statement.

I would like to thank the committee for this opportunity to present to the Subcommittee on Labor our views on House bill 11357.

Nonprofit, charitable hospitals, as you know, have been exempted under section 2(2) of the National Labor Relations Act since the 1947 Taft-Hartley amendments when Congress decided that such charitable institutions, serving the health and social needs of the community, were, in the words of the late Senator Tydings, "\* \* \* away beyond the scope of labor management relations in which profit is involved."

A distinction was drawn then between the operations of those profit-oriented institutions whose entrepreneurial goal is limited to return a profit for shareholders and institutions whose sole mission is to cure the physical and mental ills of the suffering and to provide a panoply of medical and social services unavailable elsewhere.

Thus, in balancing the right to organize and bargain collectively against the need to maintain unfettered service to the sick and injured in a charitable hospital, Congress ruled in favor of the latter.

I respectfully suggest that the need for the exemption continue to exist and is worth maintaining.

The broad array of services provided establishes the nonprofit hospital as a valuable member of any community providing services which the community should not, and indeed cannot afford to be denied.

The challenge to the nonprofit hospital today is to balance the ever-expanding public demand for community health care and the rising operational costs with the need to continue to fairly and adequately reward those who provide the service.

Unlike the profit-oriented organizations, its sources of revenue are limited and there is little or no economic cushion on which to rely.

It is because of this growing financial strain measured against the valuable services which nonprofit hospitals provide that they should not be subject to the inherently disruptive and costly activities of unions.

It is important to keep in mind that the product of any hospital is health care delivery. If patient care is to be efficient, effective, and timely, then it simply cannot be interrupted.

Strikes, picketing, and other methods designed to economically coerce a hospital, or to merely disrupt hospital operations, serve only to detrimentally affect adequate health care.

Whether done to force recognition or agreement to collective bargaining demands, one simple fact is evident: the nonprofit hospital is simply not equipped financially or otherwise with the same strengths as other profitable businesses to counter such actions. It cannot, for example, lock out employees, cease service, reschedule, or subcontract its work.

A strike at a hospital has only two possible effects:

If a union is successful, it will force the hospital to concede to what it cannot afford to, affecting its very existence.

If unsuccessful, it succeeds only in interrupting the care of patients' care, which affects the life and death of those involved.

In either case, you, the public, suffer, because the treatment that your son, your daughter, your mother, your father, requires cannot be given because the technicians just walked off the job.

It hits home, doesn't it?

And it will hit home to the American public every time a strike is called in a hospital. Nobody can possibly win from a situation which threatens injury to the life and limb of hospital patients.

The nonprofit hospital cannot survive such unpredictable and costly disruptions and continue to serve the community and the needs of the patients who demand immediate care.

We therefore respectfully request that the proposed amendment to section 2(2) of the National Labor Relations Act not be supported.

Whether or not you, the members of the committee, agree with these statements regarding charitable hospitals, there are certain observations about the health care industry which no one can question.

The first is the essential need for uninterrupted, adequate, low-cost health care, regardless of the profit or nonprofit character of the health industry's institutions.

Strikes, picketing, and other activities designed to interrupt service have no place in the field of health care.

Section 13 of the National Labor Relations Act preserves the right to strike as incident to and inherent in the economic struggle for recognition and collective bargaining in the context of normal employer-employee relationships.

In this regard, we suggest that the committee amend section 13 to exempt unions attempting to organize hospital and nursing home services from the right to strike and, further, that hearings be held to explore methods for peacefully resolving disputes in this vital industry, and penalties to be imposed on unions that breach the law.

Certainly, the health of the American public warrants and demands study in this regard. To merely pass the proposed amendment without prohibiting activity which interrupts or curtails life-giving services would be a disservice to the Nation.

Those who testified in support of H. R. 11357 before the House Committee on Labor and Public Welfare recognized the paramount need to continue service while attempting resolution of disputes. The same concern has been reflected in State legislatures.

The following States have enacted laws regulating, in whole or in part, the labor relations of employees in hospitals: Minnesota, Michigan, New York, Connecticut, Massachusetts, Oregon, Montana, New Jersey, Pennsylvania, and the State of Washington.

In all of these, with the exceptions of Wisconsin and New Jersey, the law treats hospitals differently than other employers.

Several States—Minnesota, New York, Connecticut, and Massachusetts—prohibit all strikes and lockouts and have substituted in their place mandatory arbitration.

Other States—Michigan, Oregon, Montana, Washington, and Pennsylvania—have established procedures severely limiting the circumstances under which a union can strike.

We believe that laws prohibiting or curtailing the right to strike are necessary.

However, unless there are severe sanctions imposed for breach of such laws, they soon become meaningless.

This is the situation in New York State where unions are constantly threatening to strike despite the prohibition against such activity. We believe that such laws in order to be effective must have some teeth in them.

They should include the requirements that there be temporary restraining orders issued within 4 hours after it is sought; that the union reimburse both the hospital and patients for damages and sufferings caused by union actions; that the union, including any parent organization, be subject to a substantial fine—which cannot be waived—for each day on strike; and that any employee who participates in such activity be subject to immediate discharge with loss of all benefits that might have accrued to him.

We cannot emphasize too strongly that the right to strike is totally inconsistent with a hospital's reason for existing. A hospital, whose ability to function can determine whether someone is to live or die, cannot be subject to the whims of economic warfare. Loss of life can hardly be equated with the right to strike.

What member of this committee would want to be a patient in a hospital where the employees have walked off because their economic demands were not being met?

I would even venture to say that members of the very unions that seek to change the law would be willing to forgo the right to strike if it meant that their children would die or be crippled because their fellow union members had struck.

We implore this committee to protect the lives and limbs of the patients by limiting or prohibiting the right to strike. Again, we request that the hearings be broadened to hear comments on this issue.

While not as important, there are other issues regarding labor relations in hospitals which deserve careful consideration before imposing the National Labor Relations Act upon them.

One is the character of units appropriate to a health care facility under section 9(b) of the act.

Hospitals by their very nature are divided into many autonomous departments, employing individuals in a myriad of classifications.

If no limits are imposed by law, it is conceivable that as a result of their internal organization, hospitals of the future will be confronted with numerous unions attempting to outdo one another.

Moreover, a multitude of unions would make the hospital a constant battleground for representation and jurisdictional strikes.

This fragmented approach to representation would detrimentally affect efficiency and adequate, low-cost patient care.

It is with this forecast in mind that the concept of the appropriate unit for hospitals requires extensive study.

The simplest approach would be to divide the employees into two units—professional and nonprofessional employees. It is worth noting that the National Labor Relations Board accepted such a division in the aforementioned Butte Medical Properties, 168 NLRB 266 (1967).

Another area ignored by the present bill is the treatment of supervisors.

Because of a hospital's structure, there are many persons who possess supervisory functions and who might well constitute an employee unit.

This problem is most acute with registered nurses who normally possess supervisory responsibility over other professional and non-professional employees.

There are those who recommend that these individuals be treated not as supervisors, but as a part of a bargaining unit.

Such an approach does a disservice both to the hospital and to the the employees. How can a nurse discipline an employee who is a sister member of the union?

Similarly, the employees can have no trust in an individual who is expected to report back to administration.

We believe that nurses and other individuals possessing the indicia of supervisory authority should be excluded from the bargaining unit. If the committee believes otherwise, we recommend that it consider the possibility of special provisions to the law similar to those enacted under the Pennsylvania statutes.

The above are just some of the problems that should be considered before the committee votes on this bill. We believe that further deliberation would reveal other areas that would require special treatment.

We strongly recommend, therefore, that this subcommittee schedule hearings to explore legislation which would prohibit strikes and other disruptive activities in hospitals and would deal with the other problems mentioned above.

Certainly, no one can disagree that laws that affect the lives of many should be adopted only after very careful consideration. And this is all we ask.

Thank you.

The CHAIRMAN. Certainly this legislation would deal with one basic reason for work stoppages in hospitals, and that is recognition; do you agree with that?

Mr. HICKEY. Can I comment on that?

The CHAIRMAN. The answer is either "Yes" or "No."

Mr. HICKEY. The answer is that you put it under the same prohibitions that are under Taft-Hartley.

Now, I have been a practicing labor attorney for 10 years, and I think——

The CHAIRMAN. Let me ask you this one question now.

Have there been any work stoppages in hospitals arising out of the one question of recognition of the unions? Do you know of any?

Mr. HICKEY. We don't; but we don't know anything opposite, either.

The CHAIRMAN. Do you know of any, Mr. Painter?

Mr. PAINTER. Well, I am not sure; I can't——

The CHAIRMAN. Does anybody here know? We have had other testimony.

Mr. PAINTER. Perhaps the committee should explore it by further hearings, Senator, with more competent witnesses than I.

The CHAIRMAN. Did you testify on the House side? They have had——

Mr. PAINTER. I only became involved when I saw what was happening.

The CHAIRMAN. Have you read the House testimony?

Mr. PAINTER. It is quite lengthy; I have read as much as I could——

The CHAIRMAN. Well, we are getting a lot of affirmative nodding out there.

And we had a lot of testimony this morning that work stoppages arising out of recognition questions are not infrequent. They are frequent. That's the first problem we deal with.

Now, the next problem that we face is the economic thrust. That is what you are talking about, isn't it?

Mr. HICKEY. We are talking about both.

Mr. PAINTER. Any kind of strike that disrupts the care——

The CHAIRMAN. Well, that's exactly my point——

Mr. HICKEY. I think probably the best person to come down here and testify on recognitional strikes and injunctions would be the General Counsel for the National Labor Relations Board.

I heard him testify a week ago, and I understand he gave the same speech before the ABA Committee on Labor Law—talking about expediting the procedures of the injunction so that they could get injunctions from 10 to 12 days.

What would 10 to 12 days mean and how many patients will die?

The CHAIRMAN. Well, maybe we will invite him to testify.

Mr. HICKEY. What we are saying is that under the present act—and I think the NLRB could give you statistics on injunctions—you don't get injunctions in 1 day, 2 days, 4 days; we are talking about at best 10 days, 12 days, 20 days.

Mr. MITTELMAN. Isn't it a fact that a union that is put under the National Labor Relations Act will not have to file petitions for election?

Mr. HICKEY. Well, there are a number of unions under Taft-Hartley now that—you can pick up the Board action every week and see recognitional picketing going on——

Mr. MITTELMAN. Well, I know there are instances——

Mr. HICKEY. In fact, I would say that's the predominant way of gaining recognition in the construction industry.

Mr. MITTELMAN. That may or may not be correct.

It is not a fact that today that the nonprofit hospital does not wish to recognize and the union has no procedure available to it, except to strike, to enforce its demand for recognition?

Mr. HICKEY. Well, in—

Mr. MITTELMAN. The hospital—must strike, and only then—

Mr. HICKEY. Well, in certain States it's different; but in the District of Columbia, that is correct.

We are talking on behalf of—well, everybody will concede that the economic strike isn't affected at all by being put under Taft-Hartley. But sticking with the recognitional side, recognitional strikes will still go on, they go on in our industry.

Mr. Fields has mentioned the fact that it would be 30 days—in 30 days you might be able to get the Board to act. We might be able to get an injunction under the present procedures in 10 or 12 days.

But what I am saying to you is that without adequate procedures making strikes almost impossible—

Mr. MITTELMAN. What procedure is available now to stop a recognitional strike?

Mr. HICKEY. Well, we don't know in the District of Columbia. The problem hasn't arisen. In other areas—[Laughter.]

Mr. Hickey (continuing). In other States—in Ohio—in Ohio they went into court and enjoined picketing. Now, I—

Mr. MITTELMAN. They enjoined picketing. Did they enjoin strikes?

Mr. HICKEY. They enjoined strikes, if I understand it; I am not—

Mr. MITTELMAN. How long did that take?

Mr. HICKEY. I am not familiar with all the details of the case.

What we came here to testify to is the fact that—not that we came in with the answers. But we came here because we have a lot of problems; and other people that seem to ignore—that other people should be down here testifying; that they should be giving the answers to the questions.

A good example is the union representative for proprietary hospitals. Why don't you have them tell us what their experiences in proprietary hospitals are; were there recognitional strikes? Economic strikes?

This is the information we believe the committee should have before it before—we are not saying at this point in time that we are supplying the answers. We came down here at the last moment because we saw what was happening.

We heard testimony this morning saying that section 827 is going to cure recognitional picketing. I know a strike that was costing a million dollars a day on recognitional—and we weren't able to get it enjoined.

Well, the question here today is that you have in your hand a bill. If you favor going ahead and putting hospitals under present law—and what we are saying is, go further; protect the hospitals against strikes. I think every witness here has raised this same thing—the unions have said the same thing: hospitals should be treated differently than other institutions as far as strikes. But nothing is in the present amendment that protect hospitals against strike.

What we are doing is, we are saying leave them open from present law. What is the present law?

Present law is that they can engage in strikes of economic activity; and a recognitional strike for the most part can't be stopped, because an injunction can't be gotten in less than 10 to 12 days.

Mr. MITTELMAN. Can you get an injunction in the District of Columbia for an economic strike, or not?

Mr. HICKEY. We don't know yet. It hasn't been—the question has not been presented, fortunately.

Mr. MITTELMAN. Can you get one in Virginia or Maryland?

Mr. HICKEY. That I do not know.

This whole area of injunctions in State courts, where hospitals are concerned, is a very, very open question, "iffy" question; I doubt very much whether there is—we can predict in any given State what would happen. The only State that I know that has really faced the question in an area where they haven't had—was in Ohio, and here they prohibited it.

Now, that doesn't mean that in the District of Columbia if the same question is presented—they might say that the union is free to strike.

If we were here saying to you, "Give us a law that we would want," our position would be keep us exempt, and at the same time, prohibit strikes.

But the question that we're being presented with—we are being presented with a bill that says we are going to put you under it; and we are saying, "don't pass it, but if you are going to pass it, take into consideration the very fact that everybody has conceded, union and management alike: that there is a problem with strikes in hospitals that has to be treated. You just can't ignore it." You just can't say that you can get some sort of injunction against a recognitional—picketing, but—because it just isn't so.

In New York, they have all sorts of laws against—prohibitions against strikes—with no teeth in them. They just had an organization campaign—No. 99 against the New York Hospital—

Mr. MITTELMAN. They didn't have a strike against New York Hospital.

Mr. HICKEY. They were just lucky the last time out.

You can call witnesses—

The CHAIRMAN. When was the last strike—

Mr. HICKEY. This I don't know. But I know that each time out they have threatened to strike.

The CHAIRMAN. That's correct.

Mr. HICKEY. That's the answer they used to say for the teachers in New York, until the teachers went out and struck.

Mr. MITTELMAN. Look, I don't want to argue with you about this, but—

Mr. HICKEY. All that we ask of the committee is that they explore—this is what we are here for—explore the possibility of putting some prohibition against strikes before this measure has been enacted; that is all we are here to ask.

I think that everybody recognizes the problem. We are not here to give all the answers, because we can't. We are just asking the committee to explore the possibility before the bill is passed.

Mr. FIELDS. We may not even be supporting labor or management; I think we are supporting the patient.

Mr. MITTELMAN. Do you think you would care to tell us what you think we ought to do about strikes?

Mr. HICKEY. Yes.

Well, let's go on with just the strike problem, which you have mentioned.

We do have specific provisions—suggestions that we have on the idea of strikes.

One is a temporary restraining order that could be given within 4 hours after being sought. One is fines against the union and parent organization—and I think anybody can understand the reason for including the parent organization, and also providing that it can't be waived. Because that's inevitable; after the strike is ended—

Mr. MITTELMAN. I think we have heard before about all the sanctions. What about a position that would enable unions to get a fair deal on bargaining?

Mr. HICKEY. Our basic—position—and I don't want to overstate it others have different answers—we do not believe labor relations as envisioned within the normal employer-employee context can take place in a hospital.

The reason for this is if you have ever been in a hospital for even a day, you know how this is run—it is organizational and functional supervision, up and down, across. And also everything is broken down into small, departments, classifications—I think alone there are five different classifications of therapists.

The thing you see, is that everything is done on an instant basis. The patient comes in and people are ordered to do this, this and so.

If you have the normal type of labor relations people can object, grieve about a problem; say, well, we don't think sponges should be used, we think a scalpel should be used first, as the patient is dying, I suppose the grievance would be resolved. But it does no good for the patient.

We do not believe that labor relations as envisioned in Taft-Hartley can be placed wholesale on us. For that reason alone, we object to the bill being passed. Now, whether through further study something else would come up, some alternate proposal—I assume that on the executive committee for public employees was given—now, at that time we would have to consider it. But under present law, a wholesale imposition of that on a hospital would work to the detriment of the patient.

Don't forget, if you're thinking on a nonprofit situation, we don't gain by saying we are opposed to the rule. I don't mean a dollar more in our pockets. We are talking about an allocation of resources. If a dollar goes from here, from the patient, it goes to the employee; 60 percent of our costs include wages and fringe benefits for employees; and we surely would like to have them, the employees, as happy as they—nobody is in dispute about this.

The question is, can you take an act that was designed for a whole different type of bargaining and impose it upon hospital.

Mr. MITTELMAN. I think the experience in New York illustrates that we can do just that; or at least perhaps—but as I understand your position, you're maintaining the whole thing is impossible—

Mr. HICKEY. No. What we are saying is—our position in appearing today is solely that we feel that the bill as it has gone through has ignored here the peculiar problems of a hospital.

What we are asking at this point in time is consider the problem; ask people to come down and testify; you have subpoena power. If you

are talking about the NLRB won't come down and tell you about it, well, subpoena them. That's simple enough.

We are talking about passing a law without anybody really having a good idea of what the ramifications are until after it passes, and then we will live with it.

The CHAIRMAN. Why hasn't this chamber of horrors appeared where there is provision under the law for National Labor Relations Act coverage?

Mr. HICKEY. Well—we believe what we are saying here—

The CHAIRMAN. Wouldn't some of this horror story have appeared there—

Mr. HICKEY. Well, I am not an expert on what happens throughout the rest of the country. I mean just recently there has been organizations that put stink bombs in patients' rooms.

I am not saying that this is typical. I am saying that we don't know. The committee doesn't know what happens in the bargaining process across the country.

Why not have the unions come in and tell us what happens in proprietary situations? Maybe everything is as you envision. I don't know. Maybe the nonprofit hospitals would say so and if that is so we will back off.

The CHAIRMAN. The bell says I have got to work in another place. At this point I order printed all statements of those who could not attend and other pertinent material submitted for the record.

(The material referred to follows:)



providence hospital

1150 VARNUM STREET N.E. WASHINGTON, D.C. 20017

269-4000

September 5, 1972

The Honorable Harrison A. Williams, Jr.  
Chairman, Subcommittee on Labor  
United States Senate  
Washington, D. C. 20000

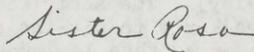
Re: HR 11357

Dear Senator Williams:

Enclosed please find a supplemental statement and proposed amendment to the National Labor Relations Act, submitted on behalf of Metropolitan Hospital, Columbia Hospital for Women, Doctor's Hospital, The Hospital for Sick Children, Fairfax Hospital, and Providence Hospital in regard to the proposed amendment eliminating the exemption for non-profit hospitals from that Act. While it remains the position of the above hospitals that the exemption should be retained, the proposed amendments will protect the public from life-threatening strikes if the exemption is removed.

We would appreciate the opportunity to present our position at the hearings. However, if this is not possible, we would request that the enclosed be included in the appendix to the record of the hearing.

Very truly yours,



Sister Rosa, Administrator  
Providence Hospital

/eb

September 5, 1972

## STATEMENT OF SISTER ROSA, ADMINISTRATOR, PROVIDENCE HOSPITAL

Mr. Chairman and Members of the Senate Subcommittee on Labor, my name is Sister Rosa, Administrator of Providence Hospital located in the District of Columbia and operated by the Daughters of Charity. With me are Messrs. Robert J. Hickey and Robert J. Smith, counsel for Providence Hospital. On August 16, 1972, I submitted a statement to this Subcommittee presenting the view of several District of Columbia hospitals that House Bill 11357 should not be adopted, at least in its present form. At that time we were invited by the Subcommittee to propose amendments to HR 11357 to correct the deficiencies in that bill in the event that the Subcommittee decided to eliminate the exemption for non-profit hospitals from the National Labor Relations Act. Pursuant to that invitation, we are submitting the following amendments which are attached.

As stated more fully in my earlier statement, the primary deficiency of HR 11357 is that it does not effectively eliminate strikes, picketing, and other activity designed to disrupt hospital operations and to cause death, injury, and suffering to the patients of the hospital affected. Because of both limited resources and the pressures of time, we have not been able to document the facts surrounding strikes at health care facilities throughout the country. We would trust that the Subcommittee would engage in such detailed investigation before any bill is passed. This could be done by a questionnaire jointly prepared by the various associations representing health care facilities and the major unions representing employees of such facilities. If necessary, the Subcommittee could use its subpoena powers to obtain this data.

However, based on news items in the public press and union newspapers, it is clear that strikes do occur and that they are not limited to recognition. They have covered contract negotiations, grievances and jurisdictional disputes. They have lasted from one hour to sixty-seven days (at the University of California Medical Center at Berkeley). The activities have ranged from strikes, picketing and walkouts to sit-ins and sick-outs. Neither the presence nor the absence of a state law prohibiting such activity has been a

deterrent. In this regard, I would like to call the Subcommittee's attention to the following colloquy from LOCAL 1199 NEWS:

"Ana O. Dumois, director of the Community Health Institute and one of four guest speakers at the conference, urged the union 'to seek other alternatives to a hospital strike.' She said 1199 is now powerful enough to 'look for new ways of resolving conflict.'

Pres. Davis, responding to Mrs. Dumois, said that if her advice had been followed in the past there would be no Local 1199 today. 'We came into being violating laws and injunctions. I hope our weapon of the strike is never used, but we will never give that weapon up,' Davis declared."

In keeping with that spirit, Local 1199 was able to extort a contract from New York hospitals after threatening to close them all down if they did not meet its demands.

Our proposed amendments not only prohibit strikes and other disruptive activity [proposed Section 13(b)], but also contain severe sanctions for breaches of such laws. Proposed Section 10(n) provides for the immediate issuance of a temporary restraining order and for substantial fines (which cannot be waived) for each day on strike. Proposed Section 303(c) requires unions to reimburse both the hospital and patients for damages caused by the union's illegal conduct. Present Section 8(a)(3) has been amended to provide that a health care facility may immediately discharge or discipline an employee who has engaged in such unlawful activity. In addition, the Act has been amended to eliminate unit fragmentation [proposed amendment to Section 9(b)] and organizational activity on hospital property [proposed amendment to Section 8(a)(1)], both of which have inherent in them the possibility of disrupting the delivery of health care and of and injury to the patient.

The proposed amendments would grant to hospital unions the opportunity to achieve recognition through the NLRB election procedures. In substitution of the right to strike, the proposed amendments provide for the peaceful resolution of disputes between health care facilities and unions. Thus, proposed Section 8(d)(2) established detailed procedures for the resolution of disputes over

the terms and conditions of a new collective bargaining agreement. Also, proposed Section 8(g) would eliminate disputes over the interpretation and application of collective bargaining contracts by requiring the parties to have in their contracts a clause providing for the adjustment of such disputes.

The amendments we have proposed will reduce or eliminate most of the major deficiencies of HR 11357. However, without more facts we cannot say that the National Labor Relations Act, even as modified by our proposed amendments, can be applied to health care facilities without further revisions. We again strongly recommend that this Subcommittee conduct additional investigations and hearings before any bill is adopted.

This statement is respectfully submitted on behalf of Columbia Hospital for Women, Doctor's Hospital, Metropolitan Hospital, The Hospital for Sick Children, Fairfax Hospital, and Providence Hospital.

## PROPOSED AMENDMENTS TO THE NATIONAL LABOR RELATIONS ACT

1. Section 2 (2) is amended by striking the phrase, "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".

2. Section 2 is amended by adding the following new subsection (14): "The term 'health care facility' shall include any hospital, nursing home, extended care facility, clinic, institution caring for the aged or any other employer whose purpose is devoted in substantial part to health care or maintenance."

3. Section 8(a)(1) is amended by adding the following: "Provided further that all organizational activity is prohibited within a health care facility."

4. Section 8(a)(3) is amended by adding the following proviso: "Provided further that the prohibition of this subsection shall not apply to discipline imposed by a health care facility for an employee's engaging in activity not protected by this Act without regard to other motives of the health care facility."

5. Present Section 8(d) is modified in the following manner:

- a. The present proviso is modified by changing the first sentence: "Provided (1), That where there is a collective bargaining contract in effect covering employees in an industry affecting commerce, other than a health care facility . . ."

The remainder of the proviso will remain the same except that subsections 1 through 4 shall be renumbered (i) through (iv).

- b. A new second proviso shall be acted:

"(2) That where there is a collective bargaining agreement covering employees in a health care facility, no party shall terminate or modify such contract or engage in any coercive activity of any nature directed towards termination or modification of such conduct.

(i) The party proposing modification or termination shall serve a written notice upon the other party of the proposed termination or modification and of the proposed time and place for the commencement of negotiations between the parties sixty days prior to the expiration date thereof, or in the event such contract contains no expiration date, sixty days prior to the time it is proposed to make such termination or modification.

(ii) Within 10 days of the receipt of the notice, parties shall agree to a time and place for commencement of negotiation.

(iii) If the parties are unable to establish a time or place for negotiation or to negotiate in good faith a new agreement resolving all the issues and disputes between them within 180 days, either party may request the services of the Federal Mediation and Conciliation Service who shall set a time or place for negotiation or immediately offer to mediate the dispute.

(iv) If in the sole discretion of the Federal Mediation and Conciliation Service mediator he believes that the dispute cannot be settled through mediation, he shall terminate his services and at the same time proffer arbitration to the parties.

(v) The mediator will furnish to the parties a list of 7 names, one of which must be selected by the parties for consideration and determination of the dispute. The parties shall select the arbitrator from a list by alternately striking names until only one remains and he shall serve as the arbitrator. The salary and expenses of the arbitrator shall be borne equally by the health care facility and the labor organization. The decision of the arbitrator shall constitute the new contract and shall be final and binding on the parties. The above arbitration procedures shall not apply if the parties by voluntary agreement determine that an alternate method or procedure is appropriate in their particular dispute."

- c. The sentence following subparagraph (4) of the present Act shall be modified to read: "The duties imposed above shall be inapplicable when . . . ." The remainder of the sentence and paragraph commencing "the labor organization or individual, which is a party to the contract . . ." shall remain unchanged.

6. A new subsection 8(g) is added, providing:

"All collective bargaining agreements between health care facilities and labor organizations must contain a clause providing a method for adjustments of disputes and grievances arising out of interpretation or application of the collective bargaining agreement. This clause must prohibit all coercive activities during the term of the contract and must contain as the last step final and binding arbitration by a neutral party or parties."

7. Section 9(b) is amended by adding the following proviso:

"Provided that only appropriate units in a health care facility shall consist of one of the following units: all professional employees, all technical employees, all clerical employees, and all other employees, excluding guards and supervisors. There shall be no combining or fragmenting of these units except that the parties may voluntarily agree to such other units."

8. Section 10 is amended by adding a new subsection (n), which provides the following:

"Whenever it is charged that any person, labor organization, or employee is engaged in strikes, picketing or work stoppages of any kind against a health care facility, the regional office of the National Labor Relations Board in which the activity occurs shall seek immediately, but no longer than within 4 hours of the request, a temporary restraining order in a United States District Court. A restraining order must issue forthwith without regard to the facts, legal issues involved, or the extent to which an investigation has been undertaken by the Regional Office. The Board shall immediately conduct a preliminary investigation of the charge which must be completed and a report submitted to the Court within 30 days of the issuance of the restraining order. Within 10 days after

receipt of the report, the Court must determine whether a preliminary injunction should issue and under what conditions. The Court shall retain jurisdiction for the purpose of issuing a permanent injunction and whatever relief it deems just and proper, provided that the Court must impose upon a person, employee, or labor organization (including any parent organization without regard to its independent responsibility) engaging in such activity, a fine consisting of not less than \$1,000 for each day on which this activity occurs, which cannot be waived by agreement of the parties."

9. Section 13 is amended by numbering the present paragraph as paragraph (a) and by adding a new subsection (b): "Notwithstanding subsection (a) and Sections 7 and 8, all strikes, picketing, work stoppages, refusal to perform any services, threats, inducements, and related activity, directed at a health care facility or at persons doing business with it, where an object thereof is to affect services provided by that facility, shall be prohibited without regard to whether it is primary or secondary in nature."

10. Section 303 is amended by adding a new subsection (c):

"Any health care facility or patient injured by reason of violation of Section 13 may sue in a United States District Court in the same manner as provided in subsection (b). In such an action, the Court may award both actual and punitive damages for injury to person and to property and for suffering."

Respectfully submitted by:

Metropolitan Hospital  
Columbia Hospital for Women  
Doctor's Hospital  
The Hospital for Sick Children  
Fairfax Hospital  
Providence Hospital

FEDERAL VS. STATE COVERAGE OF HOSPITAL LABOR RELATIONS—AS VIEWED BY  
THE HOSPITAL ASSOCIATION OF NEW YORK STATE

(Prepared by Harris, Beach and Wilcox)

(Richard L. Epstein)

I. PROPOSITION

On January 22, 1971, the Massachusetts Hospital Association formally resolved that the American Hospital Association be requested to re-examine its long-standing opposition to removing from the National Labor Relations Act the exemption for hospitals.<sup>1</sup> The Hospital Association of New York State endorses the position of the Massachusetts Hospital Association and joins with that Association in its petition to the American Hospital Association and herein sets forth its reasons for so doing.

II. THE STATUTES

Since its enactment the National Labor Relations Act has excluded from its coverage not-for-profit hospitals.<sup>2</sup> Consequently, in states where hospital labor relations are not regulated by state statute either, the hospital industry in that jurisdiction is without labor law coverage. There is, however, an elaborate pattern of variety and degrees of coverage, from specific statutory exclusion of hospitals in four states<sup>3</sup> to statutory coverage in ten states.<sup>4</sup> The remaining thirty-six states do not yield any particular pattern. They include Montana, which has a statute covering only registered and licensed practical nurses; New Jersey, which has no statutory coverage but which provides regulation by virtue of court decree;<sup>5</sup> Virginia, which has no labor statute as such, but prohibits strikes by hospital workers; and Idaho, which has no labor statute, but whose anti-injunction act gives employees the right to organize and to bargain.

III. PRESENT POSITION OF THE AMERICAN HOSPITAL ASSOCIATION

The American Hospital Association has taken the position which reflects the preference of the hospitals which are in states without labor law regulations. For years these hospitals have viewed their non-coverage as advantageous in maintaining non-union status. Some of these hospitals also feel, in addition to the alleged disadvantages of going from no coverage to federal coverage, that the federal act is not even providing solutions for the hospital labor problems that have been claimed for such federal coverage.

IV. HOSPITALS IN NEW YORK WOULD BE BETTER SERVED BY COVERAGE UNDER  
THE NATIONAL LABOR RELATIONS ACT

New York is prominent among the jurisdictions which are now covered by a state statute which is altogether undesirable. For that reason, the Hospital Association of New York joins with those who endeavor to remove the federal exemption in order to shift hospital coverage from the State Act to the National Act. The motivation, in the case of New York, is simply to avoid the profound inequities which arise from either the language or the implementation of the New York Labor Relations Act as applied to hospitals:

(a) *As to the New York Statute (referred to below as "SLRA")*

1. The NLRA provides a definitive exclusion of supervisors.<sup>6</sup> The SLRA contains no comparable exclusion.

2. The NLRA specifically prohibits the holding of an election within 12 months of a prior election.<sup>7</sup> The SLRA permits the Board to order a subsequent election at any time.

<sup>1</sup> Appendix A.

<sup>2</sup> National Labor Relations Act, Title I, Section 2(2) states in part, "The term 'employer' . . . shall not include . . . any corporation or association operating a hospital, if no part of the net earnings inures to the benefit of any private shareholder or individual . . ." See Appendix B.

<sup>3</sup> North Dakota, Utah, Vermont and West Virginia.

<sup>4</sup> Connecticut, Massachusetts, Minnesota, New York, Michigan, Oregon, Pennsylvania, Rhode Island, Wisconsin and Colorado (except for private charitable hospitals, *St. Lukes v. Ind. Comm.*, 142 Colo. 28, 349 P2d 995, 45 LRRM 2953 (1960).

<sup>5</sup> *Johnson v. Christ Hospital*, 15 N.J. 108, 211 A2d 376 (1965).

<sup>6</sup> NLRA, Sections 2(3) and 2(11).

<sup>7</sup> NLRA, section 9(c) (3) and section 9(e) (2).

3. The SLRA does not make provision for petitions and elections for decertification of recognized representatives, as does the NLRA.<sup>8</sup>

4. The SLRA has only a rule of thumb for the necessary percentage of authorization cards to permit a petition, whereas the NLRA provides specifically for 30%.<sup>9</sup>

5. The SLRA permits parties to contract for a closed shop, an arrangement which is prohibited by the NLRA.<sup>10</sup>

6. The SLRA permits the Board to designate as an appropriate unit one which includes guards along with other employees, a practice which is prohibited by the NLRA.<sup>11</sup>

7. Nor does the NLRA permit certification of a union for a unit of guards which even admits to its membership employees other than guards.<sup>12</sup>

8. The SLRA contains no schedule of conduct on the part of a union or its agents which are deemed unfair labor practices, such as is prescribed for employers<sup>13</sup> and as are specifically set forth in NLRA.<sup>14</sup>

9. The NLRA provides that professional employees shall not be included in a broader unit unless a majority of them so designate<sup>15</sup> unlike the SLRA which makes no such provision.

(b) *As to the Administration of the New York statute:*

1. The State Labor Board does not permit voting by replacements of economic strikers, as permitted by the National Board.

2. The State Labor Board does not have a statute of limitations for filing unfair labor practices comparable to the six month limitation provided by the National Board.

3. The history of unit determination shows a greater tendency toward fragmentation under the State Board than is the policy under the National Board.

4. The Federal Board adheres to a contract bar rule of three years, whereas the State Board in certain industries permits only a one year contract bar.

5. In the event of a run-off election the State Board procedure is for the run-off contest to be between the two or more unions if they together receive more votes than the number of "no" votes, regardless of the number of "no" votes registered. The National Board considers each of the choices separately and provides for the run-off election to be between the top two.<sup>16</sup>

#### V. FEDERAL COVERAGE IS ALSO MORE DESIRABLE FOR THE HOSPITALS OF ALL JURISDICTIONS ON A NATIONAL BASIS

It appears to our Association that the notion that no coverage at all is better than any federal coverage, is no longer suitable to the times. Since that view was first subscribed to, radical changes and developments in the world of hospitals and in the world of labor make it necessary to restudy the validity of that position. In a significant number of states that have not been covered by any state labor act, we have witnessed the penetration of the notorious Local 1199; we have seen the joining together of black and civil rights groups with the union mission, making the combined result a new and important force; we have seen a steady increase in the disparity between rising wage and benefit levels in private industry and the employment programs of many not-for-profit hospitals. Not least of all we have seen a spirit of growing resolve on the part of dissatisfied people to act upon their dissatisfaction in a way which brings public attention, sympathy and pressure to change the status quo.

Among the other advantages for presently nonregulated states to seek federal coverage is the possible opportunity to write the terms and conditions of coverage and regulation, rather than to bow to the whim of the legislature. Federal coverage also avoids the possibility of the New Jersey situation wherein the labor unsophisticated judiciary ordains hospital labor relations responsibilities without the benefit of a special statute or the administration of career experts.

<sup>8</sup> NLRA, section 9 (c) (1) (A) (ii).

<sup>9</sup> NLRA, section 9 (e) (1).

<sup>10</sup> NLRA, section 8 (a) (3) and section 8 (b) (2).

<sup>11</sup> NLRA, section 9 (b) (3).

<sup>12</sup> NLRA, section 9 (b) (3).

<sup>13</sup> New York Labor Law, section 704.

<sup>14</sup> NLRA, section 8 (b).

<sup>15</sup> NLRA, section 9 (b) (1).

<sup>16</sup> Consider the example of Union A receiving 10 votes, Union B receiving 12 votes and "No union" receiving 15 votes. The State Board's run-off election would be between Union A and Union B because the total is 22 versus "No union" 15. The National Board's run-off would be between Union B and "No union".

## VI. CONCLUSION

For the foregoing reasons the Hospital Association of New York State earnestly believes that it would be to the advantage of the New York State hospitals, and as well to the hospitals of all other jurisdictions, to be covered by the National Labor Relations Act either in its present form, or better still, with appropriate amendments particularly suited to hospital needs. Accordingly, the Hospital Association of New York State urges that the American Hospital Association restudy its position opposing removal of the hospital exemption from the National Labor Relations Act.

## APPENDIX A

## RESOLUTION—MASSACHUSETTS HOSPITAL ASSOCIATION

Whereas, Unions and professional groups are devoting increasing attention to organizing hospital employees using collective action tactics to force recognition where there is not an orderly statutory procedure for accomplishing recognition; and

Whereas, The several states which have enacted state legislation covering labor relations in hospitals seem to act without applying the level of consistency and expertise required for the complex health industry; and

Whereas, The National Labor Relations Board is commonly recognized as having developed the expertise and body of knowledge necessary to administer the national labor relations policy of the country in an orderly and organized way; and,

Whereas, The health care industry is recognized as among the largest industries in the United States and the largest industry whose labor relations activities are not regulated as part of the national labor relations policy; and

Whereas, The National Labor Relations Board has asserted jurisdiction over proprietary hospitals, nonprofit extended care facilities; nonprofit educational institutions, and a nonprofit hospital with a proprietary pharmacy; now, therefore, be it

*Resolved*, That Massachusetts Hospital Association requests the American Hospital Association to re-examine its present position of favoring exemption from the National Labor Relations Act and its opposition to any legislation, federal and/or state, requiring health care institutions to bargain collectively with any unions or professional groups of their employees; further, that there be prepared and submitted appropriate amendment to the National Labor Relations Act which will remove the exemption of nonprofit hospitals and will provide appropriate dispute resolution procedures.

## APPENDIX B

## NATIONAL LABOR RELATIONS ACT, TITLE I, SECTION 2(2)

"The term 'employer' includes any person acting as an agent of an employer, directly or indirectly, but shall not include the United States or any wholly owned Government corporation, or any Federal Reserve Bank, 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, or any person subject to the Railway Labor Act, as amended from time to time, or any labor or any labor organization (other than when acting as an employer), or anyone acting in the capacity of officer or agent of such labor organization."

## STATEMENT ON MASSACHUSETTS LABOR RELATIONS AND FEDERAL JURISDICTION

## BACKGROUND

The social, economic and political pressure for a national declaration of policy and legislation to grant legal status to collective bargaining between employees and their employer culminated in the Wagner Act of 1935, more formally referred to as the National Labor Relations Act. While the language of the Wagner Act did not specifically include or exclude non-profit hospitals, the National Labor Relations Board in interpreting the Act, found that non-profit hospitals did not lose their commercial status because of the lack of a profit motive and its employees should not be deprived the protection of the Act. Although the National

Labor Relations Board was supported by the federal courts in its interpretation of the federal act, several state courts, including the Massachusetts Supreme Judicial Court, held that non-profit hospitals were not engaged in trade or commerce, or were, in effect an arm of the State and accordingly excluded from coverage under the labor laws. The federal position was reversed in 1947 when the Wagner Act was amended by the Taft-Hartley Act, when, among other things, Congress specifically provided in the definition of "Employer" for the exclusion of "any corporation or association operating a hospital, if no part of the net earnings inures to the benefit of any private shareholder or individual. . . ." Senator Tydings, who offered this particular amendment on the floor of the Senate, stated: ". . . and I understand from the (American) Hospital Association that this amendment would be very helpful in their efforts to serve those who have not the means to pay for hospital service, enable them to keep the doors open and operate the hospitals." The basic legal argument offered for the amendment was that non-profit hospitals were not engaged in interstate commerce. Accordingly, the non-profit hospital was declared not to be an employer within the meaning of the National Labor Relations Act.

In 1960, the National Labor Relations Board declined to assert jurisdiction over proprietary hospitals, although it admitted it did have legal jurisdiction. The Board found that this class of hospitals was primarily local in nature, was strictly regulated by the states, and that once the Board declined jurisdiction over the labor relations of hospitals, the states would fill the void. In 1967, the Board reversed its position as to proprietary hospitals and nursing homes when it found that the states had not filled the labor relations void and further found that such facilities were no longer local in nature in view of the substantial financial interstate and national impact on commerce due to the vast expansion of national health and welfare programs.

The National Labor Relations Board, in 1970, extended its jurisdiction in the health care field to non-profit extended care facilities. In doing so, the Board accepted as its definition of such facility, the definition of the American Hospital Association, i.e., "an establishment with permanent facilities that include in-patient beds, and with medical services, including continuous nursing services, to provide treatment to patients who require in-patient care but who do not require hospital services." The NLRB held that such facilities' operations are analogous to such facilities' operations of a proprietary nature, that they affect commerce in the same substantial manner and that an employer's non-profit status is irrelevant and not a proper basis for declining jurisdiction. Accordingly, as of 1970, the NLRB asserts jurisdiction over all health care facilities, both proprietary and non-profit, that meet its dollar volume discretionary jurisdiction, with the sole exception of facilities that operate non-profit hospitals, the latter being expressly excluded by statute.<sup>1</sup>

#### MASSACHUSETTS LABOR RELATIONS IN HEALTH CARE FIELD

Massachusetts enacted its labor relations law in 1937, which was patterned after the Federal Wagner Act. Like the Wagner Act, the Massachusetts Act was based on the over-riding concern of "balancing" the . . . inequality of bargaining power between employees who do not possess full freedom of association or actual liberty of contract, and employers who are organized in the corporate or other forms of ownership associations . . ." which inequality substantially burdens and affects industry and trade. In attempting to set up this "balance", the early law provided that certain conduct by an employer would be an unfair labor practice, but the restrictions on employees and labor organizations were limited or non-existent. While employer was restricted in his activities relating to his employees' rights concerning union activities, extremely limited restrictions

<sup>1</sup> It is significantly relevant that the labor relations history in the non-profit educational field has followed a similar pattern, with the exception that Congress has never specifically excluded such institutions from the definition of "Employer" under the National Labor Relations Act. The Board refused to assert jurisdiction over non-profit educational institutions in 1951, "where the activities involved are non-commercial in nature and intimately connected with charitable and educational activities of the institution." In 1970, shortly after the Board reversed itself as to non-profit extended health care facilities, it reversed itself as to non-profit educational institutions, finding that the underlying considerations of two decades ago no longer apply. It was found that to meet the needs of the mounting numbers of students, universities were required to enlarge their facilities and economic activities. Although education is still the primary goal, universities are required to engage in activities of a commercial nature to carry out that goal. Included in the changes occurring in the past two decades are increased federal spending in education and the inclusion of non-profit, private universities under the Fair Labor Standards Act. The Board stated that this latter action by Congress reflected "the recognition that employees in the non-profit sector are entitled to the same benefits which Federal statutes provide to employees in the profit-making sphere."

were placed on employees or labor organizations. This situation was remedied under federal law by the 1947 Taft-Hartley amendments, but has never been revised by the Massachusetts legislature.

In the early administration of the Massachusetts law, the courts of Massachusetts, contrary to the federal courts, declared that non-profit hospitals were not included within the State's labor laws because, it was held, labor disputes at such institutions could not affect industry and trade. Non-profit health care facilities were therefore exempt from all labor laws until 1964, when, for the first time they were included, but only as to labor activities of registered nurses and licensed practical nurses. In 1968, non-professional employees of non-profit health care facilities were included. Within the 1964 amendments, strikes were prohibited and compulsory arbitration was required only at health care facilities. No other attempts were made to update the State's labor laws, as has been the case with federal labor legislation.

Since the inclusion of non-profit hospitals within the State's labor laws in 1964, the number of issues that have arisen have been few, but have been of great significance to the hospital industry. The issues, which have been raised in the employee representation area, relate to the scope and composition of bargaining unit and to the question of inclusion of supervisors in a bargaining unit of employees they supervise. (The first issue relates primarily to the non-professional employee and the latter issue relates primarily to the registered nurse.) The manner in which these issues have been handled by the Massachusetts Labor Relations Commission causes great concern to hospitals because of the impact on the ability of the hospital to carry out its prime responsibility of patient care, and the apparent lack of concern of the Commission for this latter factor.

The Massachusetts Commission, in fashioning bargaining units in the health care field, appears to rely substantially upon the extent to which a labor organization is able to organize an employee group. The Commission's premise for following such a practice is the statutes' language that is public policy to protect "the exercise by workers of full freedom of association, self-organization, and designation of representatives of their own choosing. . . ." It is the stated position of the Commission that the primary consideration in establishing bargaining units is to insure that employees have full benefit of self-organization and collective bargaining. The Commission fails in its duties and obligations in following such a premise because the statute plainly states that it is the public policy of the State to promote collective bargaining as a means of avoiding industrial strife and unrest, and that the protection of the right of employees to organize in order to engage in collective bargaining is but a means to carry out the primary objective. The policy followed by the Commission subverts the law by not following the mandate of the law and by its refusal to consider all the relevant facts relating to the labor, situation involved, thus resulting in a great injustice and disservice to employees employers and the community.

In the health care field, the State Commission has further ignored the additional stated public policy in the interest of preserving the continuity and improving the quality of health care to promote collective bargaining, to protect the right to hospital employees to organize and to prevent strikes and lockouts. The Commission, in following its present course, is fragmenting hospitals and is creating a situation wherein a large number of small groups will be rivaling and competing with one another, rather than cooperating with each other which is so vital to patient care. With fragmentation comes increased competition among groups of employees, increased jealousies and hostilities, increased disruptions and an increased need to resort to compulsory arbitration to settle disputes. The Commission's attitude and practices in establishing bargaining units in the health care field can have a direct impact, therefore, on the operation of a hospital and the quality of patient care.

It was recently argued by the State's Labor Relations Commission before the Supreme Judicial Court that its ruling on the bargaining unit in the case of University Hospital should be upheld since the Commission, by law, is directed to determine an appropriate unit and that its expertise, developed over the past 35 years in fashioning bargaining units, should be supported in this case. This argument ignores the significant facts that the businesses relegated to coverage by the State Labor Relations Act are quite small and do not involve the complexities of larger businesses covered by the federal law. Secondly, the State Commission has had no experience in the health care field and fashioning bargaining units in such facilities. Its lack of expertise was clearly revealed in the unit found appropriate in the *University Hospital* case wherein the Commission carved out a small unit within the Maintenance Department. Before the Commission could issue a decision, the same union had filed two further representation petitions, one for another portion of the Maintenance Department and the

second for a unit of Housekeeping personnel. The fragmentation of bargaining units that occurred in *University Hospital* does not balance the public concern with the requirement of the continuity of patient care and the right of employees to organize and bargain collectively. It is most significant that the National Labor Relations Board considers the factor of continuity of patient care in fashioning bargaining units in the health care field, and presumptively, finds that units of all non-professional employees of a health care facility are appropriate.

The Massachusetts legislature, and the State Labor Relations Commission has not followed the precedent of the federal law regarding exclusions from the bargaining units of such employees as supervisors and security guards, nor has any distinction been accorded between full-time, regular part-time and casual employees. No consideration is given to the true community of interest among employees of a particular employer in a particular industry, which is the cornerstone of establishing any appropriate bargaining unit. In Massachusetts an employee who works two hours a week for three or four weeks in a year would appear to be eligible to vote in an election even though such employee's interests are quite remote from that of the full-time or regular part-time employee. Likewise, nurse supervisors whose primary responsibility, along with patient care, is administrative control of those nurse employees under their supervision, are included in the same unit with those subordinate nurses, thus subverting both the hospital's operation and the subordinate nurse employees' freedom to organize and bargain collectively. By the same token, permitting the same labor organization to represent security guards and at the same time represent employees against whom the security guards must enforce the security and disciplinary rules of the hospital results in a conflict of interest. In short, Massachusetts labor laws and the Commission empowered to carry out the mandate of those laws are incapable of dealing with even the most basic of issues, for these are issues with which it has had little or no experience.

#### CONSIDERATIONS—OTHER STATES

The Massachusetts experience has not been singular. At the present time, there are approximately 16 states having specific labor relations laws, and, of these, some 12 include coverage of non-profit hospitals. The same inadequate handling of labor relations seems to exist for the non-profit hospitals in these states as exists in Massachusetts. The remainder of the states have taken little or no intelligent action to deal with labor relations in any industry not covered by federal legislation, including the health care field.

The growth of the health care industry has not gone unnoticed by labor unions, even in those states lacking labor relations laws. Attempts at unionization of non-profit hospital employees has advanced regardless of whether there has been any legislation sanctioning such activity. The plain fact is that labor organizations exist in non-profit hospitals, and agitation for further organization is not abating.

While the advancement of the health care field has become the center of attention for many labor organizations, it has also become a matter of great national concern. Congress has brought the non-profit hospital into the realm of the national economy, as previously indicated by its substantial financial and economic assistance in the area of construction of facilities and research, and the expansion of national health and welfare programs. The National Labor Relations Board has all but taken jurisdiction over the non-profit hospital field having already taken jurisdiction over practically every other aspect of interstate commerce that relates to the health care industry. There is no question that but for the statutory exclusion, the National Labor Relations Board would have taken jurisdiction over the entire health care field. The question with which we are faced is not whether non-profit hospitals should or will be included within the comprehensive national labor relations policy, but rather when and how.

The attitude of those states, hospitals and hospital associations wherein the tendency is to ignore the existing situation is disastrous. The chaos, disruption and uncertainty that results from the current status of hospital labor relations can best be described, as it has been for California, as "the law of the jungle." The impact of the situation was recently noted in a decision of the Illinois Supreme Court wherein the Court reversed a lower court ruling which had prohibited a strike at several hospitals based on public policy, the Court finding that the State nowhere declared that such strikes were against public policy.

It is not necessary that the hospital industry be overwhelmed by union organizational activity before action is necessary to implement more favorable legislation. Most of the national labor relations policy regulating union activities and practices for example, resulted not because a majority of unions engaged in corrupt

and abusive tactics, but rather because the activities of a few unions were of sufficient importance to warrant regulation in a more orderly manner based on a national policy.

The manner in which hospitals are being subjected to union organizational activity and the treatment accorded the hospital industry by states with or without state labor relations laws, makes imperative unified action by the hospital industry for more favorable treatment in a unified manner on a national level. The labor relations facet of the hospital industry has progressed and developed along with the rest of the modern industrial economy which has included diverse and complex organizational structures with appropriate changes, the comprehensive national labor relations policy developed over the past 35 years can be readily adapted to the hospital industry.

#### A NATIONAL LABOR RELATIONS POLICY IN HEALTH CARE FIELD

The care health industry, reported to be the third largest industry in the country, is the largest industry whose labor relations is not regulated on a national level. This factor takes on added significance when it is observed that the non-profit hospital is becoming more and more subject to national policies, such as inclusion within the federal wage and hour laws and unemployment compensation.

It is the position of the Massachusetts Hospital Association that a national policy for labor relations in the health care field is necessary in view of the impact of collective bargaining and of the enormous size and complexity of the health care industry, and that such coverage should be under the National Labor Relations Act. The Commonwealth of Massachusetts does not have the resources and experience necessary to handle the complex labor relations of the health care industry, nor does any of the other states. The experience gained by, and the resources available to, the National Labor Relations Board, indicates that removal of the exemption for non-profit hospitals from coverage under the National Labor Relations Act is most desirable at this time.

The position of the Massachusetts Hospital Association is taken with the caveat that as the National Labor Relations Act relates to the health care industry, certain modifications of the law must be made. The federal law, as presently applied to proprietary hospitals and other related health care facilities protects the right of employees of such institutions to engage in strikes. Such strikes have occurred, including one in Massachusetts at Union Hospital of New Bedford. It clearly is not in the public interest to permit work stoppages at health care facilities which would endanger the lives of patients. It is likewise recognized that hospitals must meet their obligations to their employees and that labor disputes that develop must be handled by an appropriate procedure.

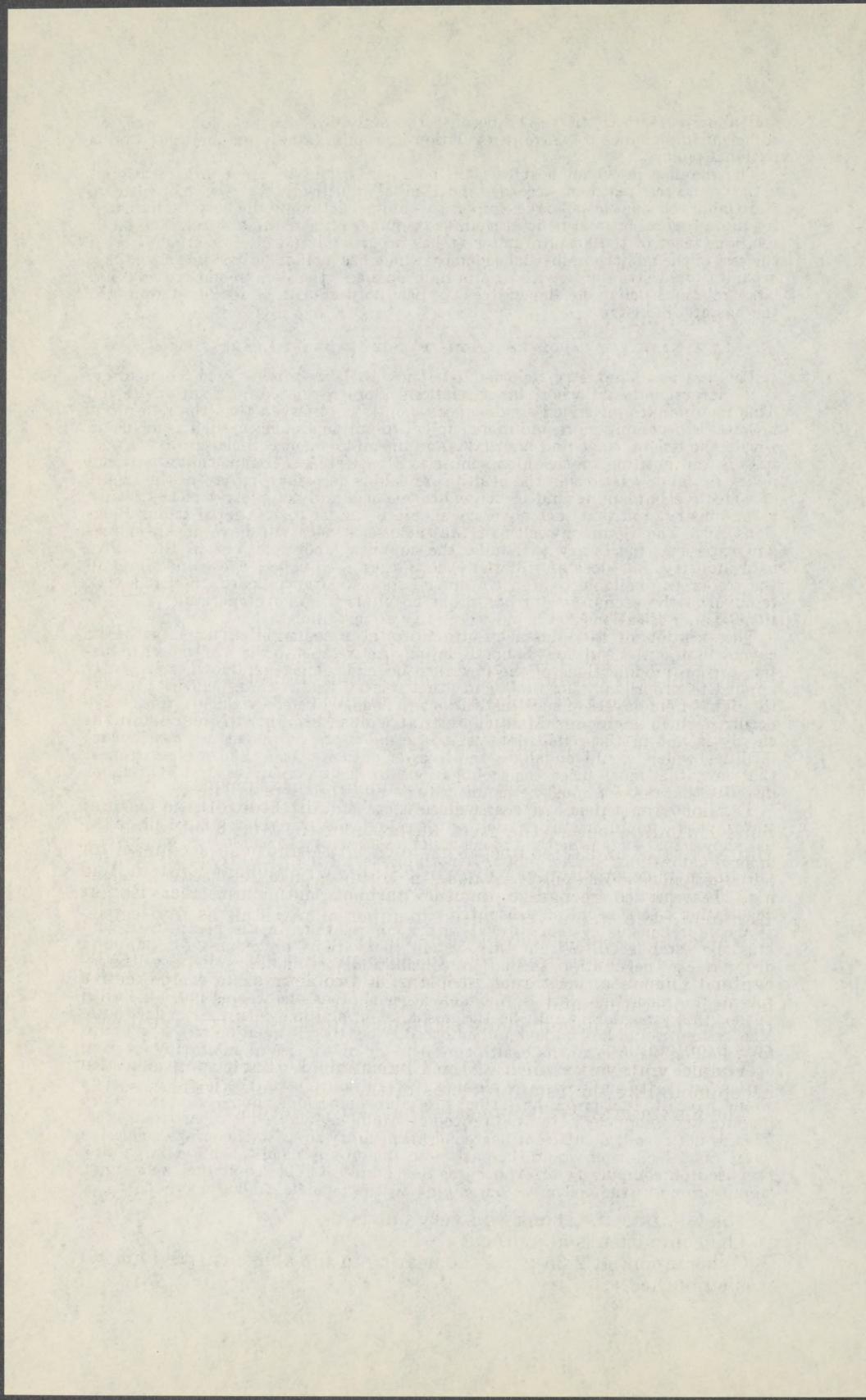
The limited experience of Massachusetts, as well as the experience of other states, with compulsory arbitration as the sole means of resolving labor disputes, has shown that such a method alone is not satisfactory to employers, employees, labor organizations or the public. If nothing else, it derogates from the primary purpose of all labor relations legislation—to promote good faith collective bargaining. These parties are more concerned with preparing for arbitration than in negotiating a settlement of a dispute.

A comprehensive system to deal with labor relations in the health care field must be established. Within this system the various procedures for handling disputes, e.g., negotiation, mediation, conciliation, fact-finding, voluntary arbitration and compulsory arbitration, should be utilized as part of a comprehensive scheme to encourage parties to reach agreement among themselves. Included within this procedure would be the absolute prohibition of strikes or lockouts. The system would be handled and enforced either by the creation of a new board for handling disputes in the health care field, or by the use of an already existing agency such as the Federal Mediation and Conciliation Service, but with expanded duties, authority and powers. Whatever the procedure used, the board or agency would have at its disposal the various procedures mentioned above, and would use its informed judgment as to what procedure would be followed in a particular case. This would permit a sufficient degree of uncertainty so as to encourage collective bargaining. No longer would the parties be able to approach collective bargaining premised on compulsory arbitration as the end result. These opinions, we submit, would promote true collective bargaining to the benefit of all concerned.

The CHAIRMAN. Thank you very much.

The committee is adjourned.

(Whereupon, at 2:35 p.m., the hearing in the above-entitled matter was adjourned.)



## COVERAGE OF NONPROFIT HOSPITALS UNDER NATIONAL LABOR RELATIONS ACT, 1972

WEDNESDAY, SEPTEMBER 6, 1972

U.S. SENATE,  
SUBCOMMITTEE ON LABOR OF THE  
COMMITTEE ON LABOR AND PUBLIC WELFARE,  
*Washington, D.C.*

The subcommittee met, pursuant to notice, at 10:15 a.m., in room 4232, New Senate Office Building, Senator Harrison A. Williams, Jr., chairman, presiding.

Present: Senators Williams, Randolph, Mondale, Javits, Taft, and Stafford.

Committee staff members present: Gerald M. Feder, counsel; Donald E. Elisburg, associate counsel; and Eugene Mittelman, minority counsel.

The CHAIRMAN. We will resume our continuing hearings on H.R. 11357. I believe this will be the concluding session.

This bill will amend the National Labor Relations Act for the coverage of hospital employees. We might depart from the listed order here in accommodation to Senator Javits. We will hear from the Greater New York Hospital Association.

Senator Javits.

Senator JAVITS. Thank you very much, Mr. Chairman.

I take great pleasure in welcoming the director of the Mount Sinai Hospital—one of the great hospitals of the world, let alone the United States and of course in my own city—and also a counsel for the hospital association of New York State, Mr. Richard Epstein; and also I want to recognize on the part of the committee, Robert Kaufman, who was a very gifted member of my staff as my legislative aide for a long period of years.

New York has a great role to play in the world as a hospital center. This is a very real problem, a problem of how to keep a hospital operating and insure workers their rights, and I know that these witnesses will contribute enormously to our ability to deal with this problem.

Thank you very much, Mr. Chairman. I thank you also for accommodating the time problems of these particular witnesses.

The CHAIRMAN. We appreciate that. Dr. Pomrinse.

STATEMENT OF S. DAVID POMRINSE, M.D., DIRECTOR, THE MOUNT SINAI HOSPITAL OF NEW YORK; ACCOMPANIED BY ROBERT KAUFMAN, COUNSEL, GREATER NEW YORK HOSPITAL ASSOCIATION; AND RICHARD EPSTEIN, COUNSEL, HOSPITAL ASSOCIATION OF NEW YORK STATE

Dr. POMRINSE. Good morning, Senator.

My name is S. David Pomrinse. I am a physician and director of the Mount Sinai Hospital, in New York City. I am appearing today as spokesman for two organizations—the Greater New York Hospital Association, of which I am a governor and a member of the executive committee; and for the Hospital Association of New York State, of which I am a trustee.

With me are Mr. Richard Epstein, counsel for the Hospital Association of New York State, and Mr. Robert Kaufman, counsel for the Greater New York Hospital Association, and when it comes to questions, I will be delighted to ask them to help me answer.

The Greater New York Hospital Association, with its headquarters in Manhattan is a coordinating agency for the programs of all the major voluntary nonprofit hospitals, long-term and extended care facilities and all the municipal hospitals in the metropolitan area. Dedicated to serving the health and welfare needs of the community, the association seeks to advance the interests of its member institutions by building cooperation among them, by assisting them in achieving ever-increasing levels of effective performance, by encouraging essential educational and research endeavors, and by interpreting all these functions to the general public and to allied professional, governmental and other organizations. The association also maintains active liaison with groups in related fields interested in improving community health and raising standards of patient care.

The Hospital Association of New York State headquartered in Albany, performs similar services for its membership which includes not only all the members of the Greater New York Hospital Association, but all of the voluntary hospitals throughout the entire State of New York as well.

After careful study of the unique needs of our member hospitals, both our associations have come to the conclusion that our best interests in New York—and this means the best interests of the many thousands of patients who look to us for care—will be served by passage of H.R. 11357, which would remove the exemption of not-for-profit hospitals from coverage by the National Labor Relations Act.

The overwhelming preponderance of our member hospitals are located in densely populated, highly industrialized urban centers. Over the past few decades we have become increasingly familiar with the conditions under which organization of our employees into unions has taken place.

We have a body of experience going back several years which includes all the circumstances which characterize the relationships between management and labor. That experience includes litigation, negotiation, work stoppages, picketing, collective bargaining and contract administration, et cetera.

In New York State, hospitals have been governed by the special provisions of the New York State labor relations law. It is on the basis of our most painful awareness of the grave inadequacies of that piece of State legislation that I have been requested by our State and local associations to appear before you today. My purpose is to help persuade you to act favorably on H.R. 11357 so that the shortcomings of the State law may be superseded by what we consider the time-proven, effective safeguards and the infinitely more rational and orderly procedures we are convinced can be expected to develop under the national law.

Let me illustrate briefly;

1. The National Labor Relations Act provides for a definitive exclusion of supervisors from the bargaining unit. The State Labor Relations Act contains no such exclusion. The need for such an exclusion is even greater in hospitals than in private industry where the exclusion has long been recognized. Hospital management requires the uninterrupted cooperation and undivided commitment of supervisory personnel at all times in order to serve the hospitals' crucial responsibility for the well-being and, in many cases, the very lives of the patients entrusted in their care.

Let me amplify on that just a bit. We are faced in New York with a situation where our nursing supervisors are in the same bargaining unit with our registered nurses, and they are constantly torn apart themselves as to whether they are, if you like, ratting on one of their sister members of the union in disciplining their subordinates. This is simply intolerable.

When we were faced with the possibility of a threat of a strike, on July 1 of this year, we were prepared to operate Mount Sinai with the staff who were not in any of the unions who were going on strike. We could have been in a much better position, believe me, had we been able to provide safe patient care with no question had our supervisors not been in the same group with the same people they supervise.

That to me is a basic point.

Senator JAVITS. Mr. Chairman, I will not ask questions at this point, but I think it would help us to have the figures. How many nurses were involved, how many supervisors?

Dr. POMRINSE. We have at Mount Sinai close to 800 registered nurses. There are 10 people called supervisors. There are about 70 called assistant supervisors, and about a hundred who are head nurses, all of whom are supervisors.

Senator JAVITS. How many nurses, did you say?

Dr. POMRINSE. Almost 800.

Senator JAVITS. And those who qualify as supervisors?

Dr. POMRINSE. Would be close to 200.

2. The State Labor Relations Act permits the Labor Board to find as appropriate a unit which groups together security guards along with other employees. This practice is not permitted under the National Labor Relations Act, which does not even allow for certification of a union of guards which also admits to its membership employees other than guards.

This provision of the national law would be of critical value to hospitals. The New York State law specifically prohibits unlawful strikes but strikes have occurred in New York hospitals nevertheless even since the law's enactment and prior to that and as recently as June 13 of this year. In a strike situation it is essential, in safeguarding patients, that we have the means and the people necessary to prevent acts of violence and to protect the hospitals' inhabitants and property.

Specifically, it is essential that we have reliable personnel capable of protecting our fragile, costly equipment from damage and destruction, our life-saving drugs from theft, and our property from pillage and destruction. Without security possible by the undiluted loyalty of our guards to the mission and purpose of the hospital and its patients, we become vulnerable to the kind of crisis and danger which too frequently accompanies labor disputes and against which industry, now regulated by the national act, is already protected.

3. The National Labor Relations Act does not permit the holding of a union election within 12 months of a prior election. In contrast, the New York State Labor Relations Law permits the Board to order a subsequent election at any time. It is important, in hospitals, that the disruptions associated with union elections, and their inevitable, disturbing effect upon patients, be permitted to take place at least no more often than once a year.

4. The New York Labor Relations Law does not require any particular minimum number of union authorization cards to be signed by interested employees as a condition to conducting an election, whereas the National Labor Relations Act requires an interest showing of at least 30 percent. This works as an additional safeguard to avoid the unnecessarily disruptive climate which accompanies election campaigns and which also proves to be a source of harassment rather than to reflect any real interest on the part of the employees.

It remains only for me to comment now on the two amendments which I understand are also under consideration. One of these would, I understand, include statutory coverage of staff nurses and physicians.

While we have genuine reservations as to the appropriateness of including these particular professional groupings under any law, neither the Greater New York Hospital Association nor the Hospital Association of New York State would treat such an amendment as cause to withdraw our support of this bill.

The other amendment under consideration would, I am informed, provide for compulsory arbitration of impasses. Since we are already operating under a type of compulsory arbitration under the New York law, this amendment would not affect our support of H.R. 11357 either.

On behalf of the two associations of voluntary, nonprofit hospitals for which I am privileged to speak, I thank you for this opportunity to make our views known.

With me here today are Richard Epstein, of Rochester, who is counsel to the Hospital Association of New York State; and Robert Kaufman, of New York City, counsel for the Greater New York Hospital Association. With their assistance I shall be happy to undertake to answer any questions which any of the members of your honored body would like to ask.

The CHAIRMAN. Thank you very much, Dr. Pomrinse.

Senator JAVITS.

Senator JAVITS. Thank you very much, Mr. Chairman. Dr. Pomrinse, it is a fact, is it not, that New York is really unique in having a State Labor Relations Law? Many other States do not have such a law; is that correct?

Dr. POMRINSE. That is correct.

Senator JAVITS. Mr. Chairman, may I inquire of the committee staff if there is an analysis of the State law situation that we could insert into the record?

The CHAIRMAN. I am informed that some of the States do have State legislation but this may not be comparable.

Senator JAVITS. Secondly, I would like to get from New York's experience some benefit for the purpose of this discussion, this consideration. Do I understand that your experience is such that you are not opposed to unionization of hospital employees?

Dr. POMRINSE. Yes, sir. Let us go back to the beginning of the New York State law.

My own hospital in 1959 withstood a 6 weeks service employees strike. These were employees who were trying to be organized. There was no law under which they could be organized.

The CHAIRMAN. Which year was this, Doctor?

Dr. POMRINSE. 1959.

It was in 1963 I believe that the New York State law took effect. Following that we recognized the union, became organized, and we worked reasonably well with them.

Comes next time, things get pretty uptight, but in time we work our way through.

The question is not whether hospitals are going to be organized; the question is how they are going to be organized.

The question is whether there will be a state of chaos, no protection to either labor or management, or whether there will be orderly procedure as unions reach out—and they are reaching out in other States: in New Jersey, in Maryland, in Pennsylvania, in South Carolina, and all up and down the local Eastern seaboard where Local 1199, the local which has organized New York hospitals, has been most active.

Their technique has been to move in some cities into the nursing homes which do not have this exemption under the National Labor Relations Act, and may not have the mechanism to govern their actions. When they establish nursing homes, they can then reach out to the voluntary hospitals in this area. So they are already in unionization procedures.

The question is whether it will be done in a chaotic fashion or whether both management and labor have some protections in an orderly procedure.

Senator JAVITS. I notice you refer to two amendments, and what you would consider in respect of those as not canceling out your support of the bill, but do you suggest from your experience any other specialized provisions of a law which would be applicable to hospital employees, that is, of applying the National Labor Relations Act to hospital employees?

Are there any affirmative amendments that you would wish to put into such a bill?

Dr. POMRINSE. None at this time, sir.

Senator JAVITS. In defining supervisory personnel which you did for me, does that not relate to the amendment regarding the statutory coverage of staff nurses and physicians?

In other words, it is true you say you have no objection to the coverage of staff nurses and physicians—I will not put it as new objection—it will not cause you to turn against the Act, but would you not wish exempted from staff nurses and physicians those whom you define as supervisory personnel?

Dr. POMRINSE. I reviewed this point just yesterday with counsel and was advised that just because somebody is a nurse she may in the course of her routine supervise nonnurses, nurses aides, and so on. In that case she should not be excluded because she is a supervisor.

But if she is a supervisor of nurses, an honest-to-God supervisor, she is boss of the nurses.

Senator JAVITS. And the same would be true of a doctor?

Dr. POMRINSE. Exactly.

Senator JAVITS. Or another professional?

Dr. POMRINSE. Exactly.

Senator JAVITS. That is correct. So that the definition in order to meet your views would need to be redefined so that it would not just numerically apply to all who held a medical degree or a nursing degree; it would apply to their function.

If their function were truly supervisory, supervision of their own peers, then they would be classed as supervisory personnel?

Dr. POMRINSE. Yes. As you know, in one or two hospitals in New York State the salaried medical staff—I am not speaking of interns and residents—but the permanent attending staff have become organized. There again you have a situation where the chief of a service, who is a boss, a supervisor, is presumably in the same union with the same people he is trying to supervise, and it simply does not work.

Senator JAVITS. I notice that your association includes what you call the voluntary nonprofit hospital. In New York we have a large number of so-called municipal hospitals, have we not?

Dr. POMRINSE. They are also included in Greater New York.

Senator JAVITS. In your association?

Dr. POMRINSE. Yes.

Senator JAVITS. However, would they be covered by the NLRA too?

Mr. EPSTEIN. No. The Hospital Association of New York State also includes municipal hospitals. I would doubt that they would come under this act.

Senator JAVITS. I am aware of the general exclusion of the NLRA to governmental agencies, but I am trying to press you to tell me that you do or do not feel there is a case to be made to giving them some other status with respect to this particular kind of bill.

Mr. EPSTEIN. The greater number of municipal hospitals is in New York City; and perhaps Mr. Kaufman would better comment on that because there are very few of them upstate.

Mr. KAUFMAN. I think we have a specialization in New York City. The municipal hospitals are no longer strictly voluntary hospitals; they are hospitals or hospital corporations.

I do not think anyone has focused on the issue as to whether, if the voluntary hospital exemption is removed they would remain under the municipal exemption. In certain ways they are still to be considered municipal employees, and in certain ways they are considered not to be. I think that particular issue would have to be faced probably for the first time if the exemption were removed, since they are doubly exempt at the moment.

I think the attitude of these municipal hospitals is very much the same as those of the voluntary hospitals. The hospitals in New York and I suppose around the country are really no different any more from any other reasonably local industry which affects interstate commerce.

The employees, the nurses, the doctors, come across the State lines to seek employment. Hospitals seek employees across State lines. Drugs and food, and so forth, all cross state lines.

Dr. POMRINSE. So do the patients.

Mr. KAUFMAN. So do the patients; right.

The impact on interstate commerce in terms of purchasing, in terms of employment, and so forth, are all substantially the same as those of other industries of that size and locality which are not covered by the act.

As a matter of fact, employees come not only from other hospitals in other areas; they come from covered industry into the hospitals, and they go back into covered industry.

The impact of somebody coming from out of NLRA and coming back in is an impact which seems really not to be supported by logic any more.

Senator JAVITS. Mr. Chairman, I would request the Chair to request of the New York City Health and Hospital Corp. an opinion as to whether they would consider that their employees would be covered by this act.

Secondly, I would request to be included information as to whether they wished to be covered: and, thirdly, what amendments they suggest to the bill before us in the light of their views as to what is best for their operation.

Senator WILLIAMS. I will certainly do that.

(The material referred to was not made available to the committee for inclusion in the record at the time of printing.)

Senator TAFT. I am just not clear whether or not these municipal hospitals are under the New York law. Is that the case, or not?

Mr. KAUFMAN. Yes; they are.

In response to Senator Taft's question, New York State has a separate law for public employees called the Taylor law, and that is the law that now governs the employees of the governmental hospitals.

Senator TAFT. Not the hospital law?

Mr. EPSTEIN. Not the hospital; that is right.

Senator JAVITS. The Taylor law and the hospital law have one thing in common, compulsory arbitration; is that correct?

Dr. POMRINSE. Yes.

Senator JAVITS. For practical purposes, it comes to the same thing.

What has been your experience with that? Why do you feel, Dr. Pomrinse, that if we should accept compulsory arbitration—and as you are aware, I take a very dim view of compulsory arbitration in labor cases, as I think do also our chairman and other members of the committee—you seem to argue somehow or other that would work if the Federal Government did it, but it does not work if the State government does it.

Why should there be any difference?

Dr. POMRINSE. I do not think I quite said that.

Senator JAVITS. Then you straighten me out.

Dr. POMRINSE. When the New York State law went through, it had compulsory arbitration. That was acceptable to the legislature of the State and essentially the associations also.

We have lived with compulsory arbitration since then.

It has been invoked, I believe, once this year. That was when there was an impasse determined, and the mechanism of compulsory arbitration was invoked.

This year was a very special thing because of the problems of cost control, the Federal Price Board, and so on. The hospitals were in a position where we could not really negotiate because we did not have anything to negotiate with.

This is the only time we have had compulsory arbitration in effect. However, it has always been in the background, and we have always known, and so has the union, that if we could not work things out, this is what was going to come next.

Speaking for my colleagues, we feel somewhat more comfortable knowing this is there. We think we can live without it, also.

Other nationally important and critical industries have been able to resolve impasse-type situations without compulsory arbitration. We think that, given the opportunity of moving to the Federal courts, given perhaps a serious situation, an emergency situation, we would be able to get the necessary relief to keep the hospitals functioning.

Senator JAVITS. Is that belief premised upon the fact that you believe or your lawyers have advised you that the Taft-Hartley law aiding an injunction would apply, or is likely to apply, in most hospital strike situations?

Dr. POMRINSE. In the major hospitals and in our situation since the union that organized is metropolitanwide, it covers even more than the city itself. A citywide strike would clearly precipitate a major health crisis.

Senator JAVITS. Remember the major health crisis is not the definition of the Taft-Hartley law. It is a national emergency that is the definition.

But a national emergency does not mean that it has to affect the whole nation geographically, because if people are going to catch scarlet fever, it will travel very fast.

Is that the sense in which your lawyers have advised you?

Dr. POMRINSE. Yes.

Senator JAVITS. So that you are satisfied that you would get a cooling-off period even without compulsory arbitration?

Dr. POMRINSE. Yes.

Senator JAVITS. I think that is very interesting and very sensible. May we ask if the State organization feels the same way?

Mr. EPSTEIN. Yes.

Dr. Pomrinse, in his appearance here today is speaking also for the State association.

I wonder if I might offer a comment or two in behalf of the State association.

Earlier you asked if the staff would provide information about the status of legislation in this area in other states.

Senator JAVITS. The status of the law.

Mr. EPSTEIN. Yes.

If it would be of any use to have it now, I could give you a quick summary of it; otherwise, I can just go on with another question.

Senator JAVITS. I do not know that we want to take the time at this point. We do have other witnesses.

Mr. EPSTEIN. The other point raised was whether we are opposed to unionization. We do not see that as the issue. We do not believe that the position of the New York State association regarding whether or not there is a statute has any significant effect on unionization.

Ultimately that decision is made by the employees of the appropriate unions. The question is only the orderliness and the procedure that would accompany aspirations of the union which is trying to organize.

If New York could be looked to as a lesson, as to what might be valuable guidance on the national scene, and if we would look back to 1959 and 1960, I think the lesson to be learned from New York is that whereas we had a considerable amount of uncertainty and chaos, interruptions, strikes, and what have you in the city of New York, and in various parts of upstate New York the Nation might benefit from the experience by having the statute and the orderly procedure first so as to avoid that kind of disruption and chaos.

It is not a matter of whether or not we are opposed to or in favor of unionization.

Dr. POMRINSE. One might comment also that the nonorganized hospitals, which would make up about 90 percent of New York State association, are at least as vigorous in support of the removal of the exemption as the organized. They have more to gain from it.

Senator JAVITS. Thank you very much Mr. Chairman.

The CHAIRMAN. Doctor, you speak for the Hospital Association of New York State as well as the Greater New York Hospital Association.

I gather that the State association in convention, or whatever the procedure is, resolved in support of this approach?

Dr. POMRINSE. Yes, sir.

The CHAIRMAN. Do you know of any other State hospital associations that are taking similar action?

Mr. EPSTEIN. I do not know the extent of their enthusiasm at this point, but Massachusetts at an earlier stage was quite active and felt strongly in support of having the exemption removed from the national act in order to get out from under the Massachusetts act.

I do not know their present position.

The CHAIRMAN. Does anybody else have any information on other States.

Senator Taft.

Senator TAFT. Thank you, Mr. Chairman.

I am a little confused about this matter of ceding jurisdiction. First of all, do you understand it is contrary to the House report?

The House committee report with regard to the bill strongly recommends that there be really a compulsory ceding requirement in the law. It points out that the National Labor Relations Board has not ceded in any cases of any substance, even though they have had this general authority from the very beginning.

It states in part that noting that at least one or more States have established collective-bargaining rights for nonprofit hospital employees pursuant to the State law, the committee urges the Board to exercise its authority pursuant to section 10(a) to cede jurisdiction to respective States or States' agencies if it determines a State law is substantially equivalent to Federal law.

You do not want ceding? You are against that provision?

Mr. EPSTEIN. Yes.

Mr. KAUFMAN. I think what section 10(a) says is that the NLRB has the power to cede jurisdiction, where the State law is not consistent with the corresponding provision of the national law; if the State law adopted provisions with respect to supervisors, with respect to guards, with respect to reasonable periods relating to elections, with respect to a number of areas where there is a difference.

I do not think in terms of the narrow outlook that New York would particularly care which law were covered. I think also we have a national outlook. I think at the moment in the view of counsel the New York law is inconsistent, and there probably is no power to cede.

Senator TAFT. Under the present law; we could of course write it into this bill if we pass this bill.

Mr. KAUFMAN. We would oppose that.

Senator TAFT. That applies to the State position as well as Greater New York?

Mr. EPSTEIN. Yes.

Senator TAFT. It is also contrary, I gather, to the New York Times, which editorialized on August 16, 1972, as follows

If Congress wants to establish a legal underpinning for hospital labor-management relations on a national basis, it would be wise to pattern it after this State's excellent statute.

As a minimum, it ought to include in the Federal bill a specific waiver of applicability in states with adequate laws of their own.

Dr. POMRINSE. All I can say is the New York Times did not consult the hospital administration. [Laughter.]

Senator TAFT. What is the matter with the New York law? That is what I am trying to find out. Evidently something is wrong with it.

Dr. POMRINSE. I have referred to several of the points. One is the inclusion of supervisors; another is not having guards, et cetera. When everybody is gone and there are four men left to protect six doors, or seven key doors in the place, it is simply intolerable.

A couple of years ago when we were threatened with a strike, there was a lot of sabotaging going on. There was nobody to turn to to depend on.

When you have four nurses out of the usual complement of over a hundred who are in the whole hospital that you know you can count

on—this is the director and three assistant directors, and everybody else is in the union—this is an impossible situation.

Senator JAVITS. Would the Senator yield?

Senator TAFT. I would be glad to.

Senator JAVITS. I do not think you and the Senator are on the same wavelength. Maybe I am wrong, but let us find out.

He is not saying that the Federal Government should cede jurisdiction to the New York law as it stands. He says, and the New York Times says, that New York State has a law equivalent to the Federal law, whatever that law may be.

Then would you object to ceding jurisdiction? Is that not correct, Senator?

Senator TAFT. That I think is very well put.

Dr. POMRINSE. That would be fine.

Senator TAFT. You have no objection in principle to having a State law apply?

Senator JAVITS. If it parallels the Federal law?

Senator TAFT. Let us go on to the next point that I would like to get your view on.

The striking difference between the State law and the Federal law is really the compulsory arbitration feature or the handling of the ultimate impasse.

I gather you feel that the national emergency provisions of the National Labor Relations Act would be adequate to handle this problem today.

Dr. POMRINSE. Yes. We feel if there is not compulsory arbitration we can live with it. We feel there is enough protection in the Federal courts under the Federal law to be able to keep us functioning, particularly if we have people like supervisors and guards out of these units. We can run the hospital for a short period of time.

Senator TAFT. You are talking about New York City now. Let me ask with regard to the State association, how about the smaller areas where the only hospital in the whole area might be shut down by a strike? Do you believe you would be covered by the NLRA adequately?

Mr. EPSTEIN. No. As a legal matter, I do not think so. I do not think under any circumstances it would meet the measure of a national emergency.

However, a large part of this notion is no strike and compulsory arbitration is academic in the sense that, notwithstanding the presence of those provisions in the New York Act, since 1963 there have been strikes and threats of strikes notwithstanding the prohibition.

I think this may be important. The reason why both management and labor would agree—and there are not that many areas of agreement between them on important issues—on the undesirability of compulsory arbitration, is that we could very well do without it as a practical matter.

Senator TAFT. Do you think there is an undesirability of having strikes?

Mr. EPSTEIN. Certainly there is; yes.

Senator TAFT. You do not agree, then, with the testimony on the House side that Mr. George Hardy, general president of the Service

Employees International Union gave, to the effect—quoting from page 34 of the record:

Invariably a lot of doctors won't move their patients and are not going to do it, but we have no choice. It is either them or us. We have to face up to our responsibility, and we have to strike.

Mr. EPSTEIN. I think the public statement will not always indicate what takes place in fact in New York City.

Senator TAFT. What did Mr. Hardy mean by saying doctors will not move their patients?

Mr. EPSTEIN. I do not know.

Dr. POMRINSE. May I guess?

My guess would be that the impression is around that if a hospital is struck, you must close, get your patients out immediately, and move them to other hospitals.

I disagree, sir. The New York City hospitals were prepared on July 1 to continue to operate. We could take care of the patients on hand and some very limited admissions.

A strike is a terrible thing. It is not fun and games; it is a terribly critical thing, but there is no reason for the kind of hysteria that has happened.

Senator TAFT. You still feel it is vital that we separate out the supervisory units?

Dr. POMRINSE. Certainly; because it becomes that much more possible to maintain the operation as you want it maintained.

We were depending upon volunteers; we were putting secretaries in the laundry, doing all sorts of strange and wonderful things to keep functioning.

I was convinced—and I am the man who is on the pan when things go wrong—we were going to be able to function if we had enough people to come in to pitch in, provided we had adequate support, to be able to continue functioning, to keep the hospital going; so that people's lives would not be threatened.

This is not an easy position to take, it is not one that I enjoy, but when the push comes to shove, it is still possible to keep working.

Senator TAFT. What do you think the relationship of reduced staff, reduced operations of that kind, would be to the question of liability on the part of the hospitals involved?

Dr. POMRINSE. We were not planning to have the thing wide open and all beds filled. The people we had were the critical people, the people who would probably turn out more work in 1 day than most of the people they supervise do in 3 days. [Laughter.]

I am not kidding. Obviously we were going to do what the patients had to have; not the things they might have liked to have had.

We pride ourselves on our food service, and there was going to be one standard meal, and so on. All of these things were boiled down. I would not recommend it for a routine operation.

Senator TAFT. You were not going to follow the oriental custom and have the family move into the hospital?

Dr. POMRINSE. Exactly. That is exactly what we were going to do, to ask each patient to have a relative stay with the patient.

These are the things you can do when push comes to shove.

Senator TAFT. What effect do you think that would have had under the National Labor Relations Act?

Dr. POMRINSE. I do not know.

Mr. KAUFMAN. I suppose it postpones it being a national emergency for a while, but I think what you have basically is a reduction of optional admissions, and things of that sort to take care of what the patients' needs are.

Senator TAFT. I was wondering whether it would be an unfair labor practice. [Laughter.]

Mr. KAUFMAN. I could not give you an opinion.

Mr. EPSTEIN. Senator Taft, you asked earlier whether or not it is the principle of the State law that we object to rather than a particular law of New York.

It is not the principle of the State law, but it is the specifics of the State law which is I am sure, as the committee knows, still in the form of the Wagner Act prior to its amendment by Taft-Hartley.

That means there is a total absence of unfair labor practices on the part of unions. That is one of the things we labor under in New York.

Second, there is a category of administration by the New York State Labor Relations Board of the act as given. These were summed up in a paper that was prepared on behalf of the State association and was given to one of the witnesses who testified before the House committee in January of this year.

If it will be of any help to elaborate on what the dissatisfactions are with the New York law and the administration of it, we would be glad to provide the committee with a copy of that.

Senator TAFT. It would be very helpful. Thank you very much.

(The material referred to was not made available to the committee for inclusion in the record at the time of printing.)

The CHAIRMAN. Senator Mondale will not be able to introduce the Minnesota association.

I would ask you if you have any remarks at this time.

Senator MONDALE. Thank you very much, Mr. Chairman.

I regret that I will not be able to introduce the Minnesota participants.

I would like to comment that Minnesota was one of the first states to regulate union-management relations in hospitals, and they have operated for some years under State law with compulsory arbitration.

Mr. Vogt represents the association. I believe he is the general counsel; and I am sure he will be prepared to fully express the point of view of the Minnesota association. I am glad he is here.

The CHAIRMAN. Gentlemen, we have a broad panel here. Please introduce yourselves.

**STATEMENT OF WILLIAM M. WHELAN, EXECUTIVE DIRECTOR, CALIFORNIA HOSPITAL ASSOCIATION, WILLIAM J. EMANUEL, ESQ., COUNSEL, CALIFORNIA HOSPITAL ASSOCIATION; THOMAS M. VOGT, COUNSEL, MINNESOTA HOSPITAL ASSOCIATION; O. RAY HURST, EXECUTIVE DIRECTOR, TEXAS HOSPITAL ASSOCIATION; ROBERT E. DEBACKER, EXECUTIVE DIRECTOR, LOUISIANA HOSPITAL ASSOCIATION; COMPRISING A PANEL**

Mr. WHELAN. Mr. Chairman, I am William M. Whelan, executive director, California Hospital Association.

To my left is William Emanuel, who is a member of the law firm of Musick, Peeler & Garrett, counsel to our association.

To my right is Mr. Robert E. DeBacker from the Louisiana Association; and to his right is Mr. O. Ray Hurst, from the State of Texas.

Of course, we have Mr. Vogt to the left of Mr. Emanuel, and since he has been introduced by the gentleman from Minnesota, perhaps we should let him start off.

The CHAIRMAN. We have just been summoned to go over and vote. Rather than break off in the middle of your statement, we will recess at this point and return within 10 minutes.

(Recess.)

The CHAIRMAN. Mr. Vogt.

Mr. VOGT. Mr. Chairman, the Minnesota Association has filed a written statement which I do not intend to read, but I will highlight it if I may.

I would ask that our entire statement be included in the record if this is possible.

The CHAIRMAN. It will be included in the record at the conclusion of your testimony.

Mr. VOGT. The Minnesota Hospital Association is appearing in opposition to H.R. 11357. Our position is based on 25 years of experience in the State of Minnesota which has utilized a different form of hospital labor disputes than the traditional strike lockout which is being incorporated as a basic part of the Taft-Hartley Act.

Since 1947, Minnesota hospitals have been covered by a law called the Charitable Hospitals Act. The law is very simple. It is quite basic, and the essential provisions are these:

There is a prohibition against strikes by hospital employees or lockouts by hospitals. Both parties are obligated to use mediation as a method of attempting to arrive at agreement. If mediation does not achieve this, then both parties are obligated to submit unresolved issues to final and binding arbitration.

This law is in addition to a comprehensive General Labor Relations Act which has provided mechanisms for certification of employee groups through secret-ballot elections by determination of what is an appropriate bargaining unit.

The net effect of H.R. 11357 would be clearly to preempt the impasse provisions of the Minnesota Act, and thus place Minnesota in a position of potentially facing a situation which we consider undesirable of strikes and lockouts.

It is our position that the Minnesota experience has been a viable one, and has proved to be, although a different concept, a workable solution to the handling of issues of this type.

I base that on the following observations regarding the law:

It seems to us that this approach is merely preserving the legitimate balance between the interests of labor organizations, between the hospitals, and perhaps most important of all, the patients of the community.

Minnesota Society, as far as its hospitals are concerned, is an extremely highly organized State. We have contracts, and particularly in the metropolitan areas, with a large number of labor organizations. They include the registered nurses, the licensed practical nurses,

X-ray technicians, pharmacists, the nonprofessional groupings, the engineers, and a variety of other groups.

Thus it is apparent that this approach has not resulted, I do not believe, in any manner in an impediment to employee organizations, yet at the same time the compulsory arbitration feature, in our judgment, has not proved to be an infringement upon the process of collective bargaining in the sense of attempting to negotiate to the extent possible in that fashion.

Despite the existence of the law over this long period of time, it is only a small percentage of cases that must arrive at a final conclusion through the mechanism of the arbitration procedures. I do not suppose that there is any impasse-type solution that works to the entire satisfaction at all times.

The arbitration features of the Minnesota act have been criticized by hospitals at times; they have been criticized at times by labor organizations. Yet it seems to us, on balance, the act has been a very workable method of resolving labor-management issues without the need to go into a strike or lockout concept which we do not consider sound as far as hospitals are concerned.

There is a final comment. I think the history of the act further supports this conclusion. The General Labor Relations Act of Minnesota, quite similar to the Taft-Hartley Act, had been in existence for a period of 8 years prior to the time that the Charitable Hospitals Act was passed. Nevertheless, there was a series of strikes that had occurred in the city of Minneapolis in the middle of the 1940's which then precipitated the action of the State legislature in passing the Charitable Hospitals Act.

We believe that this experience is something that could be considered by the committee in looking at the question of whether the simple amendment, which is to bring hospitals under the scope of Taft-Hartley to the full extent, is really the answer to it.

In summary, Mr. Chairman, our position is that no amendment to Taft-Hartley should be made without a protection or an assurance that a system of State regulations such as described would be enabled to continue in existence, whereby the hospitals and labor organizations continue to operate under that form of regulation.

The CHAIRMAN. I have just two questions.

Thank you, Mr. Vogt.

What was the nature of the dispute prior to the passage of the Charitable Hospitals Act? Were they organizational?

Mr. VOGT. No, sir; they were not organizational disputes because Minnesota law at that time, as I indicated, provided detailed mechanisms for certification of bargaining units, for determining bargaining unit issues. Thus, the disputes that occurred at that time were impasse-type issues.

The CHAIRMAN. So you had a labor relations act that covered the organizational situation prior to the arbitration features of the Charitable Hospitals Act?

Mr. VOGT. That is right.

The General Act had been in existence for 8 years prior to the Charitable Hospitals Act being passed.

The CHAIRMAN. For what period does the law of Minnesota provide for negotiations prior to the triggering of arbitration?

Mr. VOGT. There is no time period set forth in the Minnesota law. Arbitration is initiated at the request of either party after they have gone through the mediation process.

It is mandatory that the parties utilize mediation. However, there is no time period specified as to when the request must be made.

The CHAIRMAN. Either party may trigger it?

Mr. VOGT. That is correct.

The CHAIRMAN. Thank you. That has been very helpful.

(The prepared statement of Mr. Vogt follows:)

TESTIMONY OF THE MINNESOTA HOSPITAL ASSOCIATION  
ON H.R. 11357 BEFORE THE SUBCOMMITTEE ON LABOR OF THE  
SENATE COMMITTEE ON LABOR AND PUBLIC WELFARE  
SEPTEMBER 6, 1972

My name is Thomas M. Vogt. I am a lawyer representing the Minnesota Hospital Association which has 200 member hospital. For the past 10 years a significant part of my practice has been representing a large number of Minnesota hospitals in various labor relations matters. These have included collective bargaining, recognition and election issues, grievance arbitration, and arbitration proceedings under the Minnesota Charitable Hospitals Act to establish the terms and provisions of a collective bargaining agreement.

The Minnesota Hospital Association opposes H.R. 11357. The effect of the amendment would be to invalidate the Charitable Hospitals Act and its key features of arbitration of unresolved disputes in lieu of strikes or lockouts. This is a system which has proved workable for the people of Minnesota for over 25 years.

The State of Minnesota has had a long and unique experience regarding hospital employees and collective bargaining. In 1939, Minnesota enacted a comprehensive labor relations act. The law established mechanisms for resolving recognition issues including secret ballot elections; provided for the determination of appropriate bargaining units; and defined unfair labor practices by labor organizations and

employees. Non-profit hospitals were included within this statute. The approach to hospital labor disputes was thus to treat hospitals in the same manner as private industry.

But the concept set forth presented difficulties with respect to the use of the strike and lockout as a means of impasse resolution. In the mid-1940's a series of strikes occurred in the city of Minneapolis. The strikes were disruptive and bitter.

As a result of this experience, the Charitable Hospitals Act was passed in 1947. The law was in addition to the basic labor relations act and is predicated on two points. Strikes by hospital employees and lockouts by hospitals are prohibited. Both hospitals and labor organizations are obligated to utilize mediation in attempting to reach an agreement. If mediation fails, unresolved issues are submitted to final and binding arbitration.

The 25 years experience under the act has demonstrated that there are other methods of resolving impasse disputes relating to hospitals other than the traditional strike or lockout. Moreover, the law has been neither an impediment to voluntary decisions by hospital employees to organize nor an impediment to negotiation as the basic and desirable method of arriving at an agreement. Minnesota hospitals are organized to a substantial extent and the vast majority of contracts are settled without reaching the arbitration procedure.

There is no method of impasse solution which results in total satisfaction in all circumstances. The arbitration provisions of the Minnesota law have been at times criticized by both labor organizations and hospitals. Yet a balanced evaluation strongly suggests that the act has been workable while still preserving legitimate interests of labor organizations, hospitals, and most important the patients of the hospitals. Minnesota has not experienced the damaging effect of a hospital strike or lockout since the passage of the act.

H.R. 11357 fails to recognize any distinction between a non-profit hospital and any other private employer. By simply including hospitals under the overall provisions of the Taft-Hartley Act, the bill necessarily emphasizes strikes and lockouts as the primary method of impasse resolution. This is consistent with the thrust of the Taft-Hartley Act to the effect that economic power is the basis for resolving labor disputes. But the validity of the power concept in the case where the action affects the well being of patients is most questionable. The Minnesota Hospital Association believes there is a better answer for hospitals.

The problems of a hospital strike are further compounded by the nature of existing and prospective hospital bargaining units. No single labor organization represents all hospital employees and organization is typically based on craft, professional and technical groups.

Minnesota hospitals have contracts with different organizations covering non-professional employees, registered nurses, licensed practical nurses, pharmacists, x-ray technologists, engineers and others. A small unit on strike may have an immediate impact on other organized groups of the hospital.

Proponents of H.R. 11357 have argued that most hospital strikes are recognitional and that this will not be a serious problem if the provisions of Taft-Hartley are applicable to resolve such issues. It is submitted, however, that this is an over-simplification. The Minnesota Charitable Hospitals Act was not passed because of problems with recognitional strikes. A comprehensive law already existed setting forth recognition procedures. The no strike and arbitration provisions of the law were passed because of the sincere conviction that the strike lockout was not a suitable method of resolving impasses.

In conclusion, it is the position of the Minnesota Hospital Association that no amendment should be made which will pre-empt a state system of impasse resolution for non-profit hospitals. Such action in our judgment would be a step backward and create a potential for industrial strife which has not existed in Minnesota for 25 years.

The Minnesota Hospital Association wishes to thank the Committee for the opportunity of presenting our position.

The CHAIRMAN. Mr. Whelan.

Mr. WHELAN. Senator, I am William M. Whelan of the California Hospital Association, and with me is Mr. William J. Emmanuel, who is a member of the legal firm of Musick, Peeler, and Garrett, of Los Angeles, who are general counsel of the association.

We are grateful for this opportunity to testify before this committee on this important subject. We have prepared testimony and have given it to your secretary of the committee, and we hope that it can be incorporated in the record in its entirety.

I would like to briefly summarize some of the highlights of that testimony.

The CHAIRMAN. Certainly. We would appreciate that. Your statement will be included in the record at the conclusion of your testimony.

Mr. WHELAN. We suggest that H.R. 11357 deals with one of the very important issues; namely, the inclusion of nonprofit hospital industry under the provisions of the National Labor Relations Act to provide for collective bargaining; but it fails to address itself to our very basic critical concern for the right of the public, especially the sick and injured public, for uninterrupted service.

The public right to health care, we suggest, is equal in that sense to the rights of labor and the rights of management, particularly under our present concepts that prevail in this country.

Over 125 of our hospitals have had experience in collective bargaining. This experience is probably older even than that of New York, particularly in the San Francisco Bay area where it goes back to the late 1930's and the early 1940's.

We know from this experience, therefore, that we need to find a solution to the problem of the impasse, and a mechanism to define bargaining units in order to avoid further fragmentation of the hospital work force into multiple units.

You have heard testimony already this morning concerning the fact that this is a peculiarity of this industry, the very numerous units in the hospital industry. The association has had a special committee studying this for over 2 years. Amendments have been drafted by the committee, and Mr. Emanuel has taken part in it. I would very much like to have him outline for you briefly the technical provisions of those amendments.

Mr. EMANUEL. Senator Williams, Senator Taft, I think it is necessary at the outset to lay to rest a myth which has been perpetuated throughout the hearings and debates on this legislation. That myth is that virtually all strikes in hospitals are recognition strikes; that coverage under the act would eliminate recognition strikes; and, therefore, that coverage under the act would put an end to strikes in hospitals.

There are two reasons why this is specious.

First of all, recognition strikes are not prohibited under the act. Secondly, even assuming that coverage under the act would reduce the number of recognition strikes, it is naive to assume that coverage would reduce the total number of hospital strikes.

This reasoning assumes that there will not be any impasse strikes after the recognition hurdle is crossed. We submit that such reasoning is belied by both common sense and common experience.

It is further belied by our experience in California over the past 18 years, as we have outlined in our formal statement. We have had serious impasse strikes in California, on the average of one every 2 years, for the last 16 years, rather than 18 years.

I must emphasize that these were collective bargaining impasse strikes and not recognition strikes.

In view of the frequency of collective bargaining impasse strikes, we have proposed in our amendments a bargaining impasse resolution procedure which would minimize the threat of impasse strikes in hospitals.

We would urge you and your committee to give this proposal careful consideration. There are, of course, other approaches. Some proposed compulsory arbitration, as Minnesota does. Our approach is only one possible approach.

Certainly they should all be considered in depth before any action taken on covering hospitals under the act.

Our amendment incidentally would also prohibit strikes and picketing altogether in nonimpasse situations. For example, in the recognition situation, we recently had a member hospital in San Diego, which was covered under the act, where the union was entitled to an election under the Taft-Hartley Act, and the union put a recognition picket line around the hospital during the entire election campaign. This is perfectly legal.

Our amendments also deal with another critical subject in hospitals, and that is the subject of bargaining unit fragmentation and proliferation. Hospitals are unusually vulnerable to this problem because of the diversity and makeup of the work force. Very few industries outside the hospital field have the same vulnerability to bargaining unit fragmentation, and in construing the act, the National Labor Relations Board has already approved many small units.

Just to give you some examples, there are separate units of pharmacists, X-ray technicians, laboratory technologists, licensed vocational, or practical nurses.

One can easily project from this trend the situation where the Board would approve 10 or 15 or possibly even more bargaining units in one hospital, all with different contract expiration dates.

This would lead to a situation where a hospital would have absolutely no labor stability.

When General Motors negotiates, or when most industries negotiate with their unions, they reach an agreement for 2 or 3 years, and then they have labor peace and labor stability for the next 2 or 3 years.

In hospitals, this would not be true.

The hospital might reach a settlement with the union representing the bulk of the employees one week and the next week the entire hospital could be shut down by a strike, and a picket line put up by a group of four pharmacists or six stationary engineers.

There are numerous problems resulting from the bargaining unit fragmentation problem. This is the most critical. One small unit can shut down a hospital.

Our proposed amendments would provide for "for profit" bargaining units in order to avoid undue unit fragmentation and proliferation.

We believe that this proposal would strike a reasonable balance between the rights of the employees to organize on the one hand and the needs of the hospital to provide continuing and efficient patient care on the other hand.

There is one point that is not covered in our written statement that I would like to address myself to briefly, and that is the proposal by the nurses associations to amend the definition of "supervisor" found in section 211 of the act.

They propose that definition should be amended to permit the inclusion of bargaining units of registered nurses who are now excluded in covered institutions as supervisors.

We would strongly oppose any such amendment.

One of the fundamental concepts underlying the National Labor Relations Act is that supervisors are management personnel, and they cannot be both management and labor. The act recognizes a management employee who is compelled to join a union is confronted with an intolerable conflict of interest, since he is required to serve two masters, both the union and the employer.

The NLRB has already construed the definition of "supervisor" in favor of the nurses association by including bargaining units in covered institutions who in the opinion of many experts should be treated as supervisors and must be excluded.

We submit there would be absolutely no justification for further aggravating this situation by amending the definition to include still more supervising nurses in bargaining units.

The New York association today told us the problems that result from a situation where supervisors are included in bargaining units. That is perhaps the chief reason why they want out from under their State act and want under the National Labor Relations Act; because it is impossible to operate properly when management is organized in bargaining units.

We submit that if hospitals are to function efficiently, to deliver quality patient care, they must be permitted to manage their institutions, and to do so they must be assured of the loyalty of their managers.

Supervisors cannot manage employees if they are subject to discipline by the same union with which they have to deal in the day-to-day matters of labor relations.

No other employers subject to the act are subject to these conflicts of interest, and we submit that it would be utterly unjust to subject hospitals to these contracts.

We will be happy to answer any questions that you have.

Mr. CHAIRMAN. Thank you, Mr. Emanuel.

You have indicated a proposal here to amend the bill that is before us.

Who subscribes to your proposal? Do all of the States that are present at this panel?

Mr. EMANUEL. No; we speak only for the California Hospital Association. We do not speak in behalf of the other associations at the table.

Mr. WHELAN. You understand, Senator, this committee report has been considered by AHA, and AHA is favorably inclined toward this concept.

The CHAIRMAN. The Emanuel concept?

Mr. EMANUEL. Along that line, the AHA has studied this problem and has approved the concept that we are talking about today.

They have approved amendments that are very similar to these.

(The prepared statement of Mr. Whelan, with enclosures, follows:)



TESTIMONY OF THE CALIFORNIA HOSPITAL ASSOCIATION  
ON H.R. 11357, A BILL TO AMEND THE NATIONAL LABOR  
RELATIONS ACT, BEFORE THE SUBCOMMITTEE ON LABOR OF  
THE SENATE COMMITTEE ON LABOR AND PUBLIC WELFARE

September 6, 1972

I am William M. Whelan, Executive Director of the California Hospital Association, which represents some 600 acute general hospitals. With me is William J. Emanuel, who is a member of the firm of Musick, Peeler & Garrett, our legal counsel. We are here to testify on behalf of the California Hospital Association on H.R. 11357, which would extend coverage of the National Labor Relations Act to nonprofit hospitals, without taking into account the deficiencies of that law as it applies to hospitals.

The California Hospital Association speaks from a vantage point of years of experience in collective bargaining and labor relations. Some of our members in the San Francisco Bay Area have had collective bargaining agreements for more than 30 years, and the Bay Area has been widely unionized longer than any other metropolitan area in the United States. At least 125 of our member institutions have collective bargaining agreements, and many of these

**California Hospital Association**

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hospitals deal with from six to nine different unions in one institution.

The California Hospital Association is opposed to H.R. 11357 because we believe -- for reasons expressed in previous hearings by the American Hospital Association and others -- that this bill would be detrimental to our hospitals, our patients and the communities which we serve. But we are not here merely to repeat what others have said in this regard. We are here to focus attention on the major deficiencies of the National Labor Relations Act as that Act is now applied to health care institutions, and to propose specific amendments which would remedy those deficiencies in the event the Committee concludes that non-profit hospitals should be covered under the Act.

If hospitals are to provide adequate patient care services while covered under the National Labor Relations Act, solutions must be found for two major problems -- (1) strikes, picketing and impasse resolution in hospitals and (2) the fragmentation of hospitals into numerous bargaining units. The proposed amendments attached to this statement are designed to solve these problems. They are the product of a committee of experts who have been studying these problems for the past two years at the request of the

California Hospital Association. We believe they represent workable solutions and we urge you to give them careful consideration.

STRIKES, PICKETING AND IMPASSE RESOLUTION

It is necessary at the outset to lay to rest a myth which has been created by proponents of this legislation and perpetuated by witnesses at previous hearings. This myth is that virtually all strikes which occur in hospitals are strikes for recognition; that coverage under the Act would eliminate recognition strikes; and therefore that such coverage would put an end to strikes in hospitals.

It is important to note, first of all, that the legal premise of this myth is false. The Act does not prohibit recognition strikes. Although Section 8(b)(7) of the Act contains an ineffectual limitation on recognition picketing, the Act places no restrictions on recognition strikes (except in unusual situations such as where another union is already certified).

Even if one assumes that coverage under the Act would reduce the number of recognition strikes in hospitals because of the recognition procedure available thereunder, it is naive to assume that such coverage would reduce the

total number of hospital strikes. One needs only to read the daily newspapers to conclude that strikes do not cease merely because the recognition hurdle has been crossed. To the contrary, although far less than one-half of the employees in the United States are unionized, the vast majority of strikes are for purposes other than recognition.

This is substantiated by our experience with hospital strikes in California. While we have had some recognition strikes, they have been infrequent and minor compared to the bargaining impasse strikes suffered by California institutions. A partial list of the impasse strikes which have occurred in California hospitals is as follows:

In 1956, Eden Hospital was struck for five days by the California Nurses Association.

In 1958, nine member hospitals of the Associated Hospitals of the East Bay were struck for more than three weeks by the Service Employees International Union. The ability of the hospitals to provide patient care was seriously impaired, and only emergency patients were admitted during the strike.

In 1959, the Office Employees International Union struck two Kaiser Foundation institutions for approximately two weeks.

In 1959, an association of laboratory technologists struck eight member hospitals of the Associated Hospitals of the East Bay for three weeks.

In 1963, Washington Hospital was struck for four weeks by the Service Employees International Union and by unions representing the cooks and the stationary engineers. The picket line was successful in cutting off deliveries to the hospital, and only emergency patients were admitted.

In 1968, all 14 Kaiser Foundation institutions in Northern California were struck for 10 days by the Service Employees International Union. The strike forced a reduction in the admission of patients.

In 1969, seven member hospitals of the Associated Hospitals of San Francisco and the East Bay were struck for three weeks by the California Nurses Association. Deliveries were cut off and taxi drivers refused to cross the picket lines. The strike seriously impaired the operations of some

of the hospitals and as a result many patients were denied admission.

In 1972, the Office and Professional Employees International Union struck for 10 days at three Kaiser Foundation institutions. The ability of these institutions to function was impaired, resulting in a reduction in the admission of patients.

It must be emphasized that in each of the situations which I have described, the strike resulted from an impasse in collective bargaining negotiations. None of these strikes were recognition strikes. In view of this, it must be concluded that strikes in hospitals do not cease with recognition of the union. To the contrary, recognition is only the starting point, not the stopping point, for strikes in hospitals.

Although coverage under the National Labor Relations Act would facilitate unionization in hospitals and would therefore increase the number of hospital strikes, the Act contains no effective procedure for resolving collective bargaining impasses. Notices to state and federal mediation services are required as a prerequisite to striking in a contract renewal situation, but mediation is not mandatory and no other impasse procedure is provided.

While the Labor Management Relations Act provides an impasse procedure for strikes resulting in national emergencies, this procedure is inapplicable to hospitals.

If nonprofit hospitals are to be covered by the Act, it is imperative that an effective procedure be adopted to deal with collective bargaining impasses. The proposed amendments attached to this statement set forth such a procedure, which would require the following steps in the event of a bargaining impasse in a hospital:

- (1) A 90-day notice of termination of a collective bargaining agreement would be required. In negotiations for an initial agreement, the 90-day period would begin on the date of certification or voluntary recognition.
- (2) A notice to the Federal Mediation and Conciliation Service would be required at least 30 days prior to expiration of the 90-day period. Mediation by a representative of the FMCS would be mandatory.

- (3) If an agreement is not reached prior to the expiration date, there would be a 60-day cooling-off period during which a fact-finding hearing would be held and advisory (nonbinding) fact-finding recommendations would be issued.
- (4) There would be an additional 30-day cooling-off period after issuance of the fact-finding recommendations for further bargaining in light of such recommendations.
- (5) At the end of the 30-day cooling-off period, the union would be permitted to give a 30-day strike notice. If such a strike notice is given, a secret ballot strike vote would be conducted by the Federal Mediation and Conciliation Service. If a majority of the employees vote to strike, a strike would be permitted at the end of the 30-day strike notice period.

We believe that this impasse procedure would go a long way toward minimizing strikes in hospitals. We would, of course, prefer an absolute ban on strikes in hospitals, but have not proposed this because we do not

believe such a prohibition would be politically feasible unless compulsory arbitration is adopted as the final step in the impasse procedure. For reasons which are well known to the members of this Committee, compulsory arbitration is generally considered to be unacceptable by both labor and management; the hospital industry is no exception in this regard.

Although it may not be feasible to prevent all impasse strikes, we believe there is no justification for permitting any other type of strike or picketing in hospitals. For example, a recognition strike or recognition picketing cannot be justified since the Act provides a recognition procedure; yet recognition strikes are not prohibited by the Act and recognition picketing is ineffectually regulated. One of our hospitals in San Diego recently went through an entire election campaign surrounded by a recognition picket line, even though the hospital was covered by the Act and the union was therefore entitled to a secret ballot election. There are, moreover, numerous loopholes to the secondary boycott provisions of the Act which would result in strikes and picketing at hospitals. One of our hospitals in the Los Angeles area recently fell victim to such a loophole. Since no justification can be shown for non-impasse strikes and picketing in hospitals, our proposed amendments would prohibit such activity.

Another serious deficiency is the National Labor Relations Board's inability under the Act to respond quickly when a union engages in illegal strikes or picketing. Even when a strike or picketing is obviously illegal, the employer is not permitted to obtain temporary injunctive relief in the courts, and the NLRB is unable to do so in less than two weeks. While other employers may be able to withstand such illegal activity during this intervening period, a hospital and its patients would begin to suffer immediately. Our proposed amendments would correct this deficiency by permitting a hospital to seek immediate temporary relief in the courts in the event of an illegal strike or picketing.

#### BARGAINING UNIT FRAGMENTATION

The National Labor Relations Act, as currently applied to covered health care institutions, does not adequately deal with the critical problem of bargaining unit fragmentation. Health care institutions are unusually vulnerable to the practice of fractionalizing the workforce into numerous bargaining units, since they utilize many different classifications of employees, ranging from highly-skilled professional and technical personnel to various unskilled classifications. While the fragmentation

problem is not critical in most industries, it poses a serious problem in hospitals because of this unusual diversity in the make-up of the workforce.

The proliferation of units within a health care institution results in a number of problems. While most other industries have labor stability for two or three years after negotiating an agreement, a hospital can never have such stability if it is required to deal with 10 or 15 separate unions, all with different contract expiration dates. Under these circumstances one unit -- even a very small unit of four or five employees -- can close down the institution, although the hospital has reached settlements with all of the other units, since the other units will normally respect the picket line of the small unit. Unit proliferation also results in competition and whipsawing among the various units, which is not conducive to realistic collective bargaining. The proliferation of units within a hospital would also lead to rigid craft lines, such as those which exist in some other industries. This would result in jurisdictional jealousy, rather than the cooperation necessary to provide coordinated patient care services. Dealing with numerous units in a hospital also results in the expenditure of an excessive amount of administrative time and money.

Notwithstanding these important considerations and the serious threat which unit fragmentation poses in the health care industry, numerous small units have already been approved in cases involving institutions covered under the Act. Separate units of pharmacists, xray technicians, licensed vocational (practical) nurses, laboratory technologists and registered nurses have been permitted. From these decisions one can easily project numerous additional hospital bargaining units for professional, technical, departmental and craft groups.

We believe it is imperative that this trend not be permitted to continue. Our proposed amendments are designed to prevent any further fragmentation of health care institutions into small units. They would permit not more than four broad bargaining units in such institutions (in addition to security guards, who must have a separate unit if they are organized). These would include separate units for (1) professional employees, (2) technical employees, (3) clerical employees and (4) service and maintenance employees. A hospital could agree to a smaller unit if appropriate to do so in any given case, but smaller units could not be imposed upon hospitals.

We believe these amendments would strike a reasonable balance between the rights of the employees to organize

and bargain collectively and the needs of the hospital to provide efficient patient care.

We wish to thank you for the opportunity to present the views of the California Hospital Association to your Subcommittee.

AMENDMENTS TO NATIONAL LABOR RELATIONS ACT  
 PROPOSED BY CALIFORNIA HOSPITAL ASSOCIATION  
 IN LIEU OF AMENDMENT SET FORTH IN H.R. 11357

AMENDMENT

COMMENTS

1. Section 2(2) is amended by striking the phrase "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".  
 Eliminates the exemption for nonprofit hospitals.
2. Section 2 is amended by adding a new subsection (14) as follows:  
 "(14) The term 'health care institution' shall include any hospital, convalescent hospital, nursing home, extended care facility, clinic, or other institution devoted to the care of sick or aged persons."  
 Defines "health care institution" broadly, so that all of such institutions will be affected by the same rules.
3. Section 8 is amended by adding a new subsection (g) as follows:  
 "(g) (1) When a collective bargaining agreement is in effect between an employer operating a health care institution and the bargaining representative of its employees, the agreement shall continue in full force and effect, without recourse to strikes, picketing or lockouts, except as expressly permitted by this subsection (g), and any impasse in negotiations for a renewal of such agreement shall be resolved in the following manner:  
 Provides impasse resolution procedure for health care institutions in the event of an impasse in negotiations for a renewal agreement. Strikes, picketing and lockouts will be prohibited until the impasse procedure has been exhausted.

- "(A) The agreement shall not be terminated or modified unless the party desiring such termination or modification serves written notice of the proposed termination or modification on the other party not less than 90 days prior to the expiration date thereof, or not less than 90 days prior to the proposed effective date of such termination or modification, whichever date is later.
- "(B) During the first 60 days of the 90-day notice period, the party desiring such termination or modification shall offer to meet and confer with the other party at reasonable times in an effort to reach agreement, and the other party shall agree to meet and confer at reasonable times for such purpose.
- "(C) No earlier than 45 days or later than 30 days prior to the expiration of the 90-day notice period, the party serving such notice shall notify the Federal Mediation and Conciliation Service if an agreement has not been reached. If said party fails to notify the Service within the time required, the 90-day notice period shall not expire until 30 days after said party finally notifies the Service as required. Upon receipt of such notice the Service shall forthwith assign a mediator who shall promptly arrange meetings between the parties and serve as a mediator with respect to unresolved issues.
- Requires 90-day notice of termination of the agreement.
- Requires good faith bargaining during the first 60 days of the 90-day notice period.
- Requires 30-day notice to the FMCS prior to termination of the agreement. Requires mediation by Federal mediator during final 30 days prior to termination (unlike NLRA §8(d), which requires notice to FMCS but does not require mediation).

"(D) If upon expiration of the 90-day notice period an agreement has not been reached and the parties have not agreed upon a procedure for a binding resolution of their dispute, the Director of the Service shall forthwith appoint an impartial third person who shall serve as a fact-finder in connection with the dispute. Within 60 days following expiration of said 90-day notice period, the fact-finder shall hold hearings, issue subpoenas if necessary, hear testimony and argument, and issue a written report to the Director of the Service and to the parties setting forth his recommendations for settlement of the issues in dispute. The recommendations of the fact-finder shall be advisory only and shall not be binding upon either party: Provided, That in lieu of fact-finding the parties may voluntarily adopt a different procedure for a binding resolution of the dispute.

Requires 60-day cooling-off period following termination date. Requires advisory (nonbinding) fact-finding during 60-day cooling-off period, unless parties agree to a binding procedure for resolving the impasse.

"(E) During the 30-day period following issuance of the fact-finding recommendations, the parties shall meet and confer at reasonable times in an effort to resolve their dispute or to agree upon a procedure for a binding resolution thereof. If upon expiration of said 30-day period the parties have not resolved their dispute or agreed upon a procedure for a binding resolution thereof, the bargaining representative may serve upon the employer and the Service a 30-day strike notice, or the employer may serve upon the bargaining representative and the Service a 30-day lockout notice. If a 30-day strike notice is served, the Service shall within the 30-day notice period conduct a secret ballot strike vote among the employees in the bargaining unit and shall certify the results thereof. If the Service certifies that a majority of the employees in the unit eligible to vote have voted to strike, the bargaining representative may call a strike and engage in picketing upon expiration of the 30-day notice period. If a 30-day lockout notice is served, the employer may initiate a lockout upon expiration of the 30-day notice period.

Requires an additional 30-day cooling-off period for further bargaining in light of the fact-finding recommendations. If agreement is not reached during that period, a 30-day strike notice or lockout notice may be given. If a strike notice is given, a secret ballot strike vote will be conducted by the FMCS.

Provides same impasse resolution procedure in the event of an impasse in negotiations for an initial agreement.

"(2) When an employer operating a health care institution and the bargaining representative of its employees enter into negotiations for an initial collective bargaining agreement, any impasse in such negotiations shall be resolved in accordance with the procedures set forth in subsection (g)(1) of this section 8, without recourse to strikes, picketing or lockouts, except as expressly permitted therein. For such purposes, the bargaining representative shall be deemed to have served, on the date of its certification by the Board or its voluntary recognition by the employer, the 90-day notice referred to in subsection (g)(1) (A).

"(3) Except as expressly permitted by this subsection (g), it shall be an unfair labor practice for any labor organization to engage or participate in, authorize, or sanction, or to induce or encourage any individual to engage or participate in, (1) a strike or work stoppage of any kind whatsoever, whether arising out of a recognition dispute, bargaining impasse or otherwise, against an employer operating a health care institution, or (2) any picketing of, or at the premises of, a health care institution, including but not limited to a construction site where a health care institution or part thereof is being constructed; and except as so permitted it shall be an unfair labor practice for an employer operating a health care institution to engage in a lockout: Provided, That nothing contained in this subsection (g) shall prohibit publicity other than picketing for the purpose of truthfully advising the public of the existence of a dispute with the employer operating said health care institution unless an effect of such publicity is (1) to induce any employee of the employer operating such institution or any other individual, in the course of his employment, not to pick up, deliver or transport goods, not to enter said employer's premises, or not to perform services, or (2) to induce such an employee or individual to engage in a strike or work stoppage of any kind.

Provides that any strike or picketing of or lockout by a health care institution is an unfair labor practice, except in the impasse situation discussed above, designed to prohibit recognition strikes (not prohibited by NLRA) and recognition picketing (inadequately regulated by NLRA §8(b)(7), and to plug loopholes in secondary boycott and other provisions of NLRA. Proviso permits hand-billing and similar advertising which does not disrupt deliveries or result in work stoppages.

"(4) An employer operating a health care institution and the bargaining representative of its employees shall not be required to comply with the procedures set forth in subsection (d) of this section 8."

4. Section 9 is amended by adding a new subsection (f) as follows:

"Notwithstanding anything to the contrary in subsection (b) of this section 9, the Board shall not decide that any unit in a health care institution is appropriate for purposes of collective bargaining which (1) includes professional employees unless all of the professional employees employed in such institution by the employer operating such institution are included therein; or (2) includes technical employees (as defined from time to time by the Board) unless all of the technical employees employed in such institution by the employer operating such institution are included therein; or (3) includes clerical employees unless all of the clerical employees employed in such institution by the employer operating such institution are included therein; or (4) includes service and maintenance employees -- which shall be defined to include all employees except (A) professional, technical and clerical employees, (B) any individual employed as a guard to enforce against employees and other persons rules to protect property of the employer or to protect the safety of persons on the employer's premises, and (C) managerial employees and others customarily excluded by the Board from bargaining units -- unless all of the service and maintenance employees employed in such institution by the employer operating such institution are included therein: Provided, That the Board shall not disturb bargaining units narrower in scope which were in existence prior to the effective date of this subsection: Provided further, That units narrower in scope may be agreed to by the employer and the bargaining representative."

Makes the inconsistent impasse procedures of NLRB §8(d) inapplicable to health care institutions, but does not make 8(d) entirely inapplicable to such institutions.

Designed to minimize bargaining unit fragmentation and proliferation, which pose a serious threat to the efficient functioning of health care institutions. Such institutions are particularly vulnerable to the practice of fractionalizing the workforce into numerous units, and the NLRB has already shown a dangerous tendency in this direction. This section would provide for not more than four broad bargaining units in health care institutions (in addition to security guards, who must have a separate unit if they are organized) -- (1) professional employees, (2) technical employees, (3) clerical employees, and (4) service and maintenance employees. Narrower units would be permitted by agreement, and existing narrower units would not be disturbed. These four categories could be combined into fewer units, although the Board does not combine office clericals with other employees if either party objects, and under NLRB §9(b) it cannot include professional employees with nonprofessionals unless the professionals vote for such inclusion.

Gives unfair labor practice charges involving strikes and picketing at health care institutions priority over other cases in NLRB regional offices.

Same as above.

Same as above. This section is patterned generally after NIRA §10(l), although it would permit a health care institution to seek temporary injunctive relief in federal court to prevent an unlawful strike or picketing while the Board investigates and processes the institution's unfair labor practice charge. Experience under §10(l) has proven that, even in priority cases, the Board cannot respond swiftly enough in obtaining temporary injunctive relief to prevent irreparable injury.

5. Section 10(l) is amended by striking the period at the end of the first sentence and adding ", and cases given priority under subsection (n)."

6. Section 10(m) is amended by striking the period and adding "or (n)."

7. Section 10 is amended by adding a new subsection (n) as follows:

"(n) Whenever it is charged that any person has engaged in an unfair labor practice within the meaning of subsection (g) of section 8, the preliminary investigation of such charge shall be made forthwith and given priority over all other cases except cases of like character in the office where it is filed or to which it is referred. Upon filing such a charge, the charging party may petition any district court of the United States (including the District Court of the United States in the District of Columbia) within any district where the unfair labor practice in question has occurred, is alleged to have occurred, or wherein such person resides or transacts business, for appropriate injunctive relief pending the final adjudication of the Board with respect to such matter. Upon the filing of any such petition the district court shall have jurisdiction to grant such injunctive relief or temporary restraining order as it deems just and proper, notwithstanding any other provision of law: Provided, That

no temporary restraining order shall be issued without notice unless a petition alleges that substantial and irreparable injury to the charging party or other persons will be unavoidable. Upon filing of any such petition the courts shall cause notice thereof to be served upon any person involved in the charge and such person, including the charging party, shall be given an opportunity to appear by counsel and present any relevant testimony: provided further, That for the purposes of this subsection district courts shall be deemed to have jurisdiction of a labor organization (1) in the district in which such organization maintains its principal office, or (2) in any district in which its duly authorized officers or agents are engaged in promoting or protecting the interests of employee members. The service of legal process upon such officer or agent shall constitute service upon the labor organization and make such organization a party to the suit."

8. Section 303(a) of the Labor Management Relations Act is amended by adding "or 8(g)" after "8(b)(4)".

Provides additional protection for health care institutions from illegal strikes and picketing by creating a cause of action for damages.

90 day notice

60 days

30 day notice to FMCS

30 days  
(mediation)

Expiration

60 days  
(fact finding)

Fact finding report (60 days)

30 days

30-day strike notice (90 days)

30 days  
(strike vote)

Strike permitted (120 days)

JOSEPH D. PEELER  
JOHN M. ROBINSON  
MELVIN D. WILSON  
DAVID R. EVANS  
JAMES E. LUDLAM  
GERALD O. KELLY  
JESSE R. O'MALLEY  
BRUCE E. CLARK  
STUART T. PEELER  
BRUCE A. BEVAN, JR.  
CHARLES F. FORBES  
THOMAS J. REILLY  
RICHARD T. APEL  
GEORGE C. HADLEY  
THOMAS M. COLLINS  
DONALD J. DREW  
RICHARD D. DEAR  
LEONARD E. CASTRO  
J. PATRICK WHALEY  
MICHAEL W. CONLON  
MICHAEL M. MURPHY  
WILLIAM J. EHANUEL

EDWARD A. ANDRY  
JOHN B. BURNING  
DONALD R. GAIL  
JOSEPH A. BAUNDERS  
RONALD G. TRAYNER  
ROBERT E. THOMSON  
FREDERICK T. GUCKENBERGER  
ROGER B. BATHILLER  
FRANK H. SMITH, JR.  
DALE C. GUTHRIE  
LAWRENCE E. STICKNEY  
ANTHONY M. WIENNA  
GERALD A. COLLIER  
ROBERT J. HEIL  
CHARLES R. IRISH  
CHRISTOPHER A. CARR  
JAMES B. BERTERO  
JAMES L. SEAL  
ROBERT D. GIRARD  
TERENCE J. WALLOCK  
THOMAS CURTISS, JR.  
JEFFREY A. BERMAN

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1930-1982

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TELEX 67-7451

August 14, 1972

The Honorable Harrison A. Williams, Jr.  
United States Senate  
Washington, D.C. 20510

Re: H.R. 11357 - August 16 Hearing

Dear Senator:

As legal counsel for the California Hospital Association, which represents some 600 acute general hospitals, I wish to advise you that our Association fully supports the position of the American Hospital Association in opposing the proposal to include nonprofit hospitals under the National Labor Relations (Taft-Hartley) Act.

There is no group of hospitals in the country that has a broader experience in collective bargaining than the members of our Association. There are more than 150 proprietary hospitals in our Association which have been subject to Taft-Hartley for a number of years. In addition, a substantial number of our nonprofit hospitals have operated under collective bargaining agreements for many years.

Although we have had more than our share of unfortunate hospital strikes, with only minor exceptions these strikes have occurred as a result of impasses during collective bargaining -- a problem for which Taft-Hartley offers no solution. In fact, Taft-Hartley would aggravate this situation.

From our experience, we know that Taft-Hartley is deficient as a means of encouraging settlement of labor disputes, since it creates rather than solves the basic problem of the collective bargaining impasse. Taft-Hartley accepts the strike or lockout as a fundamental approach to resolving impasses. In an acute health care institution, a strike or lockout has its chief impact on acutely ill patients, not on the employer or the employees. Thus, in terms of its impact on the public, a strike against a hospital is as unacceptable as a strike by police officers.

MUSICK, PEELER &amp; GARRETT

The Honorable Harrison A. Williams, Jr.

August 14, 1972

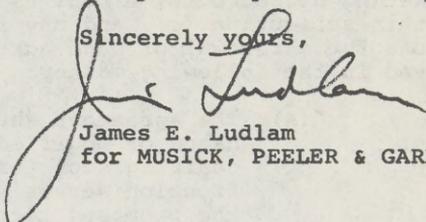
Page 2

In addition, Taft-Hartley, as currently applied by the National Labor Relations Board to covered health care institutions, does not adequately deal with the critical problem of bargaining unit fragmentation and proliferation. Health care institutions are particularly vulnerable to the practice of fractionalizing the work force into numerous units, and this practice poses a serious threat to the efficient functioning of such institutions and thus to quality patient care. However, the NLRB has ignored these important considerations and has treated health care institutions as if they were factories producing automobiles rather than institutions devoted to preserving human life.

If it is the decision of the Committee to include nonprofit hospitals under the Taft-Hartley Act, it is imperative that the Committee also consider solutions to these critical problems of collective bargaining impasses and bargaining unit fragmentation in health care institutions. We are submitting to the Committee for its consideration the enclosed amendments, which are directed to these critical problems.

We also suggest that, if Taft-Hartley is to be opened up for removal of exemptions, there is little justification in limiting your consideration in this regard to nonprofit hospitals. There are currently two other major exempt groups -- public employees and agricultural employees. If the removal of exemptions is justified at this time, we submit that the entire problem should be considered as a whole, rather than attempting to deal with only one aspect of the problem.

Sincerely yours,



James E. Ludlam  
for MUSICK, PEELER & GARRETT

JEL:st

8/14/72

AMENDMENTS TO NATIONAL LABOR RELATIONS ACT  
PROPOSED BY CALIFORNIA HOSPITAL ASSOCIATION  
IN LIEU OF AMENDMENT SET FORTH IN H.R. 11357

1. Section 2(2) is amended by striking the phrase "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".

2. Section 2 is amended by adding a new subsection (14) as follows:

"(14) The term 'health care institution' shall include any hospital, convalescent hospital, nursing home, extended care facility, clinic, or other institution devoted to the care of sick or aged persons."

3. Section 8 is amended by adding a new subsection (g) as follows:

"(g)(1) When a collective bargaining agreement is in effect between an employer operating a health care institution and the bargaining representative of its employees, the agreement shall continue in full force and effect, without recourse to strikes, picketing or lockouts, except as expressly permitted by this subsection (g), and any impasse in negotiations for a renewal of such agreement shall be resolved in the following manner:

"(A) The agreement shall not be terminated or modified unless the party desiring such termination or modification serves written notice of the proposed termination or modification on the other party not less than 90 days prior to the expiration date thereof, or not less than 90 days prior to the proposed effective date of such termination or modification, whichever date is later.

"(B) During the first 60 days of the 90-day notice period, the party desiring such termination or modification

shall offer to meet and confer with the other party at reasonable times in an effort to reach agreement, and the other party shall agree to meet and confer at reasonable times for such purpose.

- " (C) No earlier than 45 days or later than 30 days prior to the expiration of the 90-day notice period, the party serving such notice shall notify the Federal Mediation and Conciliation Service if an agreement has not been reached. If said party fails to notify the Service within the time required, the 90-day notice period shall not expire until 30 days after said party finally notifies the Service as required. Upon receipt of such notice the Service shall forthwith assign a mediator who shall promptly arrange meetings between the parties and serve as a mediator with respect to unresolved issues.
- " (D) If upon expiration of the 90-day notice period an agreement has not been reached and the parties have not agreed upon a procedure for a binding resolution of their dispute, the Director of the Service shall forthwith appoint an impartial third person who shall serve as a fact-finder in connection with the dispute. Within 60 days following expiration of said 90-day notice period, the fact-finder shall hold hearings, issue subpoenas if necessary, hear testimony and argument, and issue a written report to the Director of the Service and to the parties setting forth his recommendations for settlement of the issues in dispute. The recommendations of the fact-finder shall be advisory only and shall not be binding upon either party: Provided, That in lieu of fact-finding the parties may voluntarily adopt a different procedure for a binding resolution of the dispute.

"(E) During the 30-day period following issuance of the fact-finding recommendations, the parties shall meet and confer at reasonable times in an effort to resolve their dispute or to agree upon a procedure for a binding resolution thereof. If upon expiration of said 30-day period the parties have not resolved their dispute or agreed upon a procedure for a binding resolution thereof, the bargaining representative may serve upon the employer and the Service a 30-day strike notice, or the employer may serve upon the bargaining representative and the Service a 30-day lockout notice. If a 30-day strike notice is served, the Service shall within the 30-day notice period conduct a secret ballot strike vote among the employees in the bargaining unit and shall certify the results thereof. If the Service certifies that a majority of the employees in the unit eligible to vote have voted to strike, the bargaining representative may call a strike and engage in picketing upon expiration of the 30-day notice period. If a 30-day lockout notice is served, the employer may initiate a lockout upon expiration of the 30-day notice period.

"(2) When an employer operating a health care institution and the bargaining representative of its employees enter into negotiations for an initial collective bargaining agreement, any impasse in such negotiations shall be resolved in accordance with the procedures set forth in subsection (g)(1) of this section 8, without recourse to strikes, picketing or lockouts, except as expressly permitted therein. For such purposes, the bargaining representative shall be deemed to have served, on the date of its certification by the Board or its voluntary recognition by the employer, the 90-day notice referred to in subsection (g)(1)(A).

"(3) Except as expressly permitted by this subsection (g), it shall be an unfair labor practice for any labor organization to engage or participate in,

authorize, or sanction, or to induce or encourage any individual to engage or participate in, (1) a strike or work stoppage of any kind whatsoever, whether arising out of a recognition dispute, bargaining impasse or otherwise, against an employer operating a health care institution, or (2) any picketing of, or at the premises of, a health care institution, including but not limited to a construction site where a health care institution or part thereof is being constructed; and except as so permitted it shall be an unfair labor practice for an employer operating a health care institution to engage in a lockout: Provided, That nothing contained in this subsection (g) shall prohibit publicity other than picketing for the purpose of truthfully advising the public of the existence of a dispute with the employer operating said health care institution unless an effect of such publicity is (1) to induce any employee of the employer operating such institution or any other individual, in the course of his employment, not to pick up, deliver or transport goods, not to enter said employer's premises, or not to perform services, or (2) to induce such an employee or individual to engage in a strike or work stoppage of any kind.

"(4) An employer operating a health care institution and the bargaining representative of its employees shall not be required to comply with the procedures set forth in subsection (d) of this section 8."

4. Section 9 is amended by adding a new subsection (f) as follows:

"Notwithstanding anything to the contrary in subsection (b) of this section 9, the Board shall not decide that any unit in a health care institution is appropriate for purposes of collective bargaining which (1) includes professional employees unless all of the professional employees employed in such institution by the employer operating such institution are included therein; or (2) includes technical employees (as defined from time to time by the Board) unless all of the technical employees employed in such institution by the employer operating such institution are included therein; or (3) includes clerical employees unless all of the clerical employees employed in such institution by the employer operating such institution are included therein; or (4) includes service and maintenance employees -- which shall be defined to include all employees except (A) professional, technical and clerical employees, (B) any individual employed as a

guard to enforce against employees and other persons rules to protect property of the employer or to protect the safety of persons on the employer's premises, and (C) managerial employees and others customarily excluded by the Board from bargaining units -- unless all of the service and maintenance employees employed in such institution by the employer operating such institution are included therein: Provided, That the Board shall not disturb bargaining units narrower in scope which were in existence prior to the effective date of this subsection: Provided further, That units narrower in scope may be agreed to by the employer and the bargaining representative."

5. Section 10(1) is amended by striking the period at the end of the first sentence and adding ", and cases given priority under subsection (n)."
6. Section 10(m) is amended by striking the period and adding "or (n)."
7. Section 10 is amended by adding a new subsection (n) as follows:

"(n) Whenever it is charged that any person has engaged in an unfair labor practice within the meaning of subsection (g) of section 8, the preliminary investigation of such charge shall be made forthwith and given priority over all other cases except cases of like character in the office where it is filed or to which it is referred. Upon filing such a charge, the charging party may petition any district court of the United States (including the District Court of the United States for the District of Columbia) within any district where the unfair labor practice in question has occurred, is alleged to have occurred, or wherein such person resides or transacts business, for appropriate insunctive relief pending the final adjudication of the Board with respect to such matter. Upon the filing of any such petition the district court shall have jurisdiction to grant such injunctive relief or temporary restraining order as it deems just and proper, notwithstanding any other provision of law: Provided, That

no temporary restraining order shall be issued without notice unless a petition alleges that substantial and irreparable injury to the charging party or other persons will be unavoidable. Upon filing of any such petition the courts shall cause notice thereof to be served upon any person involved in the charge and such person, including the charging party, shall be given an opportunity to appear by counsel and present any relevant testimony: Provided further, That for the purposes of this subsection district courts shall be deemed to have jurisdiction of a labor organization (1) in the district in which such organization maintains its principal office, or (2) in any district in which its duly authorized officers or agents are engaged in promoting or protecting the interests of employee members. The service of legal process upon such officer or agent shall constitute service upon the labor organization and make such organization a party to the suit."

8. Section 303(a) of the Labor Management Relations Act is amended by adding "or 8(g)" after "8(b)(4)".

AMENDMENTS TO NATIONAL LABOR RELATIONS ACT  
 PROPOSED BY CALIFORNIA HOSPITAL ASSOCIATION  
 IN LIEU OF AMENDMENT SET FORTH IN H.R. 11357

AMENDMENT

1. Section 2(2) is amended by striking the phrase "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".
2. Section 2 is amended by adding a new subsection (14) as follows:
 

"(14) The term 'health care institution' shall include any hospital, convalescent hospital, nursing home, extended care facility, clinic, or other institution devoted to the care of sick or aged persons."
3. Section 8 is amended by adding a new subsection (g) as follows:
 

"(g) (1) When a collective bargaining agreement is in effect between an employer operating a health care institution and the bargaining representative of its employees, the agreement shall continue in full force and effect, without recourse to strikes, picketing or lockouts, except as expressly permitted by this subsection (g), and any impasse in negotiations for a renewal of such agreement shall be resolved in the following manner:

COMMENTS

Eliminates the exemption for nonprofit hospitals.

Defines "health care institution" broadly, so that all of such institutions will be affected by the same rules.

Provides impasse resolution procedure for health care institutions in the event of an impasse in negotiations for a renewal agreement. Strikes, picketing and lockouts will be prohibited until the impasse procedure has been exhausted.

- "(A) The agreement shall not be terminated or modified unless the party desiring such termination or modification serves written notice of the proposed termination or modification on the other party not less than 90 days prior to the expiration date thereof, or not less than 90 days prior to the proposed effective date of such termination or modification, whichever date is later.
- "(B) During the first 60 days of the 90-day notice period, the party desiring such termination or modification shall offer to meet and confer with the other party at reasonable times in an effort to reach agreement, and the other party shall agree to meet and confer at reasonable times for such purpose.
- "(C) No earlier than 45 days or later than 30 days prior to the expiration of the 90-day notice period, the party serving such notice shall notify the Federal Mediation and Conciliation Service if an agreement has not been reached. If said party fails to notify the Service within the time required, the 90-day notice period shall not expire until 30 days after said party finally notifies the Service as required. Upon receipt of such notice the Service shall forthwith assign a mediator who shall promptly arrange meetings between the parties and serve as a mediator with respect to unresolved issues.
- Requires 90-day notice of termination of the agreement.
- Requires good faith bargaining during the first 60 days of the 90-day notice period.
- Requires 30-day notice to the FMCS prior to termination of the agreement. Requires mediation by federal mediator during final 30 days prior to termination (unlike NLRA §8(d), which requires notice to FMCS but does not require mediation).

" (D) If upon expiration of the 90-day notice period an agreement has not been reached and the parties have not agreed upon a procedure for a binding resolution of their dispute, the Director of the Service shall forthwith appoint an impartial third person who shall serve as a fact-finder in connection with the dispute. Within 60 days following expiration of said 90-day notice period, the fact-finder shall hold hearings, issue subpoenas if necessary, hear testimony and argument, and issue a written report to the Director of the Service and to the parties setting forth his recommendations for settlement of the issues in dispute. The recommendations of the fact-finder shall be advisory only and shall not be binding upon either party: provided, That in lieu of fact-finding the parties may voluntarily adopt a different procedure for a binding resolution of the dispute.

Requires 60-day cooling-off period following termination date. Requires advisory (nonbinding) fact-finding during 60-day cooling-off period, unless parties agree to a binding procedure for resolving the impasse.

Requires an additional 30-day cooling-off period for further bargaining in light of the fact-finding recommendations. If agreement is not reached during that period, a 30-day strike notice or lockout notice may be given. If a strike notice is given, a secret ballot strike vote will be conducted by the FMCS.

" (E) During the 30-day period following issuance of the fact-finding recommendations, the parties shall meet and confer at reasonable times in an effort to resolve their dispute or to agree upon a procedure for a binding resolution thereof. If upon expiration of said 30-day period the parties have not resolved their dispute or agreed upon a procedure for a binding resolution thereof, the bargaining representative may serve upon the employer and the Service a 30-day strike notice, or the employer may serve upon the bargaining representative and the Service a 30-day lockout notice. If a 30-day strike notice is served, the Service shall within the 30-day notice period conduct a secret ballot strike vote among the employees in the bargaining unit and shall certify the results thereof. If the Service certifies that a majority of the employees in the unit eligible to vote have voted to strike, the bargaining representative may call a strike and engage in picketing upon expiration of the 30-day notice period. If a 30-day lockout notice is served, the employer may initiate a lockout upon expiration of the 30-day notice period.

" (2) When an employer operating a health care institution and the bargaining representative of its employees enter into negotiations for an initial collective bargaining agreement, any impasse in such negotiations shall be resolved in accordance with the procedures set forth in subsection (g)(1) of this section 8, without recourse to strikes, picketing or lockouts, except as expressly permitted therein. For such purposes, the bargaining representative shall be deemed to have served, on the date of its certification by the Board or its voluntary recognition by the employer, the 90-day notice referred to in subsection (g) (1) (A).

" (3) Except as expressly permitted by this subsection (g), it shall be an unfair labor practice for any labor organization to engage or participate in, authorize, or sanction, or to induce or encourage any individual to engage or participate in, (1) a strike or work stoppage of any kind whatsoever, whether arising out of a recognition dispute, bargaining impasse or otherwise, against an employer operating a health care institution, or (2) any picketing of, or at the premises of, a health care institution, including but not limited to a construction site where a health care institution or part thereof is being constructed; and except as so permitted it shall be an unfair labor practice for an employer operating a health care institution to engage in a lockout: Provided, That nothing contained in this subsection (g) shall prohibit publicity other than picketing for the purpose of truthfully advising the public of the existence of a dispute with the employer operating said health care institution unless an effect of such publicity is (1) to induce any employee of the employer operating such institution or any other individual, in the course of his employment, not to pick up, deliver or transport goods, not to enter said employer's premises, or not to perform services, or (2) to induce such an employee or individual to engage in a strike or work stoppage of any kind.

Provides same impasse resolution procedure in the event of an impasse in negotiations for an initial agreement.

Provides that any strike or picketing of or lockout by a health care institution is an unfair labor practice, except in the impasse situation discussed above. Designed to prohibit recognition strikes (not prohibited by NLRA) and recognition picketing (inadequately regulated by NLRA §8(b)(7)), and to plug loopholes in secondary boycott and other provisions of NLRA. Proviso permits handbilling and similar advertising which does not disrupt deliveries or result in work stoppages.

Makes the inconsistent impasse procedures of NLRA §8(d) inapplicable to health care institutions, but does not make 8(d) entirely inapplicable to such institutions.

Designed to minimize bargaining unit fragmentation and proliferation, which pose a serious threat to the efficient functioning of health care institutions. Such institutions are particularly vulnerable to the practice of fractionalizing the workforce into numerous units, and the NLRB has already shown a dangerous tendency in this direction. This section would provide for not more than four broad bargaining units in health care institutions (in addition to security guards, who must have a separate unit if they are organized) -- (1) professional employees, (2) technical employees, (3) clerical employees, and (4) service and maintenance employees. Narrower units would be permitted by agreement, and existing narrower units would not be disturbed. These four categories could be combined into fewer units, although the Board does not combine office clericals with other employees if either party objects, and under NLRA §9(b) it cannot include professional employees with nonprofessionals unless the professionals vote for such inclusion.

"(4) An employer operating a health care institution and the bargaining representative of its employees shall not be required to comply with the procedures set forth in subsection (d) of this section 8."

4. Section 9 is amended by adding a new subsection (f) as follows:

"Notwithstanding anything to the contrary in subsection (b) of this section 9, the Board shall not decide that any unit in a health care institution is appropriate for purposes of collective bargaining which (1) includes professional employees unless all of the professional employees employed in such institution by the employer operating such institution are included therein; or (2) includes technical employees (as defined from time to time by the Board) unless all of the technical employees employed in such institution by the employer operating such institution are included therein; or (3) includes clerical employees unless all of the clerical employees employed in such institution by the employer operating such institution are included therein; or (4) includes service and maintenance employees -- which shall be defined to include all employees except (A) professional, technical and clerical employees, (B) any individual employed as a guard to enforce against employees and other persons rules to protect property of the employer or to protect the safety of persons on the employer's premises, and (C) managerial employees and others customarily excluded by the Board from bargaining units -- unless all of the service and maintenance employees employed in such institution by the employer operating such institution are included therein: Provided, That the Board shall not disturb bargaining units narrower in scope which were in existence prior to the effective date of this subsection: Provided further, That units narrower in scope may be agreed to by the employer and the bargaining representative."

Gives unfair labor practice charges involving strikes and picketing at health care institutions priority over other cases in NLRB regional offices.

Same as above.

Same as above. This section is patterned generally after NLRA §10(l), although it would permit a health care institution to seek temporary injunctive relief in federal court to prevent an unlawful strike or picketing while the Board investigates and processes the institution's unfair labor practice charge. Experience under 10(l) has proven that, even in priority cases, the Board cannot respond swiftly enough in obtaining temporary injunctive relief to prevent irreparable injury.

5. Section 10(l) is amended by striking the period at the end of the first sentence and adding "; and cases given priority under subsection (n)."

6. Section 10(m) is amended by striking the period and adding "or (n)."

7. Section 10 is amended by adding a new subsection (n) as follows:

"(n) Whenever it is charged that any person has engaged in an unfair labor practice within the meaning of subsection (g) of section 8, the preliminary investigation of such charge shall be made forthwith and given priority over all other cases except cases of like character in the office where it is filed or to which it is referred. Upon filing such a charge, the charging party may petition any district court of the United States (including the District Court of the United States for the District of Columbia) within any district where the unfair labor practice in question has occurred, is alleged to have occurred, or wherein such person resides or transacts business, for appropriate injunctive relief pending the final adjudication of the Board with respect to such matter. Upon the filing of any such petition the district court shall have jurisdiction to grant such injunctive relief or temporary restraining order as it deems just and proper, notwithstanding any other provision of law: Provided, That

no temporary restraining order shall be issued without notice unless a petition alleges that substantial and irreparable injury to the charging party or other persons will be unavoidable. Upon filing of any such petition the courts shall cause notice thereof to be served upon any person involved in the charge and such person, including the charging party, shall be given an opportunity to appear by counsel and present any relevant testimony: Provided further, That for the purposes of this subsection district courts shall be deemed to have jurisdiction of a labor organization (1) in the district in which such organization maintains its principal office, or (2) in any district in which its duly authorized officers or agents are engaged in promoting or protecting the interests of employee members. The service of legal process upon such officer or agent shall constitute service upon the labor organization and make such organization a party to the suit."

Provides additional protection for health care institutions from illegal strikes and picketing by creating a cause of action for damages.

8. Section 303(a) of the Labor Management Relations Act is amended by adding "or 8(g)" after "8(b)(4)".

The CHAIRMAN. Mr. DeBacker.

Mr. DEBACKER. Thank you, Mr. Chairman.

I am Robert E. DeBacker, associate administrator of Schumpert Memorial Hospital, Shreveport, La. I am here today as an officer and member of the board of trustees of the Louisiana Hospital Association, a nonprofit federation of public and private hospitals, both nonprofit and proprietary.

We have submitted to the committee written testimony, and I will not take the time to read that verbatim but merely elaborate on a few points which I feel are of interest.

The CHAIRMAN. We appreciate that.

Mr. DEBACKER. We of course appreciate the opportunity of appearing before your committee.

I would like to bring up an issue that perhaps in consideration of the rights of labor and the rights of management, should not be brought up, but it is something in the headlines today; and this is the factor of hospital costs.

Senator Kennedy's committee has been concerned very greatly with the rising hospital costs. The fact that certain elements of the hospital work force desire to come under the umbrella of the Taft-Hartley Act would assume that the wage rates and present levels are below those desired.

We can only suggest that of course if wage rates do increase, these will have to be passed off in the form of increased hospital charges. I cannot recall in recent years any instance in my institutions wherein we raised rates we charged for patients that was not in a direct dollar-for-dollar basis because of a wage increase.

This has been during the over 8 years I have been at Shumpert Hospital in Shreveport, La.

The other situation is one of public safety and public interest.

The present law apparently has recognized the public safety and public interest by the exclusion of certain elements of the work force, such as the police, firemen, military, et cetera.

We feel a stable hospital work force is just as important to the protection of the public interest.

The third point I would like to bring out, I bring out because my particular hospital, Shumpert Hospital, is conducted under the auspices of the Sisters of Charity of Houston, Tex., a Catholic organization of sisters. The social teachings of the Catholic Church have always recognized the rights of labor; at the same time, we must recognize the rights of the sick who come to our doors.

I cannot, of course, put myself in the same position as our colleagues from New York State, in that we have no hospital labor relations law in the State of Louisiana; and for the most part have encountered no labor conflict.

However, I can say that in my particular institution if we were to have a strike of any type, we would be unable to care for the sick in our hospital.

The State of Louisiana at present is only 75 percent manned in its needs for registered nurses in our hospitals—probably even less than that. We need every nurse we have on our working force to care for the day-to-day needs of our patients at all times, 24 hours a day.

I would like to quote from a statement of the Catholic Hospital Association to emphasize the point we make.

We believe that the hospital and its employees bear a moral, humanitarian as well as legal obligation to insure that hospital services are not interrupted.

I am reading from a letter sent by Sister Irene Kraus, president of the Catholic Hospital Association, to this committee:

Thus, while the position of The Catholic Hospital Association regarding employer-employee relations is very specific in reflecting the rights and obligations of both management and labor consistent with the social teaching of the Catholic Church, there is also very clearly identified the right of the sick and injured to be served by the hospital.

This right overrides the right of employees to strike, as well as the right of management to shut down hospital operations—actions which are contrary to both groups' moral and humanitarian obligations of management and labor to serve the sick and injured at all times.

We could also point out, Mr. Chairman, that at the present reading of this particular act, we are opposed to it as it now reads. We have not made a thorough analysis of the amendments offered by the California Hospital Association, as well as other colleague States, to introduce into the legislation a no-strike provision; but if such amendments do in fact become the net effect of providing a no-strike amendment in the legislation, the Louisiana Hospital Association subscribes to such an amendment.

The CHAIRMAN. Thank you very much, Mr. DeBacker.  
(The prepared statement of Mr. DeBacker follows:)

TESTIMONY OF THE LOUISIANA HOSPITAL ASSOCIATION BEFORE  
SENATE SUBCOMMITTEE ON LABOR, HARRISON A. WILLIAMS, JR.  
(D-N.J.), CHAIRMAN, ON H.R. 11357

September 6, 1972

Mr. Chairman, I am Robert E. DeBacker, associate administrator of Schumpert Memorial Hospital, Shreveport, Louisiana. I appear today as an officer and member of the Board of Trustees of the Louisiana Hospital Association, a nonprofit federation of public and private hospitals, both nonprofit and proprietary. Our membership includes practically all the hospital beds in Louisiana. With me today are Charles R. Gage, executive director of the Association, and Robert W. Stratton, director of governmental relations. We appreciate the opportunity to appear before the Committee today.

The Association opposes H.R. 11357 primarily on two grounds. One, the National Labor Relations Act is geared primarily to the private sector industry. Nonprofit hospitals should be recognized as not having their same bargaining position. Two, the matter should fall within the ambit of state control. But first, let's see why the various groups are supporting the bill. Professional societies such as the American Society of Hospital Pharmacists, the American Society of Medical Technologists and the American Society of Radiologic Technologists say they want unions as means of collective bargaining, not solely as a means to get higher wages but as a means of getting a piece of the action, a part of the decision

Testimony  
September 6, 1972  
Page 2

making process.

There can be no argument with the statement that hospital employees have, until quite recently, been underpaid. That traditional pattern has been broken over the past decade and we believe hospital employees are now receiving wages equal to or above the wages in comparable jobs in other areas of the private sector. There is even now a Senate-House Conference Committee meeting to increase the minimum wage to at least \$2 an hour. Recent substantial wage increases were the single most important factor in rapidly rising hospital costs during that period. No other industry has experienced inflationary rates of more than 15% per year. This is because wages and other payroll costs account for approximately 70% of all hospital costs.

We bring these facts to the attention of the Subcommittee not to challenge the social desirability or justification for those wage increases because we recognize the prior history of underpayment, but solely for the purpose of appraising the economic impact of Section 7 of the National Labor Relations Act on the hospital field.

The affected groups say they mainly want a part in the decision making process - such things as the establishment of

Testimony  
September 6, 1972  
Page 3

appropriate standards for personnel employment, policies as to continuing education, and opportunities for members to attend seminars and workshops. Perhaps the single most costly, inefficient and potentially disruptive demand now being made by hospital unions is the claim that they should share with management the right to determine numbers of employees. This can create featherbedding situations which will inflate hospital costs at a time when the only hope for holding down hospital cost increases is in the area of creating incentives for efficiency, including automation of certain aspects of the hospital business.

The August 1972 issue of HOSPITAL WORLD focuses on one of the problems as we see it. They stated, "If any one force has galvanized the joint bargaining movement, it is a bill just approved by the House Labor Committee that would place hospitals under the National Labor Relations Act. At present, only 12 states have laws compelling hospitals to bargain with unions. N.L.R.B. coverage automatically opened the door to unionization in every state."

Is there any compelling reason to open the door to unionization in every state? We think not! Each society could work through its own state organization to get what they say they want the most, a part in the decision making process.

Testimony  
September 6, 1972  
Page 4

Now let's look at hospitals' weakness from a bargaining position. From experience under the Taft-Hartley Act we know it is deficient as a means of encouraging settlement of labor disputes since it creates rather than solves the basic problem of the collective bargaining impasse. Taft-Hartley accepts the strike or lockout as a fundamental approach to resolving impasses.

It is important to note the unique conditions which exist in the hospital environment in order to understand the consequences of encouraging more of the kinds of union demands. The hospital does not have the same bargaining strengths as other businesses. The hospital cannot be flexible in scheduling its workload or producing output. As a public service industry, the hospital field cannot counter strike threats with lockouts; it cannot survive during a strike because of the nature of its community commitments and the immediate obligations to its acute care patients. In an acute health care institution a strike or lockout has its chief impact on acutely ill patients, not on the employer or the employees. Thus, in terms of its impact on the public, a strike against a hospital is as unacceptable as a strike by police officers. In our state of Louisiana there has been within the last week an attempt at union organizing in one of our proprietary institutions,

Testimony  
September 6, 1972  
Page 5

Springhill General Hospital. There appears to be no obvious grievance. But it seems that at least the LPN's have shown an intent to become members of the union. This is difficult to understand because the LPN's have a strong state association which ministers to their needs. Considering that there is no obvious grievance, they would not have any cause to become aroused had it not been because of the influence of outside labor leaders.

This Springhill General Hospital situation also points up that in addition, Taft-Hartley as currently applied by the National Labor Relations Board to cover health care institutions does not adequately deal with the critical problem of bargaining unit fragmentation and proliferation. Health care institutions are particularly vulnerable to the practice of fractionalizing the work force into numerous units and this practice poses a serious threat to the efficient functioning of such institutions and thus to quality patient care. However, the National Labor Relations Board has ignored these important considerations and has treated health care institutions as if they were factories producing automobiles rather than institutions devoted to preserving human life.

Thank you very much for the opportunity of appearing today.

The CHAIRMAN. Mr. Hurst.

Mr. HURST. Mr. Chairman, I am O. Ray Hurst, executive vice president of the Texas Hospital Association; and I am here representing the Texas Hospital Association, and its 600 member hospitals, to express opposition to H.R. 11357, which would remove the exemption for nonprofit hospitals from the provisions of the National Labor Relations Act.

I, too, have filed a rather lengthy statement and do not propose to read it, but rather to summarize it briefly in the interest of time and in the elimination of some redundancy, hopefully.

We join the American Hospital Association in opposing this piece of legislation, and we stress that strikes, picketing, and work stoppages must not be tolerated in hospitals in our opinion.

Hospital care is people to people, and the only commodity that hospitals have to offer is the commodity of service. For that reason we are concerned that the proposed amendment fails to take into consideration that the NLRA has been tailored to meet the needs that have arisen in employer-employee relationships in nonhospital industry, or in industry as we usually think of the term.

It is to the extent in which the public interest is involved that makes the nonprofit hospital setting unique. We believe that the public interest is paramount, and it could hardly be maintained that continued operation of the hospital or hospitals is not required.

We do wish to comment that from previous testimony the act is seriously different and inappropriate, in our opinion, for application to the health care field with regard to strikes, picketing, and impasses.

We are also, as is the gentleman from Louisiana, concerned about increased health-care costs. In our view, costs will increase if open invitations are given to unionization of employees in nonprofit hospitals. I think it should be pointed out that the various Federal programs cover some 35 to 40 percent of the total health care bill now, which means that additional costs would be passed to the Federal Government.

Therefore, we would urge, if the committee has not already done so, that the Department of Health, Education, and Welfare, and possibly the Social Security Administration, be invited to testify on the potential cost impact on medicare, medicaid, and other programs.

The CHAIRMAN. They have been invited. They declined the opportunity.

Mr. HURST. Thank you, sir.

The Texas Hospital Association is very much in favor of outstanding, excellent personnel policies for employees. We have had a continuing program for almost 15 years, and our hospitals have responded in developing what appear to be excellent working conditions and salary relationships.

In conclusion, we respectfully urge the committee to vote against the removal of nonprofit hospitals' exemption from NLRA.

The CHAIRMAN. Thank you very much, Mr. Hurst. Your full statement, of course, will appear in the record.

(The prepared statement of Mr. Hurst follows:)

TESTIMONY OF THE TEXAS HOSPITAL ASSOCIATION  
ON H. R. 11357, A BILL TO AMEND THE NATIONAL LABOR RELATIONS ACT  
BEFORE THE SUBCOMMITTEE ON LABOR OF THE  
SENATE COMMITTEE ON LABOR AND PUBLIC WELFARE  
September 6, 1972

Mr. Chairman and members of the Committee: I am O. Ray Hurst, executive vice president of the Texas Hospital Association. On behalf of the Association, its Board of Trustees, and its 600 member hospitals, I am here to express opposition to H. R. 11357 which would remove the exemption for nonprofit hospitals from the provisions of the National Labor Relations Act.

In this expression of opposition, the Texas Hospital Association joins the American Hospital Association in strongly opposing the removal of the existing exemption for nonprofit hospitals. We have no desire to duplicate previous testimony -- particularly that testimony presented by Mr. David Hitt on August 16, 1972 -- however we must stress that strikes, picketing, and work stoppages must not be tolerated in life and death situations -- situations which are frequent in hospitals.

Hospital care is a people-to-people business and the only commodity the hospital has to offer is service. This service is of the type which frequently must be rendered quickly and efficiently or the results can be severe, even death. There is no room in such situations for third party intrusion or interference between the professional whose judgment forms the basis for action and the activities of those employees who take the action required.

For that reason, we are concerned that the proposed amendment fails to take into consideration the fact that the National Labor Relations Act has been tailored to meet the problems which have arisen in the employer-employee relationships in industry. In the past, Congress recognized the fact that the Act should not be applicable to nonprofit hospitals and therefore created the exemption which this bill simply eliminates. Nothing has occurred since the exemption was created which has changed the character of nonprofit hospitals as employers. The previous exemption is just as valid today as it was initially.

It is the extent to which the public interest is involved which makes the nonprofit hospital setting unique. Public interest is paramount. It could hardly be maintained that the continued operation of a hospital or hospitals is not required. The continued operation of hospitals is essential to the health, safety, and welfare of the public. Nothing should be allowed to slow or disrupt the availability or the continuity of patient care.

We do wish to reiterate from previous testimony that the Act is seriously different and inappropriate for application to the health care field regarding strikes, picketing and impasses, and the fragmentation and proliferation of bargaining units. We urge, therefore, that the Committee carefully weigh the serious implications, for the public, of work stoppages in the health field whether occurring in a single institution or on a widespread basis. If collective bargaining were to become more widespread in the hospital field as a result of enactment of H. R. 11357, the potential for more strikes in all hospitals in a broad geographic area would clearly exist.

In Texas, our 600 plus hospitals are almost equally divided into three ownership categories: nonprofit nongovernmental, nonprofit governmental, and for-profit. This means that currently, about one third (the for-profit hospitals) are now under the jurisdiction of the National Labor Relations Act, one third (the nonprofit nongovernmental) would be placed under NLRA if H. R. 11357 is passed, and the remaining one third (the nonprofit governmental hospitals) would continue to be exempt from NLRA provisions.

In Texas, hospitals regardless of ownership are rendering care to all patients. In other words, the public frequently does not know -- and if known seldom cares -- what the ownership of the facility might be if the care required is available and given. That a strike, work stoppage or impasse might interfere with or curtail that availability -- regardless of ownership -- is unthinkable.

In fact, hospital work stoppages are less conscionable, it appears to us, than would be work stoppages by community firemen. For, while both have the same

mission of being ready and on standby for emergencies, the hospital has the additional responsibility of round-the-clock care of those patients who have been already admitted. Work stoppage in the hospital, then, would be about like a work stoppage of firemen who not only failed to answer the latest alarm, but also left the scene of the several fires they had been fighting!

We must also point out the multiplicity of bargaining units which are inherent within the hospital's structure. Ranging from professional down to and including maintenance, laundry and dietary workers, the more than 100 occupational groupings could lead to a fragmentation of goals and effort to such an extent that the prime purpose of the institution could suffer irreparable harm. There is no way that a possible score or more of organized groups, under influence of a third party, could be effectively focalized to serve the immediate and critical needs of the patients.

We are also extremely concerned regarding potential increased health care cost resulting from passage of H. R. 11357. Since the advent of Medicare, Medicaid and minimum wage, the hospitals of our state -- as well as the rest of the nation -- have been in a constant state of flux. Increased demands for care have run concurrently with a constant flow of laws and regulations which have in turn pushed personnel requirements and costs ever and ever higher. As regulatory agencies, such as HEW, Department of Labor, etc., made the hospitals their special targets for surveys, inspections and audits, costs reacted accordingly and a patient day in Texas is now about \$90 a day and going higher. At the same time, Medicare and Medicaid rules and regulations have put pressure on keeping payments down, along with the President's Phase II program.

Additionally, it should be pointed out that the various Federal programs are now paying for about 35-40 per cent of the total health bill of this nation. That means, of course, that the additional costs of allowing NLRA jurisdiction in nonprofit hospitals -- and these costs will be considerable -- must be borne in large part by the federal government. We would, therefore, strongly recommend

-- if the Committee has not yet done so -- that the DHEW be invited to testify on the cost impact of such action on the Medicare, Medicaid and other federal health programs.

We do not mean to imply, that we do not believe in modern, equitable and fair personnel policies. For the past 12 years, the Texas Hospital Association has had active, forceful policies encouraging all member hospitals to upgrade personnel policies and benefits, and our members have responded to the extent that salary scales, fringe benefits and working conditions compare quite favorably with other occupational areas of our economy. We shall continue to urge that the most modern, fairest personnel policies possible be followed.

But our primary purpose is -- and will continue to be -- the welfare of the patient. We believe that it is in the best interests of the patient that he be taken care of without the interference of third parties.

In conclusion, we respectfully urge the Committee to vote against the removal of the nonprofit hospitals' exemption from NLRA. You, of course, have the decision and we pray you make the correct one. And, in our most sincere opinion, the correct decision is one which would allow no interruption of patient care because of labor activity or unrest. There just have to be better ways of solving our personnel problems if and when they exist! Thank you.

The CHAIRMAN. Perhaps you mentioned this.

Do you have a State hospitalization law?

Mr. HURST. No.

The CHAIRMAN. Have you ever had any labor-management friction that has caused work stoppages in Texas?

Mr. HURST. Not to any serious extent, Mr. Chairman. Some of our proprietary hospitals have had some problems, but they have not been to any great degree serious.

We are not soliciting any here. [Laughter.]

The CHAIRMAN. Were the viewpoints of your State association expressed to the House in its consideration of the legislation?

Mr. HURST. To my knowledge, only the American Hospital Association appeared.

Mr. WHELAN. That is my understanding, too.

The CHAIRMAN. You subscribe to the American Hospital Association view given over there, but this is the first time you have appeared?

Mr. WHELAN. This is the first we have appeared. We really did not know of the hearings, to tell you the truth. I suppose that was our own fault, but we were not notified of them and did not appear, although I believe our action was taken by our boards soon enough so that we could have in that sense; but we did not appear.

The CHAIRMAN. Senator Taft, do you have any questions?

Senator TAFT. I have no questions, Mr. Chairman.

I am interested to verify that HEW has been asked to appear; because I understood that they were to be asked, but I had no confirmation of that fact.

The CHAIRMAN. I think Senator Schweiker, representing the committee, did extend the invitation.

Senator TAFT. My staff indicates that HEW at least as late as yesterday indicated it would welcome an opportunity to testify.

The CHAIRMAN. We will talk with Senator Schweiker later.

Senator TAFT. If that is the case, as I indicate, I would very much like to hear what they have to say.

Was the Social Security Administration invited? I think the cost factor might be relevant in their view.

The CHAIRMAN. Senator Schweiker indicated that he would extend these invitations, and we will have to inquire into that.

I want to thank all of you for your very helpful testimony.

**STATEMENT OF JAMES D. NEWCOMER, VICE PRESIDENT, OHIO HOSPITAL ASSOCIATION; ACCOMPANIED BY JERRY N. RANSOHOFF AND RICHARD V. WHELAN, JR.; GEORGE H. YECKEL, EXECUTIVE DIRECTOR, MISSOURI HOSPITAL ASSOCIATION; ACCOMPANIED BY CLIFTON L. ELLIOT, ATTORNEY; MARC IHM, PRESIDENT, IOWA HOSPITAL ASSOCIATION; ACCOMPANIED BY DONALD W. DUNN, EXECUTIVE VICE PRESIDENT; COMPOSING A PANEL**

Mr. NEWCOMER. I would like to start out by introducing the members of the panel. We have from Iowa, Mr. Marc Ihm and Mr. Donald Dunn.

The CHAIRMAN. Senator Hughes wanted to be here, but regretted that he was unable to attend.

Mr. NEWCOMER. On my immediate left is Mr. Jerry Ransohoff, executive secretary of the Greater Cincinnati Hospital Council. He will appear on behalf of the Ohio Hospital Association and the Greater Cincinnati Hospital Council.

On my immediate right is Mr. Richard Whelan, labor attorney from Cleveland, Ohio, representing several hospitals in the State of Ohio.

On the far right are two representatives from Missouri, Mr. George Yeckel and Mr. Clifton Elliot, representing the Missouri Hospital Association.

Mr. Chairman and Senator Taft, the Ohio Hospital Association and the representatives here today have submitted written testimony, and we would like that to be incorporated in the record, if it takes official notice to do so.

The CHAIRMAN. It certainly will be at the conclusion of your testimony.

Mr. NEWCOMER. We will try to just highlight our testimony in the interest of time. We have had several witnesses, and we realize that some of the testimony of necessity is a duplication.

First of all I do appear on behalf of the Ohio Hospital Association which is an association of approximately 250 Ohio hospitals and health care institutions, representing more than 98 percent of all hospital beds in Ohio.

Although it is not in my written statement I should point out to the committee that we are primarily nonprofit hospitals and public hospitals, including the State, city, county, township districts, and various local government forums.

In Ohio there are no proprietary or for profit hospitals. However, the constitution and bylaws of the Ohio Hospital Association would not preclude the membership of these institutions if there were some.

The Ohio Hospital Association strongly supports the position of the American Hospital Association as it was expressed before this committee on August 16. The opposition of course to H.R. 11357 amounted in essence to the fact that the National Labor Relations Act is not an appropriate means of resolving labor disputes in hospitals and other health care institutions.

We realize that the House did hear many arguments and apparently rejected them on this issue. However, we feel that the instances before the House, particularly the regional examples of various labor strife from selected areas did tend to indicate that there was a greater need than we feel there really is for this particular legislation.

Mr. Ransohoff will address himself to the Ohio region which we feel is not atypical.

Mr. Chairman, the previous testimony before this committee and before the House Special Subcommittee on Labor, the proponents often raised the question of whether there was any difference between an employee in a for profit or proprietary hospital and an employee in a nonprofit hospital.

In addition, the question is often raised as to whether or not for profit and not for profit hospitals and health care institutions belong to the same trade or business organizations such as the various associations that have testified here today.

We agree that in respect to the task performed by a hospital employee, there is just no real difference in what they do. There is

very little difference in the labor pool; there is very little difference in the manner of compensation. We concede that fact.

We also concede the fact that many for profit and not for profit health care institutions do belong to the same trade or business organizations.

However, we feel that this tends to obscure the issue because what the proponents have attempted to do we believe is apply the golden rule and say what is good for profit hospitals must be good for the nonprofits. We would think this tends to ignore the basic concern and argument of the hospital industry.

From the testimony here today, particularly that of California, our assertion is that we do not think that the National Labor Relations Act is appropriate for health care institutions, whether they be for profit, nonprofit, or public.

The CHAIRMAN. May I make just one interruption at that point. Is Ingleside a proprietary?

Mr. NEWCOMER. It may have been, and I do not know. That one may have been converted or closed.

The CHAIRMAN. I think it was closed after a 33 months recognition strike. Go ahead, please.

Mr. NEWCOMER. Mr. Chairman, we submit that the similarity of employment conditions, and the fact of whether various health care institutions, for profit and not for profit, do belong to the same organizations cannot be relevant on the issue of appropriateness of the National Labor Relations Act.

We feel that if the golden rule is to be applied we should look at this similarity of employment conditions, if we are going to form a national labor relations policy for health employees in the sense that it should apply to all employees, regardless of the type institution in which they are employed.

We feel one other thing that we believe the committee should seriously consider is the impact or potential impact of this legislation on various other measures now pending before both the House and the Senate.

Several Senators and Members of the House are currently sponsoring measures which provide for a form of national health insurance, varying widely in approach and scope, but all of them seem to be premised on the fact that health care is not to be considered a right of the American people.

For example, we would like to point out a recent bill that was approved by this committee, Senator Kennedy's bill 3327. This of course seeks to assure that comprehensive health services are made available to all Americans, regardless of where they live and at what time or when they need them.

We submit, Mr. Chairman, that if the American citizens have a right to health care as espoused by these various proposals, and if we fully realize this goal, then all health care institutions must have a corresponding duty or social obligation to provide the services.

We feel that this right to health care is meaningless unless uninterrupted health services are available.

H.R. 11357 we feel seriously deters the achievement of this goal. In our opinion its adoption would serve to delay the badly needed comprehensive health care delivery system. Even worse, it would place the rights of certain employee groups above those of the American public.

For the foregoing reasons, the Ohio Hospital Association is opposed to H.R. 11357, and we respectfully urge the committee to reject the bill.

You will notice attached to our written testimony we do have an exhibit, and this exhibit is only tendered as an alternative or proposed alternative in the event the committee feels it would be of interest. It is virtually identical to the plan submitted by Mr. Emanuel of the California Hospital Association.

I would like to point out we do not have any particular preference as to wording. We endorse this idea in concept only.

We do have serious reservations about the limited strike reservation in these proposals, however, we do feel if there is to be a national program these concepts, and I guess exhibit A should be included in any proposal.

The CHAIRMAN. Thank you very much.

(The prepared statement of Mr. Newcomer follows:)

TESTIMONY OF THE OHIO HOSPITAL ASSOCIATION  
ON H.R. 11357, A BILL TO AMEND THE NATIONAL LABOR RELATIONS ACT  
BEFORE THE SUBCOMMITTEE ON LABOR OF THE  
SENATE COMMITTEE ON LABOR AND PUBLIC WELFARE  
SEPTEMBER 6, 1972

Mr. Chairman and Members of the Subcommittee:

I am James D. Newcomer, Vice President - Government Relations of the Ohio Hospital Association. Appearing with me are Richard V. Whelan, a member of the law firm of Thompson, Hine and Flory, Cleveland, Ohio and Jerry N. Ransohoff, Executive Secretary of The Greater Cincinnati Hospital Council. I appear on behalf of the Ohio Hospital Association, which is an association of approximately 250 Ohio hospitals and health care institutions representing more than 98% of all hospital beds in Ohio.

The Ohio Hospital Association is opposed to H.R. 11357 which removes the exemption of non-profit hospitals from the National Labor Relations Act. We strongly support the position and arguments expressed in the testimony presented by the American Hospital Association before this Committee on August 16 in opposition to H.R. 11357. The essence of the testimony of the American Hospital Association is that the National Labor Relations Act is not an appropriate means of resolving labor relations problems in hospitals and other health care institutions.

Even though the opposition arguments to H.R. 11357 were rejected in the U.S. House of Representatives which passed the bill as a non-controversial measure, we sincerely believe that the issue of the appropriateness of NLRA coverage of hospitals and health care institutions is deserving of further scrutiny by this Committee. House debate related in large part to isolated instances of labor strife in selected areas and Mr. Ransohoff will

address himself to an Ohio region which we feel is not atypical.

Mr. Chairman, in previous testimony before this Committee and before the House Special Subcommittee on Labor the proponents often raised the question of whether there is any substantial difference between an employee of a non-profit hospital and an employee of a proprietary or for profit hospital which is subject to the National Labor Relations Act. In addition the fact that many for profit and non-profit hospitals and health care institutions belonged to the same trade or business organizations was an issue raised by proponents. In terms of the tasks performed by a health worker, of the labor pool from which such employee is drawn, and of the manner of compensation, we agree that there is no substantial difference. It is also a fact that non-profit and for profit hospitals do sometimes belong to the same business or trade associations. But does this make any difference? We submit that it does not.

Citing the lack of difference in employee duties, responsibilities, compensation and the fact of common membership of for profit and non-profit hospitals in trade associations, supporters of H.R. 11357 are quick to apply the Golden Rule as sufficient justification for extending the National Labor Relations Act to non-profit hospitals. However, application of the Golden Rule overlooks the basic question presented by the hospital industry, i.e., whether the collective bargaining processes under the National Labor Relations Act are an appropriate mechanism for application to hospitals and health care institutions whether they be for profit, non-profit or public. The proponents' arguments are simply not relevant to this issue and when carefully examined it is clear that they are an unsound

pretext for expanding NLRA jurisdiction .

Since there are no proprietary or for profit hospitals in Ohio, we do not have local experience on NLRA coverage. However, the arguments and testimony presented by the AHA and the California Hospital Association are replete with examples of serious deficiencies in NLRA coverage of hospitals and health care institutions. These include strikes, work stoppages, picketing, boycotts, the resolution of impasses, the lack of speedy injunctive relief and the determination of appropriate bargaining units in hospitals, all of which ultimately work to the detriment of the public by disrupting vital health care services and/or adding to their cost.

Mr. Chairman, we submit that similarity of employment conditions in for profit and not for profit hospitals is relevant only on the issue of providing equal rights and benefits for those engaged in similar employment. It is here that the Golden Rule should be applied so that all employees of health care institutions, whether profit, non-profit, or publicly operated, are treated equally under any national labor relations law or regulations. In any such legislation the interests of the public must be paramount which simply stated means no strikes or interferences in the delivery of health services.

H.R. 11357 and the issue of NLRA coverage of health care institutions should also be examined in terms of impact upon achieving the expressed goals of making quality health services available for all Americans. Several Senators and many members of the House of Representatives are currently sponsoring national health insurance measures, which, though they vary widely in approach and scope, are based upon the proposition that "health care is a right" of the American people. This premise is stated in different ways in the various

-4-

NHI proposals and in legislation recently <sup>approved</sup> passed by the Senate. For example, Senate Bill 3327, sponsored by Senator Kennedy and most of the members of this Committee seeks to assure that comprehensive health services are available and accessible to all Americans by encouraging the development of health maintenance organizations.

We submit, Mr. Chairman, that if American citizens have a "right" to health care, as espoused in several of the National Health Insurance proposals, and if this goal is to be fully realized, then all health care institutions have a corresponding "duty" or social obligation, to provide those services to the sick. And further, the "right" to health care is meaningless unless uninterrupted health services are available. H.R. 11357, we feel, seriously deters the achievement of this goal and in our opinion its adoption would serve to delay the development of an improved comprehensive health care system. Even worse it would place the rights of certain groups of employees above those of the American public.

For the foregoing reasons the OHA is opposed to H.R. 11357 and we respectfully urge the Committee to reject the bill.

If the Committee does not agree that H.R. 11357 should be rejected we urge consideration of the proposals attached as Exhibit A. I wish to emphasize that the language is only a suggested means of resolving some of the problems anticipated by hospitals in applying NLRA type procedures to health care facilities in the event H.R. 11357 is not rejected. We do not endorse any specific language (particularly the strike provisions) but we do feel the concepts embodied therein are deserving of consideration. Mr. Whelan

*Health and Public Welfare  
Committee*

is prepared to elaborate on the suggestions and to answer questions .

Mr. Chairman that concludes my statement. Thank you for the opportunity to appear before the Subcommittee on Labor for the presentation of testimony and I will be glad to answer any questions .

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PROPOSED AMENDMENTS TO  
NATIONAL LABOR RELATIONS ACT  
IN LIEU OF AMENDMENT SET FORTH IN H.R. 11357

AMENDMENT

COMMENTS

1. Section 1 is amended by adding a new paragraph as follows:

"It is also declared to be the policy of the United States concerning health care institutions that interference with patient care should be avoided and that the right of the public to uninterrupted health care services is as important as the right of employees to organize and bargain collectively."
  2. Section 2(2) is amended by striking the phrase "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".
  3. Section 2 is amended by adding a new subsection (14) as follows:

"(14) The term 'health care institution' shall include any hospital, convalescent hospital, nursing home, extended care facility, clinic, or other institution devoted to the care of sick or aged persons."
  4. Section 8 is amended by adding a new subsection (g) as follows:

"(g) (1) When a collective bargaining agreement is in effect between an employer operating a health care institution and the bargaining representative of its employees, the agreement shall continue in full force and effect, without recourse to strikes, picketing or lockouts, except as expressly permitted by this subsection (g), and any impasse in negotiations for a renewal of such agreement shall be resolved in the following manner:

Provides impasse resolution procedure for health care institutions in the event of an impasse in negotiations for a renewal agreement. Strikes, picketing and lockouts will be prohibited until the impasse procedure has been exhausted.
- Eliminates the exemption for nonprofit hospitals.
- Defines "health care institution" broadly, so that all of such institutions will be affected by the same rules.

Requires 90-day notice of termination of the agreement.

" (A) The agreement shall not be terminated or modified unless the party desiring such termination or modification serves written notice of the proposed termination or modification on the other party not less than 90 days prior to the expiration date thereof, or not less than 90 days prior to the proposed effective date of such termination or modification, whichever date is later.

Requires good faith bargaining during the first 60 days of the 90-day notice period.

" (B) During the first 60 days of the 90-day notice period, the party desiring such termination or modification shall offer to meet and confer with the other party at reasonable times in an effort to reach agreement, and the other party shall agree to meet and confer at reasonable times for such purpose.

Requires 30-day notice to the FMCS prior to termination of the agreement. Requires mediation by federal mediator during final 30 days prior to termination (unlike NLRA §8(d), which requires notice to FMCS but does not require mediation).

" (C) No earlier than 45 days or later than 30 days prior to the expiration of the 90-day notice period, the party serving such notice shall notify the Federal Mediation and Conciliation Service if an agreement has not been reached. If said party fails to notify the Service within the time required, the 90-day notice period shall not expire until 30 days after said party finally notifies the Service as required. Upon receipt of such notice the Service shall forthwith assign a mediator who shall promptly arrange meetings between the parties and serve as a mediator with respect to unresolved issues.

" (D) If upon expiration of the 90-day notice period an agreement has not been reached and the parties have not agreed upon a procedure for a binding resolution of their dispute, the Director of the Service shall forthwith appoint an impartial person who shall serve as a fact-finder in connection with the dispute. Within 60 days following expiration of said 90-day notice period, the fact-finder shall hold hearings, issue subpoenas if necessary, hear testimony and argument, and issue a written report to the Director of the Service and to the parties setting forth his recommendations for settlement of the issues in dispute. The recommendations of the fact-finder shall be advisory only and shall not be binding upon either party. Provided, That in lieu of fact-finding the parties may voluntarily adopt a different procedure for a binding resolution of the dispute.

Requires 60-day cooling-off period following termination date. Requires advisory (nonbinding) fact-finding during 60-day cooling-off period, unless parties agree to a binding procedure for resolving the impasse.

"OHA EXHIBIT A" (Cont'd) Pg. 4

- "(E) During the 30-day period following issuance of the fact-finding recommendations, the parties shall meet and confer at reasonable times in an effort to resolve their dispute or to agree upon a procedure for a binding resolution thereof. If upon expiration of said 30-day period the parties have not resolved their dispute or agreed upon a procedure for a binding resolution thereof, the bargaining representative may serve upon the employer and the Service a 30-day strike notice, or the employer may serve upon the bargaining representative and the Service a 30-day lockout notice. If a 30-day strike notice is served, the Service shall within the 30-day notice period conduct a secret ballot strike vote among the employees in the bargaining unit and shall certify the results thereof. If the Service certifies that a majority of the employees in the unit eligible to vote have voted to strike, the bargaining representative may call a strike and engage in picketing upon expiration of the 30-day notice period. If a 30-day lockout notice is served, the employer may initiate a lockout upon expiration of the 30-day notice period.
- Requires an additional 30-day cooling-off period for further bargaining in light of the fact-finding recommendations. If agreement is not reached during that period, a 30-day strike notice or lockout notice may be given. If a strike notice is given, a secret ballot strike vote will be conducted by the FMCS.

## "OHA EXHIBIT A" (Cont'd) Pg. 5

"(2) When an employer operating a health care institution and the bargaining representative of its employees enter into negotiations for an initial collective bargaining agreement, any impasse in such negotiations shall be resolved in accordance with the procedures set forth in subsection (g) (1) of this section 8, without recourse to strikes, picketing or lockouts, except as expressly permitted therein. For such purposes, the bargaining representative shall be deemed to have served, on the date of its certification by the Board or its voluntary recognition by the employer, the 90-day notice referred to in subsection (g) (1) (A).

"(3) Except as expressly permitted by this subsection (g), it shall be an unfair labor practice for any labor organization to engage or participate in, authorize, or sanction, or to induce or encourage any individual to engage or participate in, (1) a strike or work stoppage of any kind whatsoever, whether arising out of a recognition dispute, bargaining impasse or otherwise, against an employer operating a health care institution, or (2) any picketing of, or at the premises of, a health care institution; and except as so permitted it shall be an unfair labor practice for an employer operating a health care institution to engage in a lockout: Provided, That nothing contained in this subsection (g) shall prohibit publicity other than picketing for the purpose of truthfully advising the public of the existence of a dispute with the employer operating said health care institution unless an effect of such publicity is (1) to induce any employee of the employer operating such institution or any other individual, in the course of his employment, not to pick up, deliver or transport goods, not to enter said employer's premises, or not to perform services, or (2) to induce such an employee or individual to engage in a strike or work stoppage of any kind.

Provides same impasse resolution procedure in the event of an impasse in negotiations for an initial agreement.

Provides that any strike or picketing of or lockout by a health care institution is an unfair labor practice, except in the impasse situation discussed above. Designed to prohibit recognition strikes (not prohibited by NLRA) and recognition picketing (inadequately regulated by NLRA 58(b)(7)), and to plug loopholes in secondary boycott and other provisions of NLRA. Proviso permits handbilling and similar advertising which does not disrupt deliveries or result in work stoppages.

## "OHA EXHIBIT A" (Cont'd) Pg. 6

Technical amendment. Makes the inconsistent termination and modification procedures of NLRB §8(d) inapplicable to health care institutions, but does not make 8(d) entirely inapplicable to such institutions.

Designed to minimize bargaining unit fragmentation and proliferation, which pose a serious threat to the efficient functioning of health care institutions. Such institutions are particularly vulnerable to the practice of fractionalizing the workforce into numerous units, and the NLRB has already shown a dangerous tendency in this direction. This section would provide for not more than four broad bargaining units in health care institutions (in addition to security guards, who must have a separate unit if they are organized) -- (1) professional employees, (2) technical employees, (3) clerical employees, and (4) service and maintenance employees. Narrower units would be permitted by agreement. These four categories could be combined into fewer units, although the Board does not combine office clericals with other employees if either party objects, and under NLRB §9(b) it cannot include professional employees with nonprofessionals unless the professionals vote for such inclusion.

(4) An employer operating a health care institution and the bargaining representative of its employees shall not be required to comply with the termination and modification procedures set forth in subsection (c) of this section 8."

5. Section 9 is amended by adding a new subsection (f) as follows:

"Notwithstanding anything to the contrary in subsection (b) of this section 9, the Board shall not decide that any unit in a health care institution is appropriate for purposes of collective bargaining which (1) includes professional employees unless all of the professional employees employed in such institution by the employer operating such institution are included therein; or (2) includes technical employees (as defined from time to time by the Board), unless all of the technical employees employed in such institution by the employer operating such institution are included therein; or (3) includes clerical employees unless all of the clerical employees employed in such institution by the employer operating such institution are included therein; or (4) includes service and maintenance employees -- which shall be defined to include all employees except (A) professional, technical and clerical employees, (B) any individual employed as a guard to enforce against employees and other persons rules to protect property of the employer or to protect the safety of persons on the employer's premises, and (C) managerial employees and others customarily excluded by the Board from bargaining units -- unless all of the service and maintenance employees employed in such institution by the employer operating such institution are included therein. Provided, That the Board may find appropriate a unit narrower in scope which is agreed upon by the employer and the bargaining representative."

Gives unfair labor practices charges involving strikes and picketing at health care institutions priority over other cases in NLRB regional offices.

Same as above.

Same as above. This section is patterned generally after NLRA §10(1), although it would permit a health care institution to seek temporary injunctive relief in federal court to prevent an unlawful strike or picketing while the Board investigates and processes the institution's unfair labor practice charge. Experience under 10(1) has proven that, even in priority cases, the Board cannot respond swiftly enough in obtaining temporary injunctive relief to prevent irreparable injury.

6. Section 10(1) is amended by striking the period at the end of the first sentence and adding " and cases given priority under subsection (n)."

7. Section 10(m) is amended by striking the period and adding "or (n)."

8. Section 10 is amended by adding a new subsection (n) as follows:

" (n) Whenever it is charged that any person has engaged in an unfair labor practice within the meaning of subsection (g) of section 8, the preliminary investigation of such charge shall be made forthwith and given priority over all other cases except cases of like character in the office where it is filed or to which it is referred. Upon filing such a charge, the charging party may petition any district court of the United States (including the District Court of the United States for the District of Columbia) within any district where the unfair labor practice in question has occurred, is alleged to have occurred, or wherein such person resides or transacts business, for appropriate injunctive relief pending the final adjudication of the Board with respect to such matter. Upon the filing of any such petition the district court shall have jurisdiction to grant such injunctive relief or temporary restraining order as it deems just and proper, notwithstanding any other provision of law: Provided, That no temporary

restraining order shall be issued without notice unless a petition alleges that substantial and irreparable injury to the charging party or other persons will be unavoidable. Upon filing of any such petition the courts shall cause notice thereof to be served upon any person involved in the charge and such person, including the charging party, shall be given an opportunity to appear by counsel and present any relevant testimony. Provided further, That for the purposes of this subsection district courts shall be deemed to have jurisdiction of a labor organization (1) in the district in which such organization maintains its principal office, or (2) in any district in which its duly authorized officers or agents are engaged in promoting or protecting the interests of employee members. The service of legal process upon such officer or agent shall constitute service upon the labor organization and make such organization a party to the suit."

9. Section 303(a) of the Labor Management Relations Act is amended by adding "or 8(g)" after "8(b)(4)".

Provides additional protection for health care institutions from illegal strikes and picketing by creating a cause of action for damages.

The CHAIRMAN. Mr. Whelan.

Mr. WHELAN. My name is Richard Whelan. I am an attorney of the law firm of Thompson, Hine & Flory of Cleveland. I too have submitted written testimony, but in the interest of time I would like to summarize what we consider the most important points.

The CHAIRMAN. Your testimony in its entirety will be included in the record at the conclusion of your testimony.

Mr. WHELAN. Basically the Ohio Hospital Association does not consider that the Taft-Hartley Act as it now stands takes into consideration the basic issue of hospital labor relations. That is the providing of uninterrupted care to the patients in the institution.

As the act now stands it does not provide this protection in the many instances of strikes which can occur in hospitals. For example, section 8(b)(4) prohibits secondary boycott and jurisdictional dispute picketing and strikes. However, the only remedy is through the procedures set forth in section 10(1) of the act which requires first the filing of a charge, investigation by the regional director, and the determination of reasonable causes to believe that the allegations are true, prior to seeking to enjoin such picketing.

We feel that this procedure is far too long in the case of a hospital work stoppage.

I have obtained a number of injunctions under this procedure in never less than a week to 10 days. We submit this as intolerable in a hospital situation.

A similar case can arise under section 8(b)(7) dealing with recognition strikes. Here the problem can be even worse since section 8(b)(7)(c) specifically permits picketing for recognition purposes for a reasonable period of time not to exceed 30 days.

We submit that there is no such thing as a reasonable period of time to picket a hospital.

If the committee does not concur in our suggestion that H.R. 11357 be rejected, we would certainly urge that strong and meaningful deterrents be introduced into any legislation which may be enacted to protect the patients in the hospitals.

One suggestion found in Mr. Emanuel's proposal, and in that attached to Mr. Newcomer's statement, is to permit the hospital itself the right to seek injunction against such a work stoppage.

I would submit that this and an unfair labor practice finding is not a sufficient deterrent. Any legislation in this area should go further. At least punitive damages should be permitted under section 303 of the act.

Further, we would suggest consideration of the approach taken in Executive Order 11491 which deals with employment in the Federal service which excludes from its definition of labor organizations those who strike against the Federal Government.

The second and possibly most critical question which we believe this committee must consider if legislation encompassing nonprofit hospitals under the Taft-Hartley Act is proposed, is the question of impasse resolution and hospital collective bargaining.

As the act now stands, it provides no alternative to the strike in resolution of an impasse situation in bargaining. We believe that this is unacceptable in the hospital industry.

There are several alternatives which have been suggested. Mr. Emanuel's proposal is for mandatory mediation, fact finding, and a

secret ballot on a strike conducted by the Federal Mediation and Conciliation Service. This is one approach. There are others which have wide support.

There has been suggested the creation within the Federal Mediation and Conciliation Service an impasse panel similar to that found under Executive Order 11491.

It has also been suggested that final and binding arbitration or the final offer arbitration should be considered, and this has been raised in other instances before this committee.

The ultimate question which must be decided is whether or not strikes should ever be permitted in a hospital. Even within the industry itself there is some disagreement on this point. Many knowledgeable people in hospital operation feel strongly that no strikes should ever be permitted to interfere with the care provided patients.

On the other hand, there are those equally knowledgeable and experienced who feel when a hospital is pressed to the wall by outrageous demands, there must be a point at which it can say, no, and run the risk of a work stoppage.

We do not suggest any specific resolution to this issue, but believe if this committee determines that H.R. 11375 should not be rejected, these issues must be considered, and must be resolved so that the right of the people of this country to uninterrupted health care receive at least the same protection as the right of hospital employees to organize and bargain collectively.

That completes my statement, Mr. Chairman. I thank you for the opportunity to be present.

The CHAIRMAN. Thank you very much, Mr. Whelan.

(The prepared statement of Mr. Whelan follows:)

TESTIMONY OF THE OHIO HOSPITAL ASSOCIATION  
ON H.R. 11357, A BILL TO AMEND THE NATIONAL LABOR RELATIONS ACT  
BEFORE THE SUBCOMMITTEE ON LABOR OF THE  
SENATE COMMITTEE ON LABOR AND PUBLIC WELFARE  
SEPTEMBER 6, 1972

Mr. Chairman and Members of the Subcommittee:

I am Richard V. Whelan, Jr. I am a partner in the Cleveland, Ohio law firm of Thompson, Hine and Flory and specialize in the practice of labor relations law. Our firm represents a number of hospitals throughout the State of Ohio, and I have been a member of several committees of the Ohio Hospital Association dealing with personnel and employee relations matters. I appear on behalf of the Ohio Hospital Association in opposition to H.R. 11357, which would remove the exemption of non-profit hospitals from the National Labor Relations Act.

Mr. Newcomer has indicated to you the policy reasons that the Ohio Hospital Association opposes H.R. 11357. I will address myself to the specific shortcomings of the National Labor Relations Act if it were applicable to hospitals.

Our objections to H.R. 11357 are graphically illustrated in the Statement of Policy contained in Section 1 of the National Labor Relations Act, which speaks of restoring the equality of bargaining power

between employers and employees, and protecting the full freedom of workers in organization and collective bargaining. Nowhere is found any reference to or consideration for the group most vitally affected by employer-employee relations in a hospital, the group totally without bargaining power, and indeed without freedom - the patients.

In saying this, we do not intend to criticize the draftsmen of the Act, since it was enacted to meet the problems of industry. However, it does not consider the basic problem of a Hospital - that of providing uninterrupted care to its patients. If a factory is struck, whether legally or illegally, the machines can be shut down and the gates locked. The worst that can happen is the spoilage of in-process product. In a similar situation in a hospital, however, the in-process product is human life. There is no way to stop halfway through open heart surgery, or to shut down the monitoring equipment on a cardiac patient, or to postpone the administration of oxygen. These and many other procedures must continue. The right of employees to engage in concerted activity must be subservient to the patient's right to life.

The Act simply does not give sufficient protection to the hospital and its patients from the many forms

of strikes which labor unions engage in, and from the reluctance of union members to cross a picket line. Not only does a group striking at a hospital deprive its patients of their own services, but their picket line will also serve to prevent others, both hospital employees and those of suppliers of the hospital, from providing essential services to the innocent victims of such activity, the patients.

For example, Section 8(b)(4) of the Act prohibits what is commonly referred to as secondary boycott and jurisdictional dispute strikes and picketing. Under the provisions of Section 10(1), the Regional Director of the Board may seek an injunction to stop such picketing only after an unfair labor practice charge has been filed, an investigation has been made, and reasonable cause is found to believe that the charge is true. I have obtained many injunctions through this procedure, fortunately, none at a hospital, but in no case was the injunction ever issued in less than seven days after the picketing started. Most took considerably longer. But even seven days without oxygen, medicines or other services essential to patient care is unthinkable.

The same procedure must be followed under the Act in cases of organization or recognition picketing banned by Section 8(b)(7). Here, however, the problem

can become even more acute, since Section 8(b)(7)(C) specifically permits organizational picketing not otherwise prohibited by that Section "for a reasonable period of time not to exceed thirty days." The Ohio Hospital Association submits that there is no such thing as a reasonable period of time for the picketing of a hospital.

In summary, the Act simply does not provide the protection that is essential to the safety and welfare of hospital patients, and for this reason we urge the rejection of H.R. 11357.

If this Committee does not agree that H.R. 11357 should be rejected, the Ohio Hospital Association urges that any legislation concerning hospital labor relations must meet the problems which we have outlined above and must provide a meaningful deterrent to strikes and picketing at hospitals.

The Exhibit which Mr. Newcomer submitted to the Committee suggests permitting a hospital picketed in violation of these Sections to seek injunctive relief on its own upon the filing of an unfair labor practice charge. This would certainly expedite the removal of the picket line, but neither an injunction or even a NLRB order is sufficient deterrent to such activity. We would suggest for the Committee's consideration that, at least, specific provision be made for the imposition of substantial punitive damages under Section 303 of the

Act against any organization interfering in any manner with the operation of a hospital, and, where appropriate even against individuals causing such interference.

In addition, consideration should be given to an approach similar to that found in Executive Order 11491 on Labor-Management Relations in The Federal Service, which excludes from its definition of a labor organization any organization which

assists or participates in a strike against the Government of the United States or any agency thereof, or imposes a duty or obligation to conduct, assist or participate in such a strike.

The addition of similar language to the definition of "labor organization" now contained in Section 2(5) of the Act, but applicable to hospitals, would help to provide meaningful protection to the patients of non-profit hospitals.

Another area of major concern to non-profit hospitals if the Act becomes applicable to them is the potential for the proliferation of small bargaining units of employees engaged in particular areas of specialty, since the Act, in Section 9(b), directs the Board to determine bargaining units so as "to assure to employees the fullest freedom in exercising the rights guaranteed by" the Act. There are currently at least twenty separate groups which have indicated an interest in representing

their members in collective bargaining in hospitals. The dangers in this situation are obvious - continual efforts by each group to outdo the other in obtaining wage and benefit increases for its members; the increased potential for jurisdictional disputes; and the ever-present danger of a picket line by a few employees which could endanger all of the patients in the Hospital. We submit that some limitations must be imposed so as to assure the fullest protection to the lives of patients. Mr. Newcomer's Exhibit contains a logical approach to this problem which merits your serious consideration. We urge the resolution of this problem in any legislation which this Subcommittee approves.

Mr. Chairman, the most difficult problem which this Committee faces, if it does not agree with us that H.R. 11357 should be rejected, is the question of a bargaining impasse in a hospital. The Act provides no alternative to the strike for the resolution of bargaining impasses, other than the basic duty to bargain in good faith and the voluntary use by the parties of the Federal Mediation and Conciliation Service. This, we submit is insufficient.

Mr. Newcomer's Exhibit contains one approach to the problem, that of extended negotiation, mandatory mediation, fact-finding during a cooling off period, and a secret ballot strike vote conducted by the Service.

There are others. It has been suggested that consideration be given to the creation, within the Federal Mediation and Conciliation Service, of a Hospital Impasses Panel, with powers and duties similar to those of the Federal Service Impasses Panel established under Executive Order 11491 to deal with bargaining impasses in the Federal Service. Also, of course, final and binding arbitration has been considered, as well as "Final Offer" arbitration similar to that proposed for the transportation industry.

This subject is one of considerable disagreement within the hospital industry itself. Many persons knowledgeable in the field believe that strikes should not be permitted in hospitals at any time or for any reason, because of the overriding consideration of patient care. This group would prefer the use of one of the alternatives which I have mentioned to resolve hospital bargaining impasses in preference to the ultimate recourse to strike activity, because of the potential danger to the patients entrusted to their care. Others equally experienced in the industry believe that a hospital pressed to the wall by the outrageous demands of an unyielding union should have the right to say no and, if necessary, run the risks of a work stoppage.

However, all persons of both views would certainly agree that the current provisions of the Act afford no protection to those who are most directly affected by the

result of a hospital bargaining impasse, yet who are powerless to resolve it, the newborn, the sick and injured, and the dying who fill the hospitals of this country.

Should this Committee determine that H.R. 11357 should not be rejected, the Ohio Hospital Association urges that the issues which I have raised here be considered and resolved so that the right of the people of this country to uninterrupted health care and, indeed to life itself, receive at least the same protection as the right of hospital employees to organize and bargain collectively.

Mr. Chairman, that concludes my statement.

I want to thank you and the Senate Labor Subcommittee for the opportunity to appear before you and submit the views of the Ohio Hospital Association for your consideration. I will be pleased to answer any questions which you or the Subcommittee may have.

The CHAIRMAN. Mr. Ransohoff.

Mr. RANSOHOFF. Mr. Chairman, my name is Jerry Ransohoff. I am executive secretary of the Greater Cincinnati Hospital Council. I am here to testify today on behalf of the Ohio Hospital Association and on behalf of the hospital council.

I am going to alter and shorten my testimony considerably because of similar things that have been said previously. It may be a little more ragged this way than if I had read it.

The Greater Cincinnati Hospital Council is a voluntary association of 30 hospitals in southwestern Ohio, northern Kentucky and southeastern Indiana. The system has in excess of 15,000 employees. Some of these employees are unionized, those in several public hospitals are represented by the American Federation of State, County & Municipal Employees. The private, nonprofit hospitals are not organized. There are no proprietary hospitals in our area.

We have heard testimony from the New York association, and our view is somewhat different from theirs because we see it from a somewhat different angle. We have heard and seen their testimony before.

This subcommittee has heard a good deal of testimony on the possible and probable effects of the passage of H.R. 11357 in stabilizing conditions of high turnover in some of the metropolitan areas of the United States. But these are selected areas where unionization still has not ended labor unrest. I would like to describe, for the subcommittee, another selected area, Greater Cincinnati, the 19th largest metropolitan area in the country where the situation is somewhat different.

In contrast to the high turnover in the hospital industry, described in other testimony and in speeches before the House of Representatives, employee turnover in the Greater Cincinnati area's hospitals was 28.9 per 100 employees in the year ending June 30, 1971.

In the same period, the turnover in Cincinnati area industry, as reported by the Cincinnati Industrial Institute, was 39.4 separations per 100 employees. Some of this industrial labor force is organized, some is not.

It should also be noted that the highest turnover in the Cincinnati area hospitals is in nursing service, where, in 1970-71, 46.7 of 100 employees were terminated for a variety of reasons. An analysis of the terminations in nursing service reveals that many of the people are young women, leaving for family reasons, either marriage or pregnancy, a situation which can hardly be altered by amending the National Labor Relations Act.

It is my belief that the situation that exists in the Greater Cincinnati metropolitan area is more characteristic of the Nation than situations described in other discussions of this amendment, and that creating Federal legislation to correct the situations in New York City is like creating floods to wash a few supper dishes.

I might add, at this point, that New York State has legislation which, in effect, establishes conditions in that State that are parallel to the aims of H.R. 11357. From my observation, turmoil in New York City's hospitals has not been lessened by legislation and subsequent organization. To the contrary, we have seen in hospitals familiar patterns involving strike threats, picketing and ultimately, substantial wage increases, adding costs which are passed on to patients, insurance

companies, Blue Cross, and the State and Federal Government programs.

This is not an argument against wage increases, but increases without an attendant increase in productivity is artificial and self-defeating.

In a labor-intensive industry such as the hospital system, flexibility in the use of personnel is the key to effective management along with wages geared to rising productivity. Introduction of any rigidity into the system can mean one of two things: Either more people will have to be hired to continue services and meet goals or the goals and service will have to be altered and curtailed to meet the personnel budget of the institution. The results are obvious. Health care will become more expensive at an accelerating rate with expansion of service and improvement in technology lagging far behind increase in cost, or else wages and personnel numbers will be increased within sharply limited budgets and services will be pared to meet the rising labor costs.

We have seen, in the building trades, another labor-intensive industry, this phenomenon occur. While such sky rocketing costs and decline of productivity are tolerated in the building industry, they are totally unthinkable in health care. To presume that H.R. 11357 is going to contribute, in any way, to more effective delivery of hospital care, as some proponents have indicated, is not only simplistic, it is wrong headed and simple minded.

To return to Metropolitan Cincinnati and another situation for a moment. Congress has established a minimum wage for all employees, including those in hospitals. Without the benefit of H.R. 11357, minimum wages in the Cincinnati area have been maintained at a level substantially above the Federal minimums. Currently, the lowest wage paid in Cincinnati hospitals, with isolated exceptions, is \$2.10 per hour for unskilled, starting employees. Within 3 to 6 months' experience few hospital employees are earning less than \$2.25 to \$2.50 per hour, substantially above the minimum wage.

In one study which we did several years ago on the wages and turnover in laundries, both union and nonunion, hospital and nonhospital, the turnover in hospital laundries was about two and a half people per thousand people per year. It was the lowest. Wages in the Cincinnati area hospital laundries were on the average 25 percent higher than in the commercial laundries.

I have tried to present, as background, the absence of real need for such legislation as that embodied in H.R. 11357, saving for the last the most critical reasons that H.R. 11357 represents a clear hazard to the patients served by the health system. Because it is labor-intensive, the health industry and its patients are critically dependent upon the effective team function of the people involved. While a work stoppage or slowdown may be acceptable in the building industry or the newspaper industry, it can mean pain, continued illness or even death in a hospital. Like construction and newspapers, also relatively labor-intensive, hospitals are divided into many highly specialized crafts, each of which has a vital role in the team effort. The legislation which you are now considering has contributed to fractionation and multiple craft negotiation in construction and newspapers. Six stereotypers can tie up a major newspaper. It is conceivable that 10 laboratory technologists can close a major hospital. Newspaper negotiators deal with

seven or eight craft unions. The present legislation, as written, could envision a hospital administrator dealing with 15 or more.

Behind all this discussion is the inevitable threat of strike, whether "authorized" or not, leading to immediate deterioration of service, channeling of administrative skills into nonproductive areas, increase in overall cost and increase in hazards of hospitalization. Would any of you wish to spend time in a hospital recovery room or cardiac care unit during union negotiations?

One last word: In a labor-intensive industry, the only hope of cost containment is in substitution of machinery for personnel. We have seen, in the construction industry, in transportation, in newspapers and in ship loading, the stultifying effects of job protection, in both lack of technologic progress and increasing cost.

Again, should these same conditions be encouraged in the hospital and health care industries?

It is inevitable that the Federal Government is going to play an increasing important role in financing the provision of health care. Already, in our area, medicare is paying about 35 percent of all hospital bills and through medicaid, another 5 percent. This proportion will increase. Any legislation which inordinately inflates the cost of hospital care, is going to add to the costs of an increasing variety of Federal health care programs without giving more service in return. This is a route which should be as unacceptable to the Congress as it is to the American people.

Thank you for permitting me to present the views of the Greater Cincinnati Hospital Council and the Ohio Hospital Association.

The CHAIRMAN. Thank you, Mr. Ransohoff.

Mr. Ihm.

Mr. IHM. Mr. Chairman, my name is Marc Ihm. I am president of the Iowa Hospital Association, and with me is Donald W. Dunn, executive vice president. We intend only to summarize our statement which has been placed in your hands. Our hope is that the testimony will become part of the record.

The CHAIRMAN. It will be entered in the record at the conclusion of your testimony.

Mr. IHM. I also serve as administrator of Skiff Memorial Hospital in Newton, Iowa, a city-owned institution of 125 beds, including 37 certified extended care facilities beds. Even though Skiff Hospital is city owned and city controlled, and therefore not affected by H.R. 11357, I welcome the opportunity to serve as spokesman along with Mr. Dunn for those voluntary nonprofit hospitals affected, as well as the publically owned institutions in our State.

In Iowa, there are 67 hospitals licensed by the State as short-term voluntary nonprofit institutions and 63 licensed by the State as short-term hospital units of government—city-, county-, or State-owned and operated insitutions. All of these are very similar institutions with a common mission of public service. Under either type of ownership—nonprofit institutions, church related or community sponsored or governmentally owned—these hospitals exist for one single purpose, to respond to the community's need for personal health services. The hospital is a human organization; primarily it is people, not machines,

providing personal services to the sick and injured. Hospital people—and they are the greatest—must be well qualified, well compensated, dedicated, and loyal.

As it now stands, the Taft-Hartley Act provides exemption for all the health care institutions the IHA seeks to serve—voluntary non-profit, local, State, and Federal governmental hospitals. Institutions under each of these types of control work to accomplish the public policy of health care for all our citizens and so deserve the same treatment, the same protection. If exemption continues to be sound public policy for hospitals serving the community need, it should continue for all of these hospitals. If a changed public policy is indicated, it should first and foremost assure patient protection against concerted work stoppage and, it would seem to us, should be applicable to all of our hospitals.

I am asking Mr. Dunn to continue our statement.

Mr. DUNN. Thank you. We appreciate the opportunity to be before the committee, and we also appreciate the committee's recognition of the special concerns and special considerations which must be made in hospital employment. Your concern was manifested in your retention of the 8-80-hour pay period option in the minimum wage bill S. 1861. We thank you for that committee effort, a service to hospital patients as well as to hospital employees who like it.

Our primary opposition to H.R. 11357 stems from the same basic concern for the public welfare as exhibited by the committee in S. 1861. The human organization which is the hospital must assure that skilled persons are on hand to care for people who are sick or injured.

Mr. George Meany has within the past year made reference to the costliness of strikes in the free enterprise sector of our economy—the high cost both to labor and to industry. But a special, additional, extremely high price will be exacted if strikes occur in the hospital setting. Not an economic cost, but a human cost. The human cost of loss of life. The human cost resulting from an inability to restore vital life functions because of delay in bringing appropriate skills to bear. Our first obligation in hospitals must be the same as that of government—to be able to respond effectively to the public need.

At this point we find ourselves in a somewhat different position from New York. I particularly note that when I was administrator of Henry County Memorial Hospital in Mount Pleasant, in 1957 our concern for hospital employees had us paying the lowest priced wage earner 77 cents an hour; at the same time there was being paid in New York hospitals some 72 cents an hour. That basic concern in Iowa is perhaps different from in New York.

We also differ from them in believing that we cannot tolerate work stoppages in the hospital setting.

If, in the judgment of the Congress, public policy must change to protect the hospital employee's right to organize for collective bargaining purposes, we urge that the Congress also recognize its obligation to sick patients. We believe that Congress should balance, even as hospital management must do, the concern with employee rights with patient safety.

Other persons who have testified have made reference to that fact. We would call special attention to the remarks of Dr. Dennis Pointer, formerly of the University of Iowa and now at Harvard University who makes some interesting points from his research in an article in a recent issue—spring 1972—of *Hospital Administration*.

Past experience of limited hospital activity in collective bargaining may be misleading because “. . . evidence indicates that activity in this sector is expanding on a wide scale.” Past experience does show that work stoppage has been most likely to occur in the North Central and Pacific regions of the country. He also notes that “facility size is more highly associated with agreement negotiation—employment demands—than recognitional conflict” and that “as facility size increases so does the impact of work stoppages.” Any change in public policy ought to protect patients from the health hazards of work stoppages, which are otherwise apparently on the increase.

As indicated last month to your subcommittee, Pennsylvania has an excellent State statute with protections to employees and to the public. In Iowa, we have observed the apparent social justice achieved in our neighboring State of Minnesota which has its own labor law applicable to hospitals. Under Minnesota law, the minimum patient protection—a no-strike provision—is included along with the requirement of compulsory arbitration. I am confident Senator Mondale could attest to the high degree of equity for hospital workers resulting from that system. No hospital work stoppages have occurred under that system. A forum for both parties to state their positions and a procedure for fair and equitable resolution of differences exists. Society's obligations both to sick patients and to hospital workers have been served by the mechanism of an impartial, third-party arbitrator.

Some have called our attention to the desirability of a “last best offer” arrangement, a mechanism recommended, we understand, by the Secretary of Labor in both the Johnson and the Nixon administrations. This may be a worthy modification of compulsory arbitration.

We urge examination of both the Minnesota and the Pennsylvania laws before hasty passage of H.R. 11357, which fails to recognize the special environment of hospitals and the need for special provisions in the public interest.

Senator, thank you very much.

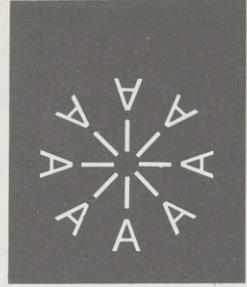
The CHAIRMAN. Thank you, Mr. Ihm.

(The prepared statement of Mr. Ihm follows:)

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DONALD W. DUNN, Executive Vice President



STATEMENT OF  
THE IOWA HOSPITAL ASSOCIATION

ON H.R. 11357

BEFORE THE  
SENATE COMMITTEE ON  
LABOR AND PUBLIC WELFARE

SEPTEMBER 6, 1972

WASHINGTON, D. C.

My name is Marc Ihm. I am President of the Iowa Hospital Association and I serve as administrator of Skiff Memorial Hospital in Newton, Iowa, a city owned institution of 125 beds, including 37 certified extended care facility beds.

With me is Donald W. Dunn, Executive Vice President of the Iowa Hospital Association. Even though Skiff Hospital is city owned and city controlled, and therefore not affected by H.R. 11357, I welcome the opportunity to serve as spokesman, along with Mr. Dunn, for those voluntary non-profit hospitals affected as well as the publicly owned institutions in our state.

In Iowa, there are 67 hospitals licensed by the state as short term voluntary non-profit institutions and 63 licensed by the state as short term hospital units of government--city, county or state owned and operated institutions. All of these are very similar institutions with a common mission of public service. Under either type of ownership--non-profit institutions, church related or community sponsored or governmentally owned--these hospitals exist for one single purpose, to respond to the community's need for personal health services. The hospital is a human organization; primarily it is people, not machines, providing personal services to the sick and injured. Hospital people--and they are the greatest--must be well qualified, well compensated, dedicated and loyal.

As it now stands, the Taft-Hartley Act provides exemption for all the health care institutions the I.H.A. seeks to serve--voluntary non-profit, local, state and federal governmental hospitals. Institutions under each of these types of control work to accomplish the public policy of health care for all our citizens and so deserve the same treatment, the same protection

-2-

or provision under the law as is the case currently under Taft-Hartley. If exemption continues to be sound public policy for hospitals serving the community need, it should continue for all of these hospitals. If a changed public policy is indicated, it should first and foremost assure patient protection against concerted work stoppage and, it would seem to us, should be applicable to all of our hospitals.

I am asking Mr. Dunn to continue our statement.

Mr. Ihm and I appreciate the opportunity to appear before the Committee to express the views of Iowa hospitals on H.R. 11357. We especially appreciate the Committee's recognition of special concerns, special considerations which must be made in hospital employment, manifest in your retention of the 8-80 hour pay period option in the minimum wage bill S. 1861. We thank you for that Committee effort, a service to hospital patients as well as to hospital employees who like it.

Our primary opposition to H.R. 11357 stems from the same basic concern for the public welfare as exhibited by the Committee in S. 1861. The human organization which is the hospital must assure that skilled persons are on hand to care for people who are sick or injured. That is awesome responsibility for Horn Memorial Hospital in Ida Grove, St. Luke's Medical Center in Sioux City, Skiff Memorial Hospital in Newton, or any of our hospitals who are where the action is. They've got to be there when people come to them in need.

Mr. George Meany has within the past year made reference to the costliness of strikes in the free enterprise sector of our economy--the high cost both to

labor and to industry. But a special, additional, extremely high price will be exacted if strikes occur in the hospital setting. Not an economic cost, but a human cost. The human cost of loss of life. The human cost resulting from an inability to restore vital life functions because of delay in bringing appropriate skills to bear. A second, a minute, an hour, a day--each of these can be the critical time span which determines success or failure in treatment of sick or injured people. And a work stoppage in the hospital setting can cause delay in treatment of one second, one minute, one hour, one day. Our first obligation in hospitals must be the same as that of government--to be able to respond effectively to the public need.

In order to fulfill that obligation, the hospital concern is for the hospital employee. No longer is he expected to subsidize health care by accepting sub-standard wages. Despite major efforts by hospitals, including statewide application of industrial engineering techniques in hospitals, spiraling costs have occurred in Iowa as well as nationwide. But in the process, two other things have occurred. There is more health care for those over 65 and there are better working conditions for hospital workers.

Your Committee has had a major role in the latter improvement. Hospital employees are now paid at least the basic minimum wage. In addition, unemployment compensation benefits are now provided hospital employees. These legislative changes--changes in public policy--although recognized by hospitals to be costly to patients, to the community, to third parties including government, were not opposed by hospitals. Because of the primary obligation to patients, concern for the employee by the non-profit hospital employer is paramount. Non-profit and publicly owned hospitals are not required to maximize dividends from profits, but are instead dedicated to provision of health services to people--maximized

-4-

quality health services--and that is possible only with qualified, trained, and loyal employees. Hospital management has long recognized this imperative relationship, and so has welcomed society's willingness to require and to pay for better working conditions for hospital employees.

If, in the judgment of the Congress, public policy must change to protect the hospital employee's right to organize for collective bargaining purposes, we urge that the Congress also recognize its obligation to sick patients. We believe that Congress should balance, even as hospital management must do, the concern with employee rights with patient safety. There can be no collective bargaining with people's health or lives.

It is sometimes argued that work stoppage in hospitals occurs only as the bargaining unit seeks recognition. However, Dr. Dennis Pointer, formerly of the University of Iowa and now at Harvard University, makes some interesting points from his research in an article in a recent issue (Spring 1972) of Hospital Administration.<sup>1</sup> Past experience of limited hospital activity in collective bargaining may be misleading because ". . . evidence indicates that activity in this sector is expanding on a wide scale." Past experience does show that work stoppage has been most likely to occur in the North Central and Pacific regions of the country. He also notes that "facility size is more highly associated with agreement negotiation (employment demands) than recognition conflict" and that "as facility size increases so does the impact of work stoppages." Any change in public policy ought to protect patients from the health hazards of work stoppages, which are otherwise apparently on the increase.

As indicated last month to your Subcommittee, Pennsylvania has an excellent state statute with protections to employees and to the public. In

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<sup>1</sup>"Work Stoppages in the Hospital Industry: A Preliminary Profile and Analysis"  
Dennis D. Pointer, Ph.D. and Norman Metzger

Iowa, we have observed the apparent social justice achieved in our neighboring State of Minnesota which has its own labor law applicable to hospitals. Under Minnesota law, the minimum patient protection--a no strike provision--is included along with the requirement of compulsory arbitration. I'm confident Senator Mondale could attest to the high degree of equity for hospital workers resulting from that system. No hospital work stoppages have occurred under that system. A forum for both parties to state their positions and a procedure for fair and equitable resolution of differences exists. Society's obligations both to sick patients and to hospital workers have been served by the mechanism of an impartial, third party arbitrator.

Some have called our attention to the desirability of a "last best offer" arrangement, a mechanism recommended, we understand, by the Secretary of Labor in both the Johnson and the Nixon administrations. This may be a worthy modification of compulsory arbitration.

We urge examination of both the Minnesota and the Pennsylvania laws before hasty passage of H.R. 11357, which fails to recognize the special environment of hospitals and the need for special provisions in the public interest.

The CHAIRMAN. Mr. Yeckel.

Mr. YECKEL. Thank you, Mr. Chairman.

I am George H. Yeckel, executive director of Menorah Medical Center, Kansas City, Mo. With me is Clifton L. Elliott, labor attorney of Kansas City, Mo., a member of the firm of Spencer, Fane, Britt & Browne. The firm acts as general counsel for the Kansas City Area Hospital Association. With me today also are Mr. Ted O. Lloyd, executive director of the Missouri Hospital Association; Mr. Kenneth Johnson, public relations director of the Missouri Hospital Association; and Mr. Gerald Malloy, executive vice president of the Hospital Association of Greater St. Louis. I am here to testify on behalf of the Missouri Hospital Association as chairman of the Governmental Relations Committee.

We are opposed to the amendment of the National Labor Relations Act by House bill 11357. While the same considerations which led Congress to exclude nonprofit hospitals from the National Labor Relations Act through the Taft-Hartley amendments still prevail and are persuasive today, we do not come here to oppose a comprehensive Federal law protecting the right of hospital employees to engage in collective bargaining through representatives of their own choosing.

We do not believe that if Congress amends the National Labor Relations Act, simply by redefining the term "employer" it will serve the public interest and common good.

The essence of that act is to protect the right of employees to engage in mutual aid and protection through concerted activity. The mainstay of that protected concerted activity has been and will remain the right to withhold services and to engage in a strike.

The strike may take several forms and while employees cannot engage in a partial strike they may on a single occasion, refuse to work overtime and walk out without notice and do so with impunity regardless of the circumstances created by the walkout. So long as the activity is not secondary in nature, employees and their unions may picket and strike without warning and without regard to the effects of the strike on the community or the employer.

As nonprofit hospitals are quasi-public institutions providing essential life-maintaining services, it is this broad right to strike to which we object most strongly. The right to strike, to threaten and to use it, cannot be minimized, for unions have asserted it to be the backbone of so-called free collective bargaining. Others before us have talked of the problems of multiple bargaining units and jurisdictional disputes which are unique in character and potentially lethal in effect in the case of hospitals. We agree with their comments.

Hospitals are by their very nature emergency institutions. Whether it is an emergency appendectomy or emergency surgery following an automobile accident, the public has the need and right to life-sustaining health care in the hospitals in our communities. Much has been said recently to the effect that the people of this country have a right to health care. If the National Labor Relations Act is applied to hospitals without recognition of the unique and special problems of the hospital as an "employer" this right is not only jeopardized, such an amendment has the potential for truncating the right through strikes and work stoppages, through picketing and jurisdictional disputes and a myriad of new problems. We hope this committee recognizes today's

hospitals in today's communities, as they were in 1947 are more than just an "employer" within the meaning of that term in the National Labor Relations Act.

Health care by hospitals is part and parcel of the obligation of our Government to provide for the public health safety and welfare. The public is more dependent upon the private nonprofit hospital than it is upon government public health services, whether local, State, or Federal. Hospitals hold the lifeblood of our communities and, if the life-sustaining services of our hospitals are stopped or interrupted for even 1 hour or 2, hearts and lives in the community may well stop with them. At the very least, the health, safety, and welfare of those patients are in grave danger. A kidney patient cannot be deprived of the use of the artificial kidney for more than 3 days. Death results.

The National Labor Relations Act does not deal with this jeopardy; it does not safeguard against the danger. This is a danger which does not exist in manufacturing plants, retail stores, or warehouses. Only a shadow of the potential danger exists in transportation and Congress has treated it there in a special manner and still seeks further answers. This act not only recognizes that strikes are the touchstone of the employer-union relationship; by virtue of its passage the supremacy clause of the U.S. Constitution requires that all of our States do likewise. The act makes no provision for the handling of disputes creating local emergencies, and it follows by virtue of preemption that States cannot either. In *Division 1287 Street Employees v. Missouri*, 374 U.S. 74, a State law dealing only with emergency disputes was set aside when applied to a union and employer covered by the National Labor Relations Act. The rationale is settled. Where the National Labor Relations Act applies, it preempts the entire field and no local or State government may intervene on behalf of its citizens, except to the extent necessary to enforce its laws against violence and mob action. The Taft-Hartley 80-day injunction available to the President is not available to him to handle local emergencies. Yet, it takes little imagination to conclude that a hospital dispute—potentially a dispute involving all hospital services in a community—can create a local emergency. In such a situation, the public has only the hope that the parties will exercise the necessary restraint and responsibility. The public deserves more.

Congress is charged with the role of protecting and enhancing public health, safety, and welfare. We suggest that passage of H.R. 31357 jeopardizes rather than secures the public health, safety, and welfare. History may well view amending only the definition of "employer" in the National Labor Relations Act to satisfy the need for hospital employees having the right to bargain collectively as simply having grabbed the nearest thing at hand, whether it fits or not. This appears to now be the verdict on applying that act to the construction industry. But while the Nation waits Congress faces the task of unscrambling the eggs.

Whether or not hospital workers should enjoy the right to organize and bargain collectively is not the issue; the issue is how they should be accorded that right compatible with the public interest in continuous and uninterrupted health care at a supportable cost.

The purpose of the National Labor Relations Act was, and hopefully remains, a public one—to safeguard commerce. It was not

simply to give employees the right to bargain collectively. We urge now that the public purpose be again given precedence over the private one.

Nonprofit hospitals are not automobile manufacturers or grain mills, are not musicians or steel foundries. They are not in business for profit. Indeed, we question whether hospitals are "employers" within the intent of the act. They serve the communities on a cost-of-service basis and depend heavily upon private financial donation to help them out of debt. In many cases, they are overmortgaged and underfinanced. They foster and protect the public interest in health, safety, and welfare. They provide the communities they serve with one of its most critical services—care of the sick and injured.

H.R. 11357 shackles this service with a system dependent upon interruption of service as its catalyst for success. While Congress ought to preempt this field, it ought to insure in doing so for all in need that continuity of service will be maintained. This requires special consideration and provisions.

This Congress has not decided that the Nation's largest employer must provide its employees with the right to strike. Congress has not, nor should it, provide Federal employees with the right to strike. Not because of an archaic doctrine of sovereign immunity or supremacy but simply because the public cannot long stand a cessation of Government services. Our communities cannot long endure the cessation of private nonprofit hospital services. In Missouri alone, 31 communities are served by only a single hospital each. In one of these communities a hospital strike would mean no service at all. The knowledge that the employees of the hospital were exercising a federally protected right would be a poor substitute for the sustaining type of health care the people of that community may require. An emergency operation cannot wait on the process of collective bargaining for the delivery of the product. Hospital employees ought to have bargaining rights, as do Federal Government employees. The right of Federal employees to bargain, and the interest of the public in protection from Federal employee strikes has, however, been accommodated. Executive Order 11491 gives employees the right to organize and bargain without the right to strike. In lieu of the strike there is a tripartite panel for the settlement of disputes.

Executive Order 11491 establishes a Federal Labor Relations Council which handles major policy questions and is hopefully equipped to deal with the uniqueness of government.

A similar panel would well fit hospitals where policy questions ought to be exempted from bargaining—for example, staffing requirements, emergency job assignments, or where a methodone treatment center should be located. These should be exempt.

A Federal services impasse panel deals with bargaining impasses. This panel alone can authorize the use of factfinding or arbitration. In postal services, the National Labor Relations Board plays a role, and after a cooling off period of 90 days, binding third-party arbitration is mandator. The Federal Mediation and Conciliation Service is available to the bargaining parties.

While all of these panels may not be required in the hospital field, most certainly a hospital disputes impasse panel is. A prohibition on strikes is. A prohibition on work stoppages because of jurisdictional type disputes is. A prohibition on picketing is.

Further, we submit, strikes and picketing in violation of law in the hospital field cannot wait on the procedures of the National Labor Relations Board, which often takes several weeks to act "expeditiously." Hospitals must be given the right to seek immediate injunctive relief against a strike. As has been frequently noted, even by the U.S. Supreme Court—Boys Markets—monetary damages provide an inadequate relief to strikes.

Nowhere is this as true as it is of the nonprofit hospital serving a community's life and death problems. The injunction is the only effective remedy. It must be given to the hospitals to insure its timely effectiveness.

Federal hospitals are covered by Executive Order 11491. While the class of citizens they serve may be limited, there is no basis for discriminatory treatment. Voluntary nonprofit hospitals have identical goals—the continuous treatment of the sick and injured without profit. There can be no basis for allowing the strike in the one and not the other. The public they serve, whether veteran or infant, must be given the same consideration, the same protection.

This consideration and protection requires that the health care services they offer be continuous and free from interruptions due to labor disputes. The National Labor Relations Act does not give this kind of insurance, and before it can be applied to hospitals, it must.

I thank you for the opportunity for speaking, and with your permission, Mr. Chairman, I wonder if I might ask Mr. Elliot to add one brief comment.

The CHAIRMAN. Certainly.

Mr. ELLIOT. I would like to stretch the one to two, because earlier the New York delegation suggested it was their opinion that the Taft-Hartley Act made injunction available to the President in emergency disputes and would be available to the President in hospital disputes.

It is our opinion that this is not true, and that there are no emergency procedures under any law today which would be available to assist a community in stopping an emergency dispute which affected the life of the community through a hospital strike.

We further understand that the administration has looked into this subject of whether or not the 80-day injunction could be used in the Kansas City construction strike, which idled some 50,000 people in Kansas City, as the strike progressed, and came to the conclusion that the 80-day injunction was not available to settle a matter which was purely local in character.

I suppose legal minds can differ on that conclusion.

The CHAIRMAN. No; it is just a difference of your opinion as to your importance as to the New Yorker's opinion of his importance. [Laughter.]

Mr. ELLIOTT. I agree.

The second point that I wanted to make is that there has been much talk that this bill would help the jurisdictional strike-type problem.

We have urged in this connection that the hospitals be given a right to seek immediate injunctive relief on their own under the National Labor Relations Act.

That relief or injunction from a strike in violation of that act, whether it be a recognition strike or secondary boycott strike, is

available only through the processes of the National Labor Relations Board.

An employer has no right to bring a lawsuit on its own behalf because of a strike, to get an injunction. To demonstrate the need for this, I am going to turn to a situation of an employer who is covered by the act.

The employer had a dispute in New Mexico for recognition with the Operating Engineers Union. The Operating Engineers Union demanded recognition on the 18th of April. Picketing commenced on the 19th of April.

On the 20th of April, the employer filed an employer petition to hold an election, 28-RM-180.

Under the provisions of the act, since the petition was filed at a time when picketing was being pursued, the Board is directed to hold an election expeditiously.

On April 30, blocking charges were filed by the Operating Engineers Union. Those charges were dismissed by the Labor Board on the 15th of May, but the election had been delayed.

The Labor as of the 15th of May continued to offer no election because the union advised that it was going to appeal the dismissal of the charges to the Board in Washington.

The election was finally held, and certification, on June 9. During this time, the union had picketed in New Mexico, Kansas and, Missouri. Having lost the election and lost the Board certification on the 9th of June, the Carpenters Union decided to help out the Operating Engineers, and they started picketing.

The Laborers Union then jumped on the bandwagon, and they started picketing. The employer under the procedures of the National Labor Relations Act was finally free from the work stoppage and the picketing in September.

Hospitals cannot endure that type of delay. The Labor Board is virtually powerless to deal with it, notwithstanding their caseload, because of the opportunity for unions to file blocking charges to delay an election, to use the strike as the pressure technique to obtain recognition where they are not in fact a majority representative.

This employer at a cost of \$6,000 a day, for which no damages were available, withstood the strike and got a certification of no representative.

The CHAIRMAN. I appreciate that example.

On the other hand, there are examples of long strikes, disruptions, where there are no provisions of the law that proscribe procedures for recognition or an election. My notes indicate that out in Cleveland, St. Louis Hospital had a recognition strike for 11 months. Is that true?

Mr. NEWCOMER. Mr. Chairman, I believe the testimony of the representative of the House Employees was that was one of the first recognition strikes. I believe that was the essence of his testimony.

The CHAIRMAN. Engelside Hospital, a Cleveland hospital, 33 months.

Mr. NEWCOMER. Yes; I just checked that. Engelside Hospital is a Cleveland hospital; however, it is presently listed in the AHA guide as a nonprofit, long term; I believe psychiatric.

The CHAIRMAN. How long was the stoppage at Cafaro Hospital in Youngstown; do you know?

Mr. WHELAN. Cafaro is a private nonprofit osteopathic hospital. I believe it was in the range of 3 weeks.

The CHAIRMAN. What is the hospital in Cleveland which is the State or county union hospital?

Mr. NEWCOMER. That would be Cleveland Metropolitan General Hospital, which consists of three institutions which are county operated.

The CHAIRMAN. They had a recognition strike which lasted 6 months, I am told.

Mr. NEWCOMER. Mr. Whelan, I think, could answer that.

Mr. WHELAN. I believe it was about 18 weeks, Senator. This was back in 1965, I believe it was.

The CHAIRMAN. I think some of those examples in the State of Ohio led Congressman Ashbrook to be one of the major sponsors for this legislation in the House. I am sure you are familiar with this.

Mr. NEWCOMER. We did contact Congressman Ashbrook, and due to his response we really did not concentrate on the rest of the Ohio Representatives. It was unexpected, really.

The CHAIRMAN. Unexpected?

Mr. NEWCOMER. Yes.

The CHAIRMAN. I would say so, too.

Mr. ELLIOT. May I point out in Kansas City we have had no recognition strikes, but every hospital bargaining unit with one exception has had a contract strike within the past 5 years—has had an impasse-type strike—but there have been no recognition strikes.

Mr. WHELAN. Senator, there have been impasse strikes in Ohio also. I am familiar with two of them.

The most recent was in December of last year at Youngstown Hospital Association.

This was a straight economic dispute. It lasted about 10 days.

Mr. YECKEL. I think it does need pointing out, Senator, that there is in effect when a strike occurs in a hospital—I was listening to Dr. Pomrinse's report on the fact that they intended to keep their operation going in the event of a strike. This is understandable. You do what you have to do.

But I do not think there is any question but that the quality of care provided the patients that remain in the hospital does go down.

We did have in Kansas City recently in the early part of the summer a strike in a hospital. They had to reduce their patient load. This was a strike of building service employees and maintenance engineers.

Then the nurses were faced with the necessity of doing a lot of jobs they ordinarily do not do to keep the facility operating. One small point—but it could be a very big point—they did note that the number of medication errors increased quite significantly during that period, as obviously they had more to do, and could not be as effective.

You multiply that by other bargaining units in the house, and I think there is no question but that a strike on the part of any one of them would cause a hospital very rapidly to close down. That, I think, is the thing that frightens us more than anything.

The CHAIRMAN. I believe there is only one department that the patients would like to see go out on strike, and that is the accounting department. [Laughter.]

We have taken the full morning and early afternoon. I appreciate your patience with our committee schedule. I wanted to run right on through, and you were very cooperative, gentlemen.

We appreciate it.

It has been very, very helpful.

I now order printed in the record all statements of those persons unable to be present at this hearing today along with other pertinent material.

(The material referred to follows:)

STATEMENT OF THE  
COMMUNICATIONS WORKERS OF AMERICA  
WASHINGTON, D.C. 20006  
AUGUST 16, 1972

H.R. 11357

The Communications Workers of America supports without qualification the enactment of H.R. 11357, which would allow employees of nonprofit hospitals to come under the protection of the National Labor Relations Act. The time is long past to repeal the statutory exemption given to nonprofit hospitals in the Taft-Hartley legislation of 1947.

Twenty-five years ago, when Congress excluded employees and employers in the nonprofit hospital industry from the National Labor Relations Act, it did so for two major reasons, which no longer hold true today. The first reason was that it was believed that the health industry did not constitute interstate commerce. The second reason was that it was then thought that nonprofit hospitals were "charitable" in nature.

The interstate commerce argument was based on the small size of the hospital industry as a whole. In 1947, that industry was a comparatively minor operation on a national level, employing only 350,000 persons. Today, in contrast, there are more than 7,000 hospitals in the United States with nearly 3 million workers, almost 10 times the 350,000 in 1947. Employment in this industry exceeds the total number of workers in aircraft, textile products, printing and publishing, chemicals and allied products, department stores, banking, hotels and other important areas of service and production.

Moreover, today, America's hospitals have combined assets of more than \$36 billion. They spend more than \$25 billion in providing services to their patients and have a yearly payroll of over \$15 billion. In addition, the annual U.S. health bill is now \$75 billion.

The extensive growth and proliferation experienced by the entire hospital industry during the last quarter-century has made a significant impact on the

-2-

nonprofit sector of the industry. Nonprofit hospitals now make up 48 percent of all hospitals and handle fully 66 percent of all admissions. They employ almost 1,400,000 workers.

Because of the growth and development of the hospital industry and the concomitant acceleration in the nonprofit hospital group, courts and agencies have recently ruled that operation of hospitals constitutes interstate commerce and this industry is thus subject to regulation by Congress. One example of this is that in 1966 the Supreme Court, in Maryland vs. Wirtz, upheld the power of Congress to bring hospital employees under the 1966 Amendments to the Fair Labor Standards Act. In addition, Congress itself has recognized the interstate commerce feature of nonprofit hospitals by including them under the Equal Employment Opportunity Act.

The second reason why nonprofit hospitals were not brought under the authority of the National Labor Relations Board 25 years ago--that they are "charitable institutions"--no longer holds true today.

This point, that the very notion of "nonprofit" hospitals is an anachronism, has been reinforced by many experts in the health industry in recent years. In fact, it was made by numerous hospital administrators who testified on this legislation when it was considered in the House.

Reverend <sup>John</sup> Simmons, who is in charge of the Pacoima Memorial Lutheran Hospital in the suburbs of Los Angeles, put the matter in proper perspective when he said:

"There is just no way to operate a hospital on charitable contributions. I could keep open maybe one day in a year, maybe, you know, if I was lucky."

The day of the charitable hospital operating solely on donations from wealthy patrons for the benefit of the poor, like the horse-drawn buggy as the principal means of transportation, is over in America.

-3-

The passage of H.R. 11357 would give Congressional recognition not only to the fact that nonprofit hospitals do constitute interstate commerce, as the Supreme Court decided in the case mentioned earlier, but also to the equally well-established fact that nonprofit hospitals are no longer "charitable institutions."

Besides these constitutional and legal arguments, there are two other compelling reasons, based on efficiency and equity, for the enactment of this legislation. H.R. 11357 would promote efficiency by stabilizing the hospital industry labor force, and it would promote equity by extending the right of collective bargaining to workers employed in the nonprofit element of the industry.

Stabilization of the labor force in America's hospitals has become a problem because hospital workers labor long hours with inadequate remuneration. In 1970, the average annual salary for all hospital employees, including doctors, administrators, nurses and other aides, was \$5,290. The poor pay in the hospitals is the main reason why one-third of the registered nurses have left the profession in recent years.

The evidence that unionization of employees greatly reduces the turnover is overwhelming. At the famous Johns Hopkins Hospital in Baltimore, the turnover rate among the so-called "nonprofessional" staff was 700 percent per year. With union recognition and a union contract, the turnover rate at the hospital is now only 10 percent.

At the Mount Sinai Hospital in New York, there was a 1500 percent turnover before unionization and 24 percent after unionization. At the Pacoima Hospital in California, mentioned earlier, the average turnover was 200 percent. Today, with union contracts and benefits, it is, in Reverend Simmons' words, "way under 100."

-4-

Because nonprofit hospitals are not under the National Labor Relations Board's jurisdiction, many of them experience "recognition strikes" on the part of employees seeking to attain status for their unions. Employers in nonprofit hospitals under current law are not required to bargain with organizations representing the hospital employees. When employers refuse to do so, employees are forced to strike--not for better wages--but to obtain recognition.

The plain fact is that current law denies nonprofit hospital employees access to the National Labor Relations Board's election procedures. H.R. 11357 would accord to these employees the right to the Board's election process, which they fully deserve, and at the same time would probably eliminate the "recognition strike" and almost wipe out the employee turnover in this industry.

We are particularly concerned about 200 employees at the Methodist Hospital in Pikesville, Kentucky, who have declared they want Communications Workers of America representation and are in the tenth week of a "recognition strike." It began after the hospital board fired several hospital workers for union activity. These nonprofessional hospital employees are entitled to decent wages and working conditions.

From the standpoint of pure equity, it is unfair that any employees doing the same work in nonprofit hospitals as is done by their co-workers in federal hospitals, municipal and state hospitals, and private hospitals should be paid less because they do not enjoy the rights of self-organization and collective bargaining. It is inequitable and discriminatory to exclude nurses, orderlies and other employees of nonprofit hospitals from coverage under the National Labor Relations Act when they would be entitled to this coverage if they were employed anywhere but in a nonprofit hospital.

-5-

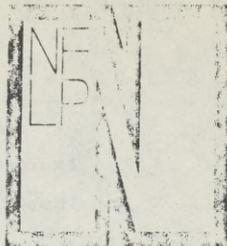
Representative John Ashbrook (R-Ohio) confronted this problem squarely and with perfect logic when he stated during House floor debate on H.R.

11357:

"It is difficult to find rationality and pragmatism in a labor policy which permits an employer to refuse to deal with employees on collective bargaining terms chosen by the employees. The consequence of such a refusal, in the form of recognition strikes and open strife, is then inflicted upon the public."

Congress now has an important opportunity to correct the inequity of excluding nonprofit hospitals from National Labor Relations Board coverage. The unfolding of events in the hospital industry during the last quarter-century has clearly shown that nonprofit hospitals both engage in interstate commerce and are no longer charitable institutions. A hospital is a business enterprise, whether its character is proprietary or nonprofit in terms of its organization. If all hospitals serve the general public's health needs, they should be governed by an even-handed public policy.

We urge Congress to correct the anachronism under which employees of nonprofit hospitals are excluded from the jurisdiction of the National Labor Relations Board. Congress can render these economically deprived employees a long-overdue justice by passing H.R. 11357.



NATIONAL FEDERATION OF LICENSED PRACTICAL NURSES INCORPORATED

4th August 1972

The Honorable Harrison A. Williams, Jr.,  
 Chairman, Senate Committee on Labor  
 Old Senate Office Building, Room 352  
 Washington, D.C. 20510

RE: H.R. 11357

Dear Senator Williams:

We are enclosing a statement supporting passage of H.R. 11357 with an amendment which will mandate procedures to follow in the event an impasse occurs between management and labor.

Since Licensed Practical Nurses place the welfare of patients above their own welfare, we do not support a "strike" policy. Therefore, it is essential that H.R. 11357 mandate procedures in the event an impasse occurs.

We would appreciate the opportunity to expand our statement in a hearing conducted by the Senate Sub-Committee on Labor.

Sincerely yours,

Etta B. Schmidt (Mrs.)  
 Executive Director

EBS/nc  
 enclosure

NATIONAL FEDERATION OF  
 LICENSED PRACTICAL NURSES



NATIONAL FEDERATION OF LICENSED PRACTICAL NURSES INCORPORATED

Statement of  
NATIONAL FEDERATION OF LICENSED PRACTICAL NURSES, to  
SENATE COMMITTEE ON LABOR AND PUBLIC WELFARE

National Federation of Licensed Practical Nurses is the professional association of Licensed Practical and Licensed Vocational Nurses in the United States. It is the only professional association which is run for and by LPNs exclusively. The association has state affiliates in forty states with individual members in ten states. The association seeks to foster high standards of nursing care, to promote the professional and educational advancement of LPNs and to advance their economic welfare. Through its state affiliates the association has collective bargaining agreements with hospitals, nursing homes and health care facilities throughout the nation. Many thousands of LPNs enjoy the benefits of our contracts. We are committed to the use of collective bargaining as the means whereby LPNs will improve their economic welfare which ultimately means improvement of their practice.

NFLPN has long believed that the right to organize and enjoy the benefits of collective bargaining should be extended to employees of all hospitals, nursing homes and other health care facilities. These statutory rights guaranteed to employees of proprietary

-2-

hospitals should not be denied to other employees merely because they work for nonprofit hospitals. Equity and simply justice require that the employees of both kinds of hospitals be treated alike. Therefore, NFLPN goes on record as being wholeheartedly in favor of the pending legislation, H.R. 11357, to restore to employees of nonprofit hospitals those rights contained in Section 7 of the National Labor Relations Act, as amended. It is the opinion of NFLPN, however, that H.R. 11357 does not go far enough.

NFLPN has wide experience in negotiating collective bargaining agreements with both proprietary and nonprofit hospitals. Eleven states exercise jurisdiction over nonprofit hospitals so we have much experience in negotiating contracts with this type of hospital. Our extensive experience has demonstrated conclusively that the trustees of a nonprofit hospital are no more eager to bargain in good faith and come to a meaningful settlement with us than are the owners of a proprietary hospital. Unless management is convinced of the very real possibility of a strike, management will evade, procrastinate, double-talk and place no meaningful offers of settlement on the bargaining table. In this respect management of both categories of hospitals think and act alike. In any kind of hospital "strike" is a dirty word. LPNs do not condone the withholding of their services to the sick, the injured and the crippled. Yet, this is the only method whereby then can compel hospital administrators to take their demands seriously. Surely there must be a better way to solve the labor relations of hospital employees than by resorting to strikes. This is the problem to which NFLPN addresses itself.

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-3-

Some of the eleven states which assert jurisdiction over employees of nonprofit hospitals have evolved unique solutions to the problem mentioned above. New York, for example, has long asserted jurisdiction over nonprofit hospitals. In 1962, New York Labor Law, Section 716, was enacted to deal with this problem. In brief, the New York Labor Law prohibits strikes in nonprofit hospitals but, as quid pro quo, mandates procedures to be followed in the event of an impasse between management and a labor union. These procedures include mediation, fact-finding and arbitration with statutory guidelines within which the arbitrators must make their awards. It has been the experience of NFLPN that the existence of such a law and at times, the mere threat to invoke its use, is sufficient to make all parties work out the terms of a satisfactory compromise. More and further experimentation by the states is needed along these lines. It would be a great tragedy if the existing state laws and procedures were eliminated by the federal preemption of H.R. 11357. Those employees who currently enjoy the benefits of state laws which seek to provide solutions to impasse in contract negotiations should not have these rights and privileges taken away from them.

It is not enough to provide representation rights to employees of nonprofit hospitals. After an organization has won the right to represent the workers there must be machinery to settle impasses; otherwise the resolution of impasses is determined by the use of raw economic strength. In a health care facility the burden of a

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-4-

strike falls upon the sick, the injured, the feeble and the aged. These are the ones least able to cope and who, through no fault of their own, are caught in the middle. For these reasons the National Federation of Licensed Practical Nurses support the removal of the nonprofit hospital exemption from Section 2 (2) of the National Labor Relations Act. However, we urge that H.R. 11357 be amended so as to prohibit the National Labor Relations Board from asserting jurisdiction over nonprofit hospitals located in states which have laws such as New York Labor Section 716, or, in the alternative, that H.R. 11357 be amended to provide the procedures contained in New York Labor Section 716 to resolve impasses in collective bargaining.

We ask for the opportunity to expand upon this statement in a hearing to be conducted by the Senate Sub-Committee on Labor.

Dated: New York, N.Y.  
August 4, 1972

*Mary B. Runnels*

Mary B. Runnels

President

NATIONAL FEDERATION OF LICENSED  
PRACTICAL NURSES, INC.

ADVANCING VOLUNTARY LEADERSHIP IN A CHANGING WORLD



## Chamber of Commerce of the United States

LEGISLATIVE ACTION GENERAL MANAGER  
HILTON DAVIS

202-659-6140

1615 H STREET, N.W.  
WASHINGTON, D.C. 20006

September 6, 1972

C

Honorable Harrison Williams, Chairman  
Subcommittee on Labor  
Labor and Public Welfare Committee  
United States Senate  
Washington, D. C. 20510

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Dear Mr. Chairman:

Attached is a statement expressing the views and recommendations of the Chamber of Commerce of the United States on H.R. 11357, a bill to amend the National Labor Relations Act.

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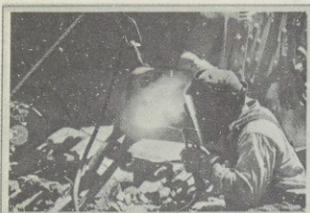
We will appreciate your consideration of these views and request that the statement be made a part of the hearing record.

Cordially,

Hilton Davis  
General Manager  
Legislative Action

Y

cc: Subcommittee Members  
Stewart E. McClure  
Eugene Mittelman



*Statement of the*

CHAMBER OF COMMERCE OF THE  
UNITED STATES OF AMERICA

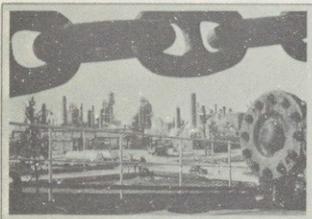


on: H. R. 11357  
An Amendment to  
the National Labor  
Relations Act

to: Subcommittee on  
Labor, Senate  
Committee on Labor  
and Public Welfare

by: O. F. Wenzler

date: September 6, 1972



The Nation's largest business federation representing local and state chambers of commerce, trade and professional associations, and business firms.

STATEMENT  
on  
H.R. 11357  
AN AMENDMENT TO THE NATIONAL LABOR RELATIONS ACT  
for submission to the  
SUBCOMMITTEE ON LABOR  
SENATE COMMITTEE ON LABOR AND PUBLIC WELFARE  
for the  
CHAMBER OF COMMERCE OF THE UNITED STATES  
by  
O. F. Wenzler \*  
September 6, 1972

The Chamber of Commerce of the United States appreciates this opportunity to present our views in opposition to H.R. 11357 -- a bill to amend the National Labor Relations Act.

The National Chamber is the largest federation of business and professional organizations in the United States and is the principal spokesman for the American business community. Representing more than 3,500 trade and professional associations and state and local chambers of commerce, and a direct membership of more than 44,000 business firms, the National Chamber has an underlying membership of more than five million individuals and firms.

H.R. 11357 is, in terms of its language, a simple bill. It would extend coverage of the National Labor Relations Act to nonprofit, nonpublic hospitals, by removing from the Act language which presently exempts such hospitals from coverage. Simple as this change of language may be, the problems its passage would create are complex.

The nonprofit, nonpublic hospital industry constitutes by far the largest segment of the total hospital industry. Of the 7,123 hospitals in the United States, 5,859 are short-term, general medical and surgical care hospitals. Of this group, 3,386 are nongovernmental, not-for-profit hospitals. Less than 15% of the total are for-profit hospitals and the remaining numbers are operated by various federal, state and local governments.

Clearly, when the average citizen needs regular, short-term, medical or surgical care, the institution most often providing that care is the nonprofit, nongovernmental hospital. It is an understatement to say that H.R. 11357 would affect the cost and the availability of health care services to nearly every American.

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\* Labor Relations Manager, Chamber of Commerce of the United States

Congress has recognized the unique character of the nonprofit hospital by granting it an exclusion from the National Labor Relations Act and not subjecting it to the labor-management philosophy and national labor policy which was designed for the private industrial sector. The nonprofit hospital, unlike private industry, is not run for the benefit of any group of investors who expect to receive a return on their investment. The issues of economic competition between labor and management which underpin our national labor policy do not exist in the nonprofit hospital. Accordingly, it would be a mistake to impose regulations based on that competition on this critical service industry.

#### Objections to Bill

The basic objections to this bill are that it would add substantially to the health care costs of all Americans at a time when those costs are already sky-high, and it would impose obligations and duties on hospitals which are ill-suited to their special needs.

The National Chamber does not oppose the legitimate interests of employees of nonprofit hospitals. Quite the contrary. We strongly support fair and responsive employee relations as an essential facet of any employment relationship, whether regulated by the National Labor Relations Act, or exempt from that Act. Only through such an enlightened approach to employee relations can the nonprofit hospital provide in full measure the crucial life protecting services for which it is intended. Additionally, good personnel practices attract better employees and insure a willing and able staff, one which can realize its primary obligation to provide humanitarian health care services and is not burdened with the petty problems and complaints which restrictive and arbitrary policies would bring about.

#### Higher Costs

A hospital is a labor intensive operation; there are around three employees for every patient. Many critical patient care operations cannot be mechanized. The impact of union demands for higher wages and fringe benefits can only be an increase in health care costs to the patient as a hospital is unable to significantly reduce costs by increased automation. In addition, hospitals would face new administrative costs in bargaining with unions, responding to union charges in administrative and court proceedings, and administering new work rules contained in union contracts.

### Strikes and Other Work Stoppages

The basic elements of the collective bargaining process are strikes, picketing and work stoppages -- the economic weapons given to organized employees. These "weapons" have no place in health care service where life and death situations are faced daily. Hospital services are at least as important as police and fire protection and ought to be available without interruption.

Recognition picketing, legal under the NLRA, may cause substantial harassment to a hospital. In addition, illegal secondary picketing activities pose a larger threat to hospitals. Under present law, employers are unable to seek injunctions to stop such picketing and the NLRB is unable to respond rapidly enough when a union violates the Act's prohibitions against secondary boycotts, jurisdictional strikes, picketing and the like. The delay involved while waiting for the NLRB to act may have little lasting impact in an industrial situation. In a hospital, it may be critical, both to those already in the hospital and to those who look to the hospital for care.

The Act has no adequate provisions for resolving bargaining impasses, relying instead upon the economic weapons of the strike. While this may be acceptable in the industrial situation, it is an unconscionable burden to place on hospitals where critical services may be affected by any strike.

The specter of a hospital being turned into a morgue because of a strike is all too real, regardless of the protestations of union leaders that they would never engage in strikes. In fact, hospital unions have called strikes, even where specific laws regulating hospital labor relations specifically bar them. If this happens when strikes are illegal, what would be the inhibiting factor if strikes are legally protected?

This is an intolerable bargain and cannot be permitted. If H.R. 11357 is to become law, at the very least there must be some protection afforded to the general public in the form of a prohibition against strikes of any kind in hospitals.

### NLRA in Need of Revision

At present the National Labor Relations Act, and the body of decisional law evolving from it, contains many gross inequities affecting those industries already covered by the Act. To extend these inequities to any other industry not

currently saddled with them would not be in the public interest. We strongly urge that, if this committee desires to amend part of the National Labor Relations Act, it continue its examination into other areas of the Act and propose far broader amendments than those contained in this bill. For instance:

-- The Act should clearly state that our national labor policy favors freedom of choice of all employees to join or not to join labor organizations.

-- As a protection to employees, no labor organization should be granted recognition unless it has demonstrated majority status through a secret ballot election.

-- Workers should be freed from the coercive impact of union fines.

-- Employers should regain their freedom of speech, to enable them to discuss with their employees the meaning and impact of unionization.

-- The use of blackmail and secondary pickets should be barred. They have no place in a valid labor dispute.

-- Restrictions should be placed on the scope of proper subjects for bargaining.

While not exhaustive, the above list does limit areas of concern. If the proposal to extend the NLRA to nonprofit hospitals is serious, then a good hard look must be taken at the Act in order that nonprofit hospitals, and the general public, not be burdened with the inequities now contained in the NLRA.

#### Conclusion

In summary, the National Chamber does not support extension of coverage of the National Labor Relations Act to nonprofit hospitals. The increased burden placed on nonprofit hospitals and the resulting increase in health care costs to the general public are sufficient grounds to move very slowly in this area. In addition, the general public should be protected from the possibilities of selfish union actions, by prohibiting strikes in nonprofit hospitals. And finally, if there is to be amendment of the National Labor Relations Act, then a review should be made of the entire Act and other amendments introduced to remove the present inequities. We strongly urge that H.R. 11357 not be reported from committee.



**HOSPITAL COUNCIL  
OF THE NATIONAL CAPITAL AREA, INC.**

1812 K STREET, N.W., WASHINGTON, D.C. 20006 • 202|296-5727

OSCAR BENWOOD HUNTER, JR., M.D.  
*President*

WILLIAM M. BUCHER  
*Executive Vice President and Director*

September 6, 1972

Senator Harrison A. Williams, Jr., Chairman  
Committee of Labor and Public Welfare  
United States Senate  
Washington, D.C. 20510

Dear Senator Williams:

As the result of your August 16, 1972 call for corrective language proposals relating to HR 11357, we are pleased to submit the attached Statement for the September 6, 1972 Public Hearing Record.

The importance of a full briefing and Committee investigation of the facts and experience on this legislation can not be over estimated.

Sincerely yours,

William M. Bucher  
Executive Vice President  
and Director

WMB:lm

Attachment - Statement for the Hearing Record

MEMBERS: ALEXANDRIA HOSPITAL • ARLINGTON HOSPITAL • CAFRITZ MEMORIAL HOSPITAL • CHESTNUT LODGE • CHILDREN'S HOSPITAL • CIRCLE TERRACE HOSPITAL • COLUMBIA HOSPITAL FOR WOMEN • DOCTORS HOSPITAL • FAIRFAX HOSPITAL • FREEDMEN'S HOSPITAL • GEORGE WASHINGTON UNIVERSITY HOSPITAL • GEORGETOWN UNIVERSITY HOSPITAL • HADLEY MEMORIAL HOSPITAL • HOLY CROSS HOSPITAL • HOSPITAL FOR SICK CHILDREN • LELAND MEMORIAL HOSPITAL • MALCOLM GROW (USAF) MEDICAL CENTER • MONTGOMERY GENERAL HOSPITAL • NATIONAL ORTHOPAEDIC AND REHABILITATION HOSPITAL • PRINCE GEORGE'S GENERAL HOSPITAL • PRINCE WILLIAM HOSPITAL • PROVIDENCE HOSPITAL • PSYCHIATRIC INSTITUTE OF WASHINGTON • ROGERS MEMORIAL HOSPITAL • SIBLEY MEMORIAL HOSPITAL • SUBURBAN HOSPITAL • WASHINGTON HOSPITAL CENTER • WASHINGTON SANITARIUM AND HOSPITAL



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OSCAR BENWOOD HUNTER, JR., M.D.  
*President*

WILLIAM M. BUCHER  
*Executive Vice President and Director*

September 6, 1972

STATEMENT  
OF  
WILLIAM M. BUCHER

Mr. Chairman and members of the Subcommittee my name is William M. Bucher. I am the Executive Vice President of the Hospital Council of the National Capital Area an organization of twenty-eight metropolitan Washington hospitals.

I appreciate the opportunity to appear before you today and to offer to the Committee amendments to HR 11357. These amendments, I believe, will protect the public in the form of a sick patient from the disruptive activities of unions in the health care industry.

I have with me Messers Robert J. Hickey and Robert J. Smith who as counsel will be pleased to respond to any technical questions the Committee may have on the proposed amendments. The proposed amendments identified as to related sections of the act are as follows:

## PROPOSED AMENDMENTS TO THE NATIONAL LABOR RELATIONS ACT

1. Section 2 (2) is amended by striking the phrase, "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".
2. Section 2 is amended by adding the following new subsection (14): "The term 'health care facility' shall include any hospital, nursing home, extended care facility, clinic, institution caring for the aged or any other employer whose purpose is devoted in substantial part to health care or maintenance."
3. Section 8(a)(1) is amended by adding the following: "Provided further that all organizational activity is prohibited within a health care facility."
4. Section 8 (a)(3) is amended by adding the following proviso: "Provided further that the prohibition of this subsection shall not apply to discipline imposed by a health care facility for an employee's engaging in activity not protected by this Act without regard to other motives of the health care facility."
5. Present Section 8(d) is modified in the following manner:
  - a. The present proviso is modified by changing the first sentence: "Provided (1), That where there is a collective bargaining contract in effect covering employees in an industry affecting commerce, other than a health care facility . . . ."
 

The remainder of the proviso will remain the same except that subsections 1 through 4 shall be renumbered (i) through (iv).
  - b. A new second proviso shall be acted:
 

"(2) That where there is a collective bargaining agreement covering employees in a health care facility, no party shall terminate or modify such contract or engage in any coercive activity of any nature directed towards termination or modification of such conduct.

    - (i) The party proposing modification or termination shall serve a written notice upon the other party of the proposed termination or modification and of the proposed time and place for the commencement of negotiations between the parties sixty days prior to the time it is proposed to make such termination or modification.
    - (ii) Within 10 days of the receipt of the notice, parties shall agree to a time and place for commencement of negotiation.

(iii) If the parties are unable to establish a time or place for negotiation or to negotiate in good faith a new agreement resolving all the issues and disputes between them within 180 days, either party may request the services of the Federal Mediation and Conciliation Service who shall set a time or place for negotiation or immediately offer to mediate the dispute.

(iv) If in the sole discretion of the Federal Mediation and Conciliation Service mediator he believes that the dispute can not be settled through mediation, he shall terminate his services and at the same time proffer arbitration to the parties.

(v) The mediator will furnish to the parties a list of 7 names, one of which must be selected by the parties for consideration and determination of the dispute. The parties shall select the arbitrator from a list by alternately striking names until only one remains and he shall serve as the arbitrator. The salary and expenses of the arbitrator shall be borne equally by the health care facility and the labor organization. The decision of the arbitrator shall constitute the new contract and shall be final and binding on the parties. The above arbitration procedures shall not apply if the parties by voluntary agreement determine that an alternate method or procedure is appropriate in their particular dispute."

c. The sentence following subparagraph (4) of the present Act shall be modified to read: "The duties imposed above shall be inapplicable when . . ." The remainder of the sentence and paragraph commencing "the labor organization or individual, which is a party to the contract . . ." shall remain unchanged.

6. A new subsection 8(g) is added, providing:

"All collective bargaining agreements between health care facilities and labor organizations must contain a clause providing a method for adjustments of disputes and grievances arising out of interpretation or application of the collective bargaining agreement. This clause must prohibit all coercive activities during the term of the contract and must contain as the last step final and binding arbitration by a neutral party or parties."

7. Section 9(b) is amended by adding the following proviso:

"Provided that only appropriate units in a health care facility shall consist of one of the following units: all professional employees, all technical employees, all clerical employees, and all other employees, excluding guards and supervisors. There shall be no combining or fragmenting of these units except that the parties may voluntarily agree to such other units."

8. Section 10 is amended by adding a new subsection (n), which provides the following:

"Whenever it is charged that any person, labor organization, or employee is engaged in strikes, picketing or work stoppages of any kind against a health care facility, the regional office of the National Labor Relations Board

in which the activity occurs shall seek immediately, but no longer than within 4 hours of the request, a temporary restraining order in a United States District Court. A restraining order must issue forthwith without regard to the facts, legal issues involved, or the extent to which an investigation has been undertaken by the Regional Office. The Board shall immediately conduct a preliminary investigation of the charge which must be completed and a report submitted to the Court within 30 days of the issuance of the restraining order. Within 10 days after receipt of the report, the Court must determine whether a preliminary injunction should issue and under what conditions. The Court shall retain jurisdiction for the purpose of issuing a permanent injunction and whatever relief it deems just and proper, provided that the Court must impose upon a person, employee, or labor organization (including any parent organization without regard to its independent responsibility) engaging in such activity, a fine consisting of not less than \$1,000 for each day on which this activity occurs, which cannot be waived by agreement of the parties."

9. Section 13 is amended by numbering the present paragraph as paragraph (a) and by adding a new subsection (b): "Notwithstanding subsection (a) and Sections 7 and 8, all strikes, picketing, work stoppages, refusal to perform any services, threats, inducements, and related activity, directed at a health care facility or at persons doing business with it, where an object thereof is to affect services provided by that facility, shall be prohibited without regard to whether it is primary or secondary in nature."

10. Section 303 is amended by adding a new subsection (c):

"Any health care facility or patient injured by reason of violation of Section 13 may sue in a United States District Court in the same manner as provided in subsection (b). In such an action, the Court may award both actual and punitive damages for injury to person and to property and for suffering."



**SOUTHERN  
STATES  
INDUSTRIAL  
COUNCIL**

FIGHTING FOR FREE ENTERPRISE SINCE 1933

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**STAFF**  
**ARTHUR HARRISMAN**  
Executive Vice President

**J. SCOTT BRISSETT, JR.**  
Secretary-Treasurer

**HARMON L. ELDER**  
Washington Representative  
1200 14th St., N.W.  
Washington, D. C.

August 24, 1972

Senator Harrison A. Williams, Jr.  
Chairman of the Senate Subcommittee  
on Labor  
Room G-237  
New Senate Office Building  
Washington, D. C.

Dear Senator Williams:

The Southern States Industrial Council, an organization representing 3,000 companies employing approximately 3,000,000 people, has a great interest in H. R. 11357, the bill your Subcommittee is considering that would place employees of non-profit hospitals under the national labor relations act.

We, therefore, respectfully request that the enclosed statement expressing our views on this legislation be made a part of the record of hearings on H. R. 11357.

Sincerely,

*Harmon L. Elder*

Harmon L. Elder  
Washington Representative

cc: Messrs. Nixon  
Miller  
Harrigan  
Grigsby

STATEMENT OF  
SOUTHERN STATES INDUSTRIAL COUNCIL  
ON H. R. 11357, A BILL TO EXTEND COVERAGE OF  
THE NLMRA TO NON-PROFIT HOSPITAL EMPLOYEES

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H. R. 11357, which is now before this Subcommittee, is one of the most important pieces of legislation to come before the 92nd Congress. It would for the first time by legislative enactment extend the coverage of the National Labor Management Relations Act beyond the limits set by Congress when it approved the act.

The significance of the proposed extension to union officials of the right to bargain collectively for 1.4 million employees of non-profit hospitals is fully recognized by the AFL-CIO. House approval of H. R. 11357 was given featured treatment in the AFL-CIO News as an important break-through in the never-ending campaign of the unions to further enlarge the already tremendous economic power conferred upon them by the Federal labor laws.

H. R. 11357 was rushed through the House after abbreviated hearings by the House Committee on Education and Labor, with limited discussion and debate, and with a minimum of publicity. Although any extension of coverage of the NLMRA enhancing the overall strength of unions by increasing the number of persons subject to unionization and payment of union dues affects directly or indirectly all employers, major employer groups were not invited to express their views on the legislation.

The House hearing record was one-sided and incomplete. We hope the Senate Subcommittee on Labor will make up for the deficiencies which marked the House's action on H. R. 11357 and conduct a thorough and searching study of all the ramifications of this bill. Pursuant to this, the Southern States Industrial Council, whose 3,000 member companies employ approximately 3,000,000 people, respectfully submits this expression of its views and asks

that the members of the Senate Labor Subcommittee give them their consideration.

For several years the Southern States Industrial Council has been asking the Congress to make changes in the National Labor-Management Relations Act of 1947 to correct its very serious weaknesses, particularly those portions of the act pertaining to the National Labor Relations Board. In 1968 and again in 1970 spokesmen for the SSIC appeared at hearings before the Senate Judiciary Subcommittee on the Separation of Powers to testify to our experiences as employers of 3,000,000 people with the act and its administration and enforcement by the NLRB. We presented evidence on how the Board has consistently decided cases before it in the way most favorable to unions, frequently at the cost of subordinating the rights of individual employees, as well as employers.

Again, in 1971, the SSIC submitted testimony to the House Special Labor Subcommittee which was holding hearings on legislation dealing with the NLRB in which we declared that a complete overhaul and reform of the national labor law was long overdue and should be undertaken without delay.

Today we wish to register the strongest possible opposition to the extension of coverage of the National Labor Management Relations Act, generally known as the Taft-Hartley Act, to one single additional individual until the act has been reformed to eliminate its pro-union bias and to free employers and employees alike from the many unfair practices promulgated by unions with Federal sanction.

In particular, the SSIC strongly opposes making non-profit hospitals -- institutions existing solely to administer to the needs of the ill and the afflicted -- subject to the strikes, slowdowns, picketing and even violence that occur in collective bargaining as it is conducted by present day unions under the NLMRA.

In manufacturing industries and service companies, production and services can be disrupted through concerted actions by unions with the effects sometimes confined to financial loss and personal inconvenience on the part of a number of people. In the case of a hospital, however, union-formulated disruptions and disturbances can cause suffering and even death. The maintenance of uninterrupted service in hospitals is equally as important as the maintenance of police and fire protection.

It was argued in the House discussion of H. R. 11357 that the hospital strikes that have occurred have been mostly due to a demand for union recognition rather than for improved wages and benefits and that, therefore, setting up the mechanics under the NLRB for such recognition would virtually eliminate strikes. That argument is absurd. Naturally, the first strikes were to win recognition, but could any sensible person deny that once the unions have won recognition as the bargaining agents for hospital employees, the next steps will be demands for higher and higher wages, and more and more benefits, with strikes ensuing if the demands are not granted? There is ample evidence, too, in New York and elsewhere, where hospital employees, having won union recognition some time earlier, have walked out on the sick and the dying.

There is the danger also that once the employees of non-profit hospitals have obtained sufficient union power, they will use that power to obtain wages far in excess of those justified by the type of work they are expected to perform. The non-profit hospital will have no choice but to pass along such increased costs, no matter how unjustified, to the patients. The great majority of those patients are middle income or lower income individuals to whom the high costs of hospital care already have become a spectre of which they stand in constant dread. These are the people whom callous union officials would squeeze even harder in order to enhance union power.

The Southern States Industrial Council, in behalf of the 3,000 employers and 3,000,000 employees represented by the organization's membership, urges the Senate Labor Committee to reject H. R. 11357 and, instead, set up hearings on the subject of a complete reform and overhauling of the present national labor laws.

August 24, 1972

STATEMENT OF  
SOUTHERN STATES INDUSTRIAL COUNCIL  
ON H. R. 11357, A BILL TO EXTEND COVERAGE OF  
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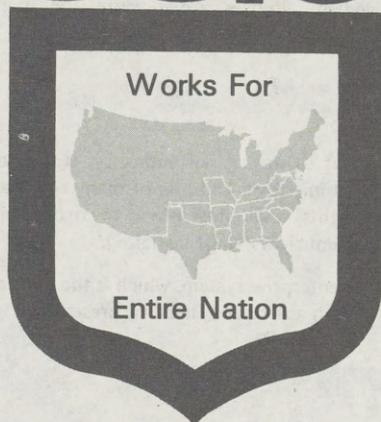
There is the danger also that once the employees of non-profit hospitals have obtained sufficient union power, they will use that power to obtain wages far in excess of those justified by the type of work they are expected to perform. The non-profit hospital will have no choice but to pass along such increased costs, no matter how unjustified, to the patients. The great majority of those patients are middle income or lower income individuals to whom the high costs of hospital care already have become a spectre of which they stand in constant dread. These are the people whom callous union officials would squeeze even harder in order to enhance union power.

The Southern States Industrial Council, in behalf of the 3,000 employers and 3,000,000 employees represented by the organization's membership, urges the Senate Labor Committee to reject H. R. 11357 and, instead, set up hearings on the subject of a complete reform and overhauling of the present national labor laws.

August 24, 1972

**FIGHTING  
FOR  
FREE  
ENTERPRISE**

**SSIC**



**Southern States  
Industrial Council**



# The Problem

## *Erosion of Free Enterprise— Loss of Individual Initiative*

Steady erosion of America's traditional free enterprise system over the past several years poses a grave threat to business and industry and to the future well-being of the nation and individual citizen.

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As more and more socialistic plans and economic controls have been implemented by the powerful federal bureaucracy, the task of operating a sound and profitable business has become steadily more difficult. The problem of finding and holding industrious, ambitious, responsible young people as employees and management trainees grows more and more acute.

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The threat to managerial authority, stifling of individual initiative, and loss of many constitutional rights, including property rights and management rights, must be halted.

The free enterprise system, which is the basis of our strength as a nation, must be preserved.

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This can be done only if businessmen recognize the danger and join in the fight to bring about a return to basic constitutional principles and a free economy.

The Southern States Industrial Council is the rallying point for this fight.

# THE COUNCIL

There is a substantial body of responsible, conservative thinking that has unswervingly supported the basic principles of our form of government — the proper role of local, state, and federal governments, and the freedom of the individual.

This thinking shapes the policies and programs of the SSIC.

The SSIC holds fast to sound economic principles.

Business-oriented conservatism finds its voice in the Southern States Industrial Council, a truly national organization.

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## **In All Fifty States**

Organized in 1933, the Council originated in the Southern states. However, the work SSIC is doing is in the interest of businessmen in all 50 states. As a consequence, SSIC has members throughout the country.

The Southern States Industrial Council is non-partisan. It deals only with principles, not political parties. It is a nonprofit business association in which dues are tax deductible as a business expense.

Members of SSIC come from all professions and all kinds of business and industry. Included in the SSIC membership are firms which together employ more than 3,000,000 people.

## *What the Council Does*

The Southern States Industrial Council wages an aggressive campaign for responsible government, a sound economy, and national security. Specific ways in which this work is carried on include the following:

**Legislation**—The SSIC maintains offices in Washington with its Washington Representative, Harmon L. Elder, in charge. Mr. Elder keeps a close watch on Congressional activities and appears at Congressional Committee hearings. He works closely with leaders of the conservative coalition in Congress and with Washington representatives of other organizations with views similar to those of the Council.

**Newspaper Column**—The SSIC issues a weekly newspaper column, "Sensing the News," written by the Council's Executive Vice President, Anthony Harrigan. It is published in daily and weekly newspapers throughout the nation. It is distributed to each member of Congress and to thought leaders throughout the country.

**Radio Programs**—An estimated 12,000,000 radio listeners are given the conservative viewpoint on current issues through the SSIC "Sensing the News" weekly radio programs on approximately 100 stations across the nation.

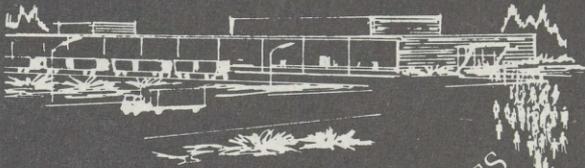
**Editorial Awards**—The SSIC offers annual cash awards to the editorial writers of daily and weekly newspapers whose editorials best interpret the spirit and goals of the free enterprise system and achievements of this system.

**Semi-Monthly BULLETIN**—The SSIC's official publication, the BULLETIN, is widely circulated among influential organizations and individuals, including members of Congress.

**Educational Materials**—More than 1,250,000 SSIC pamphlets and other pieces of literature are distributed annually. Examples of pamphlets currently in use are "Naderism", "Unions Are Obsolete", etc.

from  
**FREE ENTERPRISE**  
come the  
**PROFITS**  
which mean

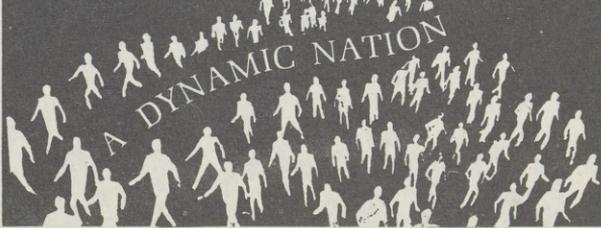
THRIVING INDUSTRY



MORE JOBS HIGHER WAGES



GREAT INSTITUTIONS



A DYNAMIC NATION

# PROGRAM FOR THE NATION

SSIC offers a Program for the Nation which includes the following points:\*

- ★ Stop inflation by reducing government spending and creating a federal budget surplus.
- ★ Limit federal welfare payments to the aged and those physically unable to support themselves.
- ★ Strengthen law enforcement to decrease crime on all levels.
- ★ Ban strikes by public employees.
- ★ Take labor management disputes from the National Labor Relations Board and place them in the federal courts.
- ★ Get the federal government out of competition with private enterprise.
- ★ Abolish compulsory unionism.
- ★ Make the anti-trust laws applicable to labor unions.
- ★ Stop federal intervention in the fields of medical care, housing, prices and wages.
- ★ Place exclusive control of the public schools in the states and their political subdivisions.
- ★ Return prayer and Bible reading to the schools.
- ★ Declare officially that our primary hot and cold war aim and purpose is total victory over Communism.
- ★ In our dealing with foreign nations, be guided by what is best for the U.S., and not what is believed to be agreeable to "world opinion."

\* Copies of the complete program are available upon request.

## SOUTHERN STATES INDUSTRIAL COUNCIL

*Executive Offices:*  
918 Stahlman Building  
Nashville, Tennessee 37201  
Telephone (615) 244-7514

*Washington Office:*  
1900 L Street, N.W.  
Washington, D.C. 20036  
Telephone (202) 833-3018

Activities of the SSIC are directed by its Officers and Board of Directors, comprised of more than 100 public-spirited business leaders. The Board determines Policy and the Council's position on major issues.

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 1900 L Street, N.W. . . . . Washington, D.C.

ahpa

association of hospital personnel administrators of greater new york #172  
post office box 413, lenox hill station, new york, new york, 10021

September 6, 1972

Senator Harrison A. Williams, Jr.  
Chairman  
Committee on Labor and Public Welfare  
U.S. Senate  
Washington, D.C. 20510

Dear Senator Williams:

Enclosed is a statement given by a representative of this association before the House of Representatives Labor Subcommittee of the Committee on Labor and Education during their hearings on H.R.11357. This association of over 180 professional Personnel Administrators strongly supports passage of H.R.11357. We would deeply appreciate you making the enclosed statement part of the public record since we feel it dramatically points out the advantages of not-for-profit hospitals being covered by the National Labor Relations Act.

Respectfully yours,

*Thomas B. Doolan*  
Thomas B. Doolan  
President

tcw  
encl.

STATEMENT OF MICHAEL BROWNE  
CHAIRMAN OF THE LEGISLATIVE COMMITTEE OF THE  
ASSOCIATION OF HOSPITAL PERSONNEL ADMINISTRATORS  
OF GREATER NEW YORK IN SUPPORT OF H.R. 11357

Mr. Chairman, my name is Michael Browne and I am Chairman of the Legislative Committee of the Association of Hospital Personnel Administrators of Greater New York. I am also Personnel Director of the Lutheran Medical Center of Brooklyn. With me today are Martin Shields, Vice-Chairman of the Legislative Committee of the Association and our counsel, Martin D. Heyert, of the firm of Kelley Drye Warren Clark Carr & Ellis. Each of us will be glad to answer any questions you may have.

The Association of Hospital Personnel Administrators of Greater New York strongly favors the enactment of H.R. 11357, which would bring non-profit hospitals and their employees under the National Labor Relations Act, as amended. My Association has 186 members who establish and administer the personnel and labor relations policies for 98 non-profit hospitals in New York City, Rockland, Westchester, Nassau and Suffolk counties in New York and in Bayonne, New Jersey and Greenwich and Norwalk, Connecticut. These 98 hospitals have a total of 38,098 beds, employ 107,572 people and, during the period July 1, 1970 to and including June 30, 1971, admitted 897,763 patients for treatment and care.

Each of our hospitals is in interstate commerce and many of them, like The New York Hospital, the Hospital for Special Surgery and Memorial Sloan Kettering Cancer Center, treat patients who

have come from every State of the United States and a host of foreign nations. For this reason, our hospitals, their employees and their patients are entitled to the same protection that the National Labor Relations Act, as amended, gives to industrial companies, profit-making hospitals and nursing homes and even to non-profit nursing homes.

In most of the States of the Union, non-profit hospitals are not subject to any legislation dealing with labor relations. In New Jersey the Courts have taken on the job of regulating labor-management relations, a job for which courts are not suited because they do not have the necessary legislative guidance or specialized expertise. In the rest of the states without legislation dealing with labor relations, however, unions are free to attempt to organize the employees and force the hospitals to recognize and bargain with them by engaging in massive strikes and violent demonstrations, such as the ones that took place in Baltimore, Charleston, South Carolina, and Chicago during the past few years. This sort of violent union conduct severely disrupts a hospital's patient care program and endangers the lives and well-being of patients. If Congress applies the National Labor Relations Act to non-profit hospitals, these hospitals and their employees and patients will have the benefit of the National Labor Relations Act's orderly representation election machinery for resolving disputes concerning union recognition peacefully and without disruption, and for protecting the rights of hospitals and employees and the welfare of patients.

Most of the hospitals whose personnel administrators are members of our Association are in the State of New York. Their hospitals are subject to New York's one-sided, out-moded Labor Relations Act that became law in 1937 and has not been up-dated in any relevant respect since then. The New York Act and its administration by the New York State Labor Relations Board have created great inequities that have worked to the detriment of the hospitals, their employees and their patients. I will mention just a few of them that Congress will eliminate if it brings non-profit hospitals under the National Labor Relations Act, which Congress modernized and improved by amending the Act in 1947 and 1959.

First, the New York Act is one-sided. It does not expressly give employees the right to refrain from union or other concerted activity. Like the original Wagner Act on which it is based, it does not prohibit any union unfair labor practices. As a result, unions are free to restrain and coerce hospital employees in the exercise of their rights to join or not join a union and to engage or not to engage in concerted activity. Unions are also free to coerce hospitals in the selection of their bargaining representatives and supervisory personnel, to refuse to bargain in good faith with hospitals, to engage in secondary boycotts involving hospitals, to strike to resolve union jurisdictional disputes at hospitals, and to engage in the unlawful recognitional picketing that the National Labor Relations

Act prohibits. Certainly, non-profit hospitals, their employees and patients are just as much entitled to protection against these unfair practices as are industrial companies, profit-making hospitals and nursing homes, non-profit nursing homes, and their employees and patients.

Second, unlike the National Act, there is no statute of limitations with respect to unfair labor practices under the New York Act. Unions can and do use stale charges of unfair labor practices against hospitals as an aid to their organizing activities.

Third, the New York State Labor Relations Board can, and often does, require hospitals to bargain with a union about the terms and conditions of employment of their supervisors, and gives to unions that represent the rank and file employees discipline and control of their supervisors as the supervisors' exclusive bargaining representatives. A supervisor owes an undivided loyalty to the hospital that employs him, without such loyalty he cannot supervise properly, but the New York Act encourages a conflict of interest. For example, can anyone believe that a supervisor is encouraged to do his job properly if his union can fine him or expel him for doing the very acts his supervisory duties call for and, when need be, for disciplining his fellow union members who work for him. The National Act eliminates this conflict of interest by excluding supervisors

from the definition of "employee", not requiring employers to bargain about their supervisors with a union, and not subjecting supervisors to union discipline for faithfully doing their duty as supervisors.

Fourth, the New York Act permits a further conflict of interest, unlike the National Act, by allowing unions that represent other kinds of employees to represent hospital guards and even by allowing the same union to represent the hospital's guards and other employees at the same hospital. In this manner hospital security is weakened because a guard may not risk a fine or other discipline by his union, for example, apprehending one of his fellow union members who is stealing drugs from the hospital or stealing from its patients.

Fifth, the New York Act permits a closed shop that requires an applicant for a job to be a member of the union before the hospital may employ him. The National Act permits only a union shop, that the employee may have to join the union after the hospital hires him.

Sixth, and most important, the New York State Labor Relations Board has Balkanized hospitals into many small bargaining units. Separate units may exist for (1) service employees (2) supervisors of service employees (3) maintenance employees

(4) supervisors of maintenance employees (5) guards (6) supervisory guards (7) office and clerical employees (8) supervisors of office and clerical employees (9) technical employees (10) supervisors of technical employees (11) pharmacists (12) supervisory pharmacists (13) social workers (14) supervisory social workers (15) physical therapists (16) supervisory physical therapists (17) licensed practical nurses (18) registered nurses (19) supervisory nurses (20) dietitians (21) supervisory dietitians, and so on among the professionals, quasi-professional and para-professionals found in hospitals such as occupational therapists, recreational therapists, rehabilitation counsellors, chemists, bacteriologists, etc., and their supervisors. This fragmentization of hospital is a cause for labor strife as each union that represents a separate unit tries to leap-frog over the settlements other unions have made, or even to leap-frog over its own settlements, to the detriment of labor relations at hospitals. Needless to say, the National Labor Relations Board does not permit this kind of fragmentization at profit-making hospitals or even at companies such as General Motors.

Seventh, unions can demand and get a representation election at New York hospitals in each of these units with only a token showing of interest based on the New York State Labor Relations Board's secret rule of thumb, while the National Board requires a showing of interest of at least 30% of the employees

the union is seeking to represent. Labor Board elections, as you know, have an unsettling effect on employees and disrupt the hospitals' routine to the detriment of its patients.

Eighth, the New York Act, unlike the National Act, permits more than one valid election each year, which multiplies unrest and disruption of hospital routine.

Ninth, the New York Labor Board does not permit permanent replacements for economic strikers to vote in a representation election as does the National Board. Thus, persons who may never again work in a struck hospital may determine the outcome of an election there, but those who replace such strikers have no vote.

Tenth, in any representation election involving two or more unions, if a majority of the employees do not vote against having any union represent them, the State Labor Board conducts a run-off election between the two unions with the most votes even if "no-union" received a plurality of the votes in the first election. The National Act on the other hand, requires that in run-off elections the choices shall be the choices in the first election that received the highest number of votes and one of those choices may be "no union".

Eleventh, the New York Act, unlike the National Act, does not expressly provide that employees who become dissatisfied with their union may petition the Board to decertify that union.

Twelfth, the New York Act imposes on both hospitals and unions compulsory arbitration not only of the interpretation or application of collective bargaining contracts, but of the terms and conditions of the contracts, themselves. Thus a total stranger, unfamiliar with the operations of a particular hospital or of hospitals generally may substitute his idea of what's fair and feasible on both the hospital and the employees whether they like it or not, and substitute his judgment for collective bargaining.

The Congress should correct these inequities by giving non-profit hospitals, their employees and patients the protection of the National Act. Certainly they are entitled to no less than what the Congress has already given to profit-making hospitals and nursing homes, non-profit nursing homes, their patients and employees.

Thank you very much for allowing me to appear before you and to express the views of the Association of Hospital Personnel Administrators of Greater New York.

## FLORIDA HOSPITAL ASSOCIATION

INCORPORATED

P. O. BOX 6905

• 315 PARK LAKE CIRCLE

ORLANDO, FLORIDA 32803

PHONE (305) 841-6230

SENATOR  
WILLIAMS, H.J.  
AUG 29 2 58 PM '72

August 24, 1972

Senator Harrison A. Williams, Jr.  
Chairman  
Committee on Labor and Public Welfare  
U.S. Senate  
Washington, D. C. 20510

Dear Senator Williams:

The Florida Hospital Association respectfully requests that the attached statement be included in the record of the Committee on Labor and Public Welfare hearings on House bill 11357 relating to the National Labor Relations Act.

Sincerely,

A handwritten signature in cursive script, which appears to read "Jack F. Monahan, Jr.", is written over the typed name.

Jack F. Monahan, Jr.  
Executive Vice President

JFMJr:jms

Enclosure

# FLORIDA HOSPITAL ASSOCIATION

INCORPORATED

P. O. BOX 6905 • 315 PARK LAKE CIRCLE

ORLANDO, FLORIDA 32803

PHONE (305) 841-6230



"Statement of the Florida Hospital Association on HRL1357, a bill to amend the National Labor Relations Act.

The Florida Hospital Association vigorously opposes the passage of HRL1357 which would remove from the National Labor Relations Act the current exemption for non-profit hospitals.

Our opposition is based on the fact that its passage would impose upon the hospital industry the additional burden of the collective bargaining process, at a time when every effort is made to stabilize hospital costs.

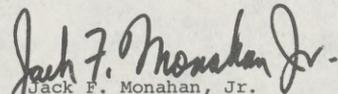
There is no real evidence that hospital employees are treated unfairly or are underpaid. The dramatic improvement in hospital wages and working conditions over the past few years has been accomplished without collective bargaining, strikes, picketing, and work stoppages.

While the American Nurses Association has indicated support of the bill I believe it is appropriate for the committee to know that within Florida at least, although there are some thirty-thousand licensed professional nurses, only about 20% are members of the American Nurses Association and the number of ANA members who are employed by hospitals is even less.

Our estimates of the additional cost to hospitals as a result of the collective bargaining process indicate that there will be an increase in cost of approximately \$50 million in the 208 hospitals in Florida during the first year under the act and the effect over the years would be incalculable.

The necessity for continued hospital operation means that there would simply be no other alternative but to meet employees demands in order to continue to serve the public.

We agree with the entire testimony of the American Hospital Association as presented to the Committee on August 16th."

  
Jack F. Monahan, Jr.  
Executive Vice President



# Federation of American Hospitals

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September 5, 1972

Senator Harrison A. Williams  
Chairman  
Subcommittee on Labor  
237 New Senate Office Building  
Washington, D. C. 20010

Dear Senator Williams:

Enclosed is testimony prepared by the Federation of American Hospitals on legislation to bring non-profit hospital employees under the National Labor Relations Act (H. R. 11357).

We would like to thank you for the opportunity to present our views on this legislation and would appreciate your making the testimony part of the record.

Sincerely,

*Michael D. Bromberg*  
Michael D. Bromberg  
Director, Washington Bureau

MDB:rt  
Enclosures

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STATEMENT OF MICHAEL D. BROMBERG  
DIRECTOR, WASHINGTON BUREAU  
AND  
SAMUEL A. WEEMS  
CHAIRMAN, LEGISLATIVE COMMITTEE  
ON BEHALF OF  
FEDERATION OF AMERICAN HOSPITALS  
ON H. R. 11357  
BEFORE THE SUBCOMMITTEE ON LABOR  
SENATE COMMITTEE ON LABOR AND PUBLIC WELFARE  
SEPTEMBER 6, 1972

Mr. Chairman and Members of the Subcommittee, my name is Michael D. Bromberg, Director of the Washington Bureau of the Federation of American Hospitals. With me is Mr. Samuel A. Weems, of Stuttgart, Arkansas, Chairman of our Legislative Committee. We would like to thank the Subcommittee for this opportunity to present the Federation's views on H. R. 11357.

The Federation of American Hospitals is a national non-profit association representing more than 500 investor-owned (proprietary) hospitals through

-TWO-

its members and affiliated state organizations. Our member hospitals range from small rural facilities to large urban and suburban investor-owned comprehensive medical care institutions. There are presently more than 1,000 acute care short term investor-owned hospitals in the United States, representing approximately 20% of the non-government hospitals. In some areas of the country investor-owned facilities represent up to 100% of the hospitals serving the population. Investor-owned hospitals have served to prevent a health crisis in a number of areas by filling a gap in construction of hospital beds in both those communities which were too poor to finance tax-exempt hospitals, or in those new towns which grew so rapidly that they could not keep up with the health needs of exploding populations.

Investor-owned hospitals have been founded by local citizens to fulfill urgent community needs, but more significantly to the scope of these hearings is the fact that investor-owned hospitals have been able to operate at a rate commensurate with or lower than the rates of other hospitals. This is true even though proprietary facilities pay taxes and are subject to the same requirements for licensing, accreditation and certification for Medicare, Medicaid and various Blue Cross programs as are other hospitals. Not only are our hospitals committed to providing quality health care at reasonable cost, but we believe the free enterprise sector of the hospital field can make a significant contribution in the development of a more effective and efficient health care delivery system.

According to the latest available statistics there are more than 67,000 beds in investor-owned hospitals located in 41 states and the territory

-THREE-

of Puerto Rico. Member facilities of the Federation include hospitals owned by practitioners; groups of physicians, businessmen and community leaders; and multiple-hospital corporations.

#### IMPACT OF H. R. 11357

H. R. 11357, as passed by the House of Representatives, would have no direct impact on investor-owned hospitals since our facilities are already subject to the National Labor Relations Act. The bill now before this Subcommittee would strike the exemption under that Act for non-profit hospitals thereby extending the organizational and other advantages of the Taft-Hartley law to hospital employees. Such an extension of the Act would in all likelihood result in increased union activity in the health field thereby indirectly causing increased activities in our investor-owned facilities.

The Federation of American Hospitals has not taken a position in support of or in opposition to H. R. 11357, primarily because we are not directly affected by this legislation. We would like to take this opportunity to discuss our experiences under Section 7 of the NLRA and our views on the indirect and direct impact of H. R. 11357 on all hospitals and the health care economy.

#### HOSPITAL WAGES

There can be no argument with the statement that hospital employees have until quite recently been underpaid. That traditional pattern has been broken over the past decade and we believe hospital employees are now receiving wages equal to or above the wages in comparable jobs in other areas of the private sector. We noted that AFL-CIO President George Meany, in a recent appearance before the House Ways and Means Committee, said that recent wage increases in the hospital field had reached a levelling

-FOUR-

off period.

These recent substantial wage increases were the single most important factor in rapidly rising hospital costs during that period. No other industry has experienced inflationary rates of more than 15% per year. This is because wages and other payroll costs account for approximately 70% of all hospital costs. We bring these facts to the attention of this Subcommittee not to challenge the social desirability or justification for those wage increase - because we recognize the prior history of underpayment - but solely for the purpose of appraising the economic impact of Section 7 of the NLRA on the hospital field.

The rapid growth of unionization in investor-owned and non-profit hospitals since proprietary facilities were included under the Taft-Hartly Act had a dramatic impact on hospital wages, costs and rates. In addition many non-unionized hospitals found it sound and necessary business policy to keep pace with those prevailing wage increases in neighboring union facilities. The inclusion of investor-owned hospitals under the NLRA therefore, had an indirect but substantial inflationary effect on many non-profit hospitals, just as collective bargaining agreements in union hospitals had a major impact on wage policies in many non-union hospitals.

#### FRINGE BENEFITS

Now that hospital employees have won substantial wage increases, the major area of collective bargaining has been fringe benefits. There is increasing pressure from hospital unions for new benefits such as educational leave, maternity leave, jury duty leave, retirement plans, medical and dental benefits.

-FIVE-

Perhaps the single most costly, inefficient, and potentially disruptive demand now being made by hospital unions is the claim that they should share with management the right to determine numbers of employees. This can create featherbedding situations which will inflate hospital costs at a time when the only hope for holding down hospital cost increases is in the area of creating incentives for efficiency, including automation or certain aspects of the hospital business.

The inclusion of investor-owned hospitals under the NLRA undoubtedly gave impetus to the demands for more and more fringe benefits. Expansion of the NLRA coverage to non-profit hospitals can be expected to encourage further efforts along these lines.

#### BARGAINING POSITION

It is important to note the unique conditions which exist in the hospital environment in order to understand the consequences of encouraging more of the kinds of union demands discussed above. The hospital does not have the same bargaining strengths as other businesses. The hospital cannot be flexible in scheduling its workload or producing output. As a public service industry, the hospital field cannot counter strike threats with lockouts and it cannot survive during a strike because of the nature of its community commitments and the immediate obligations to its acute care patients.

The transfer of patients from a hospital which has been struck involves a myriad of complex problems which can rarely be solved to the satisfaction of those involved. From a practical point of view, then, the hospital is defenseless against the strike. Public demands for continued community service generally outweigh public knowledge of the issues involved in the

-SIX-

bargaining process and consequently under the present system public opinion is not a meaningful force in a strike situation. Attached to our testimony as Exhibit A is a series of recent newspaper articles dealing with threatened strikes and work slowdowns against investor-owned hospitals. The New York situation involved more than 100 hours of continuous negotiation in the face of a union strike vote.

The Federation recommends that this Subcommittee report legislation or include amendments, in the event that H. R. 11357 is favorably reported this year, to prohibit strikes in all hospitals and substituting alternatives including a combination of conciliation, mediation, fact finding, non-binding and binding arbitration procedures. Any such legislation should apply to all hospitals and other health facilities, regardless of ownership or sponsorship. The public service characteristics of hospitals and nursing homes do not depend on the organizational structure or management but rather on the unique nature of the community services they render. For that reason we urge consistency in the application of future legislation in this area.

We thank you for this opportunity to present the views of the Federation on this most crucial aspect of health care delivery.

## Exhibit A

9 NEW YORK POST, MONDAY, JULY 31, 1972

# Vote on Hospital Strike

By BARBARA YUNCKER

Workers in 26 proprietary hospitals in the city were meeting late today to vote on whether to shut down the institutions starting at midnight.

Local 144, Service Employees International Union, which covers all non-professional workers and some semi-professional staff members in the hospitals, called two strike vote meetings to cover all shifts.

The contract with the Assn. of Private Hospitals ends at midnight. Because the hospitals are operated for profit, they cannot obtain court injunctions barring a walkout, as non-profit and government hospitals can.

The State Mediation Board has asked both parties to continue negotiations and was sending a representative to the bargaining session.

## Ask \$35

The union is asking a \$35 across-the-board increase for some 4000 workers. At least another 3000 are affected in other Local 144 contracts with hospitals that do not belong to the association but usually follow its settlement patterns.

Aaron Solomon, attorney for the hospitals, contends the present hourly rate of \$3.57 compares with the newly awarded rate of \$3.55 in non-profit hospitals. The work-week is shorter in the proprietary hospitals, however—35 hours against 40 or 37½ in the voluntaries.

The hospitals have offered 15 cents an hour. There were indications that the offer would be improved before midnight to the maximum under the 5.5 per cent federal guidelines, which would be roughly 25 cents an hour more, or just under \$8 a week, in the basic category to which nearly 90 per cent of the members belong.

The 26 hospitals directly involved account for 4200 of the city's 40,000 acute care beds.

DAILY NEWS, TUESDAY, AUGUST 1, 1972

# Extend Talks on Hospitals Pact

By MICHAEL HANRAHAN

Local 144, Hotel, Hospital, Nursing Home and Allied Health Services Union, agreed act, thus averting—at least for one day—alast night to a 24-hour extension of its contr strike set for midnight by its 10,000 members against 35 private city hospitals.

The union's contract was set to expire at 12:01 this morning, but Peter Ottley, union president, said union officials agreed to continue negotiations involving demands for a new one-year contract with a \$35 across-the-board raise. Average salaries for union workers are now about \$121 a week he said.

The hospitals, in a counter-offer yesterday, proposed a two-year contract with 15-cent hourly raises each year. That offer brought an immediate rejection and a strike vote by about 500 union members meeting at the Hotel Diplomat.

The union and the Association of Private Hospitals of Greater New York then picked up talks later at union headquarters, 233 W. 49th St.

Aaron Solomon, the attorney for the employers' association, whose members have a total of 4,200 beds for care of the public, said the situation was "very serious and quite difficult to resolve."

He said that since the hospitals involved are profit-making institutions, they are obliged to remain within the federal and

state price-control guidelines, making it impossible to meet the union's demands of a 20% hike or a \$1-an-hour wage increase for a one-year pact.

Both New York State and the federal government have special legislation concerning medical fees that hospitals can charge patients as labor costs increase.

"We are not permitted to increase our fees to the public, even if our costs rise sharply beyond our ability to meet them," Solomon said. "It is a very difficult situation."

THE NEW YORK TIMES, TUESDAY, AUGUST 1, 1972

## OFFER REJECTED BY HOSPITAL UNION

But Private Institutions'  
Employees Continue Talks

By DAMON STETSON

Members of a local union representing employees in 35 private, profit-making hospitals in the city rejected a contract offer by management yesterday, but voted to continue negotiations in an effort to reach a settlement.

About 500 members of Local 144 of the Hotel, Hospital, Nursing Home and Allied Health Services Union, meeting at the Hotel Diplomat, 103 West 43d Street, authorized their leaders to call a strike only if it was considered by them to be necessary to obtain a satisfactory agreement. Late last night the union agreed to a 24-hour extension of their contract, which was scheduled to expire at midnight yesterday.

Peter Ottley, president of the local, told the membership that the hospitals had "absolutely refused" so far to make the kind of offer that the officers could recommend for acceptance by the 8,000 members. The workers are employed in 26 hospitals affiliated with the Association of Private Hospitals, Inc., and nine additional hospitals independently represented.

The union represents licensed practical nurses, laboratory technicians, cooks and chefs, orderlies, maids and clerical workers at the hospitals. It has

been seeking an across-the-board pay increase of \$35 a week or 20 per cent, whichever is greater; a four-day work week, longer vacations and more holidays, an increase in night shift differential to 15 per cent from 10 per cent, a dental plan and greater employer contributions for welfare and pensions.

A union spokesman said that the average pay in the hospitals currently was between \$120 and \$125 a week. But minimum pay scales range up to \$204 a week for chefs in larger hospitals.

Mr. Ottley said that the management's counter offer as of 3 P.M. yesterday was for a two-year contract with an increase in pay of 15 cents an hour in 1972 and an additional 15 cents an hour in 1973, plus some benefit improvements, which, he said, the local's officers considered unsatisfactory.

Aaron L. Solomon, a lawyer

representing the Association of Private Hospitals, issued a statement late yesterday saying that his group had proposed a settlement on the basis of a wage increase of 25 cents an hour for the first year of a two-year contract for a 35-hour week and an additional 25 cents an hour in the second year.

These increases, he said, would bring the minimum hourly rate to \$3.82 1/7 in the first year and to \$4.07 1/7 in the second year.

TELEGRAM RECEIVED BY PHONE 7:20 P.M. WEDNESDAY, 8/2/72

Peter Ottley, President  
Local 144 SEIU

THE NECESSARY AND VITAL SERVICES PROVIDED BY THE  
PRIVATE HOSPITALS AND THEIR DEDICATED EMPLOYEES TO  
THE CITIZENS OF NEW YORK CITY SHOULD NOT BE INTERRUPTED.  
AS A CONCERNED CITIZEN AND AS MAYOR OF THIS GREAT CITY  
I STRONGLY URGE BOTH PARTIES TO CONTINUE AND INTENSIFY  
THEIR NEGOTIATIONS AND BEND EVERY EFFORT TOWARDS  
REACHING A FAIR AND EQUITABLE RESOLUTION OF A CURRENT  
DISPUTE QUICKLY AND WITHOUT A WORK STOPPAGE.

SIGNED

JOHN V. LINDSAY, MAYOR

THE NEW YORK TIMES, AUGUST 3, 1972

## Hospitals and Union Reach Pact On Deadline, Averting a Strike

By ROBERT D. McFADDEN

Negotiators for 8,000 unionized hospital workers and an association of 27 private hospitals here agreed on the terms of a new two-year contract yesterday, averting a strike that could have affected 5,000 patients.

The settlement by Local 144 of the Hotel, Hospital, Nursing Home and Allied Health Services Union and the Association of Private Hospitals was announced at the Commodore Hotel at 4 P.M., the deadline for a threatened strike against the association's members and eight other private, profit-making hospitals in the city.

The agreement, subject to ratification by the union membership and by association representatives at separate meetings today, calls for a \$32-a-week minimum salary increase over two years and improvements in various fringe benefits.

"The emergency is off—our demands have been met," Peter Ottley, president of the union, declared at the end of bargaining talks at the hotel.

He said the union's wage and policy committee would recommend ratification at a membership meeting at 4:30 P.M. today at the Diplomat Hotel.

The association, also expressed satisfaction that the agreement had been reached and said he would recommend ratification by the association's members.

While Mr. Ottley and Mr. Solomon stood together, grinning broadly, Solomon Kreitman, a state mediator who had participated in the talks, praised both sides for making "the honest effort to arrive at a consensus they could live with."

As negotiators celebrated the settlement with drinks and hors d'oeuvres, Mr. Ottley noted that the proposed contract, effective Aug. 1, calls for a \$20-a-week increase in the first year and \$12 in the second, raising minimum salaries from \$125 to \$157 for a 35-hour week.

The union had originally demanded a one-year contract with raises of \$35 a week or 20 per cent, whichever was greater.

The association had proposed a two-year agreement, with pay increases in each year limited to the 5.5 per cent guidelines set by the Federal government's Pay Board.

### Dental Plan Included

The agreement, which is subject to Pay Board approval, also provides for a dental prescription and optical plan for members and stipulates that every employe receive every weekend off.

Mr. Ottley also said the union had won improvements in pensions and vacations, increased pay for holiday work and added employer contributions for employe training programs.

Mr. Solomon, noting that payroll expenses account for 70 per cent of the costs of private hospitals, said the agreement would cost the association members a "substantial" amount. But he did not cite over-all costs.

The union's previous contract was scheduled to expire last Monday, but negotiations had continued under the increasing pressure of daily extensions. The union had described yesterday's deadline as final, but promised to keep members available for emergencies.

The union represents a variety of clerks, technicians, nurses aides, dietitians, cooks and chefs whose salaries at the end of the previous contract ranged from \$125 to \$204 a week.

STATEMENT OF HENRY T. WILSON  
LEGISLATIVE DIRECTOR, FEDERAL-PUBLIC SERVICE DIVISION  
LABORERS' INTERNATIONAL UNION OF NORTH AMERICA

ON BEHALF OF GENERAL PRESIDENT PETER FOSCO

TO THE SUBCOMMITTEE ON LABOR OF THE SENATE LABOR  
AND PUBLIC WELFARE COMMITTEE. A BILL TO PROVIDE  
NATIONAL LABOR RELATIONS ACT COVERAGE FOR EMPLOYEES  
OF NON-PROFIT  
HOSPITALS

August 16, 1972

Mr. Chairman and Members of the Subcommittee:

This statement is prepared by Henry T. Wilson, Legislative Director of the Federal-Public Service Division of the Laborers' International Union of North America, AFL-CIO, and is submitted on behalf of the General President, Peter Fosco.

We would like to thank the Chairman, Senator Williams and members of the Subcommittee for the opportunity to support here today HR 11357. Even though HR 11357, if passed into law, would make a slight change in the language now found in the Taft-Hartley provisions of the National Labor Relations Act, the implications of this amendment would be of lasting economic benefit to thousands of low-paid hospital employees. The House of Representatives by an overwhelming vote of 285 to 95 on August 7, passed HR 11357, which indicates strong support for this change in public policy.

With a membership of more than 600,000, the Laborers' International Union is one of the largest affiliates in the AFL-CIO. Included in our membership are thousands of hospital employees, some in federal activities such as Veterans Administration hospitals, some in the public sector at the state and local government levels, such as state and university hospitals, state mental institutions, and a number of non-profit hospitals, as well as proprietary hospitals.

The Laborers' International Union has traditionally represented the semi-skilled employees in the construction industry, and in the public sector employees who are considered "blue-collar"

and/or hourly rated employees. In the hospital area we have organized and have exclusive rights, too, in many public, as well as non-profit hospitals for the semi-skilled and non-skilled employees. These classifications include employees in the food service categories; technicians in laboratories, nurses aides, orderlies and maintenance classifications.

#### Jurisdiction Disputes Resolved

In the absence of any Federal labor policy covering non-profit hospitals, and because there are only a few states which have adopted labor policies covering non-profit hospitals, the issues raised by competing organizations attempting to organize and represent employees cannot be properly resolved except through bitter organizing campaigns which sometimes result in unnecessarily interfering with or tying up the function of the hospital.

Placing non-profit hospitals under the provisions of the NLRA will provide:

- (1) Recognized procedures for filing representation petitions.
- (2) Methods of proper intervention between competing unions; and
- (3) For elections to determine which, if any, union is the majority representative.

Following this, the union chosen by the workers may be certified by the Board as the collective bargaining representative. The established procedures of the NLRB are recognized by all unions and independent associations. The NLRB effectively resolves representational disputes; the question of jurisdiction is decided by a majority of those voting in a bargaining election.

In spite of the fact that employees of non-profit hospitals have been excluded from the provisions of the various state labor laws, these employees have been exposed to the pressures and tensions inherent in any labor-management relationship. For these workers

do not have a statutory or recognized protective right to organize and bargain collectively.

The declared policy of the National Labor Relations Act of 1935 (Wagner Act), as amended by the Taft-Hartley provisions of 1947, was to promote the full flow of interstate commerce. Under the law, interruptions caused by labor disputes over recognition and collective bargaining were substantially eliminated. These laws gave specific rights and guarantees enforced by the Labor Board and the Federal courts.

This Subcommittee is well aware of the fact that the Wagner Act did not exclude from the definition of "employer" non-profit hospitals. The Taft-Hartley amendments passed in 1947 excluded from the term "employer" any corporation or association operating a hospital, if no part of the net earnings inures to the benefit of any private shareholder or individual.

The National Labor Relations Board has in a number of cases, been confronted with the question of determining whether certain hospitals were, in fact, profit or proprietary-type hospitals.

The National Labor Relations Board has consistently refused to assume jurisdiction in what are clearly non-profit hospitals.

The Board recently has assumed jurisdiction over private universities and colleges, on the theory that the volume of business conducted is great enough to affect interstate commerce. Our union is currently involved in trying to get the Board to agree that once it has assumed jurisdiction over a private college, it has also assumed jurisdiction over a non-profit hospital which may be operated as a medical training center by the university.

#### State Laws Affecting Non-Profit Hospitals

Within the past few years five states have passed statutes providing for the right of non-profit hospital employees to organize and bargain. These include the states of New York, Massachusetts,

Minnesota, Wisconsin and Pennsylvania. Excluded from most of these laws are the general enforcement provisions in the Federal Labor-Management Relations Act. And, except for Pennsylvania, each of the states specifically prohibits the right to strike. Within the remaining 45 states there continues a decided force against the right of non-profit hospital employees to organize and bargain.

#### Limitation of Industrial Strife

It is apparent from reported news stories that there has been an increasing number of hospital strikes. Whether they are in the proprietary or non-profit field makes little difference.

Probably the most significant aspect of this part of the story is the fact that there have not been even more strikes than those that reached the public attention. Many organizing efforts failed merely because of a lack of machinery available to enforce recognition or to establish a collective bargaining relationship.

The reason for most strikes in this area is primarily to achieve some form of recognition from hospital management. In the absence of a labor-management policy imposed by law, most hospital managers have consistently operated on the theory that recognition of a union amounts to total surrender of their right to hire and fire, set policies, determine classifications and effectively discipline without cause. This holds true for administrators who are doctors or Catholic bishops or appointed Board Chairmen of a Methodist Congregation.

Within the past year our union was confronted with a hospital administrator who legally maintained that he could not recognize or deal with the union. He held to this line even after we sat across the Board room table from him. Rather than become embroiled over the question of our "legal" status, we turned our attention to the discussion and resolution of employee grievances.

During this time the hospital was confronted with a strike of nurses demanding increased pay. And, following this, we were advised by the appropriate officials that if pay adjustments were going to be granted to the low wage blue-collar workers whom we represented, they too would have to strike in order to force the hospital, through increased public pressure, to grant pay adjustments.

You must realize that the issue of recognition which plagued the employers and the labor movement in the private sector prior to the passage of the Wagner Act is the same issue which currently plagues the employer of a non-profit hospital. The present situation can properly be resolved by the inclusion of amendments proposed by HR 11357.

Along with recognition, of course, come the other benefits of collective bargaining leading to a signed written agreement, covering terms and conditions of employment. The Federal Labor-Management Relations Act provides the machinery for the resolution of unfair practice complaints and these decisions are backed up by the courts. It is this feature of the Federal labor law which has made national labor policies effective.

#### Labor Cost and Hospital Operations

The various committees of Congress, especially those concerned with bills for a national health plan, have given considerable publicity to the rising costs of hospital care. There is no doubt that the cost of hospital care is rising at an alarming rate. And yet, there has been no demonstration that these increased costs are due to the wages being paid to non-skilled workers. In fact, the reverse is true. Employees in these categories have, until very recently, been working at rates of pay substantially lower than the minimum provided by the Fair Labor Standards Act.

These employees have subsidized with their low economic levels, and their inability to make equitable demands, whatever low costs have existed in the hospital industry. While doctors have, without question, been receiving more than their fair share of the income frp, medical practice, nurses, too, through their own professional associations, have taken on the posture of collective bargaining. Nurses, like teachers, have found that organization, in the collective bargaining sense, has improved their professional economic position.

Today, because there is a shortage of doctors, as well as nurses, both are certain their demands will be met. This is increasingly true while the lower paid semi-skilled or non-skilled worker is left to scrape the barrel without any bargaining strength.

#### Fair Labor Standards Act

Prior to the 1966 amendments to the Fair Labor Standards Act, the law specifically excluded persons employed by a "Hospital or institution which is primarily engaged in the care of the sick, the aged, the mentally ill or defective, residing on the premises of such institution." The 1966 amendments to the Fair Labor Standards Act drew no distinction between public, private, or non-profit hospitals. The basic philosophy of the Act was to provide a base for the tens of millions of citizens who were denied the greater part of what in the 1930's were "the necessities of life." It is interesting to note that President Franklin D. Roosevelt in his message to Congress in support of the 25¢ an hour minimum wage law stated:

"All but the hopeless reactionaries will agree that to conserve our primary resources of manpower, government must have some control over the maximum hours and minimum wages, the evils of child labor and the exploitation of unorganized labor."

The exclusion of employees of non-profit hospitals from the rights of the Federal Labor Act is a guarantee that they will be "unorganized Labor" as referred to by former President Roosevelt. Until the application of the minimum wages and overtime provisions of the Fair Labor Standards Act of 1966 most hospital workers were exploited beyond imagination. Under the 1966 amendments these workers came in as newly covered employees on February 1, 1967 at the \$1.00 an hour minimum wage. The minimum was increased over a four-year period to the present minimum of \$1.60 an hour, effective February 1, 1971.

There is no question that organized, non-profit hospitals have some wage levels substantially above those provided for under the Fair Labor Standards Act. Yet these remain in the minority and will do so until the provisions of HR 11357 can be brought to bear. If passed, these amendments will grant all employees of non-profit hospitals a fair share of the good life and a voice in improving their working conditions.

Philadelphia St. Lukes and Childrens Medical Center

Our case files are jammed with documents involving the efforts of the Laborer's Union to organize and represent employees in non-profit hospitals. To illustrate a typical file, I would like to recite the facts involving our efforts to organize the blue-collar workers at the St. Lukes and Childrens Medical center in Philadelphia.

Prior to the passage of the Pennsylvania State law providing for the coverage of non-profit hospitals, our union had, at the request of the employees of the Medical Center, signed substantially more than a majority of a 300-employee unit. This unit included kitchen personnel, nurses aides, janitors, laundry attendants, housekeepers and maintenance personnel. These employees were fed up with their miserly wages (new employees were hired at \$1.40 an hour), total lack of fringe benefits and the hospital

management's arrogant treatment.

Following the signing of representation cards, a letter was forwarded to the hospital administrator requesting recognition of the union. No reply was received. Telephone calls were not answered. And, when it became evident that management had no intention of even discussing the matter, the employees demonstrated their determination by walking off the job.

Because of hospital management's anti-employee attitudes, the workers were determined to demonstrate their sincere desire to be represented through the union. In an effort to establish a dialogue with the hospital management, the union sought, without success, the services of the Pennsylvania State Mediation Board and other outside parties who might be successful in at least getting the parties to a joint meeting. The union exerted further pressure when it filed charges against the hospital for violations of the Fair Labor Standards Act. In retaliation, the hospital discharged one of the workers without cause. When this employee attempted to have his case heard through the hospital's own grievance procedure, it was denied him. (This situation would have come under the unfair labor practice provisions in the Taft-Hartley Act.

Because the employees represented in the strike were forced to choose between welfare checks or a return to their jobs, many submitted to return to work under duress.

By the time the Pennsylvania law providing for collective bargaining rights of public employees as well as non-profit hospitals went into effect in October, 1970, the strike had been broken and the employees had either left the hospital or returned on their knees. All efforts to petition under the new law proved fruitless because of the long delays from the time the employees desired recognition until this became possible under the new law.

If HR 11357 had been law at the time the Laborers' International Union petitioned for recognition, the employees of St. Lukes Childrens Medical Center would have enjoyed the benefits of collective bargaining and the employer would have been required to recognize and deal with the union selected by a majority of the employees. Since the law was not in effect, these employees continue to be harassed by this non-profit hospital employer.

Only the Congress can bring protection to these thousands of employees through passage of HR 11357. This is a basic protection which they both deserve and need.

The Laborers' International Union appreciates this opportunity to present its views on this matter in support of a bill which will directly affect the lives and economic well-being of thousands of hospital workers.

AUG 23 3 03 PM '72

August 23, 1972

The Honorable Harrison A. Williams, Jr.  
 Chairman, Subcommittee on Labor  
 Senate Labor and Public Works Committee  
 Senate Office Building  
 Washington 25, D.C.

Dear Senator Williams:

I am personally extremely concerned that hospitals are in danger of losing their exemption from the provisions of the Taft-Hartley Act.

The thing that concerns me most is the prospect of compulsory arbitration.

Compulsory arbitration would have to be an integral part of any hospital-union contract, unless the employees had the right to strike and management the right to "close shop". The existence of these rights would make for a better working relationship between management and a union, and would put the pressure on both to bargain "in good faith". The absence of these rights would destroy all the values of collective bargaining, and put virtually every major decision into the hands of an arbitrator. It will be difficult for the public to hold the hospital responsible (as is more and more the case) for the care it renders, having chipped away a vital portion of its decision-making authority.

Even though I'd prefer it, I can't believe that the lawmakers would allow hospital employees to strike and management to close shop. Therefore, if the exemption is removed from the Taft-Hartley Act, compulsory arbitration will become a way of life in the nation's hospitals.



*St. Patrick Hospital of Lake Charles*

(918) 436-2541 524 South Ryan St. Lake Charles, La. 70604

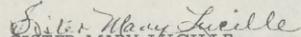
The Honorable Harrison A. Williams, Jr.  
Chairman, Subcommittee on Labor  
Senate Labor and Public Works Committee

August 23, 1972  
Page 2

I hope that you will oppose the removal of said exemption. I am convinced that you will be acting in the best interests of the general populace. In the event your opinion differs from mine or opposing forces prevail, please consider interjecting a note in favor of preserving both the employees' and management's rights under good faith collective bargaining.

Please include this letter in the record as an indication of my opposition to the removal of the exemption of the provisions of the Taft-Hartley Act from hospitals.

Sincerely,

  
SISTER MARY LUCILLE  
/President

SML:va

Copies to: The Honorable Elaine Edwards, United States Senate  
The Honorable Russell B. Long, United States Senate


**SF  
HA**

SOUTH FLORIDA HOSPITAL ASSOCIATION, INC. 2500 BAYVIEW BLVD., MIAMI, FLORIDA 33131 • PHONE 305/379-0817

 SENATOR  
WILLIAMS N.J.1

EXECUTIVE DIRECTOR/IVAN O. HARRAH

August 23, 1972

 Senator Harrison A. Williams, Jr.  
Chairman, Committee on  
Labor and Public Welfare  
U.S. Senate Office Building  
Washington, DC 20510

Dear Senator Williams:

Speaking on behalf of the Board of Directors of this Association and the hospitals comprising our membership, I request that the following statement regarding H.R.11357 be included in the record of your committee hearings regarding the aforementioned legislation.

This Association strongly opposes any legislation which would remove from the National Labor Relations Act the current exemption for nonprofit hospitals. This opposition is primarily based on the fact that hospitals are service-oriented institutions and exist to provide health and health-related services to the community which they serve. The removal of the current exemption would create a very serious, potential interruption in the hospital's ability to meet its responsibility on a full-time, on-going basis. The ability to provide health care must be ever present and cannot be jeopardized by picketing, work stoppage, strikes, or secondary boycotts.

For the reasons stated above as well as many others, we respectfully request your committee to reject H.R.11357 or any other similar legislation which may be introduced for the purpose of changing the provisions of the current statute.

Respectfully,

 Ivan O. Harrah  
Executive Director

mp

 cc Mr. Joseph F. McAloon, President  
Leo J. Gehrig, M.D., Acting Director  
Washington Service Bureau  
American Hospital Association

*St. Luke's* W/L  
 Hospital PH '72

2900 WEST OKLAHOMA AVENUE

PHONE: 647-6423  
 MILWAUKEE, WISCONSIN 53215

August 24, 1972

The Honorable Harrison A. Williams, Jr.  
 Chairman, Committee on Labor and Public Welfare  
 United States Senate  
 Washington, D. C., 20510

Dear Senator Williams:

As the Administrator of a 500 bed community non-profit hospital I am concerned about HR-11357 which proposes to remove the current exemption of non-profit hospitals from the National Labor Relations Act. My concern basically involves two areas; the collective bargaining process, and the financial impact.

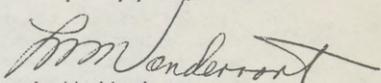
The potential interference of strikes and picketing in the community hospital as it delivers patient care to the sick and injured by means of coordinated efforts of many employees would be intolerable. In other words the smooth teamwork necessary for efficient quality care would be destroyed by the fragmentation of the various bargaining units within a hospital, as they would compete for their most favorable working conditions.

In like manner, the process would appreciably add to the cost of the hospital care. We are keenly aware of the public concern for high hospital costs and we are attempting in all ways to control rising costs which are becoming a severe problem to many patients.

Therefore I urge your committee to reject this bill in the interest of the American public served by our non-profit hospitals.

It would be appreciated if you would include this letter in the record of the Committee's Hearings on the bill.

Very truly yours,



L. M. Vandervort  
 Administrator

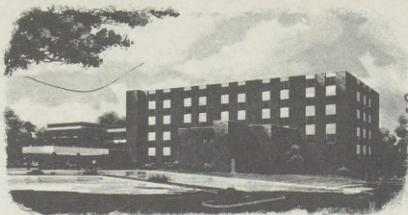
LMV:mr

cc: Senator William Proxmire  
 Senator Gaylord Nelson  
 Leo J. Gehrig, M. D.



*The caduceus represents the medical profession. The sphere represents the world-wide scope of medical practice, and the winged calf with the halo is the accepted ecclesiastical symbol of the sacrificial nature of St. Luke, the Apostle Physician. Thus, the mobile personifies St. Luke's Hospital.*

R. WINFIELD MORE, President  
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SEP 7 12 32  
 RALPH E. VANNOZZI, F.A.C.H.A.  
 Administrator

THE BRIDGETON HOSPITAL  
 BRIDGETON, N. J. 08302

September 5, 1972



The Honorable Harrison A. Williams, Jr.  
 Chairman, Committee on Labor and Public Welfare  
 352 Old Senate Office Building  
 Washington, D.C. 20510

Subject: H.R. 11357, Amendment to the  
 National Labor Relations Act  
 (Taft-Hartley)

Dear Senator Williams,

It is my understanding that your committee will be holding further hearings on the Taft-Hartley Act coverage for hospital employees.

Since our hospital is in an area of very low income I feel it important to enter strong objections to the removal of the present exemption at this time. I am sure you will recall our hospital because we treated the greatest percentage of migrant agricultural workers in the State of New Jersey, even though we were a small hospital of 128 beds. Up until the time you initiated legislation to help pay for the cost of their care, there was no payment to our hospital. Even up to this writing, we are not receiving our full cost. Because of the low average family income in the area which we serve, we have a large number of our patients unable to pay in whole or in part.

All indications point to the fact that we will have some form of National Health Insurance which, first and foremost, will provide coverage for those least able to pay; therefore, solving the financial problems of a hospital such as ours.

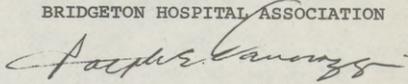
September 5, 1972

I think that at that time the question of Taft-Hartley exemption might better be decided for all concerned, particularly our patients.

I am hoping that you will consider my request and that my statement will be entered in the record at your hearings.

Respectfully yours,

BRIDGETON HOSPITAL ASSOCIATION



Ralph E. Vannozi  
Administrator

REV/gmp



# Federation of American Hospitals

Please Reply To: 1101 SEVENTEENTH STREET N.W. • SUITE 810 • WASHINGTON, D.C. 20036

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Director, Bureau of Health Law  
Weinsburg, Jacobs and Green  
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Bill Glascock, Jr., Field Director  
530 Tower Building  
Little Rock, Arkansas 72201  
501-376-6818

September 5, 1972

Senator Harrison A. Williams  
Chairman  
Subcommittee on Labor  
237 New Senate Office Building  
Washington, D. C. 20010

Dear Senator Williams:

The Private Clinics and Hospitals Association of Texas is an affiliate of the Federation of American Hospitals. Attached is a copy of the Private Clinics and Hospitals Association of Texas resolution concerning the National Labor Relations Act.

We would appreciate your making the resolution part of the record of hearings on H. R. 11357.

Sincerely,

*Michael D. Bromberg*  
Michael D. Bromberg  
Director, Washington Bureau

MDB:rt  
Attachment

"Quality Health Care Through the Efficiency of Private Enterprise"

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Pasadena Bayshore Hospital  
4000 Spencer Highway  
Pasadena, Texas 77504  
713-944-6666
- Robert C. Crosby, Executive Director**  
North Shore Hospital  
9200 N.W. 11th Avenue  
Miami, Florida 33150  
305-693-1100
- Ted P. Crowley, Administrator**  
Campbell General Hospital  
525 McCallie Avenue  
Chattanooga, Tennessee 37402  
615-265-5141
- James E. Davis**  
Director of Management Services  
Medison, Inc.  
Suite 1200  
Three Greenway Plaza East  
Houston, Texas 77046  
713-621-8131
- E. H. DeKoven, Administrator**  
Bellwood General Hospital  
10250 East Arctica Boulevard  
Bellflower, California 90706  
213-866-9028
- Joseph J. Dadds, M.D., Medical Director**  
Earl Campbell Clinic & Hospital  
525 McCallie Avenue  
Chattanooga, Tennessee 37402  
615-265-4904
- Robert L. Daren, Comptroller**  
Medical Center Hospital, Inc. &  
Duncan Physicians & Surgeons Hospital, Inc.  
1407 Whisenand Drive  
Duncan, Oklahoma 73533  
405-255-6240
- Jacob B. Freedman, D.O., Executive Director**  
Prospect Hospital  
730 Kelly Street  
Bronx, New York 10455  
212-542-1500
- Mel Cherdaniel, Administrator**  
Mt. Helix General Hospital, Inc.  
7050 Parkway Drive  
La Mesa, California 92041  
714-465-4411
- J. Allen Gian, Jr., M.D., Executive Director**  
Doctors Hospital, Inc.  
1947 East Thomas Road  
Phoenix, Arizona 85016  
602-779-5311
- Orval M. Harms, Administrator**  
The Brewer Hospital  
414 East Avenue  
Holdrege, Nebraska 68949  
308-995-4431
- Walter L. Harris, Administrator**  
McMinnville Hospital  
603 S. Baker Street  
McMinnville, Oregon 97128  
503-472-0113
- William L. Headrick, Jr., M.D., Chief of Surgery**  
South Pittsburg Municipal Hospital  
210 W. 12th Street  
South Pittsburg, Tennessee 37380  
615-837-6781
- Robert B. Hedges, Administrator**  
McClary Memorial Hospital  
402 S. Louis Avenue  
Excelsior Springs, Missouri 64024  
816-637-3121
- James F. Hughes, Senior Controller**  
Hospital Corporation of America  
210 W. 12th Street  
Nashville, Tennessee 37203  
615-327-9551
- Howard E. Johnson, M.H.A., President**  
Ranada Medical Corporation  
3838 E. Van Buren  
Phoenix, Arizona 85008  
602-275-4741
- S. Millard Johnson, Administrator**  
Creswood Hospital  
4411 McAllister Drive S.W.  
Huntsville, Alabama 35805  
205-837-1850
- Bernard Kamer, M.D., Executive Director**  
Parkcenter General Hospital  
1424 Zerega Street  
Bronx, New York 10462  
212-653-7700
- William K. Kemper, Administrator**  
Pioneer Hospital  
17831 Pioneer Blvd.  
Artesia, California 90701  
213-865-6291
- Ralph E. King, M.D., Administrator**  
Winnabow Sanitarium  
2103 W. Street  
Winnsboro, Louisiana 71295  
318-435-4545
- Leonard A. Langlois, Executive Director**  
Union Hospital of New Bedford, Inc.  
4499 Acushnet Avenue  
New Bedford, Massachusetts 02745  
617-995-4611
- Mark S. Levitan, Senior Vice President**  
American Medical Corp.  
Bercley Building  
Bala Cynwyd, Pennsylvania 19004  
215-667-1570
- Willie Melvin, Jr., F.A.A.M.A., Administrator**  
Lockwood Hospital  
9001 Lockwood  
Houston, Texas 77026  
713-672-8241
- C. George Mercy, Vice President**  
Hospital Corporation of America  
1050 Northgate Drive  
San Rafael, California 94903  
415-479-3711
- Carl H. Neuman, M.D., Syovest Hospital**  
225 Jericho Turnpike  
Syosset, New York 11791  
516-921-7000
- J. D. Norris, Jr., Administrator**  
Torbett-Hutchings-Smith Memorial Hospital  
& Torbett-Hutchings-Smith Clinic  
322 Coleman St.  
Marlin, Texas 76661  
817-936-3561
- Rebecca Northington, Administrator**  
Memphis Eye and Ear Hospital  
1060 Madison Avenue  
Suite 4049  
Memphis, Tennessee 38104  
901-725-0121
- Anton Noyes, M.D., Chairman of the Board and Executive Director**  
Saratoga General Hospital  
888 Old Country Road  
Plainville, New York 11803  
516-681-8900
- Harold O'Neal, Executive Director**  
Doctors Hospital of Sarasota  
2750 Bahua Vista Street  
Sarasota, Florida 33579  
813-958-1541
- John M. Patrisi, M.D., Pelham Bay General Hospital**  
170 Pelham Parkway South  
Bronx, New York 10461  
212-824-1000
- Joseph E. Peery, Jr., Administrator**  
Stevens Clinic Hospital  
US 92 East  
Welch, West Virginia 24801  
304-436-3161
- Samuel S. Periman, Esquire**  
Administrator  
Central Hospital, Inc.  
26-28 Central Street  
Somerville, Massachusetts 02143  
617-625-8900
- Patty F. Pettigrew, Administrator**  
Kaufman Hospital, Inc.  
405 N. Washington St.  
Kaufman, Texas 75142  
214-932-2813
- H. Wayne Ponce**  
Vice President & Controller  
Hospital Affiliates, Inc.  
1916 Patterson Street  
Nashville, Tennessee 37203  
615-327-4000
- J. K. Roan, Regional Director**  
South Central Region  
Extendicare, Inc.  
c/o Pineview Hospital, Inc.  
P. O. Box 31  
Hartselle, Alabama 35640  
205-773-2501
- Gene W. Rogers, M.D., Chetler Clinic & Hospital**  
3330 S. Lancaster Road  
Dallas, Texas 75216  
214-376-5411
- W. R. Rogers, Assistant Administrator**  
Doctors' Hospital of Hollywood, Inc.  
P. O. Box 1220  
Hollywood, Florida 33022  
305-920-9000
- Hillard E. Sadar, Senior Vice President**  
American Medical International, Inc.  
1930 Wilshire Boulevard  
Suite 1100  
Los Angeles, California 90057  
213-483-4770
- Robert J. Samuel, Vice President**  
American Medical International, Inc.  
660 South Bonnie Brae  
Los Angeles, California 90057  
213-483-4770
- Harce G. Sanders, Administrator**  
North Alabama Hospital  
P. O. Box 1089  
Russellville, Alabama 35653  
205-332-1611
- Malcolm M. Sayre, M.D., President and Co-Owner**  
Palmetto Medical Clinic and Hospital  
P. O. Box 428  
Wauchula, Florida 33873  
813-773-4186
- Samuel Seibel, Vice President**  
American Medical Corp.  
5429 McConnell Avenue  
Los Angeles, California 90066  
213-870-5863
- William E. Shub, M.D., Medical Director**  
Saugus General Hospital  
81 Chestnut Street  
Saugus, Massachusetts 01906  
617-233-3000
- Benjamin M. Stein, M.D., President**  
Brunswick Hospital Center, Inc.  
366 Broadway  
Amityville, New York 11701  
516-264-5000
- Edward R. Stelman, Executive Vice President**  
Hospital Affiliates, Inc.  
1916 Patterson Street  
Nashville, Tennessee 37203  
615-327-4000
- Don Stuart, Executive Administrator**  
Medical Center Hospital, Inc. &  
Duncan Physicians & Surgeons Hospital, Inc.  
1407 Whisenand Drive  
Duncan, Oklahoma 73533  
405-255-6240
- John L. Sundberg, F.A.C.H.A., Vice President**  
National Medical Enterprises, Inc.  
1207 Whisenand Drive  
Duncan, Oklahoma 73533  
405-255-6240
- Vance Terrell, M.D., Stephenville Hospital & Clinic**  
P. O. Box 37  
Stephenville, Texas 76401  
817-965-3115
- Willis S. Thrash, Administrator**  
South Heights Hospital  
1127 South 12th Street  
Birmingham, Alabama 35205  
205-251-0121
- Sylvia Ulfert, Executive Director**  
Westchester General Hospital  
2500 S.W. 75 Avenue  
Miami, Florida 33155  
305-226-5252
- A. J. Verdone, M.D., Chief of Staff**  
Medical Director & Head of Emergency Room  
Nicole Hospital  
1971 W. Capitol Drive  
Milwaukee, Wisconsin 53206  
414-462-0100
- Paul D. Vogen, Administrator**  
Middle Georgia Hospital  
888 Pine Street  
Macon, Georgia 31201  
912-743-1551
- M. V. (Ven) Walker, Administrator**  
Forest Grove Community Hospital  
1809 Maple Street  
Forest Grove, Oregon 97116  
503-357-2173
- Sam A. Weems, Esquire**  
Director, Legislative Bureau  
P. O. Box 921  
Stuttgart, Arkansas 72160  
501-922-7287
- Imre Weitzner, Sr., M.D., Executive Director**  
Madison Avenue Hospital  
300 76th Street  
New York, New York 10021  
212-879-1100
- Norman L. West, M.D., President**  
Gran-Banc Medical Center  
101 Circle Drive  
Hillsboro, Texas 76645  
817-82-3401
- Angel Whatts, M.D., Assistant Director of Medical Services**  
State Insurance Fund  
Sanctuary, Puerto Rico
- David G. Williamson, Jr., Executive Vice President & Administrator**  
Lewis-Gale Hospital, Inc.  
Third Street and Luck Avenue, S.W.  
Roanoke, Virginia 24007  
703-343-9311, Ext. 211
- Eugene H. Wolinsky, Administrator**  
Haverford General Hospital  
2000 Old West Chester Pike  
Haverford, Pennsylvania 19083  
215-449-0900

RESOLUTIONS ADOPTED BY THE PRIVATE CLINICS  
AND HOSPITALS ASSOCIATION OF TEXAS

WHEREAS, the Texas Private Clinics and Hospitals Association represents 35 private hospitals and 35 private clinics in the State of Texas; and

WHEREAS, this Association and its members are gravely concerned with the rising cost of medical care and it is and has been our goal to keep such costs at an absolute minimum; and

WHEREAS, it is our belief that increased union activity in hospitals and clinics will result in increased patient costs; and

WHEREAS, it is our understanding that a bill is presently pending in the United States Congress, being HR 11357, to repeal the exemption for non-profit hospitals under the National Labor Relations Act; and

WHEREAS, all hospitals, regardless of ownership or method of operation are public service institutions and it is our belief that strikes, work stoppages and other union activities in such hospitals are against the public interest;

NOW, THEREFORE, BE IT RESOLVED: That the Texas Private Clinics and Hospitals Association unanimously oppose HR 11357, the bill to delete the existing exemption of non-profit hospitals from coverage under the National Labor Relations Act.

BE IT FURTHER RESOLVED: That a copy of this Resolution be forwarded forthwith to the appropriate Senate and House Committees and Sub-Committees and members of Congress.

I certify that the above and foregoing Resolution was adopted by the Texas Private Clinics and Hospitals Association.

Dated this 30th day of August, 1972.

PRIVATE CLINICS & HOSPITALS ASSOCIATION

By: \_\_\_\_\_

*J. D. Norris, Jr.*  
J. D. Norris - President  
P. O. Box 60  
Marlin, Texas 76661



## Wisconsin Hospital Association

P. O. Box 4387  
5721 Odana Road  
MADISON, WISCONSIN 53711  
Phone: Area Code 608 274-1820

August 25, 1972

The Honorable Harrison A. Williams, Jr.  
Chairman, Committee on Labor and  
Public Welfare  
U.S. Senate  
Washington, D.C. 20515

Dear Senator Williams:

The Wisconsin Hospital Association, numbering in its membership more than 160 hospitals and related institutions, strongly opposes H.R. 11357 which would remove from the Labor Relations Act the current exemption for non-profit hospitals. We oppose the bill because we firmly believe that the provisions of the National Labor Relations Act should not be applied to hospitals or other health care institutions because strikes, picketing and work stoppages, which are the basic elements in the collective bargaining process under the Act, cannot be tolerated in a health care institution where patients' lives depend upon care given by people. Health care institutions, and the patients they serve, many of whom are critically ill, are completely dependent upon their employees who are dealing in situations involving life and death of other people, the patients served. There can be no compromise with service provided to patients, and we are convinced that serious compromise could result if employees are allowed to strike, picket, or engage in other work stoppages.

Health care institutions in Wisconsin have long been subjected to the State Labor Relations Act, and we would prefer to work under our own Employment Relations Commission than we would under the National Labor Relations Board. It is our belief that our own State agency is closer to the problems of both employers and employees and can be more effective than can a remote agency in Washington. Certainly where there are good State Labor Relations Acts covering health care institutions, these should not be disturbed and Federal law should not supersede State law in this very vital area of employee-employer relationships. If H.R. 11357 is favorably considered by the Senate, and we hope that it will not be, we do hope that recognition will be given to good State Labor Relation Acts so as not to penalize those states that have developed viable programs that are completely satisfactory to employers, such as health care institutions, now covered.

We would urge that your Committee reject H.R. 11357 in the interests of the many thousands of patients served each year by Wisconsin health care institutions. Passage of this bill could seriously threaten health care in this country, and I am sure that your Committee and the entire Senate will want to take this fact into consideration when acting on H.R. 11357.

Sincerely yours,

Warren R. Von Ehren  
Executive Director

## *Colorado Hospital Association*

3150 EAST 3RD AVENUE • (303) 388-0834  
DENVER, COLORADO 80206

August 30, 1972

Senator Harrison A. Williams, Jr.  
Chairman, Committee on Labor and Public Welfare  
United States Senate  
Washington, D. C. 20510

5

Dear Senator Williams:

The Colorado Hospital Association is opposed to H.R. 11357. We would ask that this letter be made a part of the official record of the Senate Labor and Public Welfare Committee hearing on H.R. 11357. The proposed legislation would remove the current exemption of non-for-profit hospitals from the National Labor Relations Act.

We find ourselves in conflict with this bill because it is our belief that the intent of the Act was never to include Health Care Institutions. As such, it is not structured to project the concept that all citizens of this country have a right to uninterrupted health care delivery.

It is our position that all workers are entitled to equal opportunities as employees regardless of their occupation. However, when that occupation has direct life and death situations as a part of its everyday responsibility there needs to be a special consideration. The National Labor Relations Act does not answer how the unique problems presented by the health care delivery system would be solved in such areas as, strikes, definition of bargaining units, who is, or is not, management and many other equally important questions needing special attention due to the nature of the industry. The Colorado Hospital Association feels such considerations are not built into the National Labor Relations Act and passage of H.R. 11357 would do irreparable damage to the health care industry.

To recognize the rights of the citizen to have uninterrupted care and at the same time insure the health care worker his rights as an employee can best be done on the state level.

At the state level the questions that go unanswered in the National Labor Relations Act can be answered. These questions are as follows:

1. Who takes care of the sick and injured in a strike situation?
2. Those favoring passage of this bill say the strike for recognition will no longer be necessary and as such there will be no strikes. The strikes since passage of the Wagner Act do not support this argument.



Affiliated With the  
American Hospital Association

August 30, 1972

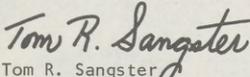
Senator Harrison A. Williams, Jr.

Page Two

3. Depriving the workers of their right to strike by imposing compulsory arbitration has not proven to work, as recent strikes of government employees, teachers, etc., have shown.
4. Who is a "supervisor" and who a "worker" under the National Labor Relations Act? Particular attention must be given to the nursing department. The Head Nurse is responsible for the activities of other nurses, licensed practical nurses, aides, orderlies, and clerks, yet there are some who feel this management position should be recognized along with non-supervisory personnel. Due to the uniqueness of the health care delivery system and the many professional occupations required to make it "tick", this same question arises many times. The National Labor Relations Act does not take this into consideration.
5. The definition of a bargaining unit in the National Labor Relations Act would allow over one-hundred (this is a very conservative estimation) collective bargaining units to be organized in a single hospital. The Chaos that would stem from such a situation would make collective bargaining impossible.
6. The very nature of health care institutions, i.e. 7 days a week, 24 hours a day operation makes the value of historical legal decision developed by the National Labor Relations Act very questionable as basis on which disputes could be decided. In fact such past decisions that have generated current policy and practice could be a deterrent rather than an asset to smooth labor-management relations in health care organizations.
7. What is wrong with the current situation in many states like Colorado? Both labor and management of the health care industry in the State of Colorado can be proud of our labor relations history. In no way can it be predicted that passage of H.R. 11357 will improve this record.

Mr. Chairman, and members of the Committee, the Colorado Hospital Association wishes to thank you for inviting our thoughts concerning H.R. 11357. This uniqueness of health care problems, compounded by the complexities of the local community situation can best be served through state and local action. We therefore urge the committees rejection of this proposed change. It is our belief such a change is not in the best interest of the health delivery system.

Sincerely,



Tom R. Sangster  
Assistant Director

TRS:vs



Women's Auxiliary Methodist Episcopal Hospital

LOUISVILLE, KENTUCKY

September 19, 1972

Senator John Sherman Cooper  
Room 125  
Old Senate Office Building  
Washington, D.C. 20510

Dear Senator Cooper:

As you are about to retire from many years of service to the people of Kentucky and the United States of America we wish to thank you for your years of dedicated service.

We are also making a request of you in behalf of the people of Kentucky and of the entire country when we ask that you vote NO on H.R. 11357 which would remove from the National Labor Relations Act the exemption for non-profit hospitals and other health care institutions. We believe it is not in the public interest to legislate the right to strike, picket or create work stoppage in the life and death situation faced daily by hospitals. Just as fire and police protection are essential to the well-being of society, so is uninterrupted life-giving health care.

We request that this message be included in the record of the Committee on Labor and Public Welfare hearings on H.R. 11357.

Thank you for supporting our strong opposition to H.R. 11357. The people of Kentucky will be appreciative of your leadership to defeat this bill.

Our best wishes go with you for many years of happy retirement activities.

Sincerely,

MEMBERS OF THE WOMEN'S AUXILIARY

NAME	ADDRESS	
11020 Mrs. R. B. ...	476 Benson Ave. Louisville, Ky	40208
Mrs. D. ...	2828 ...	40208
Mrs. J. H. ...	1234 ...	40217
Mrs. ...	1106 ...	40204
Mrs. ...	3035 ...	40206
Mrs. ...	1317 ...	40236
Mrs. ...	402 ...	40227
Mrs. ...	400 ...	"
Mrs. ...	1507 ...	40207
Mrs. ...	3705 ...	40207
Mrs. ...	500 ...	40206



## Women's Auxiliary Methodist Episcopal Hospital

LOUISVILLE, KENTUCKY

September 19, 1972

Senator John Sherman Cooper  
Room 125  
Old Senate Office Building  
Washington, D.C. 20510

Dear Senator Cooper:

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Thank you for supporting our strong opposition to H.R. 11357. The people of Kentucky will be appreciative of your leadership to defeat this bill.

Our best wishes go with you for many years of happy retirement activities.

Sincerely,

MEMBERS OF THE WOMEN'S AUXILIARY

NAME	ADDRESS	
Margie Egan Callow	2807 Jam (Olson)	452-6495
Mrs. M. W. West	2143 W. Hill	526-6716
M. Edwards	4019 Roberts ave. (16)	448-7220
Patricia Ferre	4825 C. Hartman	
Mrs. J. D. Blain	4104 Olive Rd	896-9874
Mrs. G. A. Foye	2407 Westwood Ave.	408-5873
Mrs. Emma Thomas	505 E. Broadway	634-8596
Mrs. M. B. Baker	1624 Murray St.	267-6071
Mrs. M. B. Baker	2902 Livingston	422-99
Mrs. M. B. Baker	5205 Davis St.	422-01
Mrs. M. B. Baker	5001 Adams St.	422-416
Mrs. M. B. Baker	4616 10th St. (16)	402-99
Mrs. M. B. Baker	1214 E. 1st St. (16)	422-13
Mrs. Edwina H. Sand	86 N. Lakeside Hwy	402-22
Mrs. M. B. Baker	5001 Adams St.	422-416





SENATOR  
WILLIAMS, N.J.  
SEP 7 10 34 AM '72

**CLEAR LAKE HOSPITAL**

1-713-332-2511

September 1, 1972

Senator Harrison A. Williams, Jr.  
Chairman, Committee on Labor and Public Welfare  
United States Senate  
Washington, D. C. 20510

Re: H.R. 11357

Dear Senator Williams:

As the Administrator of Clear Lake Hospital in Webster, Texas, I wish to voice my opposition to H.R. 11357 and request that my views be made a part of the hearings on H.R. 11357.

Although I am the Administrator of an investor owned hospital and although the investor owned hospitals have been subject to coverage under the National Labor Relations Board Act, I am strongly opposed to the above Bill removing the current exemption of nonprofit hospitals.

As has been stated in testimony before the Committee, hospitals should be considered as essential services just as fire protection and police protection are considered as essential services from society's standpoint. It is my belief that with the advent of requiring all hospitals to be consistent with the rest of the nation regarding wage and hours and with the advent of placing all hospitals under the necessary civil rights legislation, it would be my feeling that the rights of Labor have been adequately protected as regards employment in the health care field.

It is my feeling that the Congress of the United States should recognize that health care as a "right" of society should not be jeopardized by placing the power in the hands of a few the ability to restrict its availability to those in need.



An American Mediacorp Hospital

500 MEDICAL CENTER BOULEVARD  
WEBSTER, TEXAS  
77598

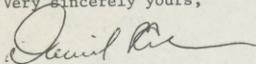
Senator Harrison A. Williams, Jr.

-2-

September 1, 1972

In my opinion, should Congress approve H.R. 11357, they would not be consistent with their previous attempts to provide health care to a broader base of our population.

Very sincerely yours,



David E. Rose, Administrator  
Clear Lake Hospital

DER:bb

cc: Mr. Edward W. Weimer  
Director, Region 7, American Hospital Association

Mr. O. Ray Hurst  
Executive Director, Texas Hospital Association

Senator John G. Tower

Senator Lloyd Bentsen

# THE CATHOLIC HOSPITAL ASSOCIATION

NATIONAL OFFICE: 1438 SO. GRAND BLVD. • ST. LOUIS, MO. 63104 • TEL. (314) 773-0646



August 25, 1972

The Honorable Harrison A. Williams, Jr.  
The United States Senate  
Old Senate Office Building  
Washington, DC 20510

Dear Senator Williams:

I am writing to you as President of The Catholic Hospital Association, an Association of over 850 hospitals and related health facilities in the United States. These health facilities consist approximately of 160,000 beds, and employ over 360,000 people who assisted in providing over 45 million patient days of care last year. The purpose of this letter is to express the view of The Catholic Hospital Association's Board of Trustees on employer-employee relations in hospitals and to identify some serious concerns that the Board of Trustees has about HR 11357, a bill to remove the current exemption of nonprofit hospitals from the National Labor Relations Act.

There has been considerable confusion in the public record concerning the position of The Catholic Hospital Association on collective bargaining and employer-employee relations in hospitals vis a vis HR 11357, the bill to remove the current exemption of nonprofit hospitals from the National Labor Relations Act. The position of The Catholic Hospital Association has been inaccurately stated in Report No. 92-1252, and in the Congressional Record-House, dated August 7 (pages H7249-7256).

To set the record straight, the official position of The Catholic Hospital Association regarding employer-employee relations is reflected in total in the enclosed Statement by The Catholic Hospital Association Board of Trustees Concerning Employer-Employee Relations as adopted in 1967. This Statement was developed with the cooperation of the Department of Health Affairs and other departments of the United States Catholic Conference and adopted by the USCC Committee on Health Affairs. This Statement has remained the viewpoint and official policy of The Catholic Hospital Association regarding employer-employee relationships.

This Statement reflects the CHA position that hospital employees have a right to form or join a union or association and that hospitals should recognize this right of employees. This position relating to the rights of labor, was developed and promulgated because of The Catholic Hospital Association's constant desire to enhance and to encourage situations of employer-employee relations in Catholic hospitals which recognize and

Senator Harrison A. Williams, Jr. /2  
August 25, 1972

reflect in practice the long standing social teachings of the Catholic Church regarding the rights and obligations of labor, as well as the rights and obligations of management.

But, at the same time, The Catholic Hospital Association's Board of Trustees recognizes the overriding right of society to have the very necessary hospital services available at all times. The Catholic Hospital Association's Statement emphasizes the necessity for hospitals to provide uninterrupted service. We believe that the hospital and its employees bear a moral, humanitarian, as well as legal obligation to insure that hospital services are not interrupted. The interruption of such hospital services which in any way could cause the loss of life, or would result in prolonged suffering or a delay in patients' recovery could not be tolerated.

Thus, while the position of The Catholic Hospital Association regarding employer-employee relations is very specific in reflecting the rights and obligations of both management and labor consistent with the social teaching of the Catholic Church, there is also very clearly identified the right of the sick and injured to be served by the hospital. This right overrides the right of employees to strike, as well as the right of management to shut down hospital operations--actions which are contrary to both groups' moral and humanitarian obligations of management and labor to serve the sick and injured at all times. This right of the sick and injured, unfortunately, has not received the very serious attention of those quoting from, or otherwise using for varied purposes, the Statement by The Catholic Hospital Association concerning employer-employee relations. The CHA Board of Trustees is also most concerned that HR 11357 overlooks this moral and humanitarian obligation of management and labor.

The proposed amendment to and the National Labor Relations Act fail to address this very basic but also very critical concern that the Board of Trustees of The Catholic Hospital Association has regarding the rights of the public for uninterrupted patient care services. Unless the basic public safety rights of the American people are incorporated into HR 11357, we predict that hospitals and/or employees will not be able, despite the best intentions of both groups, to fulfill their moral and humanitarian obligations to provide uninterrupted service. The rights of patients to have uninterrupted services prompts us to request that your Subcommittee place the rights of society above the rights of employers and employees.

We are concerned that, unless the right of the public for uninterrupted hospital service is given due consideration and is acted upon by you--Senator Williams--and your colleagues by means of amendment(s) to HR 11357, the public interest will not be served. We ask if you share our concern and further ask what alternatives you propose to alleviate or eliminate this'

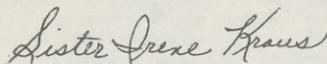
Senator Harrison A. Williams, Jr. /3  
August 25, 1972

concern? We look for a response from you specifically directed at possible amendment(s) which, if incorporated into HR 11357, would eliminate the very grave concerns for public safety that the Board of Trustees of The Catholic Hospital Association has expressed to you.

In conclusion, we reiterate our very strong and long standing position of the rights of the employees in hospitals to join a union or association. We do not waiver from such a position because we believe it to be a right and consistent with the long standing teaching of the Catholic Church regarding social justice and labor relations. But, we just as strongly reiterate our strong and long standing position of the moral and humanitarian obligations of hospitals and hospital employees to provide uninterrupted service and that any interruption, interference, or delay in the provision of such services would be contrary to the public interest and safety and cannot be tolerated.

Thank you very much for giving us the opportunity not only to correct the previous erroneous statements made concerning our views and position but, more importantly, thank you for the opportunity to express our very real concerns that HR 11357 protect the public's right to uninterrupted hospital service.

Sincerely,



Sister Irene Kraus, DC, President  
The Catholic Hospital Association

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encl

# Statement by the CHA Board of Trustees Concerning Employer-Employee Relations

## Introduction

Catholic hospitals provide a unique opportunity for the fulfillment of the Christian Apostolate of the care of the injured and infirm. They are a vital and integral part of the work of the Church.

The primary purpose of Catholic hospitals is to relieve suffering and restore health in a Christian manner which demands competence, mercy, love and respect. Such purpose and philosophy require special dedication to the patient and his welfare on the part of all who participate and contribute to his care. To achieve this mission, Catholic hospitals are to be guided by the social teaching of the Church. They should, in a spirit of justice and respect for human dignity, recognize their responsibility to provide an opportunity for happiness, personal achievement and security for those who participate in this form of Christian service.

This statement by the Board of Trustees is not to suggest that hospitals should seek unions or encourage their employes to form a union. The unionization or nonunionization is the decision of the employes themselves. This statement concerns some of the basic principles which must be considered in hospital labor-management relations.

## Statement of Basic Principles

### Employer-Employee Relations

#### *We believe*

1. Hospitals have an obligation to furnish equitable terms and conditions of employment for their employes.

2. Hospital employe practices should conform to all standards established by competent public authority.

3. Remuneration and benefits furnished employes should compare favorably with those that prevail for the community for comparable occupations.

4. Hospitals should adopt and observe standards of enlightened personnel practices.

5. Hospitals should recognize that employes have a right to form or join a union or association of their own choosing for the purpose of representation in bargaining with their employers and, further, that employes should be free of any reprisal for the exercise of such rights. Hospitals should likewise recognize the right of employes to choose not to be represented by a union.

6. Hospitals should be prepared to deal with such unions or associations should the employes elect to be represented by them.

*We further believe that collective bargaining with employe unions or associations must recognize the following rights of hospitals:*

1. Hospitals have the right and obligation to determine that the union or association does in fact represent a majority of the employes.

2. Hospitals have the right to expect that the unit of representation is appropriate for representation.

3. Hospitals have the right and the obligation to determine that the organization representing employes recognizes the character of service hospitals provide, and the implied responsibilities that flow therefrom, particularly, the necessity of affording uninterrupted service.

4. Hospitals have the obligation to have that kind of counsel which alerts them to the implications of different types of labor provisions and assists them in avoiding those errors in contract language which would make their task of operating the hospital more difficult.

5. Hospitals have the right to be represented by competent industrial relations counsel and/or form associations with other hospitals in a community for the purpose of doing joint collective bargaining. ★

# Communications

JOSEPH A. BEIRNE, *President*



## Workers of America

(AFFILIATED WITH AFL-CIO)

1925 K STREET, N.W.

WASHINGTON, D.C. 20006

TELEPHONE: FEDERAL 7-7711

August 18, 1972

File: 1.14

Senator Harrison A. Williams  
U. S. Senate  
Washington, D.C. 20515

Dear Pete:

As you know the House has passed H.R. 11357 which will put non-profit hospitals under the National Labor Relations Board. It would certainly be helpful if the Senate could move quickly on this as it would be a great help in solving a problem which our union presently has and would of course be a great help to all unions and workers in the future.

Pete, our immediate problem involves 200 hospital employees in Pikeville, Kentucky who came to our local union and asked us to help them organize and become members of CWA. We gave them assistance and received more than 95% show of interest cards. The hospital board refused to recognize our Union and the hospital workers have been on strike for more than 8 weeks simply for recognition.

I understand the House bill had Administrative support -- minority leader, the minority whip and three members of the House Republican conference. I further understand that the bill can be called up without going through the committee. If this is possible it would certainly expedite its passage.

I would appreciate your doing whatever you can to help us on this matter.

Sincerely and fraternally,

Joseph A. Beirne,  
President



STEPHEN ROGNESS, Executive Director

## minnesota hospital association

2333 UNIVERSITY AVENUE SOUTHEAST • MINNEAPOLIS, MINNESOTA 55414 • PHONE (612) 331-5571

August 30, 1972

Senator Harrison A. Williams, Jr.  
 Chairman, Committee on Labor and Public Welfare  
 United States Senate  
 Washington, D.C. 20510

5

Re: H.R. 11357

Dear Senator Williams:

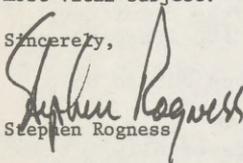
The charitable hospitals of Minnesota are concerned about H.R.11357, a bill to remove the exemption of non-profit hospitals from coverage under the National Labor Relations Act.

The non-profit hospitals of Minnesota have operated under a state law that guarantees hospital employees the right to organize and bargain collectively. The state law also provides a mechanism for peaceful resolution of bargaining impasses.

Minnesota hospitals are unique in having the longest and most extensive experience with collective bargaining. We feel strongly from past experience that before H.R.11357 is enacted into law, provision must be made for incorporating a mechanism for resolving bargaining impasses other than the strike or lockout.

We therefore request an opportunity to appear before the Senate Labor Subcommittee on September 6, 1972 to present our position on this most vital subject.

Sincerely,


  
Stephen Rogness

cc: Senator Walter F. Mondale  
 Senator Hubert H. Humphrey

SR/rc



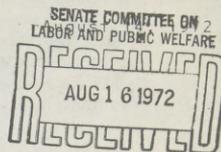
# LOUISIANA HOSPITAL ASSOCIATION

CHARLES R. GAGE  
EXECUTIVE DIRECTOR

AFFILIATED WITH THE AMERICAN HOSPITAL ASSOCIATION  
MEMBER OF SOUTHEASTERN HOSPITAL CONFERENCE

SUITE 701 - 2026 ST. CHARLES AVENUE  
NEW ORLEANS, LOUISIANA 70130 - (504) 525-7229

SENATE  
WILLIAMS  
AUG 15 1972



Senator Harrison A. Williams, Jr.  
352 Old Senate Office Building  
Washington, D.C. 20510

Dear Senator Williams:

The Louisiana Hospital Association, most other state associations and the American Hospital Association are vehemently apposed to H.R.11357 which will be up on hearing by the subcommittee on Labor on August 16. The effect of the bill would be to remove non-profit hospitals from their current exemption under the National Labor Relations Act. Since our state is not represented on the Labor and Public Welfare Committee we thought it appropriate to write you and voice our opinion on this urgent matter.

The vast majority of hospitals in this country are non-profit institutions. Opposition to H.R.11357 is based on the fact that strikes, picketing or any kind of work stoppages or interferences, all of which are primary elements of the collective bargaining process, are untenable in the providing of health services. Coverage under the National Labor Relations Act offers no protection against such interferences with patient care, nor does it offer protection against fragmentation of bargaining units in the hospital.

We urge that you as Chairman of the Senate Labor and Public Welfare Committee urge the defeat of this bill.

*Robert W. Stratton*  
Robert W. Stratton, J.D.  
Director of Governmental Relations

RWS:gmw

cc: All Members of the Committee

LEAGUE OF VOLUNTARY HOSPITALS  
AND HOMES OF NEW YORK

15 EAST 41<sup>ST</sup> STREET  
NEW YORK, N. Y. 10017

(212) MU 7-3347

WILLIAM J. ABELOW  
EXECUTIVE DIRECTOR  
AND COUNSEL

AUG 23 2 04 PM '72

August 24, 1972

Senator Harrison A. Williams, Jr.  
Senate Committee on Labor and Public Affairs  
G-237 New Senate Office Building  
Washington, D. C. 20510

Attention: Gerry Feder, Esq.

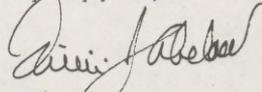
Dear Senator Williams:

The League of Voluntary Hospitals and Homes of New York requests an opportunity to present a written statement for the record in support of HR 11357 removing the exclusion of non-profit hospitals from the National Labor Relations Act and requests that the record be held open until September 12th for such purpose.

The League, which offered testimony on the Bill before the House Special Sub-Committee on Labor, is an association of 27 voluntary hospitals in the New York metropolitan area who engage in collective bargaining with a variety of unions. We believe the League to be the largest organization of its kind in the country, employing over 50,000 employees, over 27,000 of whom are represented by labor unions. Many of our member institutions have had union contracts for over ten years and the League, therefore, probably has the most extensive experience in dealing with hospital worker unions in the country.

Thank you very much for your consideration of our request.

Very truly yours,



William J. Abelow

WJA/rml



Private Clinics & Hospitals Association  
of Texas

Executive Offices  
213 Stephenville Bank & Trust Bldg.  
Post Office Box 155  
Stephenville, Texas 76401

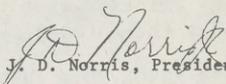
September 1, 1972

The Honorable Gerald Feder, Counsel  
Sub-Committee on Labor  
Room G 237  
New Senate Office Building  
Washington, D. C, 20510

Dear Sir,

Enclosed are 15 copies of the Resolution adopted by  
the Private Clinics and Hospitals Association of Texas.

Yours truly,

  
J. D. Norris, President

RESOLUTIONS ADOPTED BY THE PRIVATE CLINICS  
AND HOSPITALS ASSOCIATION OF TEXAS

---

WHEREAS, the Texas Private Clinics and Hospitals Association represents 85 private hospitals and 35 private clinics in the State of Texas; and

WHEREAS, this Association and its members are gravely concerned with the rising cost of medical care and it is and has been our goal to keep such costs at an absolute minimum; and

WHEREAS, it is our belief that increased union activity in hospitals and clinics will result in increased patient costs; and

WHEREAS, it is our understanding that a bill is presently pending in the United States Congress, being HR 11357, to repeal the exemption for non-profit hospitals under the National Labor Relations Act; and

WHEREAS, all hospitals, regardless of ownership or method of operation are public service institutions and it is our belief that strikes, work stoppages and other union activities in such hospitals are against the public interest;

NOW, THEREFORE, BE IT RESOLVED: That the Texas Private Clinics and Hospitals Association unanimously oppose HR 11357, the bill to delete the existing exemption of non-profit hospitals from coverage under the National Labor Relations Act.

BE IT FURTHER RESOLVED: That a copy of this Resolution be forwarded forthwith to the appropriate Senate and House Committees and Sub-Committees and members of Congress.

I certify that the above and foregoing Resolution was adopted by the Texas Private Clinics and Hospitals Association.

Dated this 30th day of August, 1972.

PRIVATE CLINICS & HOSPITALS ASSOCIATION

By: \_\_\_\_\_

*J. D. Morris, Jr.*  
J. D. Morris - President  
P. O. Box 60  
Marlin, Texas 76661

- REGISTERED NURSES GUILD
- LICENSED PRACTICAL NURSES GUILD
- CIVIL SERVICE GUILD
- TECHNICAL GUILD
- CLERICAL & NON-PROFESSIONAL EMPLOYEES

# LOCAL 144

HOTEL, HOSPITAL, NURSING HOME & ALLIED HEALTH SERVICES UNION  
233 WEST 49th STREET, NEW YORK, NEW YORK 10019 (212) 265-2366-7-8-9

*Peter Ottley*  
PRESIDENT

*Peter Byrne*  
SECRETARY-TREASURER

*John Kelley*  
EXECUTIVE VICE-PRES.

*Peter Catalo*  
GENERAL ORGANIZER

*George Hughes*  
RECORDING SECRETARY

August 14, 1972

SENATE COMMITTEE ON  
LABOR AND PUBLIC WELFARE

RECEIVED  
AUG 17 1972

RECEIVED  
AUG 17 1972

Hon. Harrison Williams  
United States Senate  
Senate Building  
Washington, D.C.

Dear Senator Williams:

On Monday, August 7th, by a vote of 285 to 95, the House of Representatives passed a bill (11357) which would give employees of non-profit hospitals the protection of the National Labor Relations Act. In all equity, the passage of this bill is long overdue.

Now there is an amendment afoot in the Senate which would include supervisors as well as other hospital employees under the Act. Since it is an established principle that supervisors have always been excluded under the NLRB, this pointed inclusion is only a delaying action designed to scuttle the bill and deny the hospital worker his due right under the law.

We strongly urge that this obvious subterfuge be seen for what it is; that it be excluded from the Act and that Bill 11357 be passed without the proposed amendment.

We urge its passage on the grounds that it will help every worker in every non-profit hospital in America. We urge it on the grounds that, as citizens, they are entitled to this protection accorded to other workers in other industries. We urge it on the grounds that the defeat of the Bill would mean discrimination to every worker in a non-profit hospital in America. We urge it on the grounds that -in equity and fair play- the hospital worker deserves the same rights and privileges as any other worker in the nation.

Local 144 urges you to vote for Bill 11357 - without any amendments and with all possible speed.

Very truly yours,

*Peter Ottley*  
Peter Ottley  
President

PO:OB  
@peiu 153.

*Irene Parkson*  
VICE-PRES.

*Harold Davies*  
VICE-PRES.

*Clarence Morgan*  
VICE-PRES.

*Frank Perez*  
VICE-PRES.

# LOCAL No. 4

33 East Congress Parkway  
CHICAGO, ILLINOIS 60605  
Phone 922-9330



*Affiliated with*  
ILLINOIS AND CHICAGO  
FEDERATION OF LABOR

*of the*

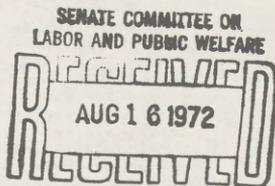
## SERVICE EMPLOYEE'S INTERNATIONAL UNION

ROBERT JOHANSEN, *President*

HYMON T. JOHNSON, *Secretary-Treasurer*

August 11, 1972

Hon. Harrison Williams  
Chairman  
Senate Labor Committee  
% Senate Office Building  
Washington, D.C. 20510



Hon. Senator Williams:

On behalf of this labor organization which numbers more than 5000 members, I am urging that you support H. R. Bill No. 11357 as passed by the House.

Very truly yours,

Robert Johansen  
President

RJ/mc

**Massachusetts Nurses Association**

20 ASHBURTON PLACE, BOSTON, MASSACHUSETTS 02108 • 742-9090

ALICE Y. CONLON  
Executive Administrator

August 14, 1972

The Honorable Harrison Williams, Jr.  
Senate Office Building  
Washington, D. C. 20510

Dear Sir:

The enclosed editorial from The New York Times reflects the views of the Massachusetts Nurses Association in regards to H. R. 11357, which proposes to include the employees of voluntary hospitals under the Taft-Hartley Act.

The Massachusetts Nurses Association, as bargaining representative for more than 7,000 registered nurses in Massachusetts, wholeheartedly supports the concept of collective bargaining and believes that hospital employees must have a voice in determining their employment conditions. Massachusetts General Law 150A declares the policy of Massachusetts "in the interests of preserving the continuity and improving the quality of health care" to be the promotion of collective bargaining and the protection of nurse employees' right to organize.

Nurses involved in the support of state legislation in 1964, extending the Massachusetts Labor Relations Law to nurses, recognized the unique nature of health care facilities and gave the right to strike, accepting arbitration as a tool for the resolution of any impasse.

The Massachusetts Labor Relations Commission has included in bargaining units all registered nurses, except directors and assistant directors of nursing service, and almost eight years of experience with that unit determination has confirmed its wisdom. Nurse bargaining units routinely resolve diverse interest among their members, and bring reason and stability to employer-employee relationships.

This amendment, H.R. 11357, is strongly supported in Massachusetts by the Massachusetts Hospital Association, which serves as labor relations counsel to hospital management. When employers seek to include themselves under Federal Labor Law, the inevitable conclusion is that the change is not in the best interest of employees.

Member of the American Nurses Association

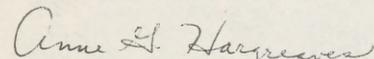
AUG 14 11 53 PM '72

The Honorable Harrison Williams, Jr.  
Page 2  
August 14, 1972

As the largest single group of providers of health care service, nurses in this state do not choose to give up their rights under the State Law, to face an uncertain status under Federal Law.

We urge you to oppose H.R. 11357 unless it should be amended to except those states which already grant collective bargaining rights to hospital employees.

Very truly yours,

  
(Mrs.) Anne G. Hargreaves  
President  
Massachusetts Nurses Association

AGH/md

Enclosure

# The New York Times

ADOLPH S. OCHS, *Publisher 1896-1935*

ARTHUR HAYS SULZBERGER, *Publisher 1935-1961*

ORVILLE E. DRYFOOS, *Publisher 1961-1963*

THE NEW YORK TIMES, SUNDAY, AUGUST 6, 1972

ARTHUR OCHS SULZBERGER  
*Publisher*

JAMES RESTON, *Vice President*

JOHN B. OAKES, *Editorial Page Editor*

A. H. RASKIN, *Assistant Editorial Page Editor*

A. M. ROSENTHAL, *Managing Editor*

EYMOUR TOPPING, *Assistant Managing Editor*

DANIEL SCHWARZ, *Sunday Editor*

CLIFTON DANIEL, *Associate Editor*

HARRISON E. SALISBURY, *Associate Editor*

TOM WICKER, *Associate Editor*

## Hospital Strike Passport

With only a few weeks of politically suffused deliberations left to the expiring Congress, an effort is well advanced on Capitol Hill to nullify the statutory safeguards adopted by New York State to prohibit hospital strikes while assuring equity to hospital employees.

The effort takes the form of an innocuous-sounding recommendation by the House Education and Labor Committee to remove from the Taft-Hartley Act the quarter-century-old exemption of employees of voluntary hospitals. To the extent that such a change would put hospital workers on a par with millions of other workers in legal protection for unionization and bargaining rights, such a change has much to commend it.

However, there is one important distinction between collective bargaining in hospitals and collective bargaining in soap factories or tin mills: A strike of hospital employees on a citywide basis creates intolerable danger to the lives of patients. In recognition of this distinction, Governor Rockefeller and the State Legislature—with the enthusiastic cooperation of Local 1199 of the Drug and Hospital Union—fashioned and passed in 1963 a model law to guarantee fair treatment for both employees and public.

That law, especially as improved by amendments in 1969, has proved remarkably effective. It provides for arbitration, rather than strikes, as the final method for resolving disputes. It has enabled nonprofessional workers in the hospitals, once among the worst-exploited elements in labor, to bring their minimum pay into the \$150-a-week zone. It has also opened the way for unionization of supervisory nurses, residents and internes. At least seven other states have somewhat similar laws.

If Congress wants to establish a legal underpinning for hospital labor-management relations on a national basis, it would be wise to pattern it after this state's excellent statute. As a minimum, it ought to include in the Federal bill a specific waiver of applicability in states with adequate laws of their own.

The House committee made a small obeisance in this direction by including in its report—but not in the bill—a plea to the National Labor Relations Board to cede jurisdiction over hospital cases to states that have laws "substantially equivalent" to the Federal statute. Unfortunately, the board's history affords little basis for hope that it will go along. It has had authority for 25

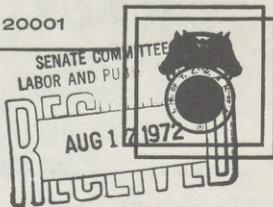
years to shift jurisdiction in all other types of cases, but has yet to shift its first case. Just by way of making sure that record is kept intact for hospital workers, eight committee members have filed a separate statement emphasizing their belief that nothing in the new law does—or should—mandate a changed approach.

Without a clear-cut mandate for priority of state law, enactment of the present House bill would be an invitation to wholesale hospital strikes and an accelerated escalation of hospital costs.

INTERNATIONAL BROTHERHOOD OF TEAMSTERS  
CHAUFFEURS · WAREHOUSEMEN & HELPERS  
OF AMERICA  
25 LOUISIANA AVENUE, N.W. • WASHINGTON, D.C. 20001

OFFICE OF  
• FRANK E. FITZSIMMONS •  
GENERAL PRESIDENT

August 16, 1972



Honorable H. A. Williams, Jr.  
United States Senate  
Washington, D. C.

Dear Senator Williams:

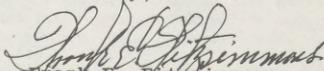
A bill to remove the exclusion in the Taft-Hartley Act for employees of private non-profit hospitals, (H.R. 11357) is currently before the Labor Subcommittee of the Senate Labor and Public Welfare Committee.

We believe this is an important bill and we urge your support of it. The right to join a union and bargain collectively is guaranteed to almost every non-profit organization which has an impact on commerce. Since passage of the Taft-Hartley Act in 1947, the Labor Board has extended its jurisdiction over all major charitable and educational institutions originally exempted, except hospitals.

We see no reason for the unwarranted discrimination against this one category of employees.

The bill recently passed the House by an overwhelming margin. We trust that you also will see fit to support this needed legislation.

Sincerely,

  
Frank E. Fitzsimmons  
General President

FEF:mn





*American Osteopathic Hospital Association*

August 25, 1972

The Honorable Harrison  
Williams, Chairman  
Senate Committee on Labor and  
Public Welfare, Subcommittee on Labor  
United States Senate  
Room 352, O.S.O.B.  
Washington, D.C. 20025

Dear Senator Williams:

The American Osteopathic Hospital Association, representing 25,000 patient beds in the United States, does not believe it would be in the best interest of the American public to remove from the National Labor Relations Act the current exemption for non-profit hospitals.

The AOHA membership is fully aware of the fact that the quality of hospital care provided patients depends to a great extent on the satisfaction of its workers with their working conditions, with their compensation, and with the communication which exist between them and the hospitals' management. The ever-rising cost of hospital care is in large part due to the increase in salaries of hospital employees.

At a time when vigorous efforts are being directed by hospitals and the Federal Government at curbing rising health costs, it would be difficult to justify the additional cost that would result from collective bargaining units in non-profit hospitals.

The original Taft-Hartley Act exempted non-profit hospitals from coverage for several important reasons which cannot be overlooked. Collective bargaining in its usual sense cannot be applied to non-profit hospitals. The non-profit community hospital is not a factory or store; in fact, it has no analogy in private industry. It does not manufacture or sell products. It deals in human beings, facing a life and death situation. No part of its net earnings inures to the benefit of any private shareholder or individual. The hospital exists only for the good of its patients, not to produce a product or make a profit.

ADMINISTRATIVE OFFICES

930 Busse Highway • Park Ridge, Illinois 60068 • Telephone (312) 692-2351

The Honorable Harrison Williams  
Page Two  
August 25, 1972

The essential relationship of hospital workers to quality care of patients also clearly differentiates hospitals from business and industry. This unique relationship must not be tampered with by any outside influence if hospitals are to provide and maintain uninterrupted and constantly available high quality health service. Implicit in the collective bargaining process under NLRB are strikes, picketing, and work stoppages. Toleration of such activities by an institution which is devoted to quality, constant health care is ludicrous. Yet, in delivering patient care and services, hospitals are wholly dependent on their employees. In the final analysis, the person who would suffer the most from a strike situation would be the one who could least afford the risk--THE PATIENT.

Sincerely yours,



E. R. Link, Jr.  
Executive Director

ERL:sd

cc: Members of Senate Committee on Labor and Public Welfare  
Subcommittee on Labor

ST. BENEDICT'S HOSPITAL, Inc.

NORTH LINCOLN AVE.  
JEROME, IDAHO  
83338

August 16, 1972

Senator Frank Church  
Senate Office Building  
Washington, D. C.

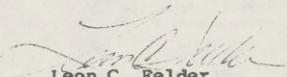
Dear Senator Church:

I understand that H.R. 11357 will come up for vote on or about August 18.

I would strongly urge you to vote No on this proposed amendment to the Taft-Hartley Act. I do not oppose employee rights in their jobs. However the right to strike, to picket, etc a medical facility is, in my opinion, very wrong. Where we have the responsibility of caring for very ill people, it indicates to me that this is a responsibility beyond that of a factory worker.

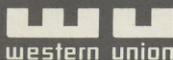
I would sincerely appreciate your help in this matter.

Sincerely,



Leon C. Felder  
Administrator

LCF/cac



# Telegram

NFB211 (49)LA051

L BOA049 MH PD TDBO COTTONWOOD IDA 15 1255P MDT

HON FRANK CHURCH

WASHDC

HR11357 AMENDMENT TO THE TAFT HARTLEY ACT O REMOVE THE EXEMPTION  
 OF PRIVATE NOT FOR PROFIT HOSPITALS FROM THE ACT IS PRESENTLY  
 UP FOR CONSIDERATION BY THE SENATE. CHANGE THIS TO THE ACT  
 WHICH WILL PERMIT WORK STOPPAGES AND INTERFERENCE WITH NORMAL  
 BUSINESS IN HOSPITALS IS INTOLERABLE AND UNJUSTIFIED IN THE  
 LIGHT OF ADEQUATE PATIENT CARE. OTHER ACTS CANNOT BE RELIED  
 ON TO PROTECT HOSPITAL AND PATIENT INTEREST YOUR ASSITANCE  
 IN DEFEATING THIS ILL ADVISED AMENDMENT IS SOLICITED

WILLIAM SCHONGALLA ADMINISTRATOR ST MARYS HOSPITAL COTTONWOOD  
 IDAHO  
 (152).

AUG 10 1972

STATION FRANK CHURCH

SF-1201 (R5-69)



# Telegram

LC074

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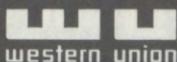
SENATOR FRANK CHURCH

WASHDC

THE DIRECTORS OF WALTER KNOX MEMORIAL HOSPITAL URGE YOU TO  
 OPPOSE HR11357

NEWTON H STATES

1972 AUG 17 AM 9:08



# Telegram

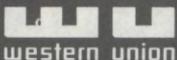
LC060

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FRANK CHURCH SENATOR

SENATE OFFICE BUILDING WASHINGTON DC

WE ARE CONCERNED WITH THE PROPOSED TAFT-HARTLEY AMENDMENT TO HR 11357 IT WOULD BE A STAGGERING HEALTH HAZARD WE SHOULD NOT PERMIT TO ALLOW HOSPITAL EMPLOYEES TO STRIKE WITHOUT REGARD TO THE WELFARE OF PATIENTS. AT A TIME WHEN WE SHOULD BE INCREASING OUR HEALTH DELIVERY METHODS, THIS WOULD BE A DAMAGING SETBACK. WE URGE YOU TO VOTE AGAINST THIS AMENDMENT AND DO ALL IN YOUR POWER TO GET OTHERS TO DO LIKEWISE. WE FEEL THIS AMENDMENT IS BEING PRESENTED WITHOUT SUFFICIENT INPUT FROM THOSE MOST CONCERNED AND TO ACT TOO HASTILY WOULD BE A MISTAKE. VERY SINCERELY,  
E LYNN REED, ADMINISTRATOR BINGHAM MEMORIAL HOSPITAL ELMER C TAYLOR, CHAIRMAN, BOARD OF TRUSTEES  
(506).

SF-1201 (RS-69)



# Telegram

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ICS IPMSKUA SPK

ZCZC 110 A PDF TDSK LEWISTON IDA 15 NFT

PMS SEN FRANK CHURCH

CAPITOL HILL DC

I URGE YOU TO OPPOSE HR11357 AS IT IS DETRIMENTAL TO HOSPITALS.

THANK YOU FOR ALL OF YOUR PAST COURTESIES

SISTER HELEN FRANCES ADMINISTRATOR ST JOSEPHS HOSPITAL LEWISTON

IDA



# Telegram

NFC080 WAE178(1750)(1-036110A228)PD 08/15/72 1749

ICS IPMBOUA BSE

ZCZC 054 A POM BOISE IDA 15

PMS SEN FRANK CHURCH

WASHDC

URGE YOUR SUPPORT IN DEFEATING HR11357 THIS WOULD IMPOSE GREAT HARD-  
SHIPS ON IDAHO HOSPITALS

DICK WILLIAMS IDAHO ELKS REHABILITATION CENTER

8F-1201 (R5-69)



# Telegram

NFC052 (22)LA073

SSK160 L BOA083 JN POM PD TDBO MALAD IDAHO 15

SENATOR FRANK CHURCH

WASHDC

OPPOSED TO THE HR11357 IS DETRIMENTAL IF PASSED PLEASE ACT  
ON THIS IS OUR FAVOR

ONEIDA HOSPITAL HANNAH HARRIS SUPT

HR11357

( 4172.

1972 AUG 15 PM 9:56

RECEIVED

AUG 16 1972

WESTERN UNION  
TELEX SERVICE

WESTERN UNION  
TELEX SERVICE

WU SEN WSH \$

STALPHHOSP BSE

1972 AUG 15 PM 8:57

TEK TEX TAPE PD BOISE IDAHO

ST ALPHONSUS HOSPITAL

SENATOR FRANK CHURCH

WASHINGTON DC

REGARDING HR11357 AMENDMENT TO THE TAFT HARTLEY ACT

WE PROTEST THIS AMENDMENT

SISTER JUSTINE MARIE ADMINISTRATOR

\$

WU SEN WSH \$

STALPHHOSP BSE



Telegram

LC027

SSU131 L BOA068 MH PD BOISE IDA 15 1130A MDT  
HON SEN FRANK CHURCH

WASHDC

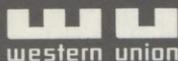
THIS EXPRESSES OUR OPPOSITION TO HR. 11357 WHICH WOULD REMOVE  
HOSPITALS PRESENT EXEMPTION FROM NATIONAL LABOR RELATION ACT.  
REMOVING EXEMPTION COULD RESULT IN STRIKES, WORK STOPPAGE,  
AND POTENTIALLY ENDANGER LIVES OF PATIENTS

E E GILBERTSON ADMINISTRATOR ST LUKES HOSPITAL  
(238).

RECEIVED

AUG 16 1972

SENATOR FRANK CHURCH



# Telegram

NFA164 WAA261(2334)(1-043966A228002)PD 08/15/72 2355 AUG 16 PM 10:49

ICS IPMBOUA BSE  
 ZCZC 113 A NL PD IDBO POCATELLO IDA 15  
 PMS SEN FRANK CHURCH  
 WASHDC

I STRONGLY OPPOSE THE AMENDMENT TO THE TAFT-HARTLEY ACT.  
 IF PASSED IT WILL PLACE THE HOSPITALS OF IDAHO IN A SERIOUS  
 POSITION AND BE A DETRIMENT TO PATIENT CARE. PLEASE VOTE  
 AGAINST HR11357

SISTER MARY MARTINA  
 ST ANTHONY COMMUNITY HOSPITAL  
 POCATELLO IDAHO

8F-1201 (RS-69)



# Telegram

NAC013(0116)(1-000474C229)PD 08/16/72 0115 <sup>1972</sup> AUG 16 AM 8:30

ICS IPMSKUA SPK  
 ZCZC 169 A NL PD MOSCOW IDA 15  
 PMS SEN FRANK CHURCH  
 SEN OFC BLDG CAPITAL HILL DC

WE SHALL APPRECIATE YOUR OPPOSITION OT HR 11357 AMENDMENTS TO THE  
 TAFT HARDY ACT WHICH AFFECT HOSPITAL EMPLOYEES THANK YOU  
 L CLAY BOYD ADMIN GRITMAN MEMORIAL HOSPITAL MOSCOW IDAHO



## Telegram

NO001(0030)(1-000010C229)PD 08/16/72 0029

ICS IPMSKUA SPK

ZCZC 168 A NL PD ~~BONNERS FERRY~~ IDA 15

PMS SEN FRANK CHURCH

US SEN CAPITAL HILL DC

HR11357 IF PASSED COLD JEOPARDIZE PATIENT CARE

BONNER GENERAL HOSPITAL JAMES BRENNICH

The CHAIRMAN. We will now adjourn.  
(Whereupon, at 1:50 p.m., the hearing in the above-entitled matter  
was adjourned.)



