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EXTENSION OF NLRA TO NONPROFIT HOSPITAL EMPLOYEES

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HEARINGS

BEFORE THE

SPECIAL SUBCOMMITTEE ON LABOR

OF THE

COMMITTEE ON EDUCATION AND LABOR

HOUSE OF REPRESENTATIVES

NINETY-THIRD CONGRESS

FIRST SESSION

ON

H.R. 1236

A BILL TO AMEND THE NATIONAL LABOR RELATIONS ACT TO
EXTEND ITS COVERAGE AND PROTECTION TO EMPLOYEES
OF NONPROFIT HOSPITALS, AND FOR OTHER PURPOSES

HEARINGS HELD IN WASHINGTON, D.C.,

APRIL 12 AND 19, 1973

Printed for the use of the Committee on Education and Labor

CARL D. PERKINS, *Chairman*



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EXTENSION OF NLRA TO NONPROFIT HOSPITAL EMPLOYEES

THURSDAY, APRIL 12, 1973

HOUSE OF REPRESENTATIVES,
SPECIAL SUBCOMMITTEE ON LABOR
OF THE COMMITTEE ON EDUCATION AND LABOR,
Washington, D.C.

The subcommittee met, pursuant to call, at 10:10 a.m., in room 2257, Rayburn House Office Building, Hon. Frank Thompson, Jr. (chairman of the subcommittee) presiding.

Present: Representatives Thompson, Clay, Ashbrook, Quie and Dent.

Staff members present: Robert E. Moss, counsel; Jeunesse M. Beaumont, subcommittee clerk, and Edith C. Baum, minority counsel for Labor.

(Text and summary of H.R. 1236 follows:)

[H.R. 1236, 93d Cong., 1st sess.]

A BILL To amend the National Labor Relations Act to extend its coverage and protection to employees of nonprofit hospitals, and for other purposes

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That section 2(2) of the National Labor Relations Act is amended by striking out 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".

SUMMARY OF H.R. 1236—EMPLOYEES OF NONPROFIT HOSPITALS

PURPOSE OF H.R. 1236

H.R. 1236 is intended to restore to employees of nonprofit hospitals the rights guaranteed to most all other employees by section 7 of the National Labor Relations Act "to self-organization, to form, join, or assist labor organizations, to bargain collectively through representatives of their own choosing, and to engage in other concerted activities for the purposes of collective bargaining or other mutual aid or protection," and the corollary right in section 7 "to refrain from any and all of such activities."

H.R. 1236 would also give to employers the rights guaranteed to most all other employers, i.e., the right to invoke the protections of the National Labor Relations Act against the unfair labor practices engaged in by unions as enumerated in sections 8, 9, 10, and elsewhere.

LEGISLATIVE HISTORY AND PURPOSE OF THE EXISTING EXEMPTION

Section 2(2) defines the term "employer" as not to 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." This "exemption" was added to the original Wagner Act of 1935 in the Taft-Hartley Amendments of 1947 for reasons which are not altogether clear.

A. Decisions Under the Wagner Act

The Wagner Act of 1935 did not exclude the employees of nonprofit hospitals from the protections afforded most other employees, and the Labor Board and the reviewing courts refused to create an exception by implication.

The only case reported under the Wagner Act is *Central Dispensary and Emergency Hospital*, 40 NLRB 1011 (1942). There, the Building Service and Maintenance Workers filed a petition to conduct an election among certain employees at the Emergency Hospital in Washington, D.C. to determine whether or not they wished to be represented by the union. The Labor Board agreed to conduct the election, and said the following:

The Hospital contends that it is a charitable institution, but neither charitable institutions nor their employees are exempted from operation of the Act by its terms, although certain other employers and employees are exempted. If Congress did not intend to except charities from the scope of the Act, an exact determination of the Hospital's status in this respect becomes immaterial . . . *employees of hospitals, like employees of automobile factories, must live upon their wages.* (Emphasis supplied.)

The Hospital appealed this Labor Board decision to the U.S. Court of Appeals for the District of Columbia. That court, in an opinion by then Judge Thurman Arnold, wrote:

Respondent (Hospital) argues that the spirit or policy of the act is such that we should read into it an exemption of charitable hospitals. . . . We are unable to follow the reasoning. . . . We cannot understand what considerations of public policy deprive hospital employees of the privilege granted to the employees of other institutions. . . . "*NLRB v. Central Disp. & E. Hosp.*, 145 F. 2d 852 (1944), *cert. den.* 65 Ct. 684.

B. The Taft-Hartley Amendments

In 1947, there were certain amendments offered to the Wagner Act. In the House, Representative Hartley introduced a bill which would have exempted from the Labor Act "institutions that qualify as charities under our tax laws," i.e., churches, hospitals, schools, colleges, and societies for the care of the needy.

The only comment on the floor of the House came from Congressman Klein, who spoke in opposition:

"Employer," for the first time, excludes charitable and educational organizations. While the number of workers thus deprived of any participation in the terms of their employment may not be large, it seems ironical that organizations devoted to the social welfare should be exempted from bargaining with their own, often underpaid employees.

The bill passed the House and it went to the Senate.

There was no committee report or proposal in the Senate comparable to that in the House. However, Senator Tydings offered a floor amendment to exclude from the term "employer" the nonprofit hospitals. Debate was very scant.

Senator Tydings explained that "this amendment is designed merely to help a great number of hospitals which are having very difficult times. They are eleemosynary institutions, no profit is involved in their operations, and I understand from the Hospital Association that this amendment would be very helpful in their efforts to serve those who have not the means to pay for hospital service."

Senator Taft then explained that "the committee considered this amendment, but did not act on it, because we felt it was unnecessary. The committee felt that hospitals were not engaged in interstate commerce; and that their business should not be so construed. We felt it would open up the question of making further exemptions. That is why the committee did not act upon the amendment as it was proposed."

The remainder of the debate was very brief, and between Senators Taylor and Tydings:

Mr. TAYLOR. What does the amendment do? Does it prevent hospital employees, particularly nurses, from organizing? Is that the sense of the amendment?

Mr. TYDINGS. It simply makes a hospital not an "employer" in the commercial sense of the term. . . .

Mr. TAYLOR. Would nurses be prevented from organizing—they are poorly paid.

Mr. TYDINGS. I don't think so. . . . They (the hospitals) should not have to come to the National Labor Relations Board. . . . A charitable institution is away beyond the scope of labor management relations in which profit is involved.

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

Mr. TYDINGS: I agree with the Senator.

The bill then passed the Senate. The conference committee accepted the Senate version, which is now part of section 2(2) of the National Labor Relations Act.

C. The 92d Congress

During the 92d Congress comprehensive hearings were held on H.R. 11357, a bill to bring nonprofit hospital employees back under the coverage of the NLRA. (See Education and Labor Committee print 73-849). The bill, which is identical to H.R. 1236, was passed by the House on August 7, 1972; no action was taken in the Senate.

EXPERIENCE UNDER THE EXEMPTION

The National Labor Relations Board, initially, extended the exemption to a host of other eleemosynary, charitable, educational and similar types of institutions:

1. Colleges and universities, *The Trustees of Columbia University*, 97 NLRB 424 (1951).
2. Symphonic orchestra, *Philadelphia Orchestra Association*. 97 NLRB 548 (1971).
3. Radio stations operated by religious organizations, *Lutheran Church, Missouri Synod*, 109 NLRB 859 (1954).
4. Institutions for the training of the handicapped, *Sheltered Workshops of San Diego, Inc.*, 126 NLRB 961 (1960).
5. Privately owned profit hospitals, *Flatbush General Hospital*, 126 NLRB 144 (1960).
6. Hotels operated by the YMCA, *Young Men's Christian Association of Portland, Oregon*, 146 NLRB 20 (1964).
7. Food service caterers at educational institutions, *Crotty Brothers, N.Y. Inc.*, 146 NLRB 755 (1964).
8. Oceanography studies conducted by private educational institution owned ships, *University of Miami, Institution of Marine Science Division*, 146 NLRB 1448 (1964).
9. Food service caterers at a hospital, *Horn and Hardart Co.*, 154 NLRB 1368.

Experience indicated that the withholding of Labor Board jurisdiction did not cut down on the number of strikes or of labor unrest. Accordingly, in recent years, the Labor Board began to assert jurisdiction over areas it had formerly left alone:

1. Private, profit hospitals, *Butte Medical Properties*, 168 NLRB 52 (1967).
2. Private, profit nursing homes, *University Nursing Home*, 168 NLRB 53 (1967).
3. Nonprofit, cooperative insurance companies, *California State Automobile Association*. 170 NLRB No. 106 (1968).
4. Professional sports, *The American League of Professional Baseball Clubs*, 189 NLRB No. 85 (1971).
5. Private colleges and universities, *Cornell University*, 183 NLRB No. 41 (1970).
6. Philanthropic lodging houses, *Penn-Keystone Realty Corp.*, 191 NLRB No. 105 (1971).
7. Nonprofit educational broadcast stations, *Pacifica Foundation*, 75 LRRM 1428.

The only broad area of charitable, educational, eleemosynary institutions wherein the Labor Board does not now exercise jurisdiction concerns the non-profit hospitals, explicitly excluded from the Labor Act by section 2(2).

CHANGES MADE IN EXISTING LAW BY H.R. 1236¹

Section 2(2) of the Labor-Management Relations Act, as amended by this bill, would provide as follows:

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 operat-

¹ Except as noted, existing law proposed to be omitted is enclosed in brackets, new matter is printed in italic, and existing law in which no change is proposed is shown in roman.

ing 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 organization (other than when acting as an employer), or anyone acting in the capacity of officer or agent of such labor organization.

Mr. THOMPSON. The subcommittee will come to order. Today, we are beginning our second series of hearings on H.R. 1236, by Mr. Ashbrook and myself, to extend coverage of the National Labor Relations Act to the employees of nonprofit hospitals.

An identical bill, H.R. 11357, passed the House in the last Congress by a vote of 3 to 1.

The passage of H.R. 1236 would have two major impacts on labor-management relations in the hospital field. First, it would bring stability by virtually eliminating the "recognition strike," which accounts for most labor-management strife.

Second, it would insure equality and dignity to the employees of nonprofit hospitals. They may do the same work in the same city as employees of proprietary hospitals, but they do not have the protections of the National Labor Relations Act.

To introduce our first witness, I would like to recognize an old friend, the distinguished legislative director of the Service Employees' International Union, Mr. Richard Murphy.

Good morning.

STATEMENT OF LESTER ASHER, GENERAL COUNSEL, SERVICE EMPLOYEES' INTERNATIONAL UNION; ACCOMPANIED BY HARRY KURSHENBAUM, DIRECTOR, AND RICHARD E. MURPHY, LEGISLATIVE DIRECTOR, SERVICE EMPLOYEES' INTERNATIONAL UNION

Mr. MURPHY. Good morning, Mr. Chairman and members of the committee. I appear before you to convey our thanks from our international president, George Hardy, for holding these hearings.

As you have already mentioned, you were successful in producing a bill last year and successful in achieving a success by having the House vote 3 to 1 in favor of it last year.

Around my house last year we talked about this as the Murphy bill, not the Thompson bill, because not too many people knew about it. More people know of it this year and, thank God, it is now known as the Thompson-Ashbrook bill.

We are pleased with the cooperation we have received from both of you.

Mr. THOMPSON. In Ohio it is the Ashbrook-Thompson bill.

Mr. MURPHY. This would stop recognition of strikes. I think we can also call this a poor people's bill. That was not talked about much last year at all, but it will help low-paid workers.

If they are able to be represented by unions, their wages will rise. Many minorities are involved, and I think we should recognize the poor people aspect of the legislation.

It is my privilege to introduce our counsel, Lester Asher, who represents the Service Employees' International Union. He will present our testimony to the committee.

Mr. ASHER. Thank you.

In the testimony we have submitted to the committee, at the bottom of the second page there is an inadvertent error, the sentence

beginning with the word "Recognition . . ." should have been preceded by the words ". . . the denial of."

The correct sentence would be, "The denial of recognition of a union as the representative of employees in nonprofit hospitals, now subject to whim and coercion, all too easily erupts in long and wasteful strikes which disrupt health care for the community."

Mr. THOMPSON. May I interrupt to state I would ask unanimous consent that your formal statement be inserted in the record and you may proceed.

[The statement referred to follows:]

STATEMENT OF LESTER ASHER, COUNSEL, SERVICE EMPLOYEES
INTERNATIONAL UNION

Service Employees International Union strongly urges extension of the National Labor Relations Act (NLRA) to cover non-profit hospitals. Among our half-million members, we represent more than 150,000 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 non-profit institution are covered by the National Labor Relations Act, including non-profit nursing homes and employees of non-profit colleges, these workers in non-profit hospitals cannot use the National Labor Relations Board procedures.

THE CONTRADICTIONS IN THE FIELD ARE PRETTY EVIDENT

The bill before your committee, H.R. 1236, merely deletes this exclusion. We urge speedy adoption of this bill, that is identical to the bill that passed the House in the last session of Congress, only to die in the Senate.

We believe that the non-profit hospital industry, a giant part of the nation's health care field, should be covered by the NLRA because 1) Employees of non-profit hospitals should have the same rights under the law as other wage earners; 2) The quality of hospital service would be enhanced because an orderly procedure for labor recognition elections would be established; 3) Systematic, standardized regulations are needed to replace varied local regulations of the industry; 4) Arguments against coverage for non-profit hospitals are no longer valid because hospitals are no longer local enterprises.

Employees of non-profit hospitals should have the same legal rights as other wage earners to use secret ballot in an orderly election to determine the wishes of the majority, and they should have the right to a voice in determining their conditions of employment. Personnel in proprietary hospitals, as well as non-profit and proprietary nursing home workers already exercise these rights granted by coverage under the NLRA. There are no legal or moral reasons why employees of non-profit hospitals should be denied these same rights under the law.

Non-profit hospitals are basically no different from proprietary hospital. In fact, a hospital can change from one status to the other, without any other outward change in condition—except in one case they are subject to the National Labor Relations Act, and in the other they are not.

For example in Los Angeles, the Queen of Angels Hospital functioned as a non-profit 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 has 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.

NLRA coverage of non-profit hospitals would enhance the quality of hospital service by improving labor relations, since workers could gain union recognition without striking. The recognition strike is the primary and most disruptive form

of labor conflict in the voluntary hospital. Preliminary data from a 1968 survey of strikes in non-profit hospitals reveal that recognition strikes averaged 32 days and resulted in an average of 3,967 man-days idle in each facility.¹ Strikes due to conditions of employment, on the other hand, had less than half the impact. Recognition of a union as the representative of employees in non-profit hospitals, now subject to whim and coercion, all too easily erupts in long and wasteful strikes which disrupt health care for the community. Extension of the NLRA to non-profit hospitals would eliminate this major cause of work stoppage by insuring the right to orderly, peaceful recognition elections.

Coverage under NLRA is needed in order to provide a systematic standard for the non-profit hospital industry. In the absence of national labor legislation covering this industry, nine states have passed laws in an attempt to regulate labor relations of non-profit hospitals in their states. The labor laws of four other states specifically exclude non-profit hospitals; one state regulates labor relations of non-profit hospitals through the courts, and the remaining states exhibit no particular pattern.²

There are two reasons why national, standardized legislation is needed to replace this patchwork of state regulation. First, many of the state labor laws are outmoded and ineffective. Most do not define unfair labor practices, or they only have limited definitions. In addition, many state laws do not follow NLRB guidelines for the composition of the bargaining unit. As a result, bargaining unit fragmentation is encouraged, resulting in a greater threat of labor conflict. NLRA coverage would provide systematic guidelines, rather than allow the location of a facility to determine its labor relations.

Second, state laws covering non-profit hospitals should be replaced because these hospitals are no longer local facilities, but comprise massive, regional health care systems. In 1971, non-profit hospitals accounted for forty-seven percent of all hospital personnel, and cared for sixty-six percent of all patients admitted.³ Net total revenue of non-profit hospitals amounted to almost \$17 billion.⁴ In 1971, the hospital industry, including the giant non-profit sector, received \$11 billion in payments from private insurance companies located throughout the nation, and \$9.7 billion from federal sources.⁵ When the \$5.2 billion from state funds are included, these sources represent eighty-two percent of the total amount spent on hospital care in 1971.⁶

Hospitals are no longer financed by predominately local sources. In addition, hospitals, including non-profit facilities, have an impact on interstate commerce through their purchases of drugs, food, equipment, fuel and other supplies that are often produced in other regions of the country. The operations of non-profit hospitals obviously fall within the definition of interstate commerce and so should be afforded national regulation of labor relations.

The 1972 Amendments to Social Security, Medicare, and Medicaid Programs (H.R. 1) place exactly the same requirements on proprietary and non-profit hospitals. Some of these restrictions include limiting the prevailing charge level for a given hospital service (Sec. 224) (a); determining the reasonable cost of inpatient hospital services under Medicaid (Sec. 232) (a); and requiring public disclosure of the extent of compliance of all health facilities under the Social Security Act (Sec. 299D) (a). Health care facilities, whether proprietary or non-profit, are considered public entities under H.R. 1, and NLRA coverage should be extended to all hospitals on the same basis.

Arguments against coverage of non-profit hospitals by the National Labor Relations Act have centered predominately on four themes. The first and most recurrent theme is that coverage by the Act would result in recognition strikes and picketing and the fragmentation of bargaining units.⁷ We feel that coverage of the Act would effectively eliminate recognition strikes and picketing, by use of mechanisms provided in the Act which call for elections within a reasonable time after a petition for election is filed. Accordingly, Section 8(b)7 of the Act provides for expedited elections, and we are sure that NLRB personnel would interpret "reasonable time" with the situations of hospitals in mind.

¹ Dennis D. Pointer, "Hospital Labor Relations Legislation: An Examination and Critique of Public Policy," *Hospital Progress*, January 1973, p. 74.

² *Ibid.*, p. 72.

³ Computed from American Hospital Association, *Hospital Statistics*, 1971, p. 21.

⁴ *Ibid.*, p. 50.

⁵ Lawrence E. Martin, "Cost Effectiveness at a Cost," *Trial Magazine*, March-April, 1973, p. 13.

⁶ *Ibid.*

⁷ Statement by David H. Hitt, Chief operating officer, Baylor University Medical Center, Dallas, Texas, *Hearings before the Committee on Labor and Public Welfare on H.R. 11357*, U.S. Senate, 8/16/72.

As for fragmented bargaining units, the NLRB provides for appropriate units using guidelines set out under Section 9(b) of the Act. These rules have been found to be far superior to those set by any state law covering non-profit hospitals, and in states not covered by an act, definition of units in the health care field has led to considerable controversy. This is inefficient for both the hospital and the union. Coverage of non-profit hospitals would ensure that the knowledge gained from experience under the Act would be applied to those situations. Past experience has shown that in 80% of the elections under the NLRA involving proprietary hospitals and proprietary and non-profit nursing homes, employee units were agreed upon by both parties before the election.⁸ Also, this fragmentation has not been the experience of SEIU bargaining units in hospitals in the past and we feel that fragmentation will be all but eliminated if nonprofit hospitals are brought under the NLRA.

The second argument for exclusion of non-profit hospitals from the NLRA presents the view that laws of this nature should be handled by each state.⁹ Many state laws on the book today covering non-profit hospitals were passed to fill a gap left by the Wagner Act in 1935. Many of these state laws are now outmoded and unsystematic. Because of the growth of regional and inter-state health care systems, hospitals are forced to deal with differing and in some cases contradictory state laws.

In hearings held on this bill last year, the New York and Massachusetts hospital associations asked for extension of coverage under the NLRA since their state laws had proved unsatisfactory. For example, the New York statute does not regulate election frequency, the percent of authorization cards required, and the inclusion of guards or supervisors in a unit. All of these potential problems are covered by provisions of the NLRA and these provisions have been used with a great degree of success to smooth the path of collective bargaining.

The third argument that has been raised against coverage is that patient safety is too critical to allow NLRA coverage of non-profit hospitals. We feel that the first step toward more stable service would be the elimination of the recognition strikes, at the present time, the most common form of work stoppage in voluntary hospitals. Coverage of the NLRA would do this.

Proprietary hospitals and profit and non-profit nursing homes provide the same type of patient care as non-profit hospitals and have been covered by the Act. What of other public services industries, such as utilities and transportation? These industries provide an essential public service, but are also characterized by a long tradition of labor management relations guided by statute.

The fourth argument holds that coverage and increased unionization will lead to rising wages and thus higher hospital costs for patients.¹⁰ In response we say first, that hospital employees only recently were given the advantage of coverage under the Fair Labor Standards Act which set a minimum for health care wages. However, there are still thousands of hospital workers who are paid poverty level wages—workers who earn too little to properly feed themselves and their families. These workers need union protection in order to secure a living wage.

Second, coverage of the National Labor Relations Act was extended to proprietary hospitals in 1967, with a corresponding increase in unionization. Despite this fact, hospital wages have risen much more slowly than the cost of hospital care. In the five year period January 1968 to January 1973, wages of non-supervisory hospital personnel have increased 43.6 percent while the CPI of semi-private hospital room rates has increased 66.8 percent.

There are many cases for increasing hospital costs other than wage increases—especially increased sophistication of medical treatment requiring more personnel per patient, more expensive equipment and lab procedures, large increases in demand related to increased insurance coverage, mismanagement of funds and utilization rates below optimum.

Certainly, none of these arguments against H.R. 1236 are legitimate reasons for depriving workers of a mechanism for determining democratically whether or not they desire to be represented by a union for collective bargaining purposes. The policy statement of the National Labor Relations Act applies equally to non-profit hospital employees:

Experience has proved that protection by law of the right of employees to organize and bargain collectively safeguards commerce from injury,

⁸ Statement by Ogden W. Fields, former executive secretary, National Labor Relations Board, *Hearings before the Committee on Labor and Public Welfare on H.R. 11367*, U.S. Senate, 8/16/72.

⁹ Statement by Myles J. Gibbons, counsel, Hospital Association of Pennsylvania, *Hearings before the Committee on Labor and Public Welfare on H.R. 11367*, U.S. Senate, 8/16/72.

¹⁰ Statement by Harmon L. Elder, Washington representative, Southern States Industrial Council, *Hearings before the Committee on Labor and Public Welfare on H.R. 11367*, U.S. Senate, 8/24/72.

impairment, or interruption, and promotes the flow of commerce by removing certain recognized sources of industrial strife and unrest, by encouraging practices fundamental to the friendly adjustment of industrial disputes arising out of differences as to wages, hours, or other working conditions, and by restoring equality of bargaining power between employers and employees . . .

It is hereby declared to be the policy of the United States to eliminate the causes of certain substantial obstructions to the free flow of commerce and to mitigate and eliminate these obstructions when they have occurred by encouraging the practice and procedure of collective bargaining and by protecting the exercise by workers of full freedom of association, self-organization, and designation of representatives of their own choosing, for the purpose of negotiating the terms and conditions of their employment or other mutual aid or protection.¹¹

We urge Congress to pass H.R. 1236 without delay, so that hospital workers receive the protections of their rights under the Labor-Management Relations Act.

Mr. ASHER. We represent a total of a half million members and more than 150,000 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 contradictions in the field are pretty evident.

We are urging that the exclusion in the statute which now excludes from the definition of employer "nonprofit hospitals" be deleted. We would urge this, from our experience, would lead to greater labor peace and greater labor stability.

From our own experience with these over 150,000 employees, we are convinced the most disruptive form of labor conflict in the nonprofit hospital field is a recognition strike. It is our experience the strikes which we have had have unfortunately come over the issue of recognition.

If the Congress would pass H.R. 1236, it would solve this problem. We believe that the main basis for any strikes in this field would be done away with.

Mr. THOMPSON. I might interrupt to talk just for a moment about the legislative history. In the 1935 act, hospital employees were covered. In 1947 they were in one version of the legislation, but the late Senior Senator Tydings of Maryland was uncertain, as indeed he had a right to be at that time, as to whether they were in commerce.

That matter, of course, has been settled by a Supreme Court case arising out of the State of Maryland. It really was not contemplated that they be excluded.

Mr. ASHER. That is correct.

Mr. ASHBROOK. On that point, there were many other groups included; college employees, for example. There was an honest effort to distinguish between interstate and intrastate which I think should be there, but for all intents and purposes it has been abolished.

One by one every group has fallen into interstate rather than intrastate. You can't name intrastate and be explicit. This is the last group held under the old concept of intrastate.

College employees and others have long since come under the interstate.

¹¹ Labor-Management Relations Act, Title I, 101(1).

Mr. THOMPSON. With the advent of Federal intervention in the form of medicare, there is absolutely no question but that they are in interstate commerce at this point.

Mr. ASHER. That is correct, these nonprofit hospitals have been subject to the provisions of the Fair Labor Standards Act and voluntarily they have been under the Unemployment Compensation Act since January 1972, and more and more they have been brought into this legislation.

I think Congressman Ashbrook's point was well taken. The Labor Board has asserted jurisdiction over nursing homes and nonprofit hospitals. They have asserted jurisdiction over monetary hospitals and nonprofit colleges and we have many cases involving professors and custodial and maintenance employees in these nonprofit colleges over which the Board has asserted jurisdiction.

The experience is very clear. There is a 1968 survey which shows strikes in nonprofit hospitals for recognition averaged 32 days a year during that 1968 period. Strikes over the other issues such as the conditions of employment have far less than half of that impact in these nonprofit hospitals.

One other thing we have run into in our experience which shows the contradictions and problems in this field is we have had a proprietary hospital where the Board has taken jurisdiction which overnight became a nonprofit hospital by changing the form of ownership and the corporate structure without its making a particle of difference to the employees involved or the patients involved.

Similarly, we have had hospitals which are nonprofit that became proprietary overnight and again, there is no change to the employees or the patients or the service involved.

I would like to flesh this out a little so the committee could understand the practical problems we run into in this field. Take, for example, a State such as Illinois, where there is no labor code whatsoever as far as these nonprofit hospitals are concerned. It is a jungle; there is no law.

The only law we do have is our Supreme Court which held in 1969 that employees of nonprofit hospitals do have the right to strike and that our Anti-Injunction Act does apply to hospital employees.

The Supreme Court held that our Anti-Injunction Act, which didn't expressly exclude hospitals, did apply to hospitals, and, therefore, peaceful strikes were permitted. We have a situation in Illinois where our local representatives today have over 24 hospitals where we have contracts.

The only strikes we have ever had in those situations are one, over the issue of recognition or, two, over the issue of unfair labor practices. If we had had Board jurisdiction, we would have had a place to file to stop the employer from discharging people, from giving out raises in the midst of our negotiations and matters which are clearly unfair labor practices.

We may have a strike against a hospital in Chicago within the next few days. It is a hospital called the Gottlieb Memorial Hospital in Melrose Park, Ill. It has about 150 beds and a total of about 400 employees in all classifications.

At the end of December last year we served a demand for recognition upon the hospital and made the statement that we represented a majority and wanted to work out arrangements for an election.

We were told, after some delay, to talk to the lawyers for the hospital. When we went to the lawyers, they delayed further by telling us they knew nothing about it. Finally, we were able to start negotiations in February of this year for the terms of an election.

We finally were able to reach that situation only through the threat of a strike. During February and March, we held many meetings trying to work out an election agreement and an appropriate unit for holding that election.

We offered in the course of these negotiations to commit ourselves that we would not strike, to commit ourselves that we would agree to a voluntary binding arbitration if the hospital would so agree.

This has become the pattern in Chicago. In all the hospitals which we have under contract or where we went to consent elections, we agreed to a voluntary, binding arbitration machinery even for the terms of a new contract.

In only one hospital is there a situation where we don't have this voluntary binding arbitration. That is because the hospital didn't want to agree to such arbitration. In this situation at Gottlieb we were finally able to work out with the lawyers all of the terms of an election, all of the terms of the appropriate bargaining units, all of the details with respect to no strikes and with respect to possible decertifications, matters of that kind.

On April 9 we were told by the hospital officials that they wanted to change all of the terms that we had agreed upon with their attorneys and with their personnel director, who we had been told had been authorized to conclude an agreement with us.

So, the top officials of the hospital now disavowed this agreement of their representatives and now say they want an appropriate unit which would include all the professionals in the hospital, all the clerical employees within the bargaining units, all the registered nurses and all the volunteers who are not employees of the hospital at all.

And that is a position totally different than what other hospitals take and different from what had been agreed with their attorneys who knew something about these appropriate bargaining unit problems.

As it stands now, there will have to be a strike because we have no place to go to have someone determine the appropriate bargaining unit and proceed with a holding of an election because the hospital at this point is apparently disavowing the arrangement which its attorneys and representatives made.

This, we believe, is a totally unconscionable type of situation. The employees in these hospitals are for the most part minority workers, low-paid workers, workers who need the protection of a labor union. It has been our experience in Chicago, certainly as we see it from our side, that bringing in a labor union, setting up a contract, bringing in a steward system where employees have a grievance procedure and have an avenue for having their gripes remedied has actually helped the administration of the hospitals.

We think our organizing in Chicago has made many of these hospitals, which were extremely loose and careless in their employment practices, has forced them to bring in personnel people.

It has meant that they have brought in classifications of their jobs, they have evaluated these jobs with respect to one another and overall it has helped the administration of the hospitals.

I would be pleased, if the committee wishes, to answer any questions which you may have. We have Mr. Harry Kurshenbaum, director of the union activities of our local 73 in Chicago. This local has been the most active in the hospital organization in that area.

I want to point out it is not the only local we have in this field. Many, many employees are organized in the hospitals in New York City and many employees are organized on the west coast where we are the leading union active in the hospital field.

Mr. Kurshenbaum is here to give his experience with the hospitals.

Mr. KURSHENBAUM. Mr. Chairman, members of the committee, I wish to thank you on behalf of approximately 1,000 people as of today, this morning, who are faced probably with the elements that Counsel Asher described; that is, organizational strikes.

At the present time, in fact today and tomorrow, one of the hospitals Mr. Asher related to, Gottlieb, now can be compounded by Oak Park Hospital which has refused to meet with us since we have had one very brief meeting with them about 4 weeks ago, and there has been a series of discharges against them.

As of tonight's meeting, a decision will be made to call a strike for purposes of recognition at Oak Park Hospital, which is adjoining Chicago, Ill. I think the thousands of people in these hospitals waiting in this jungle attempting to get some kind of semblance of recognition through an election, I think it is vital to relate to what is taking place here this morning.

I think in the 6 years since we started the organization of the hospitals in the Chicago area, I think we can describe a series of tragic circumstances that really can fill volumes. In every case that we came to a hospital, after we had a majority of the cards signed and asked for recognition, the constant refrain is, "We don't give a damn if you have 100 percent cards signed. We don't have to deal with you."

Then we would proceed to go to the doctors, to the community and plead with them that we wanted to avoid any kind of a confrontation. In a third of the 22 to 23 hospitals that we have organized, we have had organizational strikes.

They are unfortunate. We have had a cessation of services and even in the cessation of services we offered the hospitals dietary people, nurses, and maintenance people as volunteer help with no pay and were rejected out of hand.

It was through the intercession of people such as Congressmen, the mayor, people of good will, that eventually caused the strike to terminate and to get some kind of a preelection agreement.

The preelection agreement stipulated that there would be no strike in perpetuity in our situation where we were both voluntary; we agreed to this and it dealt with the question of binding arbitration.

Mr. THOMPSON. May I ask a question? Among the hospitals which you have organized and in which, or with which you have contracts, how many strikes have you had?

Mr. KURSHENBAUM. In the hospitals that we have organized I would say we have had strikes in every one.

Mr. THOMPSON. Aside from recognition strikes, where you are recognized?

Mr. KURSHENBAUM. There are none. This is unequivocal; there are none. We have offered these four hospitals we are negotiating with right now, we have offered a pre-election agreement where we would set up binding arbitration.

They have refused that out of hand even as a preelection agreement. In instances where they have begun to talk to us, in one of the four hospitals where they have begun to talk to us, they have thrown everything into the bargaining unit you can imagine—doctors, gift shop employees and volunteer employees.

Mr. THOMPSON. Doctors have their own union?

Mr. KURSHENBAUM. We may invite them in as well. We certainly look forward to their joining forces with us. The whole point is we ourselves do not care for the confrontation. We think it is difficult for the community.

We think we have developed a posture in the city of Chicago, and its area, in which the communities themselves recognize that the justification is on our part, and we hope that the plea of our own people and those who are unorganized in Chicago, that something can be done to rectify this situation, that that will go certainly toward the semblance of peace that can be established.

That is all I have to add at this point.

Mr. THOMPSON. Thank you very much.

I note some of the statistics in Mr. Asher's statement—I must confess when we embarked on this legislation 2 years ago that I had no idea of the enormity of the industry.

On page 3 of your statement you point out that in 1971 nonprofit hospitals accounted for 47 percent of all hospital personnel and cared for 66 percent of all patients admitted and 83 percent of the money.

You point out that the net total revenue of nonprofit hospitals amounted to almost \$17 billion. I think that is larger than the auto industry. In 1971 in the hospital industry, including the nonprofit sector, they received \$11 billion from insurance companies and \$9.7 billion from Federal sources, so that is an astoundingly large industry.

It just occurs to me with the average cost per patient per day being in the vicinity of \$105—of course, there has been a tremendous escalation or inflation in hospital costs and all medical costs—the people whom you are speaking for are by and large, for all practical purposes, excluded economically.

As Counsel points out, an industry with \$11 billion couldn't possibly not be in interstate commerce. Your statement is very comprehensive and very valuable.

Mr. ASHER. One important statistic, also, Congressman Thompson, is the fact we are talking of 1,300,000 people. This is the number of employees working for these nonprofit hospitals we are talking about.

Mr. THOMPSON. Yes, we recognize that.

Mr. ASHER. We are talking of 1,300,000 people who for the most part are very low-wage people, members of minority groups and the people that really need whatever help we can possibly give them.

Mr. THOMPSON. We were astounded also to learn that one of the Nation's greatest and largest hospitals, before they voluntarily had their workers organized, had a turnover of 1,200 percent in a year, theoretically every single job turned over 12 times.

In a year the economics of that are absurd, the training, the paperwork and so on. It must be terribly expensive, and the patient care

just can't be any good where you have a turnover anywhere near that large. That hospital now is down to 30 percent from 1,200.

Mr. ASHER. We don't have the actual statistics in the Chicago hospitals that we have organized from our side as to the turnover figure, but we know from statements made by the hospitals that their turnover figure has been substantially reduced where we have a union contract, a union steward system and orderly machinery for handling the grievances and complaints for employees.

The entire operations has been stabilized and improved. Along the same lines, when the National Labor Relations Board decided to take jurisdiction over nonprofit nursing homes, we wrote a brief to the Board in which we pointed out that we were dealing here with low-wage people and with minority groups and that it was very important for the Board to take jurisdiction.

The Board decided to take jurisdiction over these nursing homes. There hasn't been any wave of strikes in the nursing home area. We have found certainly in the areas of the country where we have them organized that the basic strikes in the nursing home field were in recognition, the same as in the nonprofit hospital field.

After the Labor Board asserted jurisdiction, the strike rate has been very low in those jurisdictions. Our situation in Chicago has been we have never had a strike after recognition and a union contract. The strike always came in our effort to obtain recognition.

Mr. THOMPSON. My earlier reference to percentage turnover dealt with Johns Hopkins Hospital. In the testimony last year it was pointed out that Mt. Sinai in New York, one of the greatest hospitals, had a 1,500 percent turnover, and it is now down to 28 percent since it has been organized.

Mr. Ashbrook, do you have any comments or questions?

Mr. ASHBROOK. Yes, Mr. Chairman. I have several questions. I wonder first of all what has been the experience of the Service Employees' International Union in organizing nonprofit hospitals in States with compensating labor laws of the NLRA?

Mr. ASHER. I don't think there are any entirely comparable with the NLRA. I know we organized many hospitals in New York.

Mr. ASHBROOK. That would be the closest.

Mr. ASHER. Yes, and we organized many of those hospitals and our experience has been there have not been many strikes after we obtained recognition under their new statute.

Mr. ASHBROOK. What about Minnesota? That would probably be the second that would be fairly close.

Mr. ASHER. The only hospital I know in Minnesota, I think it is one of the public hospitals, one of the State hospitals. I don't have any figures on our actual experience in Minnesota. We can work that down and submit that to you for the record at a later time.

Mr. MURPHY. We represent about 2,000 employees in Minnesota and have had, as far as I know, peaceful relationships with the hospitals.

Mr. ASHBROOK. Are there any States in which your union is operating where there are compulsory arbitration laws in the specific instance of hospital labor relations?

Mr. ASHER. New York has the arbitration procedure and Minnesota also.

Mr. ASHBROOK. What has been the result of that? It seems to me the major argument the hospital administrators make is that there can be strikes. I think the most impressive part of your testimony is that there can only be strikes if one side determines they don't want to have binding arbitration or orderly resolution of differences.

Mr. ASHER. I think the only part where we differ is we don't like the compulsory part of the statutes. The pattern I think is most desirable is what we have worked out in Illinois, a voluntary procedure.

It is binding on the parties and even applies to the terms of a new contract. The only contract in Chicago where we don't have this voluntary arbitration is where the hospital didn't want it.

They, for reasons of their philosophy, said they didn't want to have arbitration. I think the trend would be the other way, and I think most hospitals would agree with us if we wanted to set up a voluntary form of arbitration. This, I think, is the most desirable solution.

Mr. ASHBROOK. I do, too. I have always opposed compulsion. I have been one of the few in Congress voting against compulsory arbitration, even on the railroads. I think it is a bad precedent.

It would be very hard to speculate in arbitration of any kind which side comes out best. I assume there are arguments both ways. If the system is anywhere near fair, it ought to be reasonably balanced.

Mr. MURPHY. To go into your question on New York State, we have had no difficulties in upstate New York at all in any sort of situation approaching a strike. There was a situation—I don't have the data, I am sorry—in which there was a 3-hour sitdown strike at the French Poly-Clinic School & Health Center.

That was despite the fact the law provides for compulsory arbitration. In New York State even employees are by law prohibited to strike, but they have struck nevertheless. Throughout the country, I think you will find a violation of that here and there.

Mr. ASHBROOK. This has always been one of my complaints about unions, that is, they want a union shop on the basis that they will have responsibility over their employees. Then, if there is a short strike, they will say, "Well, that was a wildcat strike and we couldn't do anything about it."

In some ways you tend to put people in boxes, too. I look at both sides of that. Even in this case, as a member of this committee for 12 or 13 years, I think my record is clear. I have been a holdout on 10 or 12 pieces of legislation, but in this particular instance, if you can get by me you can get by anyone.

Mr. THOMPSON. Let the record show the Chair agrees with that.

Mr. ASHBROOK. It seems to me in this case most of the equity is on your side, although there are always two sides to any argument. After listening to the testimony for 2 years, I myself believe the equity is on the side that you have given.

Mr. ASHER. We believe so. We see no legal or moral or ethical argument as to why these employees of nonprofit hospitals shouldn't have the same rights as other employees under our labor laws or Federal employees.

Mr. ASHBROOK. I have no further questions.

Mr. THOMPSON. Mr. Clay?

Mr. CLAY. Thank you, Mr. Chairman.

Mr. Asher, perhaps you should expand on that last statement that you see no legal or other rights as to why the nonprofit hospital employees should be treated differently. Opponents of this legislation say there is a difference between employees of nonprofit hospitals and proprietary hospitals.

I might add they have not convinced me of any difference. The only difference I see is the exploitation of workers in nonprofit hospitals is far more acute than in other hospitals and the wages and benefits are far different.

Are there any basic differences in functions of employees or the kind of care or any other differences between the two hospitals?

Mr. ASHER. None whatsoever. As I said, we have had examples where, when the Labor Board took jurisdiction over a proprietary hospital they changed their legal form and overnight became nonprofit. We have had the reverse where nonprofit hospitals became proprietary and our experience has been no change for the employees involved, patient care or any of the services involved.

We see no basis whatsoever for any differences. In the nursing home area, where it is also very important, in many cases you are taking care of old, sick people and the need for care is very, very serious and very great.

There we have had the Board take jurisdiction over proprietary nursing homes and nonprofit nursing homes, and we have not had any bad experience at all. We think the need is for the employees.

As you pointed out, the fact in many cases is they are being paid substandard wages. All of these different reasons cry out for the assertion of jurisdiction by the Board over these employees of nonprofit hospitals. It is even more marked with the Board taking jurisdiction over nonprofit colleges.

Here we can represent the maintenance and custodial employees on the campuses of nonprofit colleges. We see no difference in connection with their hospital operations.

Mr. THOMPSON. If the gentleman will yield?

Mr. ASHER. We have gotten into tough decisions where, with a university like Cornell, the NLRB will assert jurisdiction over the janitors and custodial employees in their dining halls, campus buildings, and dormitories, but they can't assert jurisdiction over people working in the hospital.

The Board has come up with the fuzzy ruling that it depends on where you work in 50 percent of the overall classifications. The Board will take jurisdiction over a janitor in a Cornell dormitory, but not a janitor in a hospital building.

Mr. THOMPSON, If the gentleman will yield, that came down in the *Duke University* case. They have a central hiring system so that the women who make the beds in the dormitories are shifted from time to time to make the beds in the hospitals.

They are covered under this act when they work 51 percent of the time in the dormitory and not covered the 49 percent they are working in the hospital, which is a part of the same institution.

Mr. ASHER. The Board has gotten itself into what I am afraid is an unworkable rule. How do you determine 51 percent or 49 percent is a working rule? It would help if they could assert jurisdiction over all these institutions.

Mr. CLAY. Thank you, Mr. Chairman.

Mr. THOMPSON. Thank you, gentlemen.

Our second witness is Mr. Charles Hargett, associate director of nursing, Beekman Downtown Hospital in New York. He is accompanied by Mrs. Alice Ahmuty, the director of economic and general welfare department of the American Nurses Association. You are very welcome this morning.

Without objection, your statement and the appendixes will be made a part of the record at this point, and you may proceed as you wish.

[The documents referred to follow:]

STATEMENT OF CHARLES HARGETT, R.N., AMERICAN NURSES' ASSOCIATION

I am Charles Hargett, R.N., a member 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 constitute 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 nonprofessionals, 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 responsibilities. 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.

COORDINATION WITH STATE LAWS

The present exemption of nonprofit hospitals has denied needed protection to a large group of workers. While we firmly believe it should be ended, we must caution that it must be coordinated with the state laws that meet Federal standards.

Eleven states do cover nonprofit hospital employees, including Montana where the statute protects only registered nurses and licensed practical nurses. In these eleven states nonprofit hospitals employ over 500,000 persons, about 38 percent of the total nonprofit hospital work force.

Because of silence on the part of the Federal government, state legislation, though admittedly limited, has evolved and taken on its own peculiarities and character. Upsetting the existing relationships could cause needless confusion and strife. The substitution of Federal for state authority, the imposition of "new rules for the game," would unnecessarily unsettle many satisfactory arrangements.

Federal preemption would also abrogate the unique dispute settlement features of several state laws—in private as well as public health care bargaining. These include provisions for "cooling-off" periods, mediation, conciliation, fact-finding, advisory arbitration and compulsory arbitration. Experimentation, innovation, and preservation of developments in this area should be encouraged. Where such procedures now exist they have a significant influence on the bargaining process and the maturing of the bargaining relationships. Their sudden termination could be most damaging to the continuation of harmonious labor relations. The national emergency provisions of the Taft-Hartley Act cannot be viewed as a viable alternative to the existing state procedures.

Already existing laws and arrangements which provide protection to hospital employees should be taken into account. The provisions of Federal and State law that protect professional bargaining are, of course, a special concern of ANA. Some states have enacted provisions more favorable to professional bargaining than those found in the NLRA. As the professional association of the largest group of health professionals, the ANA seeks to retain such advantages as have been afforded and to secure them elsewhere as well.

The ANA supports the removal of Section 2(2) from the NLRA because it brings a level of protection of 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 exemption. 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:¹

* * * 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. In hospitals, for example:²

* * * 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 subdivision within the hospital."³

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":⁴

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 * * *.

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. * * *

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.

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

⁴ *Ibid.* pp. 114, 116.

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."⁵

Other sociologists cite this role of the registered nurse within the modern hospital structure:⁶

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 aides, 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 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.⁷ 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

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

⁶ Mumford and Skipper, *Sociology in Hospital Care*, Harper and Row, New York, 1967, pp. 63-94.)

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

organization of the nursing service.”⁸ 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 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.”⁹ 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.

STATEMENT OF CHARLES E. HARGETT, AMERICAN NURSES ASSOCIATION, ACCOMPANIED BY ALICE L. AHMUTY, DIRECTOR, ECONOMIC AND GENERAL WELFARE DEPARTMENT

Mr. HARGETT. Thank you, Mr. Chairman. I am Charles E. Hargett, R.N., a member of the Commission on Economic and General Welfare of the American Nurses Association. Accompanying me is Alice L. Ahmuty, R.N., director of our Economic and General Welfare Department.

The American Nurses Association has long supported an amendment to the National Labor Relations Act which would extend its coverage and protection to employees of nonprofit hospitals.

With your permission I would like to summarize the full statement that has been presented. The ANA believes that protection of the right to organize and bargain should be extended to all health care employees, professionals and nonprofessionals.

Strikes of health care employees are relatively rare. Those that do occur usually make the headlines. The majority of these have been to secure recognition from the employer, not to win better terms in a contract.

The continued exclusion of large numbers of health care employees from the jurisdiction of labor relations laws perpetuates a gross inequity. It denies these employees access to the mechanisms and procedures designed to foster the peaceful resolution of disputes.

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

⁹ Stryker, Ruth P., “A Staffing Secretary Releases Nursing Time,” *American Journal of Nursing*, Vol. 66, No. 11, November 1966, pp. 2478.

In the absence of voluntary recognition and agreement, the employees face the choice of relinquishing their right to engage in self-organization and collective bargaining, or of resorting to the strike and picket line.

Without the protection of law, nurses' attempts to bargain have often suffered rebuff and subjected nurses to summary dismissal and a variety of other forms of coercion, intimidation, and harassment.

In 1968, in recognition of the failure of their employers to voluntarily recognize and deal equitably with them, nurses voted to withdraw as national policy their longstanding no-strike pledge.

In the ANA experience, the most usual cause for disputes with employers has been the basic question of recognition. The ANA experience is not unique for in 1967, the AHA reported that while 13 percent of the hospitals with contracts experienced a work stoppage, 21 percent of those with requests for recognition were struck.

It is the ANA conviction based on over 2 decades of experience that protection of the right of health care employees to bargain cannot be achieved without Federal action. That is why we are here today speaking in favor of passage of H.R. 1236.

The American Nurses Association recognizes that the quality and quantity of nursing care are indisputably related to the welfare of practitioners and that effective nursing service requires full participation by nurses in shaping the decisions that affect the conditions under which they practice.

Collective action through their professional association maximizes the ability of nurses to effect desirable changes. The higher salaries and improved conditions obtained through collective bargaining contribute to establishing a superior professional environment in which to practice and a superior care environment for patients.

As the professional association of registered nurses, the ANA is obligated to present itself to nurses as the channel through which they can achieve employment conditions conducive to high quality nursing care.

For nurses, conditions for nursing practice and the delivery of care are an integral part of their conditions of employment. The involvement of individual nurses in the Association's economic security program is the most effective means for assuring nurses' right to participate in the implementation of standards of nursing employment and practice.

The ANA is concerned over a related matter arising out of this proposed extension of coverage of the NLRA to private, non-private hospitals. It is the determination of the appropriate bargaining unit for a group of registered nurses.

In the determination of the appropriate bargaining unit, 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 registered nurse.

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.

It would make no sense, and would defy Congress' 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 toward the registered nurses professional status, also has the effect of making her a supervisor under the act.

It is no exaggeration to say that proper regard for this distinction is vital for the protection of professional employee rights under the act. 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 nurses constitute the largest single body, requires special protection in law. So, Mr. Chairman, as you know, the American Nurses Association has supported the removal of the hospital exemption for the past 20 years.

We continue to support it, but we hope that your subcommittee can deal favorably with particular problems that confront nurses, in the interest of good patient care.

The American Nurses Association appreciates this opportunity to to present its views, and we will be more than happy to answer any questions you may have.

Mr. THOMPSON. Thank you. You have a splendid statement.

Miss Ahmuty honored us with her presence last time, and is most welcome back.

Has it been your experience or the experience of nurses in general that patient care suffers with this tremendous turnover of personnel such as we referred to at Mount Sinai and other hospitals?

Mr. HARGETT. Indeed it has been and has placed an undue burden on registered nurses in terms of teaching and retraining this high percentage of turnover. Therefore, it distracts from those duties which should be toward the patient himself.

Mr. THOMPSON. Yes, it would seem to me with such tremendous turnovers that the nurse, who as you point out has very special responsibilities and must exercise them in the absence of the physician, for instance, not only to carry out his specific orders in the administration of medicines and so on but exercise professional judgment in the absence of the physician and take initiative.

If she is diverted or distracted because of untrained support personnel, then it would seem to me that the patient would be the loser in that case. Would you agree, Miss Ahmuty?

Miss AHMUTY. Very much so, and this has been one of the primary concerns of nurses—that is, patient care—and they have organized to improve patient care. They will forgo wage increases in order to bring about changes in the institution in order that they may provide good care.

The constant turnover is a wear and tear on the nurse, which distracts her from other vital decisions which she must make for the patient.

Mr. THOMPSON. Mr. Ashbrook?

Mr. ASHBROOK. I have several questions. Do you think the statement in the report was sufficient for legislative history? Does it cover the particular problem of your relationship to the normal concepts of "supervisor"? Do you think specific language should be incorporated in the legislation?

Miss. AHMUTY. I would be more strongly in favor of having some specific modification of the term "supervisor" in the act as it relates

specifically to registered nurses. That would be our most favored position. However, we recognize this does sometimes pose problems.

Mr. ASHBROOK. Those are my only questions.

Mr. THOMPSON. We attempted—and you state it in your statement—in the report last year to deal with this problem.

In devising the report this year we shall attempt to strengthen that language. One major difficulty is in drafting language to include in such a bill. The second is in making legislative history, which we can do in the report and in colloquy on the floor, which would have the effect of calling the Board's attention, in the likely event this becomes law, to that particular situation.

I talked with the new solicitor of the Board, who was formerly minority counsel to this committee and is a very able man. I also talked to members of the Board, and they would anticipate that even absent specific statutory language with a strong legislative history, they would be able to handle this supervisor problem. They are quite aware of it.

Mr. Clay?

Mr. CLAY. I have one question. Do you have any record or figure on the difference in percentage of strikes in proprietary hospitals and non-profit hospitals?

Miss AHMUTY. In areas where they are not covered or protected by any law, the strikes which have occurred have tended to be for recognition. I think some have occurred in California, some of the striking ones.

In Massachusetts, for example, they have laws covering all the hospitals in Massachusetts. There have not been strikes in that State for recognition. They also have compulsory arbitration for interest disputes in that State.

Mr. CLAY. Are the duties the same for nurses in either hospital?

Miss AHMUTY. A sick patient is a sick patient, no matter where he is located. You perform the same functions and have to make the same kind of decisions for the care and treatment of the patients.

Mr. THOMPSON. Thank you very much. We appreciate your testimony and your support. It was very nice to see you again.

Our final presentation for the day consists of a panel of the distinguished representatives of four State hospital associations, if they would come up and take their places.

Our first witness is Mr. Thomas Lane, labor counsel, Pennsylvania Hospital Association, following whom we will hear from Mr. Thomas Vogt, legal counsel of the Minnesota Hospital Association; then Mr. James Newcomer, vice president of the government relations in the Ohio Hospital Association; and Mr. William Butler, counsel of the Michigan Hospital Association.

Gentlemen, please proceed as you wish in order, or you can engage in colloquy, if you wish.

STATEMENTS OF THE FOLLOWING WITNESSES APPEARING AS A PANEL: THOMAS LANE, LABOR COUNSEL, PENNSYLVANIA HOSPITAL ASSOCIATION; THOMAS VOGT, LEGAL COUNSEL, MINNESOTA HOSPITAL ASSOCIATION; JAMES D. NEWCOMER, VICE PRESIDENT, GOVERNMENT RELATIONS, OHIO HOSPITAL ASSOCIATION; AND H. WILLIAM BUTLER, COUNSEL, MICHIGAN HOSPITAL ASSOCIATION

Mr. LANE. Mr. Chairman, members of the subcommittee, my name is Tom Lane. I am labor counsel of the Pennsylvania Hospital Association.

We have submitted to the subcommittee a statement, attached to which is the public employee relations bill.

Mr. THOMPSON. Without objection, all of the prepared statements and supporting data and appendices will be made a part of the record at this point.

[The statements and supporting materials follow:]

STATEMENT OF THOMAS LANE, LABOR COUNSEL, THE HOSPITAL ASSOCIATION OF PENNSYLVANIA

The Hospital Association of Pennsylvania is grateful for the opportunity to appear before this subcommittee and express its views on H.R. 1236.

The Hospital Association of Pennsylvania is a statewide association representing in excess of 300 hospitals. The membership includes nonprofit, profit and governmental institutions of varying sizes and health care purposes. In addition, it represents approximately 3000 individuals connected with health care in either a technical or service capacity.

It is to be clearly understood that the Association does not come before this subcommittee to express its opposition to organizational or bargaining rights for hospital employees, regardless of the character of the hospital for which they work; that is, profit, nonprofit or governmental.

The Association does present itself before this subcommittee, however, in opposition to the granting of these rights to employees of nonprofit hospitals through the vehicle of H.R. 1236, and it is felt that this position is taken for good and sufficient reasons.

First of all, the National Labor Relations Act is geared to the private profit-making sector of the national economy, where the rules of the marketplace play the controlling role in the interrelationship between competitors, consumers and personnel. There is no need to dwell on the history of this Act and the reasons for its birth, but it must be recognized that its purposes were to guarantee employees the right to organize and select representatives for bargaining with employers and to provide a balance at the bargaining table through which, by compromise, contracts between the parties would evolve which would provide peace and stability to the employee-employer relationship.

The importance of "balance" at the bargaining table requires the compromise, concession and accommodation necessary for the settlement of disagreements and disputes. Where this "balance" is lacking, one party submits itself to the domination and control of the other.

When one addresses attention to the nature of a nonprofit hospital, it must be recognized that its purposes and functions are completely different than those of the private, profit-making institutions presently falling within the ambit of the

National Labor Relations Act. The purpose of a nonprofit hospital is to provide health care service to the public, not to make money from the consumers of its service, and to safeguard the health and welfare of the consumers at the lowest possible cost.

The government has recognized the special role that these institutions play, and, through its laws, has encouraged their use, knowing full well that if these services were not performed by the nonprofit hospital, the government, itself, would be required to so do. To a large extent today, the government does control the hospitals in the way of laws and rules and regulations promulgated thereunder. The state departments of health, welfare, and insurance, among others, have day to day operational controls in effect, and grants from governmental bodies at all levels are necessary to sustain these hospitals. Nonprofit hospitals are, in fact, performing a governmental service to the citizens of their communities.

There is accompanying this statement a copy of the Pennsylvania Public Employee Relations Act, which Act recognizes the fact that these institutions are, in reality, public service institutions created for and supplying services analogous and equivalent to services of the government. Nonprofit institutions, including hospitals, are included within the coverage of this Act.

The most important difference between the Pennsylvania Act and the National Labor Relations Act concerns itself with "balance" at the bargaining table, that element so necessary for equity to exist. The most potent weapon in the union arsenal in the bargaining arena is the threat of a strike, and when, or if, it occurs in the private sector, the impact is felt the greatest by the employer and to a much lesser extent by the consumer, since, in most situations, the consumer has a secondary source to fulfill needs. However, the private sector employer can fight back by the use of a "lockout," or some other appropriate economic measure, and a balancing of power is more likely to occur.

If, however, a nonprofit hospital was required to sit at the bargaining table under the present provisions and applications of the National Labor Relations Act, the "balance" so necessary for this equity would not exist. A threat of a strike, or a strike, itself, has its impact not primarily on the public service employer, but directly on the citizens of the community which the employer serves. The health and safety of that community is at stake. How would an employer achieve the necessary "balance"? It is bound, by necessity, to provide a continuity in health care services, and an interruption in these services could create damages beyond repair, wreaking havoc in communities throughout our state.

The Pennsylvania Act has to a great degree answered many of the problems that have been raised by employee, as well as employer, groups. Employees are given organization rights; they may select representatives for bargaining; elections for this purpose are guaranteed; dual representation may not exist; appropriate units must be structured, taking into account the problem of overfragmenting an employer's work force; a management rights clause is included in the Act; good faith bargaining is required; and impasse procedures, in the way of mediation and fact-finding, are provided.

Obviously, and of most importance, a difference in treatment of the strike exists. A strike may take place after all impasse procedures are followed, as long as the health, safety or welfare of the public is not endangered. This decision is made by the courts, and injunctions, fines and penalties may be imposed, depending on the facts and circumstances of each case.

It is felt that a thorough analysis of the Pennsylvania Act should be made. In the hospital setting, the unions and the employers have a greater opportunity of approaching the bargaining table with as much balance as possible, taking into consideration the overriding concern for the interest of the public.

The Association feels that the interest of the citizens of the Commonwealth of Pennsylvania would best be served by the continued operation of the Commonwealth's Public Employee Relations Act, which includes the nonprofit hospitals within its coverage.

It is with some degree of amazement that so much effort is being concentrated on an attempt to equate nonprofit hospitals employing approximately 1,500,000 persons throughout the United States with profit-making health institutions employing approximately 100,000 persons, rather than with governmental hospitals employing approximately 1,000,000. In Pennsylvania, all state and local governmental, as well as nonprofit, hospitals fall within the ambit of its Act. All state hospitals are presently organized, as are many local government and nonprofit hospitals. Private hospitals presently falling within the coverage

of the National Labor Relations Act, as of this time, are not so organized. Generally speaking, the private institutions are, with rare exception, small in size and, cumulatively, hire slightly in excess of 4,000 persons through the state.

In conclusion, the Hospital Association of Pennsylvania recommends:

1. That the nonprofit hospitals, as creatures of and regulated by state governments, should be subject to whatever controls each state determines should be imposed in the area of labor relations; or

2. That any legislation enacted at the national level should not be applicable to states which have developed a labor relations law applicable to nonprofit hospitals; or

3. That any law developed at the national level accommodate for the differences which exist between the nonprofit hospitals performing quasi-governmental functions in providing public health service and the private segment of our economy operating for the purpose of making a profit and subject to the economic controls of the marketplace.

H.R. 1236, in its present form, in no way inures to the interest of the citizens of our Commonwealth and would create problems of a greater magnitude than exist presently in any state of this nation. Because of the progress in the health service field of the employee-employer relationship over the last ten years, the necessity for such drastic action does not exist. It is like an application of DDT; it not only kills the evil, but the good along with it.

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

**THE
PUBLIC EMPLOYEES'
COLLECTIVE
BARGAINING ACT**

1 Establish said public in public employees to organize and bargain
2 collectively through selected representatives, including
3 public employees and other employees, through
4 organization and institution of compulsory
5 mediation and fact-finding in collective bargaining
6 impasses; providing arbitration for certain public employees
7 for collective bargaining impasses; defining the scope of
8 collective bargaining; establishing unfair employee and
9 employer practices; prohibiting strikes for certain public
10 employees; permitting strikes under limited conditions;
11 providing penalties for violations; and establishing
12 procedures for implementation.

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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 employee 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

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.

Prior Printer's Nos. 1598, 1830Printer's No. 1836

THE GENERAL ASSEMBLY OF PENNSYLVANIA

SENATE BILL

No. 1333 Session of
1970

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

As amended on second consideration, July 13, 1970

AN ACT

Establishing rights in public employees to organize and bargain collectively through selected representatives; DEFINING PUBLIC EMPLOYEES TO INCLUDE EMPLOYEES OF NONPROFIT ORGANIZATIONS AND INSTITUTIONS; providing compulsory mediation and fact-finding, for collective bargaining impasses; providing arbitration for certain public employees for collective bargaining impasses; defining the scope of collective bargaining; establishing unfair employee and employer practices; prohibiting strikes for certain public employees; 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 employee 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 employee, 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 Employee 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 employee" or "employee" 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 employees, confidential employees, CLERGYMEN OR

OTHER PERSONS IN A RELIGIOUS PROFESSION, EMPLOYEES OR PERSONNEL AT CHURCH OFFICES OR FACILITIES WHEN UTILIZED PRIMARILY FOR RELIGIOUS PURPOSES AND those employees 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 employees, 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 employees 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 employees 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 employee" means any employee 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 employee, authority, commission, legal representative, labor organization, employee 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 employee, with his written consent, an amount for the payment of his membership dues in an employee organization, which deduction is transmitted by the public employer to the employee 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 employee" shall mean any employee 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 employee" means a public employee employed by the Commonwealth or any board, commission, agency, authority, or any other instrumentality thereof.

(16) "Management level employee" means any individual who is involved directly in the determination of policy or who responsibly directs the implementation thereof and shall include all employees 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 employees: 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 employees who have joined an employee organization or who join the employee organization in the future must remain members for the duration of a collective bargaining agreement so providing with the proviso that any such employee or employees may resign from such employee 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 employee functions as a supervisor.

ARTICLE IV Employee Rights

Section 401. It shall be lawful for public employees to organize, form, join or assist in employee 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 employees 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 employee 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 employees.

Section 602. (a) A public employer may recognize employee 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 employee 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 employee 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 employee, a group of public employees or an employee organization may notify the public employer that thirty percent or more of the public employees 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 employee, group of public employees or employee 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 employees 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 employees 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 employees 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 employees 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 employees, unless a majority of such professional employees vote for inclusion in such unit.

(3) Not permit guards at prisons and mental hospitals, EMPLOYEES DIRECTLY INVOLVED WITH AND NECESSARY TO THE FUNCTIONING OF THE COURTS OF THIS COMMONWEALTH, or 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 to be included in any unit with other public employees, each may form separate homogenous employee organizations with the proviso that organizations of the latter designated employee 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 employees at the first level of supervision to be included with any other units of public employees 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 employee 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 employees in a unit appropriate for collective bargaining purposes shall be the exclusive

representative of all the employees in such unit to bargain on wages, hours, terms and conditions of employment: Provided, That any individual employee or a group of employees 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 employee or a group of public employees 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 employees to meet at reasonable times and confer in good faith with respect to wages, hours and other terms and conditions of employment, or the negotiation of an agreement or any question arising thereunder and the execution of a written contract incorporating any agreement reached 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 employee 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 employees 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 employees, 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 employees 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 EMPLOYEES 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 employee 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, EMPLOYEES 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 employees 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 employees 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 employee 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 employee 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 employee 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 employee 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 employee 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 employee organization or the employee 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 employee representatives for such participation by the public employer shall be subject to the requirements of "meet and discuss."

ARTICLE XI

Picketing

Section 1101. Public employees, 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 employees 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 employee 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 employee organization.

(4) Discharging or otherwise discriminating against an employee 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 employee representative which is the exclusive representative of employees 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) Employee organizations, their agents, or representatives, or public employees are prohibited from:

(1) Restraining or coercing employees 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 employees 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 employee 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 employees, 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 employee 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 employee 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 employee 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 employees, 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 employees 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 employees 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 Employee Organizations

Section 1701. No employee 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 employee 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 employees 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 employees, 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 Employees, A.F.L.-C.I.O., Philadelphia and vicinity regarding its representation of certain City Employees," 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 employees; prohibiting such strikes; providing that such employees 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.

STATEMENT OF THOMAS M. VOGT, LAWYER, REPRESENTING THE MINNESOTA HOSPITAL ASSOCIATION

My name is Thomas M. Vogt. I am a lawyer representing the Minnesota Hospital Association which has 200 member hospitals. 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, 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. 1236. 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 in 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. 1236 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. 1236 have argued that most hospital strikes are recognition 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 recognition strikes. A comprehensive law already existed setting forth recognition procedures. The no-strike and arbitration provisions of the Charitable

Hospitals Act were passed because of the sincere conviction that the strike lockout was not a suitable method of resolving impasses in hospitals.

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.

STATEMENT OF JAMES D. NEWCOMER, VICE PRESIDENT, GOVERNMENT RELATIONS

Mr. Chairman and Members of the Special Subcommittee on Labor: I am James D. Newcomer, Vice President—Government Relations of the Ohio Hospital Association. Our offices are located at 88 E. Broad St., Columbus, Ohio 43215. 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. 1236 which removes the exemption of non-profit hospitals from the National Labor Relations Act. Ohio hospitals support the position and arguments expressed in the testimony presented by the American Hospital Association before this Committee last year in opposition to H.R. 11357. The essence of the testimony of the American Hospital Association was that the National Labor Relations Act is not an appropriate means of resolving labor relations problems in hospitals and other health care institutions.

We are aware that in the 92nd Congress the opposition arguments to H.R. 11357 were overwhelmingly rejected by the House of Representatives and the bill passed as a relatively non-controversial measure. Nevertheless, we sincerely believe that the issue of the appropriateness of NLRA coverage of hospitals and health care institutions is deserving of further careful scrutiny by this Committee.

Mr. Chairman, in testimony before this Committee on H.R. 11357 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 terms of the tasks performed by a health worker, of the labor pool from which such employees are drawn, the manner of compensation, we agree that there is no substantial difference. However, there is no difference between non-profit hospital workers and employees in government owned and operated hospitals and if the thrust of H.R. 1236 is to improve the lot of hospitals employees, shouldn't all hospital employees be included in the bill? Proponents also noted that many for profit and non-profit hospitals and health care institutions belonged to the same trade or business organizations. It is true that non-profit and for profit hospitals do sometimes belong to the same business or trade associations. It is also true that government hospitals belong to the same business or trade associations, but again government hospitals are not encompassed by the bill.

In 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. 1236 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. Proponents' arguments are simply not relevant to this issue and when carefully examined it is clear that their arguments are an unsound pretext for expanding NLRA jurisdiction.

Since there are few proprietary or for profit hospitals in Ohio, we do not have local experience on NLRA coverage. However, the arguments and testimony presented on H.R. 11357 by 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 problems relating

to 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 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 owned and operated, are treated equally under any national labor relations law or regulations. We further submit that in any such legislation the interests of the public must be paramount which means that strikes or interferences in the delivery of health services must be prohibited or held to an absolute minimum.

We feel that H.R. 1236 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 members of the House of Representatives and many members of the Senate 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. Though this premise is stated in different ways in various NHI proposals, essentially most of these bills seek to assure that comprehensive health services are available and accessible to all Americans.

We submit, Mr. Chairman, 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 hospitals and related health care institutions have a corresponding "duty" or social obligation, perhaps even a legal obligation, to provide those services to the sick. A citizens "right" to health care would be meaningless unless *uninterrupted* health services are available. H.R. 1236, we feel, seriously deters the achievement of this goal and in our opinion its adoption would be an impediment to the development of an improved comprehensive health care system. Even worse, H.R. 1236 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. 1236 and we respectfully urge the Committee to reject the bill.

If the Committee does not agree that H.R. 1236 should be rejected, we strongly urge consideration of the suggested amendments we have attached as Exhibit A. 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. 1236 is not rejected. We do not embrace any specific language, we feel that the concepts embodied therein are deserving of this committee's consideration and action.

Mr. Chairman that concludes my statement. Thank you for the opportunity to appear before the Special Subcommittee on Labor, and I will try to answer any questions.

PROPOSED AMENDMENTS TO NATIONAL LABOR RELATIONS ACT IN LIEU OF AMENDMENT SET FORTH IN H.R. 11357

AMENDMENT AND 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".

Eliminates the exemption for nonprofit hospitals.

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 the sick or aged persons."

Defines "health care institution" broadly, so that all of such institutions will be affected by the same rules.

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.

"(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 90-day notice of termination of the agreement.

"(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 good faith bargaining during the first 60 days of the 90-day notice period.

"(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 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 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.

"(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).

Provides same impasse resolution procedure in the event of an impasse in negotiations for an initial agreement.

"(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 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.

"(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 (d) of this section 8."

Technical amendment. Makes the inconsistent termination and modification procedures of NLRA § 8(d) inapplicable to health care institutions, but does not make 8(d) entirely inapplicable to such institutions.

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."

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) professionals 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 NLRA

§ 9(b) it cannot include professional employees with nonprofessionals unless the professionals vote for such inclusion.

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).”

Gives unfair labor practice charges involving strikes and picketing at health care institutions priority over other cases in NLRB regional offices.

7. Section 10(m) is amended by striking the period and adding “or (n).”

Same as above.

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 or 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.”

Same as above. This section is patterned generally after NLRA § 10(11), 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.

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.

STATEMENT OF H. WILLIAM BUTLER, ATTORNEY AT LAW, DETROIT, MICH.,
REPRESENTING THE MICHIGAN HOSPITAL ASSOCIATION

Hospital care is a people-to-people business and the only commodity the hospital has to offer is service. This service is the type which frequently must be rendered quickly and efficiently to prevent physical impairment or death. There is no room in such situations for third party intrusion or interference between the professional whose judgment forms the basis for treatment, and those employees who render the services prescribed.

If American citizens have a “right” to health care 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. The “right” to health care is meaningless unless *uninterrupted* health services are available.

H.R. 1236 fails to deal with the very basic critical concern for the right of the public, especially the sick and injured public, for uninterrupted service. The bill also does not resolve the problem of fragmentation of hospitals into numerous bargaining units.

Although coverage under the National Labor Relations Act would facilitate unionization in hospitals 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 for strikes resulting in national emergencies, this procedure is inapplicable to individual hospitals.

Regarding the equally critical problem of bargaining unit fragmentation, health care institutions are unusually vulnerable to the practice of fractionalizing the work force 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 composition of the workforce. A hospital can never have stability if it is required to deal with 10 or 15 or more separate unions, all with different contract expiration dates.

Under Michigan law employees of Michigan's nonprofit hospitals already have the rights guaranteed to most all other employees by Section 7 of the National Labor Relations Act, "to self-organization, to form, join, or assist labor organizations to bargain collectively through representatives of their own choosing, and to engage in other concerted activities for the purposes of collective bargaining or other mutual aid or protection."

The Michigan Labor Relations and Mediation Act was originally enacted in 1939. It included a procedure for the resolution of impasses in collective bargaining in hospitals. In 1949, the Act was amended to provide for a fact finding procedure. Ever since the hospital provision was enacted, it has operated with success. There has been only two non-profit hospital strikes since the law was first enacted.

The Michigan statute provides that in the case of an impasse unresolved by mediation the Employment Relations Commission certifies the dispute to the Governor. The Governor appoints a commission consisting of three neutral members and two non-voting members nominated by the two parties involved in the dispute. The commission holds hearings and issues a fact finding report, after which the employer and union are required to continue bargaining. The procedures in Michigan are somewhat similar to the national emergency provisions of the Taft-Hartley Act. The procedure has been used over 52 times since 1949. It has worked well. In only one instance since 1949 has a hospital or union refused to accept the recommendations of the Governor's special commission. In the one case there was a strike, but it was caused by a factor not connected with the statutory procedure.

The National Labor Relations Board has a heavy caseload. Its backlog is well known and much publicized. It would seem to be a mistake to saddle the NLRB with additional work, particularly from those states, like Michigan, which have a successfully operating procedure for the resolution of collective bargaining impasses between hospitals and unions representing their employees.

Should this Committee determine that H.R. 1236 should not be rejected, the Michigan Hospital Association urges this Committee to follow the precedent used with the Occupational Safety and Health Act of 1970. In Section 18, paragraphs (b) and (c), provision is made for the existence of state OSHA plans which meet Federal standards and have the approval of the Secretary of Labor. The same provisions could be established by amending H.R. 1236 to allow state labor relations plans, such as exists in Michigan, to be the regulatory agency for non-profit hospitals labor relations instead of the National Labor Relations Board.

Stated another way, the amendment to H.R. 1236 proposed by the Michigan Hospital Association would provide that Federal jurisdiction would be yielded wherever states have provided effective procedures and remedies conforming to the Federal standards. This would apply, for example, where state laws have created labor relations boards or similar bodies with the power and duty to conduct elections, certify the results, and remedy unfair labor practices.

Michigan is a highly industrial state, steeped in the labor movement tradition. The Michigan Hospital Association is not only cognizant of that tradition but wants to see the jurisdiction for Michigan's non-profit hospitals left to the Michigan Employment Relations Commission. This can be achieved by this Committee through two courses of action. It can leave intact the existing exemption for non-profit hospitals from the National Labor Relations act or it can amend H.R. 1236 in the manner we have recommended.

AMENDMENTS TO NATIONAL LABOR RELATIONS ACT PROPOSED BY MICHIGAN
HOSPITAL ASSOCIATION IN LIEU OF AMENDMENT SET FORTH IN H.R. 1236

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 of 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 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 10 is amended by adding a new subsection (o) as follows:

"(o) Any State which, at any time, desires to assume responsibility for development and enforcement therein of hospital labor relations laws for nonprofit hospitals with respect to which a Federal standard has been promulgated shall submit a State plan for the development of such standards and their enforcement, and (1) The Secretary shall approve the plan submitted if it meets the criteria established under the National Labor Relations Act, and (2) if the Secretary rejects a State plan he shall afford the State submitting the plan due notice and opportunity for a hearing before so doing."

9. Section 303(a) of the Labor Management Relations Act is amended by adding "or 8(g)" after "8(b)(4)".

Mr. LANE. From the standpoint of the Hospital Association of Pennsylvania, we want this subcommittee clearly to understand that this association does not come before this committee to express its opposition to organizational or bargaining rights for hospital employees regardless of the character of the hospital for which they work, be they profit, nonprofit, or governmental.

The association, however, does present itself before this subcommittee in opposition to granting these rights to these employees of nonprofit hospitals through the vehicle of H.R. 1236. It is felt that we have sufficient reasons in support thereof.

I have had the opportunity to spend in excess of 2 years studying this problem for the State of Pennsylvania, and I drafted the legislation, copy of which you have before you.

Primarily, we started off with the National Labor Relations Act as our base. We studied it, and studied acts of other States, and then we made some accommodations in order to take care of those institutions where continuity of services was required as far as the citizenry of the Commonwealth is concerned. Nonprofit hospitals fit into this category.

There is no need for us to go into the history of the NLRA. We know it gives recognition and bargaining rights, but it does one other thing of extreme importance: by its structure, since it is dealing and has dealt primarily with the private sector of our economy, it has created a balance between the parties at the bargaining table. This balance, therefore, permits compromise, accommodation, and concession in arriving at an agreement over that table.

The unions' most potent weapon is either the threat of the strike or the strike itself. Countervailing pressure by employers in the private sector, of course, is the lockout and the utilization of any other economic weapons at their control.

This, however, does not occur in the nonprofit hospital. The nonprofit hospital's purpose is to give health care and service to the citizens of the community which it serves. Therefore, it is not a matter of fighting back with economic power and control. With the strike weapon at the hands of the unions, an imbalance is created at the bargaining table, and with this weapon they are able to dictate, control and dominate the bargaining.

We recognize this fact in Pennsylvania, and we granted to all employees covered by the act, with a few exceptions, a limited right to strike. This was limited to the extent that a strike would be per-

mitted until the health, safety, or welfare of the community was affected.

In that way, it depends on who strikes, there is a flexibility as to personnel; and also there is a flexibility on how long a strike would be permitted. Strikes can be enjoined, it reaches the point that it deleteriously affects the health, safety, or welfare of the community.

It is in this area that we have our greatest concern. We feel that by simply utilizing H.R. 1236 and bringing into play the National Labor Relations Act in its present posture, that this important balance would be missing, and something has to be done to correct it or else you are not going to get an equitable agreement arrived at over the table.

In Pennsylvania we have all of the State hospitals organized. We have 34 or 35 contracts in the nonprofit hospitals. We have no proprietary hospitals organized as of this time.

Mr. THOMPSON. You mean none in the State are organized?

Mr. LANE. That is correct.

There, in fact, is—as the service employees' representative testified—there is an election going on right this day at one of our nonprofit hospitals in Pennsylvania in which they are involved.

So we feel that there has to be some accommodation made in the passage of any legislation in this area.

Now we have had, I think, a great deal of success in Pennsylvania. I think that there is as close a balance as possible, as arrived at in the method in which the act is structured. We have had two strikes since the passage of the act, one of which lasted for 3 days and one of which lasted for 6 hours.

The one for 6 hours was in violation of a "no strike" provision of the contract and was quickly enjoined. The one for 3 days was eventually settled and taken care of. It was a strike of service people. The hospital functioned regardless. We find that we are most satisfied with the structure of the act.

The unions are very active in their organizational efforts. They have the right to organize, they have the right to bargain, but there is some limitation on their ability to utilize the strike weapon.

We have required a pattern of bargaining: they must go through mediation, they can be required to go through factfinding, and it is only after they go through bargaining, mediation, and factfinding that any strike is permitted to any extent.

Naturally, I do not think a strike in a hospital under the Pennsylvania law would be allowed to go on too long, because obviously the welfare and the health of the community, would be affected; and obviously it would in a short time be enjoined. However the threat of the strike, or the utilization of the strike even for a limited time creates a balance at the bargaining table, and so an equitable type of agreement ultimately can be reached.

If the unions had the unlimited right to utilize the weapon of the strike, as they would have under the National Labor Relations Act, then we would not have the equity developed at the bargaining table which is so necessary in this interrelationship between the employees and the employers.

I have noted in last year's testimony that New York had some objections to their particular act, but every one of the objections that New York has was taken care of in the Pennsylvania act.

I also noted here today that the nurses had a problem with the definition of supervisors. Let me say this: The definition of "supervisor" in the Pennsylvania act is the exact definition contained in the National Labor Relations Act. The registered nurses are organized and have organized. They have organized in every State hospital that we have. The registered nurses themselves under the rank of head nurse are permitted in rank-and-file units. The head nurses are determined to be first-level of supervision, and even they have some organizational rights; they do not quite have the same bargaining rights as the rank and file.

So in the determination of supervisory status for nurses, the definition that is utilized in the national act has not excluded them from coverage.

Our position is rather threefold: First of all, we have to recognize the fact that there are 1.5 million employees throughout this country who are in nonprofit hospitals. There are a million who are in governmental hospitals, and there are only about 100,000 who are in proprietary hospitals.

It is my personal opinion that the nonprofit hospital is much better equated with governmental hospitals because they are providing a public service, they are not in the business for the money, and we are not balancing money against money, we are balancing human life against money, and there has to be some adjustment in the structuring of this legislation which takes this into consideration; and we feel that simply bringing within the ambit of the National Labor Relations Act nonprofit hospitals, would not accomplish that end.

From the standpoint of Pennsylvania we feel the nonprofit hospitals are really creatures of the State, they are performing a quasi-governmental service function, they are controlled by the State on a day-by-day basis by some regulation or another, whether by departments of health, welfare, or insurance, someone sits on them day by day. We feel the matter of labor relations should be a matter within State control.

Mr. THOMPSON. I wonder how many of the nonprofessional employees in hospitals could afford to be patients in those very hospitals in which they work.

Mr. LANE. Well, let me say this—

Mr. THOMPSON. The average cost being somewhere around \$105 a day for a semiprivate room.

Mr. LANE. Whether they can afford it or not, they are patients in those hospitals and are taken care of on some basis or another just the same as anyone else throughout the entire Commonwealth, be it through some governmental funding arrangement or be it through some hospital arrangement. Many of the hospitals do have arrangements with their employees relative to their care when those particular employees are patients.

Mr. THOMPSON, I hasten to say you have a number of really great hospitals in the State of Pennsylvania. They are so good. As a matter of fact, I happen to be a neighbor of Pennsylvania, you know, we own the other half of the bridges in New Jersey.

Mr. LANE. Yes; I understand that.

Mr. THOMPSON. I note with some interest and amusement that when physicians in my area become ill, they hop on the train and go to Philadelphia.

Mr. LANE. I might add that the physicians at the State hospitals are organized in Pennsylvania.

Mr. THOMPSON. I might note the presence of our distinguished colleague from Pennsylvania, Mr. Dent, at whose request you are here.

Mr. LANE. I recognize Mr. Dent, I have met Mr. Dent on several occasions.

Continuing with our position, I think, in lieu of the foregoing that any legislation enacted at the national level should not be applicable to States which have developed labor relations laws applicable to non-profit hospitals; or that any law developed at the national level should accommodate for the differences which do exist between non-profit hospitals which perform these public services or quasi-governmental functions in providing public health service, and the private segment operating for the purpose of making a profit.

Congressman Clay asked about the differences. There is no difference between an employee working for a profitmaking institution or a nonprofitmaking institution, but there is a difference between the employers and the functions which they perform.

In the ultimate, we must look out for the interests of the people of our Commonwealth, and we feel the passage of H.R. 1236 in its present form does not inure to their best interests.

Mr. THOMPSON. Thank you very much.

Mr. VOGT. My name is Thomas Vogt, legal counsel for the Minnesota Hospital Association. The Minnesota Hospital Association has opposed the provisions of H.R. 1236 because of the impact this bill would have on an established method of State-legislated hospital management relations.

Minnesota has had a unique experience; the hospitals in Minnesota, particularly those in the metropolitan areas, have been highly organized for many years. For example, in Minneapolis and St. Paul, the vast majority of hospitals have contracts with Building Service Local 113 covering nonprofessional employees, the Minnesota Nursing Association, Minnesota Licensed Practical Nursing Association, X-ray Technological Society, pharmacists, engineers, and a variety of other groups. So, as a matter of background, we have had substantial unionization in hospitals.

For a period of some 25 years, Minnesota law has rejected the concept which is incorporated in the Taft-Hartley Law to the effect that impasse solution can take the form of strikes, lockouts, or other economic pressure.

Rather, since 1947 Minnesota has had a law which is based on three key parts: No. 1, both the union involved and the hospital are obligated to use mediation in an attempt to resolve their dispute.

Secondly, if mediation fails, there is an absolute prohibition on hospital strikes and lockouts.

Thirdly, if the parties are unable to reach an agreement on their contract, there is final and binding compulsory arbitration applicable to both the hospital and the various labor organizations.

I believe the history of this act may have some significance to this committee because many of the factors that led to the passage of this law, I believe, are present here. Since 1939, Minnesota has had a very comprehensive method of labor relations regulation in general.

At that time, a law was passed which covered private industry and set forth mechanisms for handling recognition issues, secret ballot

elections, determination of what was the appropriate bargaining unit, and definition of what would constitute an unfair labor practice. Hospitals were included as part of that particular law in the same manner private industry would be covered.

However, following that, in the middle Forties there was a series of strikes occurring in Minnesota, particularly in the city of Minneapolis. These were not recognition strikes. At that time the union involved had been recognized and had been certified.

The strikes related to contract impasse issues, and it was that experience which led the Legislature of the State of Minnesota to pass the Charitable Hospitals Act, which substitutes the method I described in lieu of the strike-lockout procedure which is implicit in the National Labor Relations Act.

I believe the experience we have had since 1947 has been a very good one as far as stabilizing hospital labor relations in Minnesota. The act has been a workable one. We have not been confronted with what I consider to be the enormous disadvantages of hospital strikes.

At the same time, the arbitration features have not been used as a substitute for true collective bargaining. The vast majority of contracts in Minnesota are settled without the utilization of the arbitration procedures.

I think with this background that the concern we have is an apparent one: the passage of this law, by simply bringing nonprofit hospitals under the coverage of this act, would place the State of Minnesota in the same position it was in some 25 years ago, which was not a good situation.

MR. THOMPSON. Well, you know, Minnesota does have a good act. As Mr. Ashbrook in an aside points out, the fact that you have a good act negates really the argument that the passage of this legislation would create strikes. We think it would have the opposite effect, and likely we wouldn't be here today if the majority of the States handled the labor relations matters as has Minnesota. The unhappy fact is you are almost totally unique.

MR. VOGT. This may be true, if there had been more State legislative acts. The important thing to the Minnesota Hospital Association is the fact that this legislation in its present form would place Minnesota back into the position it was in prior to the enactment of the Charitable Hospitals Act. We would be subject to, as I understand the way the legislation is drafted, the possibility of economic strikes in the same fashion as any private industry.

The deletion of the exemption for nonprofit hospitals would preempt the Minnesota Act, thus leaving us without that legislation which we consider to have been effective over this long period of years.

MR. THOMPSON. The only substantial difference would be compulsory arbitration.

MR. VOGT. That is correct. This, of course, as I have indicated, has been the key point in the Charitable Hospitals Act. Without the compulsory arbitration features, we then again have the prospect or certainly the possibility of impasse-type strikes occurring, which was the reason for the passage of the State legislation in the first place.

MR. ASHBROOK. It would not be accurate to say you would go to the same situation; that would be a No Man's Land which does not exist. You would not be in that situation.

Mr. VOGT. We would be in the position where there is no prohibition against a strike against a hospital. That was the situation in 1945. We were at that time covered by the General Labor Relations Act which provided the mechanism for recognition and unfair labor practice determinations. It would thus place us, as I see it, in that exact same situation.

The point I want to make in conclusion is that it seems to us unfortunate that a law designed to achieve certain objectives could invalidate a State law that has a recognized history of being successful for the people of that State. I believe we have had that experience.

It is our position that no change should be made which would have the effect of preempting that method of impasse resolution.

Mr. ASHBROOK. We know this happens every day, I agree to an extent. Oregon always has had a policy for forest conservation. That doesn't mean we will let the other States continue to cut trees just because we don't want to disrupt Oregon's situation.

Some States are forward-looking, and we can't take the position that because one State has a good act, we can't move into that area if there is a need throughout the country. I am solicitous of your view, but we wouldn't legislate anywhere if this was the case.

Mr. THOMPSON. Mr. Newcomer.

Mr. NEWCOMER. Mr. Chairman, members of the committee, I am vice president, Government Relations, of the Ohio Hospital Association.

In order to save time, since we covered many of the arguments in my prepared statement, I will try to highlight some of them.

I should point out that Ohio is one of those States that has no State collective bargaining law. The only statute we have relating to hospital employees relates to those that are public employees, and it states that public employees shall not strike. That is virtually all it says.

It does not provide a legislative mechanism for recognition or anything else. It just says public employees shall not strike.

Mr. THOMPSON. We have pending before us another bill which would include all public employees under the act and give them collective bargaining rights.

Mr. NEWCOMER. That is one of the points that I have tried to make in my testimony, at least with regard to public hospital employees. The association is opposed to H.R. 1236, and we do support the argument that the American Hospital Association presented before this committee on the bill last year, and we think that the committee has perhaps tended to overlook in a sense what I consider to be the basic part of the American Hospital Association's testimony.

What we are trying to say, maybe we have not said it clearly enough, we don't believe the National Labor Relations Act is an appropriate collective bargaining recognition type mechanism for any health care institutions. We feel the health care institutions, whether proprietary, public, nonprofit, nursing homes, all the various types, we just don't feel this type legislation is appropriate and, if anything is to be done, we should have some type of legislation that will meet those special needs.

I don't think there is another industry in our entire economy that has the same type of problems, responsibilities, and services. For that reason we are opposed to the bill.

I would like to take a minute to explore a little bit the arguments of the proponents—two that have come up at virtually every hearing.

First, the question of whether or not there is a difference between the employees in a proprietary hospital and nonprofit hospitals. We concede there is no real difference, they do the same thing, they are drawn from the same labor market, the manner of compensation and fringe benefits are pretty much the same.

On the other hand, what about the public hospital employee? You can't say in Ohio a prohibition against strikes is of any particular benefit. We have a large number of public hospitals in Ohio, I think with employees in excess of 20,000, so we wonder about these people and if the bill is that good for the nonprofits and proprietaries, how about this large section of the health community that is public of various types, counties, joint townships, districts, and so on, up to the State hospitals.

It seems to us you are going to have—the way the system is developing, in many instances you have public employees and nonprofit hospitals cooperating, they are trying to urge neighborhood clinics and things of that nature. They will be working side by side.

The health maintenance concept I am sure would try to bring in both the public and nonprofit sector to the extent they could to establish these health maintenance organizations.

I think we have to take a broader look at the problem and recognize the part the public hospitals play on the part of their employees.

Before I mention the exhibits, the other argument, of course, was the common membership of proprietary hospitals and nonprofit hospitals in the same business associations or organizations, hospital councils, whatever they may be.

This again applies, at least in Ohio, and I am certain in some other States, government hospitals also belong to these same organizations. We have no proprietary hospitals in Ohio of the general acute care type. We have a few psychiatric and specialty hospitals, two or three. We have really no experience in Ohio with hospitals under the National Labor Relations Act at all. Basically we are just public and not for profit.

We have attached to our testimony, Mr. Chairman, an exhibit that is marked "exhibit A," which contains various proposed amendments we feel are deserving of the committee's consideration, that relate to the main problems expressed here today and by hospitals generally, the strikes and fragmentation of the bargaining unit, and some way to resolve the impasses.

We would wish that the committee would give them serious consideration because we do feel we are a little bit different than any other industry. It may be that we are bigger than the auto industry, but I fail to see how the same mechanism for this can apply. You can shut down and buy another type car.

Mr. THOMPSON. My reference was to the number of dollars. I see no analogy, although probably you can get just as good medical care in an auto factory as you can in some hospitals.

Mr. ASHBROOK. While we are on that point, it raises the question: Are you so different that a hospital should be able to engage in practices and policies that would be considered unfair in every other situation between management and labor?

Mr. NEWCOMER. I am sorry, I missed that.

Mr. ASHBROOK. Of course there is a difference, we recognize that. But are hospitals so different that they should be able to engage in practices between employer and employee that in every other segment of society would be considered improper and in some cases maybe illegal? Are you really that different? That is the thing that gets me.

Mr. NEWCOMER. Mr. Ashbrook, I believe, and it is our position, that they are that different that they are deserving of a separate type treatment in this labor relations area. Part of the reason for this is the acceptance now of the doctrine of health care being the right of the people.

How do you equate the people's right to the services with the type services we have under the National Labor Relations Act? It seems a work stoppage or interruption of these services which government is paying billions of dollars for themselves, public, private, not-for-profit, it seems their rights are paramount, and I don't think putting the hospitals under the National Labor Relations Act accommodates to the extent it should, the public and citizens' interests.

Mr. ASHBROOK. I don't think you mean what you said. When you said "Yes," you meant hospitals could engage in unfair labor practices because of their position. I don't think you mean that.

Mr. NEWCOMER. No, that is not what I meant. If that is what I said, I retract it.

Mr. ASHBROOK. For example, you are a hospital administrator, 78 percent of your people want to organize; that is the open, honest American way of doing things. The hospital can look at its employees and say, "Go to hell."

What is the equity in that?

Mr. NEWCOMER. Mr. Ashbrook, if 75 percent want to organize, we found usually if there is enough pressure for it, they do get organized.

Mr. ASHBROOK. You still are in the position of saying "no," being able to fire, being able to move against those who would be leaders of the organizing drive, do all the other things that in every other segment of an employer-employee relationship would be illegal. That is the basic inequity that moves me to support this bill.

I can understand the hospitals' position; I am no enemy of the hospital. My shortcoming is, I am a little blunt. It appears to me the position of the hospital is an unfair one. You have your employees, in effect, over a barrel, and want to keep them there. I don't think that is fair, and I think that is the reason for this bill.

Mr. NEWCOMER. Mr. Ashbrook, at least as far as our organization is concerned, when disputes and problems in the labor area do occur in Ohio, we have been trying to drum into management's head that the only person more important to the hospital than employees is the patient.

Naturally, some people won't look at it that way; there have been some abuses and standoffs. However, there won't necessarily be more unfair labor practices because we are not within the NLRA.

Mr. ASHBROOK. A gentleman spoke of balance. When we talk of balance—I have listened to the hearings for 2 years—what would be considered balance in labor relations between the administrator of the hospital and the average employees in hospitals throughout the country?

What would you conceive to be the balance today? You want a balance and you are afraid of an imbalance. Where do you think that balance is today, looking at it fairly?

Mr. LANE. Do you mean countrywide or the State of Pennsylvania?

Mr. ASHBROOK. I said specifically countrywide, having listened to testimony 2 years, where is the balance now?

Mr. LANE. It started with the proposition we are not opposed to organization and bargaining rights, we think they should occur. We have no objection to that. It is after the organizational efforts have taken place and they are organized and they want to bargain. Now we get to the balance question.

Mr. ASHBROOK. We are talking about employees in a hospital coming in and saying, "I want to organize." Where is the balance now? Isn't it on the side of the administrator, who can say, "Forget it"?

Mr. LANE. There is no question, if they are not under some law that requires that they be permitted to organize; that is true.

Mr. ASHBROOK. For the most part, they have told them they can't, and taken every tactic available to prevent the organization from doing so. Is that your concept of balance?

Mr. LANE. No; we are not opposing organizational rights and we think the hospital employees should have organizational rights. What we are saying is we need the balance at the negotiating, we need the balance after they have the organization. The balance I referred to is that balance.

Mr. ASHBROOK. You basically have conceded nationwide in States other than Pennsylvania and Minnesota that there is no balance where they want to organize only because they have no tools to organize.

Mr. LANE. I think that goes without saying.

Mr. THOMPSON. Only 11 of the 50 States have any act at all.

Mr. LANE. About 26 of the States deal with the problem.

Mr. THOMPSON. Only 11 have laws. All 50 States deal with the problem. They are going to deal with it—

Mr. LANE. Some are organized under Attorney General's opinions and some under other things.

Mr. DENT. May I ask a question, Mr. Chairman?

Mr. THOMPSON. Yes.

Mr. DENT. What would you say the experience in Pennsylvania has been under its new law?

Mr. LANE. The experience in Pennsylvania from the standpoint of hospitals?

Mr. DENT. Yes; only from hospitals. I know the other stories.

Mr. LANE. From the standpoint of hospitals, the experience in Pennsylvania is good. There have—there are 34 or 35 contracts already entered into. There have been 151 efforts made at organizing. They have been successful, the unions have been successful, in approximately 75 to 80 percent of the cases.

We have a provision against fragmenting or proliferation of units. The Labor Board is guarded, they are told, "Take into consideration when applying a 'community interest' doctrine not to fragment the employer too much," so there are not many wall-to-wall hospitals organized, but they are organized on various units and some are wall to wall.

Mr. ASHBROOK. Would the gentleman yield?

It appears to me in your Pennsylvania act your section 706 would give the employer the right to hire or fire at any time, which would be logically inclusive during a vote, and you said a vote is coming up today or tomorrow in your State. Would it be true you could hire or fire during the time of the vote?

Mr. LANE. No, you could only fire for just cause consistent with legislation. If someone is not performing their job properly, we can fire them. We have many unfair practice cases alleging they were fired because of union activities. Where this was true, those people were reinstated and received back pay.

We have an unfair practices section, an extensive one, almost the same as the National Labor Relations Act. We have that both from the standpoint of the employer and the employee.

Mr. ASHBROOK. If this terrible act were enacted, 883 cases would be, based on what is happening in Pennsylvania—Pennsylvania and Minnesota—probably help rather than hurt—

Mr. LANE. We are not arguing the balance of rights, the thing we are opposed to is the strike weapon; there is the difference, there is where the imbalance exists. These hospitals cannot stand strikes just like that. They have to have some mechanism to stop it, because the public—there is the big difference—the public is directly impacted. In the private sector the employer is directly impacted.

Mr. THOMPSON. What you are saying really is that the public wants to keep subservient the nonprofessional or low-paid hospital employee, and doesn't break up this feudal system, and hospitals really are a feudal system. In other words, we have these lower paid employees under our thumb and we are going to keep them there.

Mr. LANE. We don't say they should be subservient. We have advocated in our act before you that there is a limited right to strike and they can strike until this danger exists, and it does exist much more quickly in a hospital.

Mr. ASHBROOK. Of course it does. Did you read the testimony compiled over the past 2 years, or listen to the testimony previously? You are saying if this passes, there is no hope. All the testimony we received—was it Mr. Asher? His direct statement was that in virtually every case where they sit down, being reasonable people, you come to some arbitration provisions.

You are in effect saying if this passes there will be strikes. In cases where they have organized, there have not been strikes.

Mr. LANE. If a hospital has to depend on the beneficence of the union itself, they are not in a bargaining position. I bargain with them every day.

Mr. ASHBROOK. If the employees have to depend on the beneficence of the hospital, they haven't done very well, either.

Mr. LANE. There has to be a balance.

Mr. THOMPSON. They would work for nothing.

Mr. ASHBROOK. Our balance doesn't come by one side having an arbitrary advantage over the other side. You are in an absolute arbitrary position which is not consistent with any other aspect of employer-employee equity. I see no point in arguing that you are much different insofar as the service you have to supply to the public.

Mr. LANE. The balance between the employee and the safety and health of the public, not between the employee and employer;

and there has to be some consideration given to the health and safety of the public in general.

Mr. ASHBROOK. But you still cannot——

Mr. LANE. It is life against money, not money against money.

Mr. ASHBROOK. You can't look to your employees time after time and say, "We're performing a service, and as part of this service you have to give up wages."

Mr. LANE. We are not dictating in any of the negotiations in the hospitals of Pennsylvania, because there is more of a balance existing. The hospitals are afraid of even a limited strike.

Mr. ASHBROOK. Getting back to the 50 States, you are making more arguments for the bill rather than against it. The situation exists because there isn't a no man's land. Maybe your legislation would be different than this, but there is not a no man's land which has led to most of the strikes because of recognition. Most of your arguments and the gentleman from Minnesota, to my thinking, have given us reason to go ahead with this legislation instead of not passing it.

Mr. LANE. I started my testimony out by saying we are not opposed to organizational and bargaining rights. That is the first thing I said. Then I said we have to deal with this problem of balance differently because if you use the vehicle of 1236 you have now created an imbalance so you are not going to be able to get proper bargaining posture and the likelihood of strikes will go up tremendously.

Mr. ASHBROOK. It all gets back to the point of who is in balance.

Mr. DENT. Would you yield?

Are you suggesting because Pennsylvania has a law under which you have learned to live with in the State, that any Federal legislation should take that into consideration and give States the right to pass their own legislation within certain criteria, or are you saying on the other hand that the NLRB would have to set some kind of criteria on a strike vote?

Would it be that you would suggest this legislation should carry with it compulsory arbitration, with the arbitration award being made retroactive to the date of the original difference between the employer and employee?

What we are trying to say is, there is hardly any way you can give a man the right inherent in our land in all other occupations to join together with others for their mutual protection, as it were, and the advancement of their working conditions, unless he does have some kind of a counterbalance in the form of a strike weapon somewhere along the line.

If you don't have compulsory arbitration, some kind of arbitration method set up, some kind of pause like they have in Pennsylvania between a walkout or strike, the employee must have something to balance the power. The power is now in the hands of the administrators.

Mr. LANE. Our experience so far shows there is a balance and contracts are being executed which are not being dictated by the hospitals.

Mr. THOMPSON. If that is the case in Pennsylvania and Minnesota, I can assure you it is unique.

Time is running out and we have yet to hear from the patient gentleman from Michigan, Mr. Butler.

Mr. BUTLER. Mr. Chairman, I have to defer to the committee for patience; I think you have been very patient through the diatribes to which you have been subjected.

Mr. THOMPSON. We don't consider it diatribes. It has been very useful.

Mr. BUTLER. I am in a unique position here, Mr. Chairman, I share the fate of a volunteer; I am not actually the attorney for the Michigan Hospital Association, but I became concerned when H.R. 1236 was here because I represent eight or nine hospitals and because I have been involved in labor negotiations for a long time, and negotiated contracts both on behalf of hospitals and private industry. So I think I have a little perspective on the National Labor Relations Act as applied to private industry and as applied to hospitals. To conclude my involvement in the health care field, I married a registered nurse.

I would like to make a few quick comments because I want to call the committee's attention to the fact that, first of all, there is in Michigan a very excellent law. And those clients I represent stand very much for the concept of collective bargaining. We have in the past and continue to, both before the Michigan act and subsequent to its passage.

In fact, I represent several Catholic hospitals and they have always declared, as a part of their religious precept, for representative bargaining.

I think we have to be careful how we bruit the term "collective bargaining" about. Michigan has had collective bargaining throughout its history, and it can be said that Michigan is an industrialized State. Since 1949, under the Michigan act, we had collective bargaining. But we recognize a distinctive difference between the collective bargaining we ordinarily contemplate as involved with industrial factors and that involved in human care.

The Michigan act, in its entire history has had since 1939 two strikes—since 1949, one. We have provisions not for compulsory arbitration but factfinding, which have proved effective.

I appreciate Congressman Ashbrook's wise concern that, "Fine, Mr. Butler, you gentlemen have fine State acts, but we have States where we have no protection for the workingman and his rights."

First, we recognize that Michigan, probably because it has its experience and has worked so effectively, has done a good job in the hospital field. By the way, over 97 or 98 percent of the patients in Michigan are taken care of by nonprofit hospitals. We have few proprietary hospitals, three, I think, representing about 200 beds. One is located so far north we never hear from it, in the Upper Peninsula. Michigan is divided into two parts: Upper Peninsula and Lower. We don't know which part owns the bridge in Mackinaw.

The collective bargaining in Michigan is a collective bargaining, which, in my opinion equates and protects both parties. I think, Congressman Ashbrook, you are right in expressing your ideas that "where is your protection for the workingman or hospital employee in the non-State-act State?" if you can use that term.

We recognize that problem. First, for Michigan we are unalterably opposed to H.R. 1236 as written. It emasculates and destroys a fine law which has established good relationships.

Second, we recognize if something is to be done, the bill we propose, and which is attached to my prepared statement, accomplishes this.

But we have gone farther in Michigan in this respect, we recognize OSHA, the Occupational Safety and Health Act, has provided a very wise formula for sharing State and Federal jurisdiction.

As you know, that act provides, in keeping, I think, with a good philosophy, if the State does a good job it shouldn't be preempted. It provides if the State comes up with a good plan, the plan can be adopted by the Federal laws.

We have added in our exhibit, I direct your attention to it, a new section that provides that in Michigan, if we come up with a satisfactory plan, jurisdiction would be given to the State—following the OSHA principle.

There is no use for anybody on your committee saying to me, "Mr. Butler, if the National Labor Relations Act allows a State to take jurisdiction, the Board can concede that jurisdiction."

Bluntly, and ungrammatically speaking—they ain't never and ain't never going to do this. The Board has gone to the other extreme.

For example, Michigan has the unique situation where our symphony orchestra is organized. You can imagine the minor impact of this on labor in the great industrial State of Michigan. But the National Labor Relations Board has preempted the State and taken jurisdiction.

We, from Michigan, have a workable act, a very effective board. We have had only two strikes and, most important, the Michigan balance of collective bargaining is this—it protects the patients from untoward strikes, and they can occur only after there has been fact-finding by a panel appointed by the Governor and after the employees themselves have had the right to have a strike vote.

I have seen in the testimony, many times, comments to the effect that times have changed since the exemption of nonprofit hospitals was first injected in 1947 in the Taft-Hartley Act. I sit as a trustee on four hospitals, one Catholic and three other hospitals. There has been a very major change. I want to just draw your attention, for a second, to it.

When I negotiate for an industrial organization, I am not as afraid of a strike because there are always alternate sources of supply. We have duplication in the normal pragmatic course of the development of industry.

In Michigan this is not the case in hospitals. We have had community planning for years and have tried to follow the mandates of Congress in avoiding unnecessary duplication of hospital beds. As a result of our planning activities in Michigan, we have no surplus or excess of hospital beds in the metropolitan areas.

Most of our hospitals that I have personal knowledge of operate between 75 to 90 percent of capacity. So if a hospital is closed by a strike, there is no other place for those persons to go and there are no alternative facilities available.

We even have the recently enacted Hospital Licensing Act and Hospital Certification Act, whereby we can't even build a new hospital bed unless a clear need is shown. So, gentlemen, there is no equality of collective bargaining in the hospitals in Michigan in the sense that we have alternatives.

When I sit down to bargain, I am just as afraid of the impasse strike as of the organizational strike. If they close that hospital down, we have acutely ill patients that still must be cared for.

There has been another change since 1947—most hospitals today, as a result of the emphasis on long stay and utilization have gotten rid of the half-ill ambulatory patient. We are constantly emphasizing "turn these patients over," with the result we have more acutely ill people in the hospitals today than we did 5 years ago.

If you ask me, the only way you will preserve these equities which are important from the standpoint of the public and the patient and these equities in bargaining, whether organizational or impasse, is to have some curtailment of the right to strike which is not in the Taft-Hartley Act.

Mr. ASHBROOK. I can't help noting how the position has moved from Pennsylvania to Michigan. You don't even have compulsory arbitration.

Mr. BUTLER. We don't need it.

Mr. ASHBROOK. You don't have compulsory arbitration, and you still don't have it. The great bugaboo is that "if we have this bill, we will have strikes."

Most of the testimony we have had in 2 years is that you don't have strikes. Every one of you say where you have collective bargaining you do not have strikes. In your testimony you say the procedures are somewhat similar to the Taft-Hartley Act we are talking about.

I don't want to sound facetious, but the more I listen, the more you give us ample reasons for enactment of this legislation. We have gone from compulsory arbitration to factfinding. You don't have strikes in Pennsylvania; you said two, in your statement, since 1939. Yet if this bill passes, it will open up, horror of horrors, strikes.

I think the testimony this morning of these gentlemen has given indication whether it is compulsory arbitration or factfinding, you don't have strikes.

Mr. THOMPSON. I think it is helpful in passing the act.

On page 2, you cite, of your two strikes, that in one case there was a strike but it was caused by a factor not connected with the statutory procedure.

Mr. LANE. What can happen with imbalance, there is imbalance by application of our act to schools. We have had 117 strikes in 2 years.

Mr. THOMPSON. In schools?

Mr. LANE. Yes; because it didn't take care of one factor there to create the balance.

Mr. ASHBROOK. Having a child out of school a week isn't the worst thing that can happen. As a matter of fact, the kids kind of like it. So you are not talking of the same situation. An employee in the hospital will not take the same position as a teacher. Teachers realize they are not shorting the kids that much. Employees of a hospital realize they would.

Mr. BUTLER. I'd say I have wasted 8 hours from my office and have had an unpleasant trip here if I left the impression I am in favor—

Mr. ASHBROOK. I didn't say you were in favor, I said your arguments seem to augur more in favor than against.

Mr. BUTLER. No; because I would say if we were turned in to the National Labor Relations Act as it now reads, you would totally destroy the balance we have on impasse bargaining. Here is why: If we reach an impasse in bargaining in Michigan, both the union and hospital then have a right to turn, and must, as a matter of fact, turn to impartial factfinding.

Don't take impartial fact-finding lightly. These are conscientious people appointed by the Governor, and they make a careful survey of all the issues, which are then published; and then the employees have a right to vote whether they want to strike or not.

Here is the total effect of that: When that factfinding comes out, it is publicly disclosed not only to the patients and community but the employees themselves, and much of the argument that went on at the bargaining table is more or less dissipated with that, with the result that the parties have a more rational approach.

This is why we don't have these strikes. These impartial——

Mr. ASHBROOK. You might not have them with the passage of this act.

Mr. BUTLER. I am afraid we would. When we reach an impasse, in industrial bargaining the favorite expression is, "Hit the bricks." It is a quick way for parties to apply pressure.

Mr. ASHBROOK. Throughout the country the evidence is clear that it has not worked that way. We have been watching it for 2 years, and it is an uncontroverted fact.

Mr. BUTLER. Some of the strikes in New York hospitals are a terrifying thing. I don't want to take umbrage, but I am flying in the face of your conclusions, that if you pass the National Labor Relations Act you will eliminate recognition strikes.

If you read the National Labor Relations Act carefully, there are a lot of things unions can do.

Mr. THOMPSON. I read the act carefully and have been working here with it for 20 years. During those 20 years I have seen an absolutely dramatic drop in the number of strikes in any industry. I think you will concede that is a fact.

Mr. BUTLER. It hasn't necessarily been because of the act.

Mr. THOMPSON. You know the last thing any responsible labor union person wants to do is go on strike and the last thing an employer wants to do, really, is to lockout.

Mr. BUTLER. I agree, and this troubles me. I am glad I am not sitting where you are; you will have to solve this. I don't know any more responsible unions than the automobiles, yet how many times during the last three bargaining sessions have they had an unavoidable strike at the local levels where they were unable to control the people?

Mr. THOMPSON. The reason for that—I agree they are the most sophisticated industry with relation to strikes—is that they have not taken into consideration local problems. It has been the overall structure that they have concentrated on as distinguished from the particular local problem which is unique.

Mr. BUTLER. I think so, Mr. Chairman.

One more thing before I surrender the floor. You talked about the tremendous imbalance and you took issue with the gentleman from Pennsylvania—I am glad I wasn't sitting in his chair. I want to make an observation. That is, that you don't want to minimize the effect of the picket line. There is a constitutional right to picket which unions, whether representing hospitals or anybody else, exercise, and that picket line, at least in my industrial State of Michigan, is a brick wall. It cuts off deliveries, a host of services, and the end result is that it is a coercive weapon that cannot be taken lightly. I do not feel that those States not under the act are helpless.

Mr. THOMPSON. The distinguished ranking member of this committee, Mr. Quie of Minnesota, is here and has a couple of questions or observations.

Mr. Quie.

Mr. QUIE. One question.

I would like to ask the gentleman from Michigan, Mr. Butler, what year was the strike?

I understand you said that you had had only one strike since 1949.

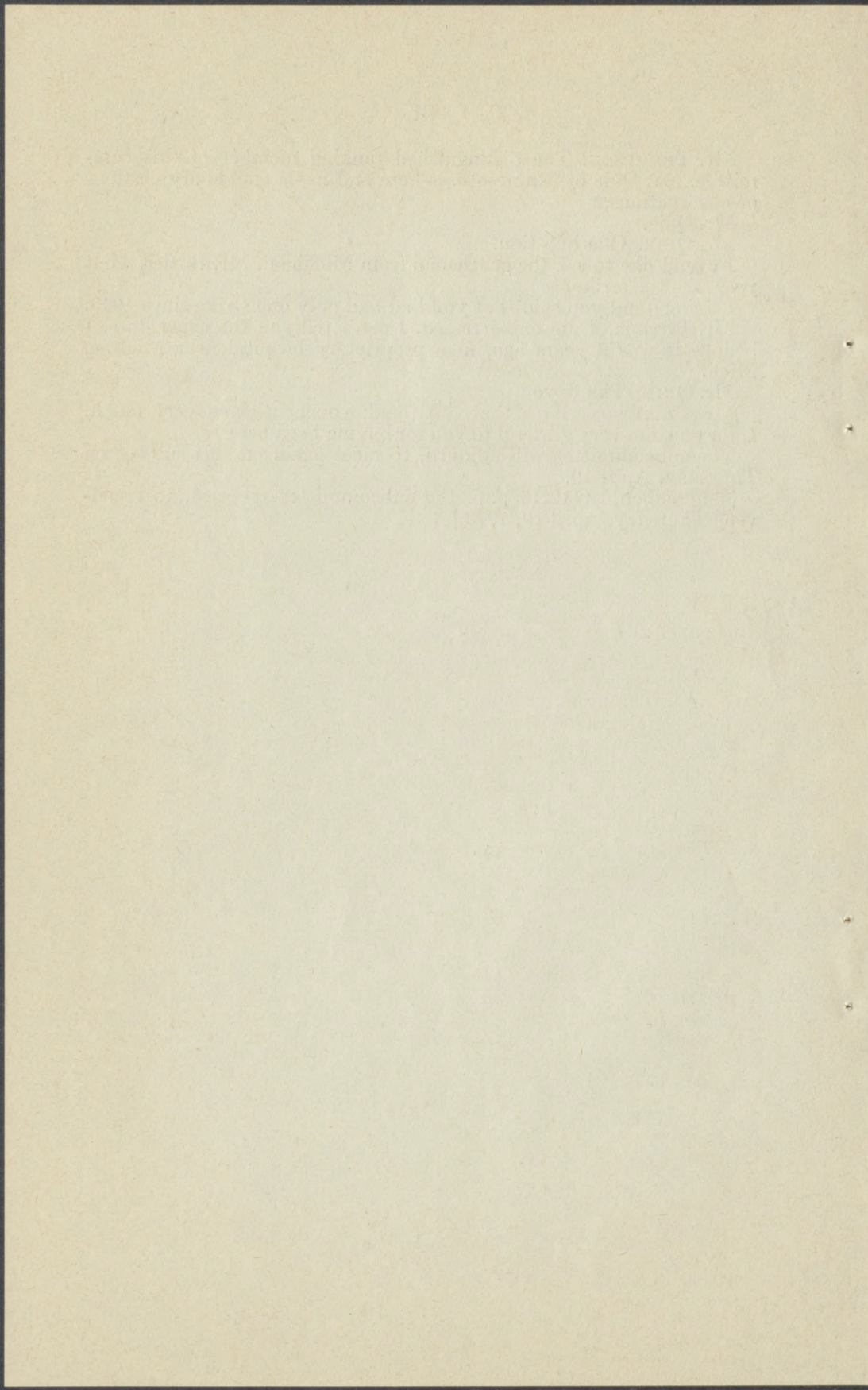
Mr. BUTLER. I am embarrassed, I can't tell you the exact date. I believe it was 2 years ago, in a proprietary hospital near Monroe, Mich.

Mr. QUIE. Thank you.

Mr. THOMPSON. With that, we thank you gentlemen very much. I, for one, am very grateful to you for having been here.

The subcommittee will adjourn, to meet again on this subject on Thursday, April 19.

[Whereupon, at 12:15 p.m. the subcommittee recessed, to reconvene Thursday, April 19, 1973.]



EXTENSION OF NLRA TO NONPROFIT HOSPITAL EMPLOYEES

THURSDAY, APRIL 19, 1973

HOUSE OF REPRESENTATIVES,
SPECIAL SUBCOMMITTEE ON LABOR
OF THE COMMITTEE ON EDUCATION AND LABOR,
Washington, D.C.

The subcommittee met at 10 a.m., pursuant to recess, in room 2257, Rayburn House Office Building, Hon. Frank Thompson, Jr. (chairman), presiding.

Present: Representatives Thompson, Clay, and Ashbrook.

Staff members present: Robert E. Moss, counsel; Daniel H. Pollitt, special counsel; Jeunesse M. Beaumont, subcommittee clerk; Edith Baum, minority counsel for labor.

Mr. THOMPSON. The subcommittee will be in order.

Today we are concluding our hearings on the bill H.R. 1236, to extend coverage of the National Labor Relations Act to the employees of nonprofit hospitals.

The testimony to date, accumulated over 7 days of hearings, clearly convinces me that the passage of H.R. 1236 is important to the hospital industry. There are others who feel otherwise, I realize.

H.R. 1236 will bring stability by reducing the number of recognition strikes and would promote equity by treating employees of nonprofit hospitals the same as all other employees under the NLRA.

We have a rather unusual situation which I would like to explain to you. The Senate has recessed for its Easter holiday, and we are to recess today. The Mass Transit Act is on the floor; and the House, in an unusual situation, went into session at 10 o'clock. There will no doubt within a few minutes be bells ringing for a quorum call, which means that Mr. Clay here and myself and other Members will leave probably immediately, so we will just recess. We have 15 minutes within which to answer, and then we will come back. Then there will certainly be a vote at 11 o'clock on an amendment. Then we might have others. But we will nevertheless continue when we return.

Our first witness is an old friend, the Director of Organization of local 1199, Mr. Elliott Godoff. It is nice to see you again, Mr. Godoff.

STATEMENT OF ELLIOTT GODOFF, DIRECTOR OF ORGANIZATION, NATIONAL UNION OF HOSPITAL AND NURSING HOME EMPLOYEES

Mr. GODOFF. Thank you, Mr. Chairman.

I want to speak in favor of H.R. 1236.

Mr. THOMPSON. Mr. Godoff, before you start, we might as well leave, and we will be back here within 15 minutes. My prediction was about 1 minute off.

(Whereupon, a brief recess was taken.)

Mr. THOMPSON. All right, Mr. Godoff.

Mr. GODOFF. In the statement, it says that it is not entirely clear on why the employees in nonprofit hospitals were excluded from the National Labor Relations Act. Mr. Chairman, I say that, to me, it is very clear that there are some elements in this country who would like to keep hospital workers on the same level as the farmworkers, and the exploitation in this field has been going on for many, many years. Those who exploit love to continue it forever and a day.

However, I think that reality is a very important thing. Everybody has to recognize that the health field, the nonprofit health field in our country, is enormous. It is more than 2 million people. It is inconceivable that we can go on for much longer to exclude so many millions from the right to organize and the right to bargain collectively.

Even at this date, I think it is clear that there is a tremendous need and a tremendous desire on the part of hospital employees throughout the country to organize. And our own history has been studded with struggle and strife because we were stymied and stopped from exercising a right to organize and bargain collectively.

I know that in previous testimony a chart was submitted that there were more strikes, for economic reasons than for organizational reasons for the right to representation.

Mr. THOMPSON. May I ask you a question at that point? We have been told by witness after witness that there have been more recognition strikes than any other kind.

Mr. GODOFF. That is correct.

Mr. THOMPSON. One large group maintains that the contrary is true—that there have been more strikes where there has been recognition. What is your experience?

Mr. GODOFF. The experience is quite the opposite. I think that it depends on what you are looking at and where you are looking at it. It so happens that most of the strikes that they are talking about have occurred in the areas covered by the National Labor Relations Act in the proprietary field and not in the voluntary field.

Our experience—and I would like to recite it—our union is rather new; and, by the way, it is now known as the National Union of Hospital and Nursing Home Employees. We actually began to organize around 1958 and 1959. It happened that in early 1959 we approached some seven hospitals in New York City, where we had majorities of the workers organized, and we asked them to sit down with us and to bargain with us or to give us an election.

Those hospitals told us that they would not give the workers the right to choose a union under any circumstances because they were excluded from any law.

Those people who are constantly coming here and elsewhere and telling you how much they are worried about the sick and about the patients said: "If you don't like it, you can do whatever you want; you can go out on strike." And we did. For 46 days, some 6,000 or 7,000 workers were on the streets, suffering, and thousands of patients were suffering for a simple reason—the right to hold an election to determine whether these workers do, in fact, want to be represented by a union.

That same story has repeated itself in many areas. I think that it is going to repeat itself much more because you cannot take 2 million people in a country where everybody else has the right to organize and the right to bargain collectively and say to them: "You work for a nonprofit institution, and therefore you will be denied those rights."

MR. THOMPSON. What is the nature of the current strike in Charleston, S.C.?

MR. GODOFF. That was a different kind of a strike, Mr. Chairman. That was not a nonprofit hospital. That happened to have been a State institution. I might tell you that the issues were different. It was not only recognition but the fact that here was a State institution which received funds from the Federal Government and signed statements that they would be a fair practice employer, engaged in a practice of paying white workers doing the same work; that is, a nurses' aide who was white was getting 40 cents an hour more than a black.

In that same hospital, even though they pledged in writing to the Government that they would not have separate facilities, they had separate facilities for blacks and whites, and the indignation was there, it was so great.

The workers organized and wanted to meet with management and to try to correct some of these injustices. It took 100 days—100 days of struggle—until, on a Presidential level, the order was given to sit down and try to resolve these problems, and so they were.

But that was an unusual strike, Mr. Chairman. Most of the strikes are over the question of representation. We have now a very peculiar situation. We have a country where the news of the world is heard in 5 minutes and news that happens in any State is known all over. We now have more than a dozen States which, in their wisdom, have seen fit to enact laws giving employees in voluntary hospitals the right to organize and the right to bargain collectively.

Now, if it exists in 12 States—and I don't think that any witness can come here and say that those States are now on the verge of collapse, that the hospital system has been destroyed because of this; on the contrary, they are still there and they are the most prestigious institutions in the country, which are organized. They are alive and kicking.

So I think that the argument that, in some areas which are not covered by State legislation, these workers must be excluded, I think, is simply ridiculous. The workers in New York are now covered by a State act. Rhode Island was the most recent to enact a law giving the nonprofit employees the right to organize and bargain collectively. Massachusetts has the act, and Connecticut. In your State, Mr. Chairman—in New Jersey—

MR. THOMPSON. We have a nightmare.

MR. GODOFF. Well, I will tell you, you have something extremely interesting, because, in your State, we had some strikes on the question

of representation. Suddenly our attorneys looked at the New Jersey constitution and they found that it says that every citizen of New Jersey has the right to organize and bargain collectively.

We went to court in a proceeding which took nearly 5 years. The supreme court of that State ruled that the employees had a constitutional right to organize and bargain collectively. The chancery court now is substituting for a State labor board for a national act. They are the ones who set units, ask somebody to run elections, determine unfair labor practices; in other words, they substitute for labor legislation.

So, in New Jersey, even though there is not a State act and even though there is no coverage, there is at least some minimal relief where something can be done.

We have recently organized Mountainside Hospital in your State, and that was done through the courts; and in a number of other institutions that was done through the courts.

But, in other States, like Ohio, throughout the South, all over, these workers are suffering, and the only way they can think in terms of winning that right is to strike.

I can tell you right now, in spite of all the fears that have been brought before your committee, our union does not believe that the hospital field or a hospital per se is a very good arena for strike and for struggle.

I think that there has to be an assumption that there are reasonable people who are in unions and that the workers who work in those hospitals and who give of themselves 365 days per year, providing service for people, that those workers are not itching and straining to go out on strike every minute in order to win some special benefit, because they have shown great patience and great endurance.

Mr. THOMPSON. Isn't it a fact that, in almost all of your contracts, you have voluntary no-strike clauses?

Mr. GODOFF. In all of our contracts. I think it is customary that in most contracts for the duration of the agreement, there would be no strikes, no stoppages, and that all outstanding issues are submitted to a third party, to arbitration, for the purpose of settling these things.

Mr. THOMPSON. You see, the fundamental thesis of the National Labor Relations Act, its intent, is to reduce, if not eliminate, strikes. Its history has shown that there have been fewer strikes, fewer conflicts, as a result of the inclusion under the act of various types of workers.

Now, we have legislation before us to include State, county, and municipal employees under the Federal act. We have legislation before us to include agricultural workers under the act.

We share your view that there should be a Federal law. The pattern of the 11 or 12 State laws varies greatly.

We had a panel before us at our last hearing on which was represented the State of Pennsylvania, which has an act; the State of Minnesota, which has probably the best act; the State of Ohio; and the State of Michigan. By the time we finished listening to those men, all representing their respective hospital associations, we felt that—even though they didn't want this bill—they were the most valuable witnesses that we have had before us in favor of the bill because of the great diversity they illustrated.

One has compulsory arbitration. Michigan has fact-finding. Pennsylvania has something else. It is a crazy-quilt pattern, and it ought to be uniform.

Mr. GODOFF. That is absolutely correct. I can just tell you that we are seeing right here in this city a very interesting situation which speaks in favor of this bill. In the city of Washington, because it is the Capital and because there is a cognizance of the fact that there is a National Labor Relations Act, et cetera, it has been the policy of most of the hospitals here not to contest, not to raise the question of the legal exclusion from the act, and they have, in the main, consented to elections to be conducted so that their workers would have the right to representation.

As a matter of fact, a week from today at Georgetown University Hospital, our union will be involved in a very big election. The interesting thing, the university, because it is covered by the act, because universities were very recently included—

Mr. THOMPSON. Under the Cornell case?

Mr. GODOFF. That is right. So that when we approached them for recognition for the hospital employees, they said: "No; we are covered by the act." They made us go through the whole rigmarole. A year passed by before the board ruled that the part of the university is included but the university hospital is excluded.

So we were in a very precarious position. We went for an election. We won, covering the university employees whom we were not seeking to represent in the first place. Now we are going after the hospital separately. This is the same employer, the same institution.

Mr. THOMPSON. You are working under the Duke University case, in which it was held that although the employees were those of a common employer and the maids, for instance, made beds in the dormitories one week, where they were covered, and in the hospital the next week, where they were not covered?

Mr. GODOFF. Right. And you have people who, by some accident, work in the hospital who voted in the NLRB election covering the university but they are excluded but the rest of the employees are included. So you have some of the people in the hospital covered by the act and other people who are not covered by the act.

But I think the fact that speaks most for it is that there is a movement and a recognition in many States that, in order to avoid unrest—not only strike, unrest—in order to keep a morale among the employees in order to take care of the sick, that there is a need to have a channel to give the people the right to representation.

The fact that more and more States have acted accordingly, even though not uniformly, indicates that the need is there. I think it is ridiculous that we should have it in a dozen States and we should have the rest of the States uncovered under this act.

I think that you know, Mr. Chairman, and happened to have been a witness to negotiations in your State, where we used your good offices. I think that you could be a witness to testify to what lengths we went and under what atmosphere we were negotiating in order to avoid strike and strife in a hospital and the efforts which were made to resolve things peacefully.

Only about a month or so ago, I was invited to speak at a seminar in Richmond—at the University of Virginia in Richmond. I spoke to them about our national union. One of the people there came over

to me and said: "We are prepared to take 100 strikes to keep one union out of our State."

Now, I think that unions come before you to testify for this bill not because they are looking for strikes, not because they are looking for struggle. They are coming here because there is a basic need for the workers to have representation and to do something about the terribly low wages and the poor conditions and the exploitation that goes on in the hospitals.

Yet the managements who are so concerned with strikes are willing, under the present circumstances, to go without the act and to take representation strikes and to fight.

The injunctions are not the answer to these things, because you can have a million injunctions, but the strikes will go on and the struggles will go on and the patients will be inconvenienced unless there is uniform legislation saying that hospital employees are equal, the same as the employees in any other area.

I think that you can leave it to the wisdom and to the decency of people who work in hospitals that they will do everything in their power provided the other side is willing to tango a little bit and stretch out a finger if not a hand to sit down with them and do something gradually to improve the conditions of those workers.

So I think that the strike threat is a false and misleading issue in this thing.

There is a need. I think some of the leading institutions in our country are now organized. Johns Hopkins in Baltimore, a famous institution, is organized. I don't think that anyone is going to testify that it is falling apart. Columbia Presbyterian Hospital in New York, the largest voluntary hospital in the country probably, was organized only last month. It is still there and as beautiful as ever.

University Hospital in Boston has been organized. It is functioning as well as ever. In New York, many of the leading hospitals are there and they are doing as well as they ever did.

So I think that to create scares and create false issues is not the answer. I think that this act should be changed and the employees in voluntary hospitals should be included and some uniformity should be provided for the people who work in this important field.

Mr. CLAY. Mr. Chairman, I would like to ask him a question on those hospitals that are organized. How does the rate of turnover in unorganized hospitals compare with the rate of turnover in hospitals that are organized?

Mr. GODOFF. I would like to answer this question. I think it is fortunate that sitting in this room is a representative of one of the very important leading hospitals in New York City, Mr. Metzger, who is going to be a witness before you. I know that even a long time ago he told me that, with the coming of the union, the turnover has been so drastically and radically changed, there has been so much more stability than ever before.

In the older days, I think there was a 1,500 percent turnover. I think it came down to something—he will be able to speak for himself—to somewhere around 2 percent. I would guess that today it is probably even less than that.

So I think, from the point of view of stability of personnel, the ability to train them, the ability to promote them, I think that has been greatly increased.

I might also tell you some of the benefits of collective bargaining. In this contract in New York City, which is with the League of Voluntary Hospitals, it is a number of institutions where we represent over 30,000 of our members, we have developed in the course of collective bargaining a training and promotion program which is a joint operation between management and the union, joint trusteeship. The management pays 1 percent of gross wages to it.

At the present time we are training people from the ranks, from low-paid jobs, and from the unskilled; we are giving them high school equivalencies, we are training them for nursing, practical nursing, technicians, X-rays technicians, all kinds of licensed jobs.

I think that, in the long run, this is going to be a tremendous service in filling areas which are so badly needed in hospitals, for providing the skills that are necessary to have patient care.

So I think, all in all to your question, there has been much greater stability. There has been a vast decrease in the turnover, and I think that the morale among the employees has certainly improved, in my opinion, to a great extent.

Mr. THOMPSON. Mr. Ashbrook, do you have any questions?

Mr. ASHBROOK. Mr. Chairman, I don't have any questions. I think what he said speaks for itself. I would reiterate what we said in our meeting last week—that, if anything, the record indicates the threat of strike is a phony one, because there just aren't strikes except for recognition. The recognition controversy is what we are trying to work out in this legislation. So I subscribe to what you state, and I have no questions to ask.

Mr. THOMPSON. I commented before you arrived about the panel representing four States at the last hearing and appearing in opposition to the legislation.

Mr. ASHBROOK. It actually spoke in favor of it.

Mr. THOMPSON. That's right, it actually spoke in favor of it.

Thank you very much, Mr. Godoff.

Mr. THOMPSON. Our next witness is Mr. David H. Hitt, the chief operating officer of the Baylor University Medical Center, accompanied by Mr. Clifton Elliott, labor counsel, Missouri Hospital Association, and Dr. Leo J. Gehrig, vice president, Federal Relations, American Hospital Association.

Dr. Gehrig will make the introductions for the benefit of the members and the stenographer.

STATEMENT OF DAVID H. HITT, CHIEF OPERATING OFFICER, BAYLOR UNIVERSITY MEDICAL CENTER; ACCOMPANIED BY CLIFTON ELLIOTT, LABOR COUNSEL, MISSOURI HOSPITAL ASSOCIATION, AND LEO J. GEHRIG, M.D., VICE PRESIDENT, FEDERAL RELATIONS, AMERICAN HOSPITAL ASSOCIATION

Dr. GEHRIG. Thank you, Mr. Chairman.

I would like to thank you and the committee for affording us this opportunity of presenting the views of the American Hospital Association. Further, I would like to thank Mr. Moss of the committee staff for his courtesy.

We appreciate the limitations on your time and we are going to attempt to be brief. But in speaking directly to the pertinent issue

before you this morning, H.R. 1236, the association, I believe, appropriately is not going into a long discussion of its policies and efforts relating to personnel practices or to point up available data regarding significant increases which have occurred in hospital salaries during the last several years.

In sum the association is most mindful of the responsibility of hospitals to their employees, to their patients, and to the community which they serve, and the community which supports them. I am hopeful and confident that in facing this difficult issue members of the committee and Congress will consider seriously the deep concern we express today.

I must say in the comfort of this room the phrase, "continuity of patient care" almost seems abstract. But as a physician and an individual who has been involved in health care over my active life I would say that if we could stand amidst the busy sector of an emergency room, of a delivery room, of a coronary care unit, or intensive care unit, or even by the relative quiet bedside of a child or adult who is seriously ill, I think then the meaning or even a discussion of interruption or diminution of patient care services, to whatever extent the institution has capability large or small, would take on a very real and different meaning.

I say this in full sincerity. We are not here to raise a charade. We are here to discuss what is a very real concern. It is to that real life situation that we are speaking, and in that term and without going further, I would like to briefly restate what the chairman did. Mr. David Hitt, a member of the American Hospital Association's board of trustees, and also the chief operating officer of the Baylor University Medical Center, and Mr. Clifton Elliott, a labor attorney from Kansas City, Mo., accompany me to present the AHA testimony. We thank you for your courtesy.

MR. HITT. Mr. Chairman, I have a prepared statement which we are submitting for the record.

MR. THOMPSON. Without objection, all statements will be included in the record preceding the witness's appearance. Then you may read it or you may summarize.

MR. HITT. Mine is a summary, and there is nothing substantially different about what I will say here this morning from what is in it.

[The statement referred to follows:]

STATEMENT OF DAVID H. HITT, CHIEF OPERATING OFFICER, BAYLOR UNIVERSITY MEDICAL CENTER, DALLAS, TEX.

I am David H. Hitt, Chief Operating Officer, Baylor University Medical Center, Dallas, Texas. With me are Clifton L. Elliott, a labor attorney from Kansas City, Missouri, and a member of the firm of Spencer, Fane, Britt, and Browne; and Leo J. Gehrig, M.D., Vice President of the American Hospital Association. I am testifying on behalf of the American Hospital Association, which is an association of some 7,000 hospitals located throughout the United States.

STATEMENT OF AHA'S POSITION

The AHA strongly opposes H.R. 1236, which would remove from the National Labor Relations Act the current exemption of not-for-profit hospitals. Our opposition to the bill is based on the sincere belief 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—basic elements in the collective bargaining process under the NLRA—cannot be tolerated in the life and death situations faced daily by hospitals. We believe it is clearly not in the

interest of the American public to legislatively authorize such labor activities for general application in an environment where seriously ill persons must be treated. Policemen and firemen have had their right to strike curbed in the overall interest of public safety. Hospital services are, from society's standpoint, certainly at least as essential and must be available without interruption.

To recognize why hospitals and other health care institutions should not be brought under the NLRA, one needs only to understand the essential nature of health care services to a community. Health care institutions 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 health care institutions is the delivery of patient care services and in providing these vital services, often under emergency conditions, such institutions are wholly dependent on the close coordination of many different professional, skilled, semi-skilled, and unskilled workers. In community hospitals across the country today, for example, there are almost three employees for each inpatient. The fundamental needs of sick persons cannot be met by machines. Around-the-clock availability of health care personnel working closely together as a team is absolutely essential for health care institutions to meet their responsibilities to patients and the community. Any interruption, interference, or delay in patient care services results in increased morbidity or loss of life.

H.R. 1236 would amend the NLRA in only one way—remove the current exemption of nonprofit hospitals from the provisions of the Act. It would not attempt to deal with any of the inadequacies of the Act as applied to health care institutions.

The Act is seriously deficient and inappropriate for application to the health care field in two basic aspects. The first involves strikes, picketing, and work stoppages. The second pertains to the proliferation of bargaining units. Both of these areas have serious implications with regard to interruption of patient care services.

1. Strikes, Picketing, and Work Stoppages

The National Labor Relations Act has no mechanisms for effectively dealing with a wide range of union activities relating to strikes, picketing, and work stoppages and, consequently, would fail to provide needed protection for hospital patients from real or threatened interruptions in patient care services.

Recognition strikes and recognition picketing are permitted under the NLRA if a petition for election has been filed within 30 days from the commencement of picketing. Thus, interruption of patient care services are permitted under the law if a union has filed a timely election petition.

For example, an institution in San Diego last year 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, NLRA does not provide adequate protection from secondary boycotts and secondary picketing. This deficiency is compounded by the inability of the National Labor Relations Board to respond rapidly enough in obtaining injunctive relief from the courts when a union violates the Act's prohibitions against secondary boycotts, jurisdictional strikes, picketing and the like. An employer under the Act cannot on his initiative obtain an injunction against illegal strikes or picketing. Delays of two weeks or more are common while awaiting action by the NLRB to obtain injunctive relief in the courts. In the meantime, hospitalized patients must suffer from the effects of these illegal activities.

The NLRA's most serious deficiency is that it has no provision for effectively resolving impasses in collective bargaining negotiations that often lead to strikes and work stoppages. The Association believes every reasonable effort must be provided for resolving bargaining impasses in health care institutions because strikes in such institutions are intolerable.

There are no definitive studies that have measured the full scope of labor activities in the health field, but strikes, picketing, and work stoppages have occurred throughout the health care industry and hospitals have experienced their impact. While it has been alleged that almost all hospital strikes result from recognition activities, Department of Labor statistics show that only 41 percent of work stoppages in health care institutions over the past 10 years have been related to recognition. The majority of patient care disruptions were related to non-recognition problems involving wages, hours of work, job contract, job security, etc. It is evident that simple extension of the NLRA to cover nonprofit hospitals would provide no solution to this problem. Passage of H.R. 1236 in its present form would undoubtedly increase the number and scope of inter-

ruptions in patient care services. In most impasse situations so far, there has been the potential for transfer of patients to other nearby hospitals. However, the problem would become much more serious if strike activities involved all of the hospitals within a community.

2. Multiple Bargaining Units

The NLRA also fails to deal adequately with the problem of multiple bargaining units within a health care institution. There are over 125 separate occupational classifications in the health care field with an overwhelming percentage of the employees in 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 of the health team 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 NLRA, employees of health care institutions would be fragmented into numerous small bargaining units. The NLRB, 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:

(a) Any of these bargaining units, no matter how small, could close down an entire facility because of the general practice of all bargaining units to respect, reciprocally, picketing by others. As an example, a small unit of four stationary engineers (who run boiler rooms) could disrupt or close down an entire hospital by establishing a picket line that would be honored by other employees.

(b) 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 could interfere with patient care when employees refuse to perform tasks outside of those defined by their bargaining units. Such inflexibility would seriously impair efforts to provide efficient, coordinated and high quality patient care services.

(c) The various bargaining units within the health care institution would each compete for the most favorable wages, hours, and working conditions. Such continuing competition would interfere with the necessary team work which is critical in treating sick patients.

(d) Dealing with many bargaining units in a hospital would unquestionably result in higher administrative and legal expense. It is difficult to justify such 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 to control rising health care costs.

The American Hospital Association's firm opposition to enactment of H.R. 1236 is based on the fact that it would bring nonprofit hospitals under the NLRA, a law that does not adequately protect the public from interruptions of patient care. The Association's position represents the opinion of the vast majority of the hospital field. While the Hospital Associations of Massachusetts and New York have supported this legislation, their support is largely based on the extreme difficulties they have encountered under their own state labor laws. Furthermore, Mr. Chairman, we believe it is fair to say that there is full agreement across the hospital field that if Congress acts to bring nonprofit hospitals under the NLRA, Congress must include in the legislation provisions which protect the public from the dangers of strikes and work stoppages in the life and death situations which prevail in health care institutions. The inclusion of such provisions and protection must not be left to chance or ignored.

CONCLUSION

Mr. Chairman, we reiterate the American Hospital Association's strong belief that enactment of H.R. 1236, which would subject not-for-profit hospitals to

the provisions of the National Labor Relations Act, with all of its significant limitations and shortcomings as it would apply 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.

Thank you for the opportunity of presenting these views to your Committee.

APPENDIX A

WORK STOPPAGES IN MEDICAL AND OTHER HEALTH SERVICES, 1962-71¹

Year	Summary			Private			Governmental		
	Total	Non-recog-nized ²	Recog-nized ³	Total	Non-recog-nized ²	Recog-nized ³	Total	Non-recog-nized ²	Recog-nized
1971-----	54	32	22	36	18	18	18	14	4
1970-----	75	43	32	49	23	26	26	20	6
1969-----	65	39	26	43	22	21	22	17	5
1968-----	49	31	18	28	14	14	21	17	4
1967-----	46	25	21	27	13	14	19	12	7
1966-----	37	26	11	19	10	9	18	16	2
1965-----	14	5	9	13	5	8	1	0	1
1964-----	14	8	6	14	8	6	NA	NA	NA
1963-----	14	7	7	13	6	7	1	1	0
1962-----	6	4	2	6	4	2	NA	NA	NA
Total-----	374	220	154	248	123	125	126	97	29

¹ Source of data: U.S. Department of Labor, Bureau of Labor Statistics, Washington, D.C.

² Includes wage, wage-related, hours of work, job contract, job security, etc.

³ Includes category defined as union organization and security.

Mr. HITT. The American Hospital Association strongly opposes H.R. 1236. Our opposition is based on the sincere belief 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, basic elements in the collective bargaining process under the National Labor Relations Act, cannot be tolerated in the life and death situations faced daily by hospitals. Policemen and firemen, for example, have had their right to strike curbed in the overall interest of public safety. Hospital services are, from society's standpoint, certainly at least as essential and must be available without interruption.

Health care institutions have no true analogy in industries that manufacture or sell products. The primary purpose of health care institutions is the delivery of patient care services and in providing these vital services, often under emergency conditions, such institutions are wholly dependent on the close coordination of many different professional skilled, semiskilled, and unskilled workers. The fundamental needs of sick persons cannot be met by machines, but are absolutely dependent upon around the clock availability of health care personnel working closely together as a team.

Mr. THOMPSON. May I interrupt you at that point?

Mr. HITT. Yes.

Mr. THOMPSON. The experience at Mount Sinai Hospital in New York and Johns Hopkins was that they had in the vicinity of a 1,200-percent turnover per year before they were organized in their non-professional help. Now that being the case, does not that disrupt patient care and divert the professional and semiprofessional attention from their duties, the nurses, for instance.

Mr. HITT. Mr. Chairman, I cannot conceive of conditions that would lead to a 1,200-percent turnover rate in a hospital.

Mr. THOMPSON. Well, whether you can conceive of them or not, the fact is that they existed. Later I am sure Mr. Metzger will tell us specifically about it. It is a matter of documentation.

Mr. HITT. Well, this condition doesn't apply in the conditions that I am familiar with. I cannot conceive of that being justified under any circumstances, although there might be something in the labor market in those places that might have done it. I don't know those labor markets, but I can't conceive of them.

Mr. THOMPSON. Mount Sinai's turnover was 1,500 percent in 1959.

We can ask Mr. Metzger what it is at this point now.

Dr. GEHRIG. Mr. Thompson, I think it might be most helpful when Mr. Metzger is here that you get a full description of that.

Mr. THOMPSON. We will get it, I am sure.

Dr. GEHRIG. We were not able to verify that figure, very honestly, for that period. In the Johns Hopkins situation I believe there is a quotation about 1,000 percent a year, and our followup with the officials in that institution with regard to that period suggested that it was between 30 and 35 percent. If the figure is real, and I think it is very important that they be verified, and I am pleased that Dr. Metzger will be here to do that, it implies a broad and fast turnover in hospitals across the country.

We have data to indicate to you that the turnover rate in hospitals across this country and by region—and we would be glad to submit this data to you—is very much less and falls in the range of 40 percent per year.

Mr. THOMPSON. That is pretty high.

Mr. ASHBROOK. Don't you think that is high?

Dr. GEHRIG. No; but we were just finished speaking of a rate that is 1,500 percent. We are not suggesting a great deal of pleasure with a turnover rate even that high. There have been studies of why there is turnover in hospitals, and we can provide sufficient documentation which points out that union organization is not a primary issue for decreased turnover, nor is there among studies a consistent factor which provides the solution to rapid turnover.

Mr. THOMPSON. What is the percentage at Baylor?

Mr. HITT. Something around 40 percent. It runs 3 to 3½ percent a month. But I think you have to keep in mind that we employ the wives of students in the schools there, knowing that there is an absolute termination date when their husbands will graduate. We have had some employees who worked as many as three times, who quit for a while to have a baby and come back. There are a lot of reasons when you employ women that you have a somewhat higher turnover rate than would be acceptable in an institution that employed men, for example.

Mr. THOMPSON. I am glad that Gloria Steinem isn't here.

Mr. HITT. Well, that is a fact.

Mr. ASHBROOK. Mr. Chairman, it would be helpful, as you make some of these points, if we would raise some questions at the time. The one statement that has been made by both gentlemen that I think must be explored is the inference—you used the word "continuity"—that you have continuity, and you would not have continuity if the bill passes. I just can't accept that as a premise. I notice

on the first page of your statement you say, "because strikes, picketing, and work stoppages cannot be tolerated in life-or-death situations in hospitals." You have them now. You cannot say throughout this country you don't have the specter of strikes, picketing, and work stoppages.

I think the inference that this cannot happen now, and if the bill passes it will happen, or to your statement, Doctor, that you have continuity of services now and if this bill passes you would not have continuity of services, requires exploration. I don't think the facts bear that out.

Mr. HITT. Mr. Ashbrook, we do cover that in our summary. I wonder if it is all right to ask questions at the point we finish the summary rather than to take a chance on duplicating it?

Mr. ASHBROOK. As a premise, you cannot say that you have strikes, picketing, and work stoppages facing the vital work of such hospitals in April 1973, before the bill passes. You could not possibly have that premise.

Mr. HITT. Our premise is that this will be increased under the National Labor Relations Act.

Mr. ELLIOTT. I think the difference between the situation now and the situation which the amendment poses is giving employees a federally and legally protected right to strike. Under the National Labor Relations Act, as is pointed out in the statement, there are a number of situations where employees have a federally protected right to strike.

Mr. ASHBROOK. They have a constitutional right to strike now, don't they?

Mr. ELLIOTT. No. The Constitution does not give an employee the right to strike. The Supreme Court held before the LMRA was introduced—

Mr. ASHBROOK. You don't think the employees in Charleston had a right to go out on strike?

Mr. ELLIOTT. Not and maintain their jobs.

Mr. ASHBROOK. They had a right to strike.

Mr. ELLIOTT. But the employer had a right to cancel their employment.

Mr. ASHBROOK. Which would be considered right in any other aspect.

Mr. ELLIOTT. What the National Labor Relations Act does is protect the employee's employment if the employee engages in a strike. If employees do not have this federally protected right guaranteeing them employment during a strike, then if you give them that right it is our premise that this will increase the incidence of strikes.

Mr. ASHBROOK. We will go into that later. The facts don't indicate that is the case where unions have received bargaining status and recognition by hospitals. I think that terrible premise being extended in this particular area doesn't scare us quite as much as it would scare you. I don't exactly think that that is an awful principle to extend to a considerable number of employees.

I speak as a person who takes a rather independent view on this committee. I am certainly not one who takes the labor line very often, but I don't think that is such a terrible principle to extend to a considerable number of employees.

Mr. ELLIOTT. I don't know of any other group of employees in this country who have the right to strike, where the right to strike may cause death.

Mr. THOMPSON. Has that ever happened?

Mr. ELLIOTT. The proprietary hospitals have only been subject to the act since 1967. We have 5 years of experience, and nursing homes for a shorter period of time. How do you know whether it has happened or not? We have tried to get statistics on whether or not it has happened.

Mr. THOMPSON. Did you get any?

Mr. ELLIOTT. We did not; no. But I think there are reasons for that.

Mr. THOMPSON. Sure; because nobody has died as a result of a strike.

Mr. ELLIOTT. The reason is, we don't know whether anybody has died as a result of a strike.

Mr. THOMPSON. You don't always know why people die in hospitals. Doctors make mistakes once in a while, more often than lawyers.

Mr. ASHBROOK. I might say this is the situation where an employer is able to tell his employees to go to hell, or to engage in what otherwise might be considered as unfair labor practices, which would be punitive. So, it is the other side of the coin on the employer's side in my way of thinking of acts of injustice and unfairness. It is human nature to want to keep something that is in your behalf. To that extent the hospitals are a lot like the unions. I find many times the unions have various agreements. In the printing industries, for example, trying to get them to give up a few basic things is rather tough. They have the same mental attitude I think hospitals have in this particular situation. Nobody wants to give up something that is good when they have it.

I just don't see how in fairness and justice, you can keep that position when no other employer in a major area can, in effect, tell the employees to go to hell. It is just about that simple.

Mr. THOMPSON. If you will yield.

I notice an absence in your statement of any reference to what would happen if you were included under the act, the advantages to be found in national mediation and conciliation services, for instance, and the protection in other sections of the act which is designed to get people off the streets and to the bargaining table.

Mr. ELLIOTT. The Federal Mediation and Conciliation Service is available to nonprofit hospitals now. In those nonprofit hospitals in which I have engaged in negotiations we have been contacted by the Federal Mediation and Conciliation Service and have used their services in bargaining disputes.

Mr. THOMPSON. That has worked?

Mr. ELLIOTT. In those situations in which I have been involved, yes. In other situations, no.

Mr. THOMPSON. Then you would still enjoy that same right?

Dr. GEHRIG. Mr. Chairman, I would like to state that we would like very much if we could go through our summary. I think you have raised a very important issue we would like to deal with. It would be repetitive to go into the full exploration of your comments. I think it would be most helpful for us to go through the summary first.

Mr. THOMPSON. All right. In that case, why don't we recess to vote, and we will try not to interrupt you, although we reserve the right to.

[Brief recess taken.]

Mr. THOMPSON. Gentlemen, I hope you will forgive the interruption. There will be more, I am sure. Please proceed.

Mr. HITT. H.R. 1236 would amend the NLRA in only one way, remove the current exemption of nonprofit hospitals from the provisions of the act. It would not attempt to deal with any of the inadequacies of the act as applied to health care institutions.

The act is seriously deficient and inappropriate for application to the health care field in two basic aspects. The first involves strikes, picketing, and work stoppages. The second pertains to the proliferation of bargaining units. Both of these areas have serious implications with regard to interruption of patient care services.

(1) Strikes, picketing, and work stoppages: The National Labor Relations Act has no mechanism for effectively dealing with a wide range of union activities relating to strikes, picketing, and other work stoppages and, consequently, would fail to provide needed protection for hospital patients from real or threatened interruptions in patient care services.

Where strikes are prohibited under the NLRA, for example, in the few recognition strikes that are illegal; secondary boycotts; and other unfair labor practices, patient care would be faced with the National Labor Relations Board's inability to respond rapidly in obtaining injunctive relief from the courts. An employer under the act cannot on his initiative obtain an injunction against such illegal activity.

As applied to health care institutions, the NLRA's most serious deficiency is that it has no provision for effectively resolving impasses in collective bargaining negotiations that often lead to strikes and work stoppages. The association believes every reasonable effort must be provided for resolving bargaining impasses in health care institutions because strikes in such institutions are intolerable.

There are no definitive studies that have measured the full scope of labor activities in the health field, but strikes, picketing, and work stoppages have occurred throughout the health care industry and hospitals have experienced their impact. While it has been alleged that almost all hospital strikes result from recognition activities, Department of Labor statistics show that only 41 percent of work stoppages in health care institutions over the past 10 years have been related to recognition. The majority of patient care disruptions were related to nonrecognition problems involving wages, hours of work, job contract, job security, et cetera. It is evident that simple extension of the NLRA to cover nonprofit hospitals would provide no solution to this problem. Passage of H.R. 1236 in its present form would undoubtedly increase the number and scope of interruptions in patient care services.

(2) Multiple bargaining units: The NLRA also fails to deal adequately with the problem of multiple bargaining units within a health care institution. There are over 125 separate occupational classifications in the health care field with an overwhelming percentage of the employees in 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.

The NLRB, for example, has already recognized separate bargaining units for pharmacists, laboratory technologists, radiological technicians, registered nurses, and licensed practical or licensed vocational nurses; in addition, engineers, carpenters, plumbers, electricians, maintenance workers, and clerical workers are a few of the categories recognized. 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.

This multiplicity of bargaining units within an institution would have the effects of increasing both the numbers and likelihood of sympathy strikes, jurisdictional disputes, and leapfrog bargaining.

In summary, the American Hospital Association's position represents the opinion of the vast majority of the hospital field. While the hospital associations of Massachusetts and New York have supported this legislation, their support is largely based on the extreme difficulties they have encountered under their own State labor law. Furthermore, Mr. Chairman, we believe it is fair to say that there is full agreement across the hospital field, including these States, that if Congress acts to bring nonprofit hospitals under the NLRA, Congress must include in the legislation provisions which protect the public from the dangers of strikes and work stoppages in the life-and-death situations which prevail in health care institutions. The inclusion of such provisions and protection must not be ignored or left to chance.

CONCLUSION

Mr. Chairman, we reiterate the American Hospital Association's strong belief that enactment of H.R. 1236, with all of its significant limitations and shortcomings, as it would apply 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.

Thank you for the opportunity of presenting these views to your committee.

I would like to ask Dr. Gehrig to close with just a statement.

Dr. GEHRIG. I think we might leave it up to the chairman's questions. I am sorry that we persisted in our request to complete our summary statement, but we would be pleased now to respond to any questions that you might have.

Mr. THOMPSON. Well, don't be sorry. Perhaps we should apologize for having interrupted you. But from time to time questions occur which might slip our minds. It is somewhat difficult to sit here and review a statement which you have read only once and make notes with respect to questions.

Is there any real difference between proprietary and nonprofit hospitals, in your judgment?

Mr. HITT. No, sir. I think the issues are the same. They have patients and we have patients, and the lives of both types of patients are equally vital.

Mr. THOMPSON. Are there any really eleemosynary or charitable hospitals left where the patients don't pay anything?

Mr. HITT. Yes. There are hospitals that have other sources of funds to pay for them. Many hospitals, if not all, perform charitable services for a great many patients.

Mr. THOMPSON. Oh, yes, I recognize that.

Mr. HITT. So to that extent they certainly fit the category.

Dr. GEHRIG. I think I might add the problem of individual services to patients is certainly one we face. Really this past year we have noted a very high percentage of hospitals who have proclaimed and carried out an open door policy where the patients' admission is not subject to his ability to pay. There is the problem, however, because even though we provide service for patients who cannot pay, someone must pay for it. So the services are paid for by distribution of costs to the other patients. So we must add that the ability of the hospitals to provide such services does have to be based on a financial feasibility because they do have to pay their employees.

Mr. THOMPSON. Yes, we recognize that. Unhappily there is a tremendous disparity of income in the hospital structure, for instance, between the surgeon and the kitchen helper, because of the very nature of the industry, I suppose. I was astounded and restated it any number of times, by the fact that the American people will pay for medical services in excess of \$17 billion a year. In other words, it is a larger industry than the automobile industry. It is almost incredible. Equally incredible are the wages, the low wages of many of the non-professional employees in hospitals.

Now, had the hospitals voluntarily recognized, notwithstanding their economic problems, and I realize that they have them, the need for its lower grade employees to make a living wage so that indeed they could afford to be a patient in the hospital, for instance, we would not be faced with this situation today, nor would we be faced with it if several States had enacted laws, instead of only 11 or 12 States.

I think counsel has some questions with respect to that.

Dr. GEHRIG. Mr. Chairman, could I make a comment on your observation. I think it is quite true. You mentioned a rather large sum in the purchase of health care. We could only agree with you. As a matter of fact, both the Government and hospitals are extremely concerned about rising health care costs. We are attempting to do many things to minimize these costs, yet maintain quality services.

We have, I think, taken a different view with regard to the low-wage employee. For example, in our testimony before Mr. Dent in the minimum wage situation, we supported the minimum wage bills and stated that AHA wanted to be sure that employees in health care institutions were equitably dealt with in terms of wages they earn, and the desire of hospitals to pay employees wages comparable with other industries in the area.

Mr. THOMPSON. Do you think you are doing that now?

Dr. GEHRIG. I think a very real effort is being made. I would suggest that if one looks at the increase in wages to hospital employees, data which is available, you will find that the percentage increases over recent years has been rather significant. We could provide those to the committee. But I honestly believe a very real effort is being made. Hospitals are at this time, as you said, besieged by economic problems that range all the way from the necessity of providing services

to individuals who can't pay to other provisions like economic stabilization.

Mr. HITT. I wonder if I can read from a book by Dr. Feldstein, "The Rising Cost of Hospital Care." He is an economist. He said on page 64 or 65:

Most hospital employees do jobs that are not done in other industries. It is therefore generally impossible to ask whether in closely comparable occupations the wages of hospital workers are increasing relative to those in other industries. For a number of clerical and housekeeping activities, however, such direct comparisons are possible. The evidence presented in table 5.6, which is included in this, indicates that in 1956 to 1957 local nonhospital wage rates were generally 20 percent or more above those for the same jobs in hospitals. Since then this gap has been closing. By 1966 the differences had disappeared in a number of jobs in cities. In 1969 hospital employees often had higher earnings workers in the same job categories. Although hospital nurses have historically been paid less than were nurses working in industries, this differential has also generally disappeared by 1969. In New York State and San Francisco hospital nurses received higher wages than those in industry.

I might quote two figures as an indication of this. Between 1965 and 1968, a 3-year period, hospital wages increased 22.1 percent on the average. Between 1969 and 1971 hospital wages increased 34.3 percent. Now 34.3 percent in a 3-year period is very respectable compared with others. I realize that this has to be related to a base, and you have to deal with that question.

Mr. THOMPSON. But everything else being relative, you know a 33-percent increase over \$1 an hour is \$1.33 an hour.

Mr. HITT. During this period the minimum would have been minimum wage, so you are not talking about a dollar. I would like to make this point to close out response to this. The \$17 billion figure you said is lower to the extent that these wages are lower, and it will be higher to the extent that these wages are higher. So the two things have to be related. If the high costs are to be criticized, and the low wages criticized simultaneously, then we are in for more criticism on one or the other in the future, too.

Mr. THOMPSON. Assuming the minimum wage at \$1.65, a 33-percent increase would be 54 cents, which is still a very low wage, particularly in a high cost of living area.

Mr. HITT. But it does indicate a desire to catch up.

Mr. THOMPSON. Yes. Does that book give any statistics as to percentage increase in income of doctors during that period?

Mr. HITT. No, sir. I don't have that.

Mr. THOMPSON. What would you estimate, Dr. Gehrig, that would be.

Dr. GEHRIG. I really don't have that figure. I suspect we might be able to secure it for you.

Mr. THOMPSON. It would be interesting to see, because I suspect that it would be in about the same area, perhaps a little more.

Dr. GEHRIG. I would suggest too that when one talks about a percentage here it is talking about a percentage taken across the board of hospital employees. In other words, it includes them all.

Mr. THOMPSON. Including the doctors?

Dr. GEHRIG. I think you find a majority of physicians are probably not employed by the hospital, so the bulk of doctors are private practitioners, and it would not apply.

Mr. THOMPSON. I see. You know, the American Nurses Association strongly supports this legislation?

Dr. GEHRIG. Yes.

Mr. THOMPSON. Mr. Pollitt.

Mr. POLLITT. A few technical questions about your testimony, starting on page 3.

The first one is that the National Labor Relations Act has no meaning and is imperfect in dealing with a wide range of union activities relating to strikes. We have already mentioned the mediation and conciliation services which is a big addition to the act in the Taft-Hartley amendments of 1947. I believe it has been helpful where you have experienced it.

Second, you talk about recognition strikes and recognition picketing, and that the act is not very helpful there. I think my first comment is that if you have recognition picketing now you have nothing to turn to, whereas under the Act you would.

The second one, I would like to ask whether you have omitted the fact that 8(b)(7)(C) permits recognition picketing if you file a petition, but if the petition is filed the election process is expedited and then if the union loses the election, then they cannot continue the recognition picketing. In addition, 8(b)(7)(C), which permits recognition picketing after the petition for the election is filed, says that the picketing must stop if any employees employed by any other employers refuse to cross the picket line.

Mr. ELLIOTT. If I may cite an example that lawfully occurred with one of our clients under the National Labor Relations Act. The employer first had a dispute in New Mexico with a demand for recognition by the Operating Engineers Union. The union demanded recognition on the 18th of April, and the picketing commenced on the 19th of April. On the 20th of April the employer filed an employer petition to hold an election, No. 28-RM-180X. 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. The union then filed blocking charges on April 30th. Those charges were dismissed by the Labor Board May 15, but the election had been delayed. The Labor Board, as of May 15, continued to offer no election because the union advised 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 picketing in New Mexico, Kansas, and Missouri. Having lost the election, and lost Board certification on June 9, the operating engineers lost, 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.

Mr. POLLITT. What sort of picketing?

Mr. ELLIOTT. Recognition picketing.

The conclusion of it is that the employer was not free from picketing and work stoppages due to the original demands of the operating engineers in April until the month of September, and all of this was consistent with the Board processes.

Mr. POLLITT. Had these unions secured a majority of the cards from the eligible people in the unit and presented them to a hospital?

Mr. ELLIOTT. This was not a hospital. This was an employer covered under the National Labor Relations Act. This is a provision proper for them to use under the act. The union lost the election by a significant vote.

Mr. POLLITT. But the union also protested 8(a)(1) violations?

Mr. ELLIOTT. Which were dismissed after the regional director investigated it. The union appealed to the Board in Washington and they were again dismissed, but through the use of blocking charges the election was delayed and the picketing was substantially drawn out.

Mr. POLLITT. But no one honored the picket line.

Mr. ELLIOTT. The picket line was honored. The employers lost millions of dollars.

Mr. POLLITT. How about the proviso of section 8(b)(7)(C)?

Mr. ELLIOTT. Recognition picketing is proper provided an election petition has been filed.

Mr. POLLITT. And it says unless in effect such picketing is to allow any individual employed by any other person in the course of his employ not to pick up, deliver, or transport any goods and not perform any services.

Mr. ELLIOTT. That applies two ways. In the first place the Board has read that exclusion out of the act, but that does not come into effect when the union is recognition picketing, having filed for an election.

Mr. POLLITT. I am reading from 8(b)(7)(C).

Mr. ELLIOTT. I understand, but the union has a right to strike the employer for recognition. It can do so with impunity for 30 days.

Mr. POLLITT. No, it can do so for a reasonable period of time not to exceed 30 days.

Mr. ELLIOTT. The Board has concluded that a reasonable period of time is 30 days. There is no case I am aware of where the Board has said it is less than 30 days.

Mr. POLLITT. I am aware of some.

Mr. ELLIOTT. Well, I am not. Would you agree that as a rule the Board says 30 days?

Mr. POLLITT. That is the normal situation unless there is some emergency. I would assume a hospital would create an emergency.

Mr. ELLIOTT. But the act would not specifically provide, as the amendment is currently drawn, that hospitals would be recognized as an emergency.

Mr. POLLITT. The act does not deal with hospitals, or construction, or transport, or with perishables. It leaves it up to the discretion of the Board.

Second, you talked about on page 4, secondary boycotts, and secondary picketing. Are hospitals ever engaged in disputes involving other persons so that somebody follows a dispute to the hospital and pickets the hospital secondarily?

Mr. ELLIOTT. Yes.

Mr. POLLITT. Well, would you expand on that.

Mr. ELLIOTT. Particularly if the hospital is doing construction work, if I follow your example right.

Mr. THOMPSON. You would not have patients in that area, would you?

Mr. ELLIOTT. No. Well, yes you could.

Mr. POLLITT. The union is being picketed by people other than someone employed by the hospital?

Mr. ELLIOTT. Yes.

Mr. POLLITT. How does that situation arise?

Mr. ELLIOTT. In a number of different ways. If the hospital has contracted interior remodeling, or installation of services and the contractor with whom they are dealing goes on strike and the hospital is involved in a picket as a result of that strike.

Mr. POLLITT. That is a primary strike against the subcontractor doing the work?

Mr. ELLIOTT. In most of those situations you are able to set up a separate gate. But the situation here is the hospital can be involved in a secondary situation and the employer has no immediate relief. My experience with the Board is that you have to plan on 30 days to get injunctive relief.

Mr. POLLITT. You say it does not provide adequate protection. Section 10(1) requires the Board, when it issues a complaint to immediately seek an injunction from the Federal court.

Mr. ELLIOTT. But as a matter of practice "immediately seek" has resulted in delays, I would say, of a minimum of 2 weeks. We have had situations where it has been as long as 5 weeks before the Board has been able to go in and get a temporary restraining order.

Mr. POLLITT. Section 303 authorizes the injured party to file for damages in the Federal courts.

Mr. ELLIOTT. But I think the Supreme Court recognized in the *Boys Market* case that damages were not much relief to the company struck. It is not much solace to the patient suffering.

Mr. POLLITT. Suppose you sued employee Local 10, and you put it before the local jury what the damages are, and suppose they awarded \$1 million.

Mr. ELLIOTT. I would have a lot of trouble collecting from Local 10. If I joined the national I might be able to do that.

Mr. POLLITT. Suppose they did that, do you think Local 10 would be involved in secondary picketing thereafter?

Mr. ELLIOTT. They might not against that particular employer. I am not saying unions are not concerned about the effect of damage considerations. I think they are, but generally by the time you file the damage has been done. Our position is that patient care cannot wait for that to occur.

Mr. POLLITT. You don't think section 10(1), mandatory injunction, and section 303, damage suits, are adequate?

Mr. ELLIOTT. No. I am not blaming the Labor Board, because they are doing the best job they can. But they have a number of situations under the act where they are required to act expeditiously and they cannot act expeditiously at the same time on all of them. The workload of the Board necessitates what we consider an unreasonable delay.

Mr. POLLITT. What do you have now when there is secondary picketing against a nonprofit hospital?

Mr. ELLIOTT. The procedure would be to file a charge with the Board against the union.

Mr. POLLITT. You are nonprofit. You are not covered.

Mr. ELLIOTT. We have another person that is.

Mr. POLLITT. So you can go after the unions, but if you violate the act they cannot go after you?

Mr. ELLIOTT. That is right.

Mr. THOMPSON. That is a nice situation to be in. I don't blame you for wanting to keep it that way. You have them under your thumb, why let them out?

Mr. ELLIOTT. The act allows any person to file. The problem we are pointing out is that the mere procedure is, if this act is extended, that the hospital files a charge with the Labor Board. With that charge it must also file a request for expedited investigation, and for a temporary injunction. The Board will then investigate the merits of that charge. The mere fact of Board understaffing, and I think there has been testimony in the past to the tremendous increase in case-load that the Board is suffering, the mere problems of staffing require the Board to have a delay in just investigating.

After the Board conducts the investigation, then they set down the charge on their agenda within the internal regional office. Then the agenda will determine whether there is merit with the charge. Then the regional office, in order to get authority to get a temporary injunction, must go to the General Counsel in Washington and get authority from him to file. The delays are unavoidable.

Mr. POLLITT. Thank you.

Mr. THOMPSON. Thank you very much, gentlemen. We have no further comments.

Dr. GEHRIG. We appreciate your providing us with the opportunity. We realize we have a difference of opinion in terms of attitude.

I would like to say, from the standpoint of America's health care community, we have found you very supportive of vital programs to improve health care for all our citizens. We do appreciate that, and really we appreciate but don't particularly enjoy the fact that we sit on opposite sides today. Both very sincerely, I am sure.

Mr. THOMPSON. Thank you very much.

Our third witness, Mr. Norman Metzger, is familiar to this subcommittee and a leading expert in the field. I might add, Mr. Metzger, I read virtually all of your most recent book you were so kind to send me, "Labor-Management Relations in the Hospital Service Industry." I found it to be superb. I was glad to see Anne Sommers' introduction.

STATEMENT OF NORMAN METZGER, ON BEHALF OF THE LEAGUE OF VOLUNTARY HOSPITALS AND HOMES OF NEW YORK, THE ASSOCIATION OF HOSPITAL PERSONNEL ADMINISTRATORS OF GREATER NEW YORK, THE HOSPITAL ASSOCIATION OF NEW YORK STATE, AND THE GREATER NEW YORK HOSPITAL ASSOCIATION, ACCOMPANIED BY MORTON M. MANEKER, ATTORNEY

Mr. METZGER. My coauthor is here—Dr. Pointer.

I am here in a double capacity, if you will. I am representing the League of Voluntary Hospitals of New York City and the Association of Hospital Personnel Administrators of Greater New York in one statement, and I am representing the Hospital Association of New York State and the Greater New York Hospital Association in another statement. Now, I have prepared both statements. You have them in front of you.

I would like to identify myself and then, at your pleasure, either read them, my preference, but I don't want to impose upon you, or you can just ask questions.

Mr. THOMPSON. Your preference is to read them?

Mr. METZGER. No.

Mr. THOMPSON. Without objection, both statements will be made a part of the record at this point, then you may summarize.

[The statements referred to follow:]

STATEMENT BY NORMAN METZGER, ON BEHALF OF THE LEAGUE OF VOLUNTARY HOSPITALS AND HOMES OF NEW YORK AND THE ASSOCIATION OF HOSPITAL PERSONNEL ADMINISTRATORS OF GREATER NEW YORK

Chairman Thompson, members of Congress, ladies and gentlemen, thank you for the opportunity to appear here today to address myself again to the proposition that the exemption of voluntary, non-profit hospitals from the provisions of the National Labor Relations Act should be rescinded.

I am Norman Metzger and I speak to you from the experience of a quarter of a century in the labor arena, mostly in the health services sector. I am Vice-President for Personnel of the Mount Sinai Medical Center in New York City and Associate Professor of Administrative Medicine at the Mount Sinai School of Medicine and I am on the faculties in hospital administration at Columbia University and the City University of New York. I am co-author with Dr. Dennis D. Pointer of "Labor Management Relations in the Health Services Industry: Theory and Practice," a study in depth of current problems to which I shall refer. It was published in 1972.

I speak to you now on behalf of the League of Voluntary Hospitals and Homes of New York, of which I am a director and past President and on behalf of the Association of Hospital Personnel Administrators of which I am the Chairman of its Legislative Committee and past President.

The League is the bargaining representative for 33 voluntary hospitals and homes in New York City which, collectively, operate 49 separate institutions and employ over 60,000 employees, more than half of whom are represented by various labor unions. Besides service to patients in some 15,000 beds, our member institutions provide extensive out-patient services and are responsible for some staffing with a large component of unionized employees under contracts at ten New York City municipal hospitals.

The Association of Hospital Personnel Administrators of Greater New York has approximately 200 members who establish and administer the personnel and labor relations policies for over 100 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 hospitals have a total of over 40,000 beds, employ in excess of 100,000 people and annually admit almost a million patients for treatment and care.

Each of these hospitals is in interstate commerce and many of them treat patients who have come from every State of the United States and a host of foreign nations.

With me is Mr. Morton Maneker, an experienced labor attorney active in hospital matters, and a member of the New York City firm of Proskauer, Rose, Goetz & Mendelsohn. At the conclusion of my testimony, we will be pleased to answer any questions the Committee may have.

Part of what I am here to tell you you heard from me seventeen months ago. Most of it, however, is new and what I repeat are self-evident truths which become increasingly urgent as union organization in voluntary hospitals proliferates at an accelerating rate with accompanying strife and chaos to the detriment of hospitalized patients throughout the United States.

This rapid growth is unionization is the crux of the problem. It is the experience of voluntary hospitals nationally and, certainly, our painful experience in New York City, that the greatest difficulties in labor-management relations occur during the organizational—that is, the recognition—process and not in the processes of negotiating and enforcing contracts with established unions of our employees.

I should like to emphasize that the greatest disruption occurs during the unionization effort, not with the employees after they have become unionized. If the theory behind excluding voluntary hospitals from the provisions of the National Labor Relations Act was to inhibit unionization, and if it ever had any validity, it has become an unworkable, obsolete concept.

The facts, which are published and which are contained in my book, support this contention utterly. In 1967, 21 per cent of all hospitals facing organizational

efforts by their employees experienced work stoppages or other forms of disruption as against 13 per cent for hospitals with labor contracts. It is easy to understand that however strenuously a hospital administration may resist organizational activity, once it becomes a fait accompli, the relationship proceeds more amicably.

Enactment of H.R. 1236, in my estimation, would recognize an inevitability and provide for a system of order and reason where now there is, simply, chaos. It is primarily for this reason, out of deep concern of hospital management with the need for change, that I cross from my side of the negotiating table to urge that this bill become law within the shortest possible time.

Bearing in mind that there always is a third party at interest in conflicts between hospital managements and employees—that is, the patient who, unlike other consumers, is a “captive”—I ask what logic allows the inequity of the exclusion of non-profit voluntary hospitals from the provisions of the National Labor Relations Act to continue? We are the largest component of what is the nation's most important industry, no less than its second largest, perhaps its largest, and certainly its most complex. With increasing federal concern over health care delivery, why should our employees be deprived of a mechanism for the orderly exercise of their right to organize? And, why should not our industry be entitled to the same protection under the National Labor Relations Act as, say, General Electric or General Motors?

Certainly it is a more prudent avenue than pursuing the chimerical idea that by denying them a systematic procedure you are stifling their desire or their will to organize. I foresee, conservatively, that by mid-decade 25 per cent of all hospitals in the United States will be organized. And, since it will be accomplished, it is certainly preferable that it be done in relative peace rather than in hostility, within the context of tested procedures now available to most of the workers and employers in our country.

Because the National Labor Relations Act presently excludes not-for-profit hospitals, the established and tested standards contained in that Act for relations between such employers and their employees are not available to our industry.

Besides the growing problem of recognition, hospital administration faces two other dilemmas in labor relations which could be solved or, at least, ameliorated by enactment of H.R. 1236 and I should like to touch just briefly on those.

The National Labor Relations Board has demonstrated a reasonable and workable approach to the unique problems of bargaining units in profit-making hospitals, profit-making nursing homes and, in recent years, to nonprofit, long-term care facilities, including nursing homes, over which the Board now exercises jurisdiction. Thus, the problem of balancing the desires of groups of employees with the necessity of avoiding over-fragmentation of hospitals with a multiplicity of unions is particularly within the existing expertise of the Board. No special provisions need be made in the Act, and no special amendments need be considered to accommodate this area of concern.

The problem of resolving possible impasses in bargaining between voluntary hospitals and unions of their employees is a subject which generates concern, and much emotionalism and rhetoric. This Committee has or will probably hear suggestions for extensive and far reaching amendment of this bill to deal with that problem. Proposals have been offered to outlaw strikes and impose compulsory arbitration.

I do not subscribe to such a philosophy, and believe there are better alternatives, more likely to bring order into what is now chaos, and that such provisions are, at least, premature.

Regardless of what the long range answer, legislative or administrative, may be to this problem, the primary purpose of H.R. 1236 will undoubtedly be thwarted by amendment in this vein. It would be naive not to recognize that the support by organized labor for this simple and desirable amendment of the National Labor Relations Act will disappear if substantial additional amendments are considered. Opponents of this bill are well aware of this political fact of life.

Furthermore, the various state demonstrate a great dichotomy on who is included and who is excluded from their labor laws and, therefore, national legislation is imperative to create a systematic procedure in this major industry. I will have more to say on the state laws in a few minutes.

As I emphasized before, most of the strife is in the pre-unionization period, during organization and the campaign for recognition, and not after the union has been established and is negotiating. Therefore, until the Congress and the voluntary hospitals have had some experience under the proposed H.R. 1236, it would not be appropriate to apply such a methodology.

It is an easily defensible doctrine that hospital services are just as critical to the health and security of a community as transportation, and the law *now* has provisions for mediation. These, more frequently than not, suffice to produce agreement and avert stoppages and we believe that all hospitals—non-profit hospitals included—should come under these provisions of the law. In time, the existing procedures for handling National Emergencies probably will provide the most workable model for handling hospital bargaining impasses.

In New York State, we have had a law barring strikes of hospital workers and providing for compulsory arbitration, but, regretfully, I cannot tell you that the existence of that law has been too helpful in our day-to-day dealings with unions and I have no reason to believe that such a provision in the national law would be any more effective.

Finally, to recapitulate, our employees have and are exercising the legal right to participate in collective activity. Mechanisms insuring, protecting and controlling that process in the voluntary hospital sector of the industry would substantially free us from the use of coercion as an instrument and technique. Thus, it would reduce the incidence of labor conflict and erase many inequities forced on hospital managements by antiquated state labor legislation.

For these reasons primarily, the League of Voluntary Hospitals and Homes of New York and the Association of Hospital Personnel Administrators of Greater New York strongly favor prompt enactment of H.R. 1236.

In addition, on behalf of the Hospital Association of New York State and the Greater New York Hospital Association, I would like to offer the following:

STATEMENT BY NORMAN METZGER, ON BEHALF OF THE HOSPITAL ASSOCIATION OF NEW YORK STATE AND THE GREATER NEW YORK HOSPITAL ASSOCIATION

The Hospital Association of New York State, with its headquarters in Albany, includes in its membership all of the voluntary hospitals throughout the entire State of New York. It performs for its membership services similar to those performed by the Greater New York Hospital Association, in New York City, which is a coordinating agency of all the major voluntary non-profit hospitals, long term and extended care facilities and all the municipal hospitals in the metropolitan area. The Association is dedicated to serving the health and welfare needs of the community. It seeks to advance the interest 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.

After careful study of the unique needs of our member hospitals, the Associations have come to the conclusion that their best interests in New York—and this means the best interest of the many thousands of patients who look to our member institutions for care—will be served by passage of H.R. 1236, 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 characterized the relationships between management and labor. That experience includes litigation, negotiation, work stoppages, picketing, collective bargaining and contract administration.

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 two Associations to appear before you today. My purpose is to help persuade you to act favorably on H.R. 1236 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 briefly illustrate:

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 had long been recognized. Hospital management requires the uninterrupted cooperation and undivided commitment of supervisory personnel at all times in order to serve the hospital's crucial responsibility for the well-being and, in many cases, the very lives of the patients entrusted to their care.

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 December, 1972. 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 made 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 election, 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 of conducting an election, whereas the National Labor Relations Act requires an interest showing of at least 30 per cent. 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.

For these reasons, therefore I hope your honorable body will act to bring about this essential change in the provisions of the National Labor Relations Act.

Mr. METZGER. Fine. I am Norman Metzger. I speak from the experience of 25 years in the labor arena. Most of that has been spent in the health sector. I am vice-president for personnel and labor relations at the Mount Sinai Medical Center. We have some 4,000 of our employees in various unions. I am also an associate professor of administrative medicine at the Mount Sinai School of Medicine, an adjunct associate professor at the City University, and a professor on the faculty of Columbia University on their graduate program of hospital administration.

As you kindly pointed out, I am the co-author, with Dennis Pointer, of a book which deals exactly with what you have been talking about. In fact, two of the chapters have a great deal of import to this discussion. One is incidence of recognitional strikes vis-a-vis the strikes over contract terms.

I don't want to burden you with the details. We maintain—Dr. Pointer and myself—that the facts bear out that most of the strikes are recognitional in character. Therefore, from that flows the fact that, if we had an orderly procedure throughout the country, we would diminish this major problem.

Second, Dr. Pointer and I wrote an article that I refer you to—in fact you have it and I have it in my hand—on the whole situation of work stoppages in the hospital industry, a preliminary profile analysis.

Mr. THOMPSON. By unanimous consent, it will be included in the record.

[The documents referred to follow:]

TOWARD A NATIONAL HOSPITAL LABOR RELATIONS POLICY: AN EXAMINATION OF LEGISLATIVE EXEMPTION

(By Dennis D. Pointer, Ph. D.)

Employees of a voluntary, non-profit hospital, due to the nature of their employment, are expected to maintain high levels of professionalism and efficiency. At the same time, they receive no reciprocal, administrative protection of employment rights, wages, or other job aspects in comparison to those normally enjoyed by unionized employees. Dennis D. Pointer is an Assistant Professor in the Graduate Program in Health Care Administration at the City University of New York and an Instructor in the Department of Administrative Medicine at the Mount Sinai Medical School.

Public policy toward the collective rights of employee groups and the industrial relations of management has become increasingly complex and detailed since the passage of this nation's first comprehensive labor law in 1935. As union organization has both broadened its membership base and increased its penetration in American society, government by statute, court decisions and executive order has been deeply and irreversibly ingrained into the process of industrial relations. Until recently, however, government involvement has generally been limited to the industrial sector of the economy. Legislation dealing with the protection and systematic control of collective employee organization activity has usually excluded governments themselves, be they federal, state, or local, and institutions considered to be eleemosynary in character.

FEDERAL LABOR LEGISLATION

The generation of labor legislation at the federal level has generally been a reaction to problem situations either real or imagined. For example the Norris-LaGuardia Act was a direct response to the diversity of judge-made law and the extremely repressive use of the injunction and the yellow dog contract. The Wagner Act, though slightly more prescriptive than restrictive, stemmed from a desire to foster union organization and collective bargaining, thereby mitigating in some ways the effect of the Depression, and to reduce the incidence and impact of recognition strikes. The passage of the Taft-Hartley Act was directly associated with the occurrence of wide spread strikes after the close of World War II and the perceived need to establish balance in labor policy between labor and management rights. Finally, the Landrum-Griffin Act was stimulated by disclosures of the misuse of union funds by leadership and certain unethical practices on the part of managements.

Because of the problem-response nature of labor legislation generation, public policy regarding industrial relations in health care facilities has generally been neglected. Prior to the mid-1960's, unions had little impact on the hospital industry. As late as 1967, fewer than 8 percent of the nation's hospitals had contracts with union organizations, and only 2 percent of the hospitals had experienced any type of labor conflict.¹ Public policy and subsequent legal structures were not required to regulate and/or protect activity that neither existed nor had impact on any wide scale.

HOSPITAL LABOR POLICY

As union organizational activity in hospitals increased, much labor policy was modified to adjust for this development. Proprietary hospitals were included under the jurisdiction of the Taft-Hartley Act due to several National Labor Relations Board decisions in the early 1960's. Federal hospital employees were granted organizational and collective negotiation rights by Executive Order 10988, issued in 1962 and later modified in 1969.² The collective organization rights of state

¹ Dennis D. Pointer and Harry Graham, "Employee Organization Requests for Recognition, Collective Bargaining Agreement Negotiation and Work Stoppages in Hospitals," *Monthly Labor Review*, Vol. 44 (May, 1971), pp. 54-58.

² For a more complete discussion of the labor law status of various hospital ownership patterns, see: Dennis D. Pointer, "The Federal Labor Law Status of Health Care Facilities," *LABOR LAW JOURNAL*, Vol. 22, No. 5, pp. 278-286.

and local publicly-employed hospital workers have been increasingly protected during the latter 1960's; by August, 1969, thirty-six states insured the bargaining rights of at least some portion of their employees.³

Public policy regarding the labor-management relations of voluntary, non-profit hospitals is far less developed. The employees of such facilities are specifically excluded from the coverage of the Taft-Hartley Act. Although eighteen states have enacted comprehensive labor legislation, only nine jurisdictions protect and regulate the collective organizational and contract negotiation activity of at least some segment of the employees of voluntary hospitals. Therefore, in forty-one states, voluntary, nonprofit hospitals are in no way required to recognize or bargain collectively with their employees. The absence of legislation protecting voluntary hospital employees does not make collective activity illegal; rather such activity is left unregulated and union and management disputants may battle freely over the acceptance or rejection of collective bargaining. In essence, the employees of voluntary hospitals and the hospitals themselves are placed in a legal "no man's land"—guidelines for behavior are not specified.

Voluntary facilities constitute the largest single sector of the hospital industry, representing 48 percent of the total number of hospitals, 66 percent of the admissions, and 54 percent of the total industry payroll expense.⁴ Additionally, collective employee organizational activity is far greater in voluntary hospitals than in any other control and ownership category. In 1968, voluntary, non-profit hospitals received 52 percent of the total number of recognition requests, had 54 percent of the negotiated contracts and accounted for 57 percent of the total number of hospitals that experienced a work stoppage.⁵

Thus, structured public policy regarding labor relations is virtually nonexistent in that sector of the hospital industry which is the largest and, by all indications, appears to be attracting the greatest amount of organizational activity on the part of unions. However, channels for changing policy are emerging. The House of Representatives' Committee on Education and Labor is presently considering H.R. 11357 which would amend the Taft-Hartley Act to include within its jurisdiction the employees of voluntary, nonprofit hospitals. It is the objective of this article to examine the logic of voluntary hospital exemption from the nation's labor legislation and that exemption's impact upon the quality of employee-employer relations and labor conflict. Public policy is inextricably linked to the development and behavior of the institutions it helps to create and subsequently, through enacted legislation, attempts to regulate. A dynamically changing environment stimulates the need to critically evaluate the structure underlying previously delineated policy so that such policy can be reformulated in the light of evolving demands.

THE [II] LOGIC OF EXEMPTION

"... representational issues are likely to remain prominent ones, since large and growing groups of the labor force are not unionized . . . Indeed, some of the most troublesome strife in recent years has arisen among hospital workers (who) . . . are unprotected under present labor legislation in their union activity or not given access to machinery for determining their wishes about collective bargaining."⁶

Generally, the employees of voluntary, nonprofit hospitals have been excluded from the provisions of labor legislation (at both the state and federal level) on the basis of any one or a combination of the following arguments:

- 1.—The institution is a hospital and the operation of such organizations are of such importance that their exemption is indicated.⁷
- 2.—The organization is nonprofit in character.⁸
- 3.—The facility is semipublic in nature and engages in functions that if not executed would have to be assumed by the government.⁹

³ Advisory Commission on Intergovernmental Relations, *Labor-Management Policies for State and Local Government* (Washington, D.C.: Government Printing Office, 1969), pp. 12-24, *passim*.

⁴ "Guide Issue," *Hospitals*, Vol. 45 (August 1, 1971), p. 462.

⁵ Dennis D. Pointer, "Employee Organization in Health Care Facilities: An Exploratory Analysis and Evaluation," (unpublished Ph.D. thesis, the University of Iowa, 1971), see especially Chapters VI and VII.

⁶ *The Public Interest in National Labor Policy* (New York: The Committee for Economic Development, 1961), pp. 74-75.

⁷ *Society of New York Hospital v. Hanson*, 185 Misc. 937, 59 N.Y.S. 2d 91, 10 LC ¶ 62,965 (N.Y. Sup. Ct., 1945), aff'd, 272 App. Div. 998, 73 N.Y.S. 2d 835 (1st Dep't., 1947).

⁸ This argument was cited in *Central Dispensary and Emergency Hospital v. NLRB*, 145 F. 2d 852, 9 LC ¶ 62,400 (D.C. Cir., 1944), cert. denied 324 U.S. 847 (1945) and affirmed in *Jewish Hospital of Brooklyn v. John Doe*, 252 App. Div. 581, 300 N.Y. Supp. 1111, 1 LC ¶ 18,068 (2d Dep't., 1937).

⁹ *Western Pennsylvania Hospital v. Lichter*, 340 Pa. 382, 17 A. 2d 206, 3 LC ¶ 60,292 (1941).

4.—The charitable character of such organizations is sufficient assurance of fair-dealing with employees to make the regulation of labor relations unnecessary.¹⁰

5.—The institution does not fall within the definition of the jurisdiction conferring words of the commerce clause of the Constitution or the specific labor statute.¹¹

I find the logic of these arguments taken separately or together confusing. Let us examine each statement in turn.

CRITICAL SERVICES

The first argument contends that hospitals are unusual institutions providing critical services that if curtailed or seriously disrupted would be deleterious to the general public health and safety; few indeed would deny the plausibility of this statement. However, the rights to organize collectively and bargain with management are extended to the employees of proprietary, state and federal hospitals as well as to an increasing proportion of firemen, policemen and public school teachers.¹² Are the services provided by these individuals and the institutions in which they are employed any less critical than the functions performed by voluntary hospitals?

NONPROFIT NATURE

Due to the fact that, in most cases, only voluntary hospitals are excluded from federal labor legislation and the state statutes modeled after it, the jurisdictional touchstone for these exemptions appears to stem from the non-profit status of voluntary hospitals rather than the nature of services provided. Indeed, the wording of that section of the Taft-Hartley Act that excludes certain types of hospitals from coverage makes no mention of function as a basis for exemption but rather states that the Act:

“ . . . shall not include . . . , 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 . . . ”¹³

Thus the basis for the exemption is clearly the nonprofit character of the hospital. It is extremely important to observe that exempted health care facilities are not excluded from the jurisdiction of the Act because of their eleemosynary character (that is, because they are charitable). The Act makes no mention of the charitable nature of voluntary hospitals as the criteria for specific exclusion.¹⁴

The nonprofit nature of voluntary hospitals appears to be a strange criteria upon which to establish the exclusion of these facilities from the jurisdiction of national labor legislation. Indeed, in several decisions, the National Labor Relations Board (NLRB) has held that the nonprofit character of an enterprise is not sufficient grounds to warrant exclusion from the Taft-Hartley Act.¹⁵ This author is unable to cite any cases holding that the power conferred on Congress by the commerce clause of the Constitution is in any way limited to those organizations having a motive of financial gain.¹⁶ Nonprofit hospitals enter into contracts with many firms whose activities are in every sense of the term “commercial.” Transactions with such enterprises do not lose their commercial character even though the voluntary hospital has a motive other than profit. The first case dealing with the labor law status of a voluntary hospital under the Wagner Act noted:

“The commerce clause looks to the activities that are carried on, rather than to the motives. The jurisdiction conferring words of the National Labor Relations

¹⁰ *Trustees of Columbia University v. Herzog*, 269 App. Div. 24, 9 LC ¶ 62,578; *affd.*, 295 N.Y. 605 (1945).

¹¹ This argument was forwarded in *Central Dispensary and Emergency Hospital v. NLRB*, cited at footnote 8. There is some indication that this argument provided the primary rationale for excluding voluntary hospitals from the jurisdiction of the Taft-Hartley Act; Note: 93 *Congressional Record* (Daily), May 12, 1947.

¹² The union organization of “critical function” public employees appears to be progressing at a rather rapid rate. Note the observations of Jack Stieber, “Collective Bargaining in the Public Sector” in *Challenges to Collective Bargaining*, ed. by Lloyd Ulman (Englewood Cliffs, N.J.: Prentice-Hall, Inc., 1967), pp. 65-88.

¹³ National Labor Relations Act of 1947, Public Law 101, 80th Congress, 1st Session as amended by Public Law 188, 82nd Congress, Section 2(2).

¹⁴ The National Labor Relations Board has in several instances excluded charitable, nonprofit organizations from the Act. However, the fact still remains that this was not the express logic for the exemption of voluntary hospitals in Section 2(2).

¹⁵ For example see: *Walnut Hills Country Club*, 145 NLRB at 81, 1963 CCH NLRB ¶ 12,723. This general principle was also forwarded regarding the status of nonprofit organizations under the Wagner Act; see: *NLRB v. Polish National Alliance*, 332 U.S. 643, 8 LC ¶ 51,182, and *Christian Board of Publications v. NLRB*, 113 F. 2d 678, 2 LC ¶ 18,738 (D.C. Cir., 1942).

¹⁶ The notion that enterprises nonprofit in character are not exempted from legislation incipient in the commerce clause can be traced back to the mid-1800's; for example see: *Caminetti v. U.S.*, 242 U.S. 470. In this case the Supreme Court noted that the use of the word “traffic” in the title of the White Slave Traffic Act did not indicate that Congress intended that the Act was to apply only to transportation undertaken with a profit motive.

Act, "trade, traffic, commerce, transportation or communication" are words of activity, and when used together do not give a connotation of essential motive." ¹⁷

SEMPUBLIC CHARACTER

The third argument utilized to gain an exemption of voluntary hospitals from labor legislation is that such facilities are actually semipublic in character in that if for some reason their functions were curtailed or eliminated completely, these functions would have to be carried out by the state. Most state constitutions note that it is the duty of the political subdivision to protect the "public health and safety." While voluntary hospital employees are considered to be providing a quasi-governmental service, they possess none of the benefits that consideration should warrant. That is, the employees of voluntary hospitals excluded from the jurisdiction of labor laws through the quasi-governmental function argument are provided with no benefits that would "subsidize" them for that exclusion. Such employees are not covered by guaranteed tenure, promotion review boards, grievance appeal panels, job security provisions or adequately developed pension plans common among civil and state service employment.

CHARITABLENESS ASSURES FAIRNESS

Voluntary hospitals are also exempted from labor legislation through the rationale that they are charitable institutions and that because of this fact they will treat their employees equitably as a matter of course. Traditionally this has not been the case. Burling et al.¹⁸ and Coser¹⁹ note that historically, hospital employees have been underpaid, overworked and often treated unfairly as a rule rather than as an exception. Hepner et al. observes that personnel practices in hospitals are generally archaic and that employees suffer the consequences.²⁰ Data indicate that both fringe benefits²¹ and rates of pay²² are much lower in the hospital industry than they are in other sectors of the economy. It appears that the employees of voluntary hospitals are expected to participate in assuming a portion of their employers' charitable purpose rather than benefiting from that charity. It seems strange that the employees of voluntary hospitals should be expected, in some instances, to subsidize the health care bill of the community which they serve while the charitable nature of that institution is often used as the justification for withholding collective bargaining rights.

NONPARTICIPANT IN INTERSTATE COMMERCE

The final argument forwarded to exclude the employees of voluntary hospitals from the coverage of labor legislation is that the institution in which these individuals are employed is not considered to be in interstate commerce.²³ However, in *NLRB v. Jones and Laughlin Steel Corporation*, the Supreme Court noted that:

"Although activities may be intrastate in character considered separately, if they have such a close relation to interstate commerce that their control is essential or appropriate to protect that commerce from burdens and obstructions, Congress cannot be denied the power to exercise that control." ²⁴

Thus the Court reasons that to be included under the auspices of the nation's labor law, an enterprise need not be in interstate commerce per se but rather need only affect that commerce. The *Central Dispensary and Emergency Hospital* case, decided by a federal court, observes that the activities of a nonprofit, voluntary hospital can be considered both in and affecting interstate commerce.²⁵ Additionally, several recent decisions by the National Labor Relations Board note that certain types of health care facilities can be considered to be in and affecting

¹⁷ *Central Dispensary and Emergency Hospital*, cited in 44 NLRB 533, at 540; see also: *Central Dispensary and Emergency Hospital v. NLRB*, cited at footnote 8.

¹⁸ Temple Burling, et al., *The Give and Take in Hospitals: A Study of Human Organization in Hospitals* (New York: G. P. Putnam's Sons, 1956), p. 162.

¹⁹ Rose L. Coser, "Alienation and the Social Structure: A Case Analysis of a Hospital," in *The Hospital in Modern Society*, ed. by Elliot Freidson (Toronto, Canada: Collier-MacMillan, Ltd., 1963), pp. 231-265.

²⁰ James O. Hepner, et al., *Personnel Administration and Labor Relations in Health Care Facilities* (St. Louis, Missouri: C. V. Mosby and Sons, Inc., 1969), p. 3.

²¹ Stephen Franklin, "Fringe Benefits, Hospitals and Unions," (unpublished Master's thesis, the University of Iowa, 1968), especially Chapter IV.

²² The American Hospital Association has noted that "despite . . . substantial salary increases over the last two years, hospital workers remain among the lowest paid groups in the national economy." Data indicates that the average hospital wage is about 75 per cent of the average manufacturing wage. See: "Guide Issue," *Hospitals*, Vol. 42 (August 1, 1968).

²³ See for example: Comments of Mr. Tydings, 93 *Congressional Record* (Daily), May 12, 1947. Here Senator Tydings states that voluntary hospitals should be excluded from the provisions of the Taft-Hartley Act because "... a hospital is a local institution." Senator Tyding's amendment to exempt voluntary hospitals from coverage was subsequently included in Section 2(2) of the Act.

²⁴ *National Labor Relations Board v. Jones and Laughlin Steel Corporation*, 301 U.S. 1, 1 LC ¶ 17,017 (1937).

²⁵ See footnote 17.

interstate commerce if their gross annual revenue exceeds a specified dollar amount.²⁶

THE RIGHT TO ORGANIZE?

I hold that orderly processes for determining representation questions should be created to cover the employees of nonprofit hospitals. That is, the rights of voluntary hospital employees to engage in collective organization and to bargain with their respective employers should be guaranteed and protected, as they are for other segments of the labor force. The principle of self determination warrants consideration because it extends into the employee-employer relationship a procedure that is in every way congruent with our democratic values. Additionally, it facilitates the mitigation of an undesirable alternative: a decision for or against collective bargaining based solely on management's or union's power to coerce.

"There is no reason why these employees (hospital workers) should not be free from coercion . . . if they choose to consider unionization and every reason to feel that determination of their wishes about representation through the procedure of secret ballot is preferable to a procedure solely involving pressure tactics either for or against union recognition."²⁷

The title of this section "The Right to Organize?" may appear a bit presumptuous in that the question may be forwarded (and quite properly so): is the act of collective organization a right? Indeed, in the historical sense, collective organization and subsequent contract negotiation activity were considered privileges.²⁸ However, on January 17, 1969, the Eighth U.S. Court of Appeals (St. Louis, Missouri) handed down a decision that could well establish a significant judicial precedent regarding the issue of whether belonging to a union is a right or a privilege.²⁹

In this case, *Gage v. Woodward*, two employees of the North Platte, Nebraska Street Department alleged that they had been fired because of their union affiliation. The principal issue in the litigation centered on whether the appellants had a right of action for damages and injunctive relief under Section 1 of the Civil Rights Act of 1871.³⁰ This issue in turn revolved around the question of whether the employees had a constitutional right to belong to a union. Based on two precedents,³¹ the Court unanimously ruled that the First Amendment right of association protected the option to join a union. The Court also observed that discharging an employee because of union affiliation was an abridgement of due process guaranteed by the Fourteenth Amendment.³²

If it is agreed that the act of collective organization is a right, then that right should be operationalized for all segments of the labor force, including the employees of voluntary hospitals. It must be stressed that public policy intent in the absence of specific legislation denoting and controlling that intent is sterile. The National Industrial Recovery Act passed in 1933, included Section 7(a) which guaranteed employees the right to organize. However, the provision lost much of its significance because no control and protection mechanisms were provided (that is, sections similar to the unfair labor practices stipulated in the Wagner and Taft-Hartley Acts). Here public policy was delineated, although no procedures were established to insure that that policy would be executed.³³ Thus it appears that

²⁶ Note: *Medical Center Hospital and Building Service Employees' Union, Local 122*, 168 NLRB 266, 1968-1 CCH NLRB ¶ 21,915; and *University Nursing Home, Inc.*, 168 NLRB 263, 1968-1 CCH NLRB ¶ 21,916.

²⁷ See footnote 6, at p. 77.

²⁸ Kurt L. Hanslowe, *The Emerging Law of Labor Relations in Public Employment* (Ithaca, New York: New York State School of Industrial and Labor Relations at Cornell, October, 1967), p. 11.

²⁹ This ruling deals specifically with public employees, although the legal rationale provided could equally well be applied to other sectors of the economy.

³⁰ 42 U.S.C. 1983. This section notes that: "Every person who, under color of any statute, ordinance, regulation, custom or usage, of any state or territory, subjects or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity or other proper proceeding for redress."

³¹ *Thomas v. Collins*, 323 U.S. 516, 9 LC ¶ 51,192 (1945) and *McLaughlin v. Tilendis*, 398 F.2d 287, 59 LC ¶ 13,219 (7th Cir., 1968).

³² The facts of this case were extracted from: Advisory Commission on Intergovernmental Relations, *Labor-Management Policies for State and Local Government* (Washington, D.C.: Government Printing Office, 1969), pp. 56-58, *passim*.

³³ Phillip Taft, *Organized Labor in American History* (New York: Harper and Row, Publishers, 1964), pp. 416-423, *passim*.

once a consensus regarding public policy has been determined, legislation should be enacted or amended to solidify that policy rather than relying on the intention of individuals or groups to conform.

THE RIGHT TO STRIKE?

The act of collective employee organization (that is, gaining representation) is a means rather than an end. Organization without collective bargaining is meaningless as collective bargaining without work stoppages or the threat of stoppages is impotent.³⁴ Once the right of voluntary hospital employees to organize is espoused, the subsequent issue surrounding labor conflict gains prominence. Initial evidence indicates that while hospital administrators are concerned about the effect of unionization on increased operating costs and decreased management prerogatives, they express more concern over the effect of potential work stoppages on the hospital's ability to provide services.³⁵ While this concern may be valid for the individual hospital, it may be mitigated when one focuses on the aggregate of all hospitals (the industry as a whole).

I contend that the creation of mechanisms to determine representation and the encouragement and protection of the process of collective bargaining in voluntary hospitals would reduce both the number and the severity of work stoppages in these facilities due to recognition and terms of employment disputes. Indeed, the intent of the Taft-Hartley Act (and the Wagner Act which it amended) was to do just that in the industrial sector. Section 1(b) of the Act, denoting a declaration of public policy and the purpose of the legislation states:

"Industrial strife which interferes with the normal flow of commerce . . . can be avoided or substantially minimized if employers, employees and labor organizations each recognize under the law one another's legitimate rights in their relations with each other . . ."

It is the purpose and policy of this Act, in order to promote the full flow of commerce, to prescribe the legitimate rights of both employees and employers in their relations affecting commerce, to provide orderly and peaceful procedures for preventing the interference by either with the legitimate rights of the other . . .³⁶

Data indicates that the incidence and impact of work stoppages in the industrial sector has decreased rather markedly from the ten-year period preceding 1935 (when the Wagner Act was passed) to the present.³⁷ Thus, rudimentary analysis would tend to indicate that the intent of the Act has, at least partially, been fulfilled. This longitudinal reduction in work stoppage impact could be hypothesized to be the result of union-management relations becoming more mature over time due to the mandated necessity of mutual interaction. Managements and unions appear to have increasingly learned to adapt to each other and become progressively more sophisticated in the manner in which they engage in the process of collective bargaining.³⁸

TAFT-HARTLEY EFFECT

Traditionally, strikes in the industrial sector have stemmed from four issues: union recognition, employee grievances, organizational jurisdiction and demands related to terms of employment. With the passage of the Wagner and Taft-Hartley Acts, work stoppages in the industrial sector due to the first three issues have been almost entirely eliminated.³⁹ Recognition disputes have been replaced by election procedures supervised by the National Labor Relations Board, conflict over grievances has been mitigated through the process of collective bargaining itself (that is, over 90 percent of all negotiated agreements provide for the arbitration

³⁴ Donald E. Cullen, *National Emergency Strikes* (Ithaca, New York: New York State School of Industrial and Labor Relations at Cornell, 1968), pp. 4-5.

³⁵ Michael Hynes, "A Measurement of the Responsiveness of the American Hospital Association to Its Membership," (unpublished master's thesis, the University of Iowa, 1969), data obtained from survey questionnaire but not incorporated into body of the thesis.

³⁶ Data compiled on work stoppage duration, frequency, participation, and loss. Rank order correlations (trend) varied from -.421 to -.128. Data extracted from *Handbook of Labor Statistics*, Bulletin No. 1666 (Washington, D.C.: Bureau of Labor Statistics, 1970), pp. 340-345, *passim*. A discussion of this topic is also provided in Neil W. Chamberlain and James Kuhn, *Collective Bargaining* (2nd ed.; New York: McGraw-Hill Book Company, 1965), pp. 397-399.

³⁷ Many labor scholars conclude that this evolution is indeed demonstrable and significant. See for example: W. Willard Wirtz, *Labor and the Public Interest* (New York: Harper and Row, Publishers, 1964), especially Chapter III; Joseph A. Beirne, *New Horizons for American Labor* (Washington, D.C.: Public Affairs Press, 1962), pp. 55-57; Richard A. Tester, *As Unions Mature* (Princeton, New Jersey: Princeton University Press, 1958), especially Chapter X; and Arnold R. Weber, "Stability and Change in the Structure of Collective Bargaining," in *Challenges to Collective Bargaining*, ed. by Lloyd Ulman (Englewood Cliffs, New Jersey: Prentice-Hall, Inc., 1967), pp. 13-36.

³⁸ A. Howard Myers, *Labor Law and Legislation* (4th ed.; Cincinnati, Ohio: Southwestern Publishing Company, 1968), pp. 172-179.

of grievance disputes), and jurisdictional conflict has been drastically reduced through the mechanisms outlined in Sections 8(b) (7) (A), 8(b) (7) (B) and 8(b) (7) (c) of the Labor-Management Relations Act.

What implications do these trends have with regard to the reduction of labor conflict in the voluntary hospital sector if such facilities were included under the jurisdiction of the Taft-Hartley Act?

First, it appears that the great proportion of labor conflict in the voluntary hospital industry is precipitated by issues other than terms and conditions of employment. Table I demonstrates that the impact of recognition strikes far exceeds the impact of work stoppages over terms and conditions of employment on the criteria of days of duration and man-days idle. Over twice as many man-days idle are experienced per work stoppage when the issue is recognition than when the issue is collective bargaining contract content. Thus it would appear that the foundation for much of the labor conflict in voluntary, nonprofit hospitals could be substantially eliminated through adoption of a mechanism that would determine recognition issues through election rather than coercion.

Second, it seems that there is little relationship between the amount of collective bargaining and the incidence of work stoppage in the hospital industry. Table II demonstrates that hospital size categories experiencing the greater increase in the number of negotiated contracts do not experience a similar increase in the number of work stoppages; in fact the relationship is negative. That is, there is an inverse relationship (Spearman rank order correlation = $-.08$) between percentage increase in collective bargaining activity and percentage change in work stoppage incidence. If recognition strikes were excluded from the percentage change in the number of work stoppages, the negative relationship would probably increase in strength. Additional investigation might substantiate that increased organizational activity in the hospital industry (both in the form of seeking recognition and negotiating contracts) may not necessarily lead to a proportional increase in work stoppages—in fact it may precipitate a decrease!

Initial, albeit rudimentary, analysis appears to indicate that the protection of recognition activities and the process of collective bargaining itself could foster conditions leading to a reduction of aggregate work stoppage impact in the hospital sector.

TABLE I.—DIFFERENTIAL IMPACT OF WORK STOPPAGES IN VOLUNTARY HOSPITALS BY TYPE OF PRECIPITATING ISSUE, 1968

Issue	Number of employees ¹	Duration ²	Man-days idle ³
Recognition.....	72.15	32.25	3,966.70
Terms of employment.....	158.30	15.40	1,841.50

¹ Mean number of employees involved per facility reporting a work stoppage.

² Mean number of days duration per facility reporting a work stoppage.

³ Mean number of man-days idle per facility reporting a work stoppage.

Source: Dennis D. Pointer, "Employee Organization in Health Care Facilities: An exploratory Analysis and Evaluation," (unpublished Ph. D. thesis, the University of Iowa, 1971), p. 382.

TABLE II.—COMPARISON OF PERCENTAGE CHANGE IN COLLECTIVE BARGAINING AGREEMENT NEGOTIATION AND INCIDENCE OF WORK STOPPAGES BY HOSPITAL SIZE, 1967-70

Hospital size (adult beds):	Percentage change in agreements negotiated ¹	Percentage change in work stoppage incidence ²
6 to 24.....	115	-67
25 to 49.....	108	-14
50 to 99.....	72	-33
100 to 199.....	71	-8
200 to 299.....	84	-41
300 to 399.....	69	-35
400 to 499.....	123	-39
500 plus.....	129	-69
Total.....	106	-13

¹ Percentage increase in the number of negotiated collective bargaining agreements.

² Percentage change in the incidence of work stoppages (number rather than impact).

Sources: Dennis D. Pointer, "Employee Organization in Health Care Facilities: An Exploratory Analysis and Evaluation," (unpublished Ph.D. thesis, the University of Iowa, 1971), ch. VI; and unpublished data (mimeo) from the American Hospital Association Annual Survey of Hospitals.

CONCLUSIONS

I have attempted to document the legal illogic forming the foundation for the exemption of voluntary hospitals from the jurisdiction of this nation's labor legislation. Additionally I have discussed the status of union organizational activity of an employee as a demonstratable legal right and the impact of mechanisms protecting recognition activity and collective bargaining in the incidence of work stoppages both in the industrial and hospital sectors. It is my opinion that:

- 1.—arguments forwarded for excluding voluntary hospitals from the jurisdiction of labor legislation are illogical and internally inconsistent;
- 2.—participation in a union organization is a legally demonstrable right;
- 3.—legislative protection of employee organizational activity in the voluntary hospital sector would reduce the utilization of coercion as a employee-employer relations technique;
- 4.—mechanisms insuring, protecting and controlling the process of employee organization recognition in the hospital industry would substantially mitigate the foundation for much labor conflict; and
- 5.—the process of collective bargaining itself would increase the sophistication of employee-management relations while not necessarily increasing the incidence of labor conflict.

In these instances I agree with the Presidential Advisory Commission on Labor when it states: "All members of this Committee are convinced that free collective bargaining should constitute the primary procedure by which the essential terms and conditions of employment shall be determined . . . When obstinate industrial disputes have occurred, involving strikes in important industries, there has been an inclination to question the efficacy of collective bargaining. Its record emerges, nonetheless, as one of outstanding progress within a single generation."³⁹

Perhaps the original notion to exclude voluntary hospitals from the coverage of the Taft-Hartley Act twenty-five years ago was laudable in that it was hoped that such action would forestall or completely eliminate the unionization of such facilities (and hence contribute to some social good). Employee organizational activity in hospitals is now a reality—approximately 11 per cent of all registered hospitals in the country are organized to some extent and the number is growing dramatically (data available indicate about a 30 percent increase per year). The need for enforceable, workable, uniform and equitable procedures of employee-employer relations in the nation's second largest industry is critical.

WORK STOPPAGES IN THE HOSPITAL INDUSTRY: A PRELIMINARY PROFILE AND ANALYSIS*

(Dennis D. Pointer, Ph.D., and Norman Metzger)

INTRODUCTION

Although trade unions have been representing individuals employed in the health services industry since the early portion of this century,¹ the assurgence of collective employee activity in hospitals from an isolated phenomenon to a movement of wide spread impact has occurred almost totally within the last decade.² Between 1961 and 1967 the proportion of hospitals which have negotiated collective bargaining agreements has more than doubled. In 1967 approximately 7 percent of all hospital employees were covered by negotiated agreements, data indicate that this figure might well approach 15 to 20 percent by 1975.³

One of the major considerations of hospital administrators, legislators and the consumer-public, when addressing the many faceted challenges of collective employee activity in health care facilities, is the threat of critical service disruption

³⁹ The President's Advisory Committee on Labor-Management Policy, *Collective Bargaining* (Washington, D.C.: Government Printing Office, 1962), p. 1.

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¹ Several unions were actively representing pharmacists and drug clerks in the late 1800's; source: "Twenty-Fifth Anniversary Issue," *1199 Drug News*, Vol. 24 (New York: Local 1199, Retail Drug Employees Union, 1957), pp. 3-7. The first published instance of union organization in a hospital is "Employees of Hospitals Have 5 State Unions," *San Francisco Chronicle*, June 18, 1919 (Xerox copy).

² Walter J. Gershenfeld, "Organization and Bargaining in Hospitals," *Monthly Labor Review*, Vol. 91 (July, 1968), pp. 51-62.

³ Data relating to the extent of recognition and collective bargaining agreement negotiation activity in hospitals presented here and elsewhere in this paper are extracted from the doctoral dissertation of the primary author. See: Dennis D. Pointer, "Employee Organization in Health Care Facilities: An Exploratory Analysis and Evaluation," (unpublished Ph.D. Thesis, The University of Iowa, 1971), especially Chapter VI.

due to labor-management conflict. Reservations regarding the extension of organizational and collective bargaining rights⁴ to hospital employees generally reduces to two connected arguments: (1) "the recognition of a union is a direct invitation to strikes,"⁵ and (2) "intolerable conditions would be created if critical hospital services were substantially curtailed or eliminated completely due to a strike."⁶

THREE VARIABLES TO EXAMINE DATA

While an examination of the incidence and impact of work stoppages in the hospital industry is crucial for the generation and subsequent evaluation of hospital labor policy, empirical data pertaining to this area are virtually nonexistent. Thus, it is the objective of the investigation presented here to provide a preliminary profile of work stoppages occurring in registered hospitals in the United States. To facilitate the analysis, work stoppage incidence and impact will be examined in terms of three structural variables: hospital control and ownership, size as measured by number of beds and geographic location.

The data for this study were gathered by the American Hospital Association in a two phase project conducted during 1968.⁷ In the initial stage of the survey all registered hospitals were mailed a postcard questionnaire designed to elicit whether they had experienced any form of collective employee activity (request for recognition, agreement negotiation and/or work stoppage) during 1967. Those facilities that responded affirmatively received the "1967 Survey of Collective Bargaining in Hospitals," the primary source of the data presented here. The useable response rates of the two survey instruments were 97.2 percent and 71.6 percent respectively. Sample correspondence analysis indicated that the return of the 1967 collective bargaining survey was representative of the population of hospitals that experienced collective employee activity during 1967.⁸

HOSPITAL CONTROL AND OWNERSHIP

In 1967, 2.0 percent of the nation's 7,172 hospitals experienced a work stoppage. As can be noted through an examination of Table 1, the incidence of strikes varied markedly by type of facility control and ownership. The percentage of hospitals that experienced work stoppages ranged from 2.6 percent of state and local facilities to 0.2 percent of federal hospitals. Fully 94.6 percent of the total number of work stoppages during the survey year occurred in voluntary or state and local government hospitals.

Statistical analysis indicated that the distribution of the number of hospitals that experienced work stoppages was dissimilar to the distribution of the total number of registered hospitals by type of control and ownership ($p < .05$). That is, work stoppage incidents occurred disproportionately across control category relative to the number of facilities in that category. Additionally, a test of contingency demonstrated that work stoppage incidence was significantly associated with hospital control and ownership pattern ($p < .05$).

⁴ Prior to 1960 collective employee activity was generally considered a privilege that a sovereign government or governmental subdivision could protect and regulate if it so chose; see Kurt J. Hanslowe, *The Emerging Law of Labor Relations in Public Employment* (Ithaca, New York: New York State School of Industrial and Labor Relations at Cornell, October, 1967), p. 11. However, *Gage v. Woodward*, a case heard in the Eighth U.S. Court of Appeals (January 17, 1969) has been interpreted as laying the foundation for the consideration of organizational activity as a legal right; see: Advisory Commission on Intergovernmental Relations, *Labor-Management Policies for State and Local Government* (Washington, D.C.: U.S. Government Printing Office, 1969), pp. 56-58, *passim*.

⁵ Martin R. Steinberg, "Unions and Voluntary Hospitals," *Hospital Management*, Vol. 87 (June, 1980), p. 25.

⁶ This argument has been used in several instances to deny hospital employees legal protection for collective activity; see for example: *Western Pennsylvania Hospital v. Lichter*, 340 Pa. 382, 17A, 2d 206 (1941), cited in 7 LRRM at 1132.

⁷ The authors would like to express their appreciation to the American Hospital Association and Jon D. Miller, Ph.D., former Director of the Bureau of Research Services, American Hospital Association for making this data available. An initial analysis of a portion of the data compiled by this project is presented in Jon D. Miller and Stephen M. Shortell, "Hospital Unionization: A Study of the Trends," *Hospitals*, Vol. 43 (August 16, 1969), pp. 67-73.

⁸ Author's note: Due to the presence of some sample erosion, comparisons evaluated in the context of all registered hospitals or the total number of employees will be underrepresented (i.e., on the conservative side). For the phase one instrument the sample return can be, for all practical purposes, considered as the population.

TABLE 1.—DISTRIBUTION OF WORK STOPPAGES BY TYPE OF HOSPITAL CONTROL AND OWNERSHIP

	Registered hospitals		Hospitals with work stoppages		Percent of classification with work stoppages
	Number	Percent	Number	Percent	
State and local.....	2,141	29.9	56	38.1	2.6
Voluntary.....	3,692	51.5	83	56.5	2.2
Proprietary.....	923	12.9	7	4.8	.8
Federal.....	416	5.8	1	.7	.2
Total.....	7,172		147		2.0

The incidence of work stoppages, except in the case of federal hospitals, is highly associated with the extent of collective employee activity (i.e., requests for recognition and collective bargaining agreement negotiation). For example, in state and local governmental and voluntary hospitals where the incidence of work stoppages is high (2.6 and 2.2 percent respectively experienced strikes), fully 6.0 percent of such facilities received recognition requests. On the other hand, in proprietary hospitals, only 1.4 percent received recognition requests, and less than 1 percent of the facilities experienced work stoppages. This analysis conforms with the observation of Kerr who states that labor conflict rarely occurs unless employees are formally organized.⁹ Spontaneous work stoppage activity in the absence of trade union or paramedical association organization is minimal.

The low incidence of work stoppages in federal governmental hospitals, despite the high degree of collective employee activity (22.6 percent of such facilities had negotiated agreements), is probably due to the fact that strike activity by federal employees is expressly forbidden by law.¹⁰ Additionally, the employee organization recognition and collective bargaining mechanisms initiated by E.O. 10988 have probably served to generally eradicate many potential causes of labor-management conflict.¹¹ The high incidence of work stoppages in state and local governmental hospitals is somewhat surprising in that a majority of the states granting public employees organizational and collective bargaining rights also prohibit strikes.¹² The relatively high degree of conflict activity, however, might well reflect the use of mass resignations and "sick calls."

During the mid-1960's the American Nurses Association (ANA) and the American Federation of State, County and Municipal Employees (AFSCME) began using these techniques on a wide scale to enforce recognition and terms of employment demands in hospitals. Previous investigation has indicated that the organizational activity of the ANA and AFSCME, and hence the use of the "non-strike" work stoppage, was heavily concentrated in state and locally controlled hospitals.¹³

In previous studies Kochery and Strauss,¹⁴ Hepton¹⁵ and Osterhaus¹⁶ observe work stoppages in hospitals, especially when such facilities are not covered by labor law, may be more highly associated with recognition than terms and conditions of employment issues. This relationship is tentatively supported by the data in Table 2. Analysis indicated that across all control categories approximately 13 percent of the hospitals with negotiated agreements experienced work stoppages during the survey year, while 21 percent of those with requests for recognition experienced conflict.

⁹ Clark Kerr, "Industrial Conflict and Its Mediation," *American Journal of Sociology*, Vol. 31 (November, 1954), pp. 230-233.

¹⁰ 69 Stat. 624 (1955). Striking or asserting the right to strike are declared to be felonies.

¹¹ Executive Order 10988 issued in 1962 established mechanisms whereby union organizations can be chosen to represent and bargain for federal employees' this order was amended and supplemented by E.O. 11491 in 1969. Together these enactments provide protection and control of collective bargaining in the federal government similar to the provisions of the Taft-Hartley Act; the major differences being: (1) discrimination by unions is prohibited, and (2) strikes are illegal. See: William B. Vosloo, *Collective Bargaining in the United States Federal Civil Service* (Chicago: Public Personnel Association, 1966).

¹² Advisory Commission on Intergovernmental Relations, *Labor Management Policies for State and Local Governments* (Washington, D.C.: U.S. Government Printing Office, 1969), pp. 12-24.

¹³ Approximately 55 percent of the recognition requests and 57 percent of the negotiated collective bargaining agreements in state and local hospitals during the survey year were accounted for by the ANA and AFSCME. Although mass resignations and sick calls are technically strikes when used to enforce terms of employment or recognition demands, they are less easily dealt with in the legal sense than traditional walk-outs.

¹⁴ David R. Kochery and George Strauss, "The Nonprofit Hospital and The Union," *Buffalo Law Review* Vol. 9 (Winter, 1960), p. 268.

¹⁵ Estelle Hepton, *Battle for the hospitals*, Bulletin No. 49 (Ithaca, New York: New York State School of Industrial Labor Relations at Cornell, 1965), p. 17.

¹⁶ Leo B. Osterhaus, "Labor Unions in Hospitals and Their Effect on Management," (unpublished PhD. Thesis, The University of Texas, 1966), p. 384.

TABLE 2.—PERCENT OF HOSPITALS EXPERIENCING WORK STOPPAGES WITH NEGOTIATED AGREEMENTS AND WITH RECOGNITIONAL REQUESTS

Control	Percent of hospitals experiencing work stoppages	
	With agreement	With recognitional request
State and Local	11.3	28.9
Voluntary	16.9	18.9
Proprietary	11.1	20.0
Federal	1.1	0
Total	12.8	20.9

Statistical analysis denotes that the percentage of hospitals experiencing work stoppages with request for recognition and with negotiated agreement is significantly different ($p < .05$). While the probability of having a work stoppage is comparatively high during the recognitional demand phase of the labor-management relationship, the chance of experiencing a work stoppage is reduced by nearly 50 percent once a collective bargaining agreement is negotiated. With the exception of federal governmental hospitals, this relationship appears to be more pronounced as the amount of collective activity increases.

During the survey year, less than one hospital employee in one hundred (0.61 percent) participated in a work stoppage.¹⁷ The percentage of employees involved in conflict by control category varied from 0.04 percent in federal hospitals to 0.74 percent in voluntary hospitals. Nearly 98 percent of the hospital workers involved in work stoppages were employed by state and local governmental and voluntary hospitals. Statistical analysis indicates that selected measures of work stoppage impact (mean number of employees involved, strike duration and number of man-days idle per hospital having a work stoppage) did not vary significantly across type of control and ownership ($p < .05$).

It is interesting to note, however, the difference between the average duration of work stoppages in the hospital industry and the non-agricultural sector of which it is a subcomponent. The average duration of work stoppages in hospitals during 1967 was 34.1 days; for the same year the average duration of all nonagricultural work stoppages was 22.8 days.¹⁸ Thus, fewer hospital employees participated in work stoppages than nonagricultural workers generally (see *Supra* note No. 17) but the stoppages lasted longer.

FACILITY SIZE

An examination of Table 3 indicates that the percentage of hospitals experiencing work stoppages varies considerably by facility size as measured by number of beds. Statistical analysis denotes that the distribution of the number of hospitals experiencing strikes is dissimilar to the distribution of the total number of registered hospitals by facility size ($p < .05$). The rank order correlation between facility size and the percentage of hospitals experiencing work stoppages is 0.88, thus indicating that as facility size increases so does the probability of having labor conflict.

It appears that trade unions and paramedical associations, active in representing and attempting to represent hospital employees, perceive larger hospitals as more organizable lucrative than smaller facilities. Previous investigation confirms this observation in that both requests for recognition and agreement negotiation are highly associated with facility size (rank order correlations of 0.86 and 1.00 respectively). Again, as with control and ownership, the extent of recognitional and collective bargaining activity is directly related to the incidence of work stoppages.¹⁹

¹⁷ Author's note: In the nonagricultural sector of the economy, of which the hospital industry is a subcomponent, 3.8 percent of the total number of employees took part in work stoppages during 1967. See: U.S. Bureau of the Census, *Statistical Abstract of the United States, 1969* (Washington, D.C.: U.S. Government Printing Office, 1969), p. 239.

¹⁸ Bureau of Labor Statistics, *Handbook of Labor Statistics, 1968*, Bulletin No. 1300 (Washington, D.C.: U.S. Department of Labor, 1968), p. 301.

¹⁹ Interestingly, not only are a great percentage of larger hospitals covered by a negotiated agreement but the proportion of organized employees also is highly associated with facility size (rank order correlation equals 0.79). That is, as hospital size increases so does the probability of having a greater proportion of employees under contract.

TABLE 3.—DISTRIBUTION OF WORK STOPPAGES BY FACILITY SIZE

Beds	Registered hospitals		Hospitals with work stoppages		Percent of classification with work stoppages
	Number	Percent	Number	Percent	
Under 25.....	542	7.6	1	0.7	0.2
25 to 49.....	1,629	22.7	11	7.5	1.7
50 to 99.....	1,734	24.2	20	13.6	1.2
100 to 199.....	1,365	19.0	33	22.4	2.4
200 to 299.....	686	9.6	19	21.9	2.8
300 to 399.....	375	5.2	19	12.9	5.1
400 to 499.....	220	3.1	16	10.8	7.3
500 plus.....	621	8.7	28	18.4	4.4
Total.....	7,172		147		2.0

Table 4 depicts the percentage of hospitals experiencing work stoppages with negotiated agreements and with requests for recognition by facility size. The rank order correlation between size and the percentage of hospitals experiencing conflict with a negotiated agreement is 0.79; that is, as hospital size increases so does the probability of having a work stoppage associated with terms and conditions of employment demands.

Conversely, the rank order correlation between facility size and the percentage of hospitals experiencing conflict with a request for recognition is—0.33. As hospital size increases the probability of having a work stoppage related to demands for employee recognition decreases. Preliminary data appear to indicate that smaller hospitals are more willing, relatively, to take a stand against collective employee activity in the initial stages (demands for recognition), but once recognition is achieved and a collective bargaining agreement is negotiated the probability of work stoppage is reduced. Larger hospitals seem to be relatively less willing (or less able) to take a stand against employee organization recognition activity leading to a strike, but once recognition is achieved the possibility of work stoppages related to terms of employment issues increases.

TABLE 4.—THE INCIDENCE OF WORK STOPPAGES WITH REQUESTS FOR RECOGNITION AND NEGOTIATED AGREEMENTS BY FACILITY SIZE

Beds	Percent of hospitals having work stoppages	
	With negotiated agreement	With recognition request
Under 25.....	0.0	25.0
25 to 49.....	10.3	43.8
50 to 99.....	10.6	22.2
100 to 199.....	12.4	25.0
200 to 299.....	11.5	12.5
300 to 399.....	20.0	17.0
400 to 499.....	17.6	25.8
500 plus.....	12.0	18.7
Total.....	12.8	20.9

RELATIONSHIP TO WORK STOPPAGES

An examination of the impact of work stoppages denotes that the mean number of employees involved and the mean number of mandays idle per hospital experiencing a strike varies significantly across facility size ($p < .05$). Generally, as facility size increases so does the impact of work stoppages. Since facility size is more highly associated with agreement negotiation than recognitional conflict, work stoppages precipitated by terms of employment demands in large hospitals account for a substantial proportion of the relationship.²⁰

On the other hand, smaller hospitals experience a relatively higher incidence of strikes with requests for recognition. The mean number of employees involved in recognitional conflict is the least of any work stoppage issue.²¹ Thus, the impact of strikes in smaller hospitals is somewhat mitigated.

GEOGRAPHIC LOCATION

As indicated by the data presented in Table 5, the incidence of work stoppages occurring in registered hospitals during the survey year varies markedly across regions of the country. Statistical analysis indicates that the distribution of the number of hospitals experiencing work stoppages is dissimilar to the distribution of the total number of registered hospitals by region ($p < .05$). Additionally, hospital location by region was shown to be significantly associated with the extent of work stoppage activity ($p < .05$).

The percentage of hospitals having a work stoppage range from a low of 0.3 percent in the West South Central region (Arkansas, Louisiana, Oklahoma and Texas) to a high of 4.4 percent in the Pacific region (Alaska, California, Hawaii, Oregon and Washington). Three regions—Pacific, East North Central and West North Central—account for approximately 64 percent of the total number of work stoppages, although they contain only 42 percent of all registered hospitals.

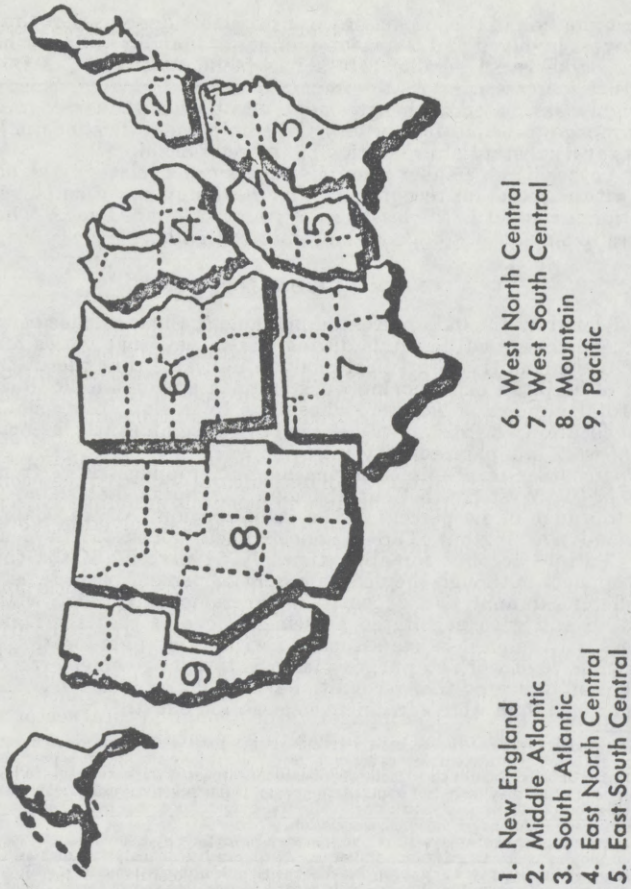
A differential analysis of hospitals experiencing conflict with requests for recognition and with negotiated agreement denotes that the incidence of work stoppages with request is less associated with geographic location ($r=0.41$) than is the incidence of work stoppages with negotiated agreement ($r=0.84$). Previous investigation indicated that recognitional activity was relatively more widespread geographically than were agreement negotiation efforts.²²

²⁰ As indicated in *supra* note no. 19, relatively more larger hospitals have negotiated contracts and a greater proportion of these hospitals' employees are organized; industrial units are more prevalent in facilities with a large number of beds. Each of these factors increases the impact of work stoppages in hospitals with a large number of beds when they do in fact occur. Author's note: An industrial unit encompasses all or a majority of a particular hospital's employees in a single collective bargaining group; i.e., all employees are represented by the same trade union or paramedical association.

²¹ The mean number of employees involved in work stoppages by issue is as follows: recognition—66.36; terms of employment—89.43; grievance and other—75.02. Statistical analysis indicated that the mean number of employees involved in work stoppages differed significantly by issue ($p < .05$).

²² The dispersion of recognitional requests by geographic location showed approximately 30 percent more variability than did the dispersion of negotiated agreements. See: Pointer, *op. cit.*, pp. 255 and 303.

TABLE 5
DISTRIBUTION OF WORK STOPPAGES BY GEOGRAPHIC LOCATION



	Registered hospitals		Hospitals with work stoppages		Percent of classification with work stoppages
	Number	Percent	Number	Percent	
1.....	415	5.8	3	2.0	0.7
2.....	896	12.5	17	11.6	1.9
3.....	925	12.9	17	11.6	1.8
4.....	1,169	16.3	31	21.1	2.6
5.....	551	7.7	7	4.8	1.3
6.....	901	12.6	23	15.6	2.6
7.....	956	13.3	3	2.0	.3
8.....	441	6.1	6	4.1	1.4
9.....	918	12.8	40	27.2	4.4
Total.....	7,172		147		2.0

Thus, conflict related to terms of employment demands is highly concentrated geographically in those regions that are most highly organized (Pacific, East North Central and West North Central). Work stoppages associated with requests for recognition are geographically dispersed due to the dynamically expanding hospital organizational efforts of trade unions and paramedical associations in areas other than those where they have traditionally been most successful.

Table 6 attempts to place in perspective the prevalence and impact of stoppages in the hospital industry and the nonagricultural sector of the economy of which it is a subcomponent. Work stoppages in hospitals account for 3.7 percent of the total number of strikes, 0.7 percent of the workers involved in labor management conflict and 1.4 percent of the total number of man-days idle due to work stoppages.

Examination of the table indicates that there is an association between the impact of work stoppages in the nonagricultural sector and the hospital industry. The rank order correlations across a region of three criterion variables between the nonagricultural and hospital sectors are: (1) number of work stoppages—0.73; (2) number of workers involved in conflict—0.67; and (3) number of man-days idle due to work stoppages—0.87. Thus, those regions experiencing the greatest impact from work stoppages in the nonagricultural sector also experience the greatest impact from strikes in health care facilities.

TABLE 6.—SELECTED INDICES OF THE IMPACT OF WORK STOPPAGES FOR THE NONAGRICULTURAL SECTOR AND THE HOSPITAL INDUSTRY BY REGION

Region	Work stoppages				Workers involved in stoppages				Man-days idle			
	Industrial sector ¹		Hospital sector		Industrial sector ¹		Hospital sector		Industrial sector ¹		Hospital sector	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
New England.....	309	6.5	3	1.7	102,350	5.2	61	0.4	1,672,400	6.6	678	0.2
Middle Atlantic.....	1,155	24.4	21	11.7	469,100	24.0	3,865	28.3	5,606,000	22.1	66,818	18.5
South Atlantic.....	492	10.4	22	12.3	220,800	10.3	648	4.8	2,842,100	11.2	4,674	1.3
East North Central..	1,258	26.6	42	23.5	570,200	29.1	3,000	22.0	7,358,000	29.1	168,135	46.7
East South Central..	321	6.8	8	4.8	171,600	8.8	163	1.2	1,836,400	7.3	3,773	1.0
West North Central..	350	7.4	25	13.9	138,490	7.1	2,254	16.5	1,894,670	7.5	64,868	18.0
West South Central..	259	5.5	5	2.8	100,470	5.1	364	2.7	1,424,000	5.6	1,086	.3
Mountain.....	169	3.6	6	3.4	54,710	2.8	121	.9	728,700	2.8	2,435	.7
Pacific.....	426	9.0	47	26.3	148,810	7.6	3,163	23.2	1,953,600	7.7	47,241	13.1
Total.....	4,739		179		1,956,530		13,639		25,316,370		359,708	

¹ Bureau of Labor Statistics, Handbook of Labor Statistics 1968, Bulletin No. 1600 (Washington, D.C.: U.S. Department of Labor, 1968), p. 315.

Note: Nonagricultural ("industrial") sector data are for the year ending Jan. 1, 1968.

A great deal of the organizational and collective bargaining activity in hospitals is conducted by trade unions that have their base in the industrial sector.²³ An adequately organized foundation outside the hospital arena may facilitate the

²³ Fully 36 percent of the total number of union contracts with hospitals are held by organizations that have a solid membership base in the nonagricultural sector of the economy; these organizations are: The Service Employees' International Union, Hotel and Allied Services Union, Hotel Restaurant Employees and Bartenders' Union; and The National Hospital and Nursing Home Employees Union (affiliated with the Retail, Wholesale Department Store Union).

effectiveness of initial organization and subsequent ability to initiate work stoppage activity in health care facilities. A developed organizational structure in the industrial sector might expand a trade union's base for providing financial and organizational support for hospital employees involved in work stoppages through associated locals in the same area. For example, the Hospital Employee's Labor Program (H.E.L.P.) is the direct outgrowth of two Chicago trade unions: Local 73, Building Service Employees' Union and Local 743, Teamsters' Union.²⁴ Both of these parent locals provide H.E.L.P. with financial and organizational support in recognition, contract negotiation and work stoppage activity.

SUMMARY AND CONCLUSIONS

Although the hospital industry has faced a traditionally limited demand for employee organization recognition and collective bargaining agreement negotiation,²⁵ evidence indicates that activity in this sector is expanding on a wide scale. Labor leaders have realized that hospital employee organizations may provide a needed supplement to currently declining relative union strength in the nation's nonagricultural work force.²⁶ Paramedical associations have been increasingly faced with the fact that they must represent their membership regarding terms and conditions of employment or accept the transference of this function to trade unions—they have generally preferred the former alternative.²⁷

As collective employee activity in the hospital industry continues to expand, increasing concern is being voiced regarding disruption of the provision of medical and health care services due to work stoppages stemming from recognition and collective bargaining demands. The public attention focused on this issue is being amplified due, in part, to several factors. First, the effort to organize hospital employees has incorporated many of the dynamic facets of the trade union movement that have not surfaced since the massive organizational drives of the 1930's.²⁸ Hospital employees are embracing the techniques of sit-ins, candlelight parades, provoked mass arrests and sit down-strikes to dramatize their demands. Secondly, hospital organizational campaigns in many intercity and southern facilities have been strongly identified with the civil rights movement.²⁹ The combination of "soul power" and "union power" has injected elements of cause orientation and militancy into the organization of hospital employees—the line between civil rights and employee rights has often become blurred.³⁰ Finally, the effects of hospital strikes are often dramatic (or dramatized) in that services perceived as critical to public welfare and safety are curtailed or substantially eliminated. One may note also that the thought of capitulating to employee wage demands often sends shivers up the collective spines of administrators faced with skyrocketing costs and increased public scrutiny regarding health care expenditures.

Amid all the commotion and concern (much of which is of course justified) one notes that work stoppage activity in the hospital industry is relatively slight. Initial, albeit rudimentary, analysis has indicated that only 2.0 percent of the nation's 7,172 hospitals experienced work stoppages during 1967, fewer than one hospital worker in one hundred participated in such strikes. Generally facilities that are large, voluntarily or state and locally controlled and located in the East

²⁴ "Two Labor Unions Launch Drive to Organize 40,000 Workers at Chicago Hospitals," *Modern Hospitals* Vol. 107 (December, 1966), p. 182; and "AFL-CIO, Teamsters Team up to Organize Chicago Hospital Employees," *Hospitals*, Vol. 40 (November 16, 1966), p. 40.

²⁵ It appears that the primary factors inhibiting union activity in the hospital sector historically are: (1) the preoccupation of the trade union movement with organizing more easily accessible and lucrative components of the labor force; (2) the low density of health care facilities in any given area; (3) the relatively small number of employees in hospitals when compared with business enterprises in which unions have traditionally concentrated organizational activity; (4) the unstable nature (i.e., high turnover) of the hospital labor force; (5) the large proportion of women employed by health care facilities; (6) the large number of professional and semiprofessional employees in the hospital setting; and (7) the traditional lack of legal protection for employee organization activity in hospitals.

²⁶ Union membership in the United States as a proportion of employees in nonagricultural establishments has been increasing moderately in absolute terms (17,490,000 members in 1956 to 18,910,000 in 1968), while decreasing in relative terms (33.4 percent of employees in nonagricultural establishments in 1956 versus 27.9 percent in 1968). Source: Bureau of Labor Statistics, *Statistics Directory of National and International Labor Unions in the U.S.*, BLS Bulletin No. 1665 (Washington, D.C.: U.S. Department of Labor, 1970), p. 67.

²⁷ James O. Hepner, et al., *Personnel Administration and Labor Relations in Health Care Facilities*, St. Louis, Missouri: C. V. Mosby Company, 1970, especially Chapter IX.

²⁸ See for example: A. H. Raskin, "A Union with a Soul," *New York Times Magazine*, Section No. 6 (March 22, 1970).

²⁹ The Southern Christian Leadership Council (SCLC) has been active as an organizational arm of the National Hospital and Nursing Home Employees' Union in southern hospitals; see: "Local 1199's National Arm Calls Charleston Strike," *Hospitals*, Vol. 43 (April 16, 1969), p. 122. Additionally, Mrs. Martin Luther King, Jr. has recently been named an honorary Vice-President of the union.

³⁰ A. Samuel Cook, "Hospitals Face New Union-Black Alliance," *Modern Hospital*, Vol. 113 (October, 1969), pp. 78-87, and "Union Power and Soul Power Are Winning Combinations," *Modern Hospitals*, Vol. 113 (October, 1969), pp. 78+.

North Central, West North Central and Pacific regions are most likely to experience a work stoppage. Labor-management conflict is highly associated with the extent of trade union and paramedical association demands for recognition and collective bargaining agreement negotiation; that is, work stoppages rarely occur in the absence of some type of formal organization. In essence strike activity in hospitals is relatively concentrated by facility size, geographical location and control. This concentration, however, should be mitigated somewhat as employee organization activity continues to expand.

Work stoppages are more prevalent in hospitals experiencing requests for trade union or paramedical association recognition than those hospitals having negotiated collective bargaining agreements. Although policy inferences are difficult if not impossible to draw when given such preliminary data, it might be that the total impact and incidence of work stoppages in this hospital industry could be markedly reduced by establishing (or more accurately expanding the use of) mechanisms designed to protect and control worker self determination regarding employee organization representation. As early as 1961 an independent study commission sponsored by the Committee for Economic Development noted that,

"... representation issues are likely to remain prominent ones since large and growing groups of the labor force are not unionized ... some of the most troublesome strife in recent years has arisen among hospital workers ... [who] are unprotected under present labor legislation in their union activity or given access to machinery for determining their wishes about collective bargaining.³¹" Indeed, the opening section of the Taft-Hartley Act (from which provisions voluntary, state and local, and federal hospitals are exempted) denotes in a declaration of public policy that,

"Industrial strife which interferes with the normal flow of commerce ... can be avoided or substantially minimized if employees, employees and labor organization each recognize under the law one another's legitimate rights in relations with each other."³²

[From the Monthly Labor Review, May 1971]

RECOGNITION, NEGOTIATION, AND WORK STOPPAGES IN HOSPITALS

(By Dennis D. Pointer and Harry Graham)

EMPLOYEE ORGANIZATION, subsequent collective bargaining, and the associated possibility of work stoppages in health care facilities have come into widespread public, professional, and academic attention, as the organizational activities of unions and professional paramedical associations have expanded tremendously during the last decade. This sector of the economy is expected to be one of the Nation's largest employers by 1975,¹ and labor leaders have realized that hospital employee organization may provide a needed supplement to union strength, currently in a relative decline as a portion of the Nation's nonagricultural labor force.² Professional paramedical associations are increasingly faced with the fact that they must actively represent their members regarding terms and conditions of employment or accept the transfer of this function to trade unions.

Although employee organizations have been active in hospitals since early in this century,³ the growth of hospital unionism from an isolated phenomenon to a movement having nationwide scope and impact has occurred only during the past decade.

Employee organizations, be they trade unions or professional paramedical associations, are intensifying their efforts to organize and bargain for those individuals employed in the health care industry. The Nation's hospitals had over \$33.5 billion in total assets in 1969. Factors inhibiting employee organization growth in hospitals have been greatly mitigated during the past decade, and several unions and paramedical associations have demonstrated that hospital employees can be viably organized. Hospital unionism, nevertheless, is in its

³¹ *The Public Interest in National Labor Policy*, New York: The Committee for Economic Development, 1961, pp. 74-75.

³² *National Labor Relations Act of 1947*, Public Law 101, 80th Congress, 1st session as amended by Public Law 188, 82nd Congress, 1st session, Section 1(b).

¹ National Commission on Community Health Services, *Health Manpower: Report of the Task Force on Health Manpower* (Washington, D.C. Public Affairs Press, 1967), pp. 30-34.

² Union membership in the United States as a proportion of employees in nonagricultural establishments has been increasing moderately in absolute terms (17,490,000 members in 1956 to 18,910,000 in 1968), while decreasing moderately in relative terms (33.4 percent of employees in nonagricultural establishments in 1956 versus 27.9 percent in 1968). See *Directory of National and International Labor Unions in the United States* (BLS Bulletin 1665, 1970), p. 67.

³ Note: "Employees of Hospital Have 5 State Unions," *San Francisco Chronicle*, June 18, 1919.

infancy. Only 7.7 percent of the Nation's 7,172 hospitals had negotiated collective bargaining agreements in 1967, and scarcely 7 percent of the 2.2 million individuals employed by these facilities were covered by such contracts.

Research on employee organization activity in hospitals is scarce. Most of the literature in the field can be generally classified as (1) studies expressing opinions regarding the propriety of labor organization in hospitals or the description of specific organizational or work stoppage experiences,⁴ and (2) studies dealing with the examination of causal relationships between narrowly defined variables.⁵

The research reported here was designed to provide an empirical profile and analysis of employee organizations' activities in hospitals located in the United States, in regard to recognition, agreement negotiation, and work stoppages. Data collected through a survey of hospitals⁶ was subdivided into two groups of variables, primary and structural. Primary variables are those measures that were chosen to best describe the sum total of collective employee activity in health care facilities. They are the number of hospitals experiencing (1) employee organization requests for recognition, (2) collective bargaining agreement negotiation, and (3) work stoppages. Structural variables are those measures that were chosen to best differentiate the distinctive characteristics of various hospital organizational environments. They are (1) type of hospital control and ownership, and (2) facility size as measured by number of beds.

For the purpose of this study, hospitals were subdivided into four ownership and control categories: (1) voluntary hospitals, which are organized as nonprofit institutions with authorization from the State to provide a public service; (2) State and local hospitals, which are subdivisions of and organizationally integrated with State or local governments and are supported fully or in part by State or local tax funds; (3) Federal hospitals, which are organizationally integrated with and supported by the Federal Government (for example, Veterans Administration and military hospitals); and (4) proprietary hospitals, which operate for the purpose of providing a profit for their owners.

The underlying contention of the research design is that the structural variables are significantly associated with the probability that a given hospital will (1) receive a request for employee organization recognition, (2) have a negotiated collective bargaining agreement, or (3) experience a work stoppage.

REQUEST FOR RECOGNITION

During the survey year, 5.7 percent of the total number of registered hospitals located in the United States received a formal request for collective bargaining recognition from an employee organization. (See table 1.) Requests for recognition were made relatively more frequently in federally controlled hospitals and in facilities with a large number of beds.

⁴ An examination of articles listed in the *Cumulative Index of Hospital Literature* between 1945 and 1970 indicated that most of the citations dealing with unionization could be classified in this category. Source: *Cumulative Index of Hospital Literature* (Chicago, American Hospital Association, 1945-1970).

⁵ See, for example: Karen Hawley, "Economics of Collective Bargaining by Nurses" (unpublished master's thesis, Iowa State University, 1967); G. Dale Meyer, "Determinants of Collective Action Attitudes Among Hospital Nurses: An Empirical Study of a Behavioral Model" (unpublished Ph. D. thesis, the University of Iowa, 1970).

⁶ The data pool for this study was collected by the American Hospital Association (AHA) in a two-phase project conducted in 1968. In phase one, a postcard questionnaire was distributed to the 7,403 then existent hospital facilities located in the United States, inquiring as to whether the hospital (1) had a negotiated collective bargaining agreement with any segment of its work force; (2) had received a request for recognition from any trade union, professional association or group of its employees; or (3) had experienced any work stoppages. A total of 7,194 of the phase one questionnaires were returned in usable form for a response rate of 97.2 percent. The 1,300 facilities that indicated an affirmative reply to any one of the phase one elements received the "1967 Survey of Collective Bargaining in Hospitals"; the information gathered by this instrument constituted the data base for this study. The degree of correspondence of the phase two return to the population of hospitals that had experienced some form of employee organization activity in the survey year was established through a chi-square goodness-of-fit analysis on three variables (number of hospitals with requests for recognition, negotiated agreements and work stoppages) across geographic location.

TABLE 1.—PERCENT OF HOSPITALS RECEIVING ORGANIZATION REQUESTS, HAVING NEGOTIATED AGREEMENTS, AND EXPERIENCING WORK STOPPAGES

Hospital type and size	Registered hospitals		Percent of hospitals		
	Number	Percent	Receiving organization requests	Having negotiated agreements	Experiencing work stoppages
All hospitals.....	7,172	100.0	5.7	7.7	2.0
Control:					
State and local.....	2,141	29.9	6.0	5.4	2.6
Voluntary.....	3,692	51.5	5.7	8.1	2.2
Proprietary.....	923	12.9	1.4	4.9	.8
Federal.....	416	5.8	13.0	22.6	.2
Bed size:					
Under 25.....	542	7.6	.6	1.5	.2
25 to 49.....	1,629	22.7	.9	2.3	.7
50 to 99.....	1,734	24.2	2.4	5.4	1.2
100 to 199.....	1,365	19.0	6.0	8.9	2.4
200 to 299.....	689	9.6	9.6	14.0	5.1
300 to 399.....	375	5.2	13.9	14.7	2.8
400 to 499.....	220	3.1	18.2	15.5	7.3
500 or more.....	621	8.7	17.2	17.6	4.4

Of all Federal hospitals, 13 percent received requests for recognition during the survey year, denoting a considerable amount of initial organizational activity in this environment. Prior to the issuance of Executive Order 10988 in 1962, the collective activity of Federal employees was not protected and no mechanisms were provided for formal union recognition. However, before 1962 collective employee activity in the Federal Civil Service, although isolated, encompassed a significant number of employees and employee organizations.⁷ When provisions were established for recognition of and negotiation with employee organizations by agencies of the Federal Government, already existent organizations expanded into agencies with low densities of collective membership and relatively large numbers of employees. Veterans Administration and military hospitals were prime areas of concentration.⁸

On the other hand, only 1.4 percent of the proprietary hospitals received recognition requests during the survey year, probably because the great majority of these types of facilities are small in size,⁹ and a large proportion are located in the South and in small rural communities.¹⁰ Traditionally, enterprises located in such environments are less easily organized.¹¹ It must be noted parenthetically that it may be that the inhibition of recognitional activity, due to the aforementioned factors, is greater than the organizational stimulus provided by the favorable legal environment. Proprietary hospitals with a gross annual revenue exceeding \$250,000 are included under the coverage of the Taft-Hartley Act.

There are dramatic differences across facility size in the percentage of hospitals receiving recognition requests, varying from only 0.6 percent in facilities with less than 25 beds to 17.2 percent in facilities with more than 500 beds. The rank order correlation between facility size and the percentage of hospitals with requests is 0.86. That is, recognitional activity is highly associated with facility size. Considering the close relationship between facility size and personnel complement, this finding is hardly unexpected.

Hospitals with less than 100 beds constitute the greatest proportion of hospitals (54.5 percent) and have the smallest proportion of employees (13.4 percent). The average personnel complement of a less-than-100-bed facility is 82.6 employees.¹²

⁷ President's Task Force on Employee-Management Relations in the Federal Service, Staff Report No. 11: *Employee-Management Relations in the Federal Service* (Washington, D.C., U.S. Government Printing Office, 1961), pp. 10-11.

⁸ William B. Vosloo *Collective Bargaining in the United States Federal Civil Service* (Chicago, Public Personnel Association, 1966), pp. 114-115.

⁹ In the survey year the 769 existing proprietary hospitals employed 84,000 individuals for an average of 109 workers per facility. This figure is far below the 307 workers per facility average of all registered hospitals. Source: "Guide Issue," *Hospitals*, August 1, 1969, pp. 476-478.

¹⁰ Lloyd L. Cannedy, "The Historical Viability of For-Profit Hospitals," *Hospital Progress*, November, 1970, pp. 65-71.

¹¹ Solomon Barkin, "Organization of the Unorganized," in *Unions, Management and the Public*, ed. by E. Wight Bakke et al. (New York, Harcourt, Brace and World, Inc., 1967), 3d ed., pp. 118-120.

¹² "Guide Issue," *Hospitals*, August 1, 1969, pp. 476-477.

On the other hand, those facilities with more than 500 beds employ 34.4 percent of the employees, but account for only 1.7 percent of the hospitals, thus making the average personnel complement of such facilities 631.6 employees.¹³

COLLECTIVE BARGAINING AGREEMENT NEGOTIATION

During the survey year, 7.7 percent of the registered hospitals in the United States had negotiated collective bargaining agreements with employee organizations. Negotiated agreements—like recognition requests—are relatively more concentrated in large or federally controlled hospitals, and probably for the same reasons.

The tabulation below compares the percent of hospitals (excluding Federal facilities) with negotiated agreements in 1961 and 1967:¹⁴

	1967	1961
All-non Federal hospitals	6.8	3.2
Control:		
Voluntary	8.2	4.3
Proprietary	4.9	4.3
State and local	5.4	1.0
Bed size:		
6 to 99	3.6	1.5
100 to 199	8.5	5.8
200 to 299	12.3	6.2
300 to 399	14.5	6.2
400 to 499	12.5	6.3
500 or more	11.8	3.1

Overall, the percentage of hospitals with negotiated agreements has more than doubled. The greatest expansion of activity occurred in hospitals under State and local control and hospitals with a relatively large number of beds. An increasingly attractive organizational environment has been provided in State and local hospitals by the enactment of numerous public employee bargaining bills during the period.¹⁵ The moderate increase of collective bargaining agreements in voluntary hospitals may result from the fact that the collective rights of voluntary hospital employees are neither protected nor controlled by the Taft-Hartley Act,¹⁶ and few State labor laws extend coverage to such employees.¹⁷

In 1961, the distribution across facility size of the percentage of hospitals with negotiated collective bargaining agreements was markedly bell-shaped; that is, facilities with relatively few and relatively many beds were the least organized. By 1967, the picture had changed: the distribution across facility size was direct—the larger the bed size category, the greater the percentage of hospitals with negotiated agreements.

WORK STOPPAGES

One of the major concerns of hospital administrators and legislators is the possibility of disruption of critical services during a labor-management conflict. Their reservations regarding the extension of organizational and collective bargaining rights to the employees of hospitals generally involve two associated fears: (1) "the recognition of a union is a direct invitation to strike";¹⁸ and (2) "intolerable conditions would be created if critical hospital services were substantially curtailed or eliminated completely due to a strike."¹⁹

¹³ Ibid.

¹⁴ Federal hospitals were not included in the 1961 study of collective bargaining in hospitals. Data on 1961 was provided by Jon D. Miller, Bureau of Research Services, American Hospital Association.

¹⁵ Advisory Commission on Intergovernmental Relations, *Labor-Management Policies for State and Local Government* (Washington, D.C., U.S. Government Printing Office, 1969), pp. 12-24. See also Joseph P. Goldberg, "Changing policies in public employee labor relations," *Monthly Labor Review*, July 1970, pp. 5-14.

¹⁶ For a more complete treatment of the Federal labor law status of health care facilities see: Dennis D. Pointer, "The Labor Law Status of Health Care Facilities: The Taft-Hartley and Landrum-Griffin Acts," *Hospital Progress*, October 1970, pp. 83-86.

¹⁷ For a more complete discussion of the state labor law status of hospitals, see: Dennis D. Pointer, *Unionization, Collective Bargaining and the Non-Profit Hospital*, Monograph Series No. 13 (Iowa City, Iowa, The Center for Labor and Management, 1969), especially chapter 2.

¹⁸ Martin Steinberg, "Unions and Voluntary Hospitals," *Hospital Management*, June 1959, p. 25.

¹⁹ *Western Pennsylvania Hospital v. Lichtliter*, 340 Pa. 382, 17A 2d 206 (1941), cited in 7 LRRM at 1132.

Of the total number of registered hospitals located in the United States, 2.0 percent experienced a work stoppage during the survey year. In 1967, labor conflict in hospitals accounted for 3.7 percent of the total number of work stoppages recorded in the economy.²⁰ The type of hospital control and facility size were significantly associated with the incidence or nonincidence of work stoppages.

The low percentage of Federal hospitals that experience work stoppages probably results from the legal ban on assertion of the right to strike or the act of striking by Federal employees.²¹ The small amount of labor conflict in proprietary hospitals was expected, since less than 5 percent of such hospitals had negotiated agreements and fewer than 2 percent received recognition requests. Hospitals under State and local control and voluntary facilities had the highest proportion of work stoppages; they also accounted for 83.5 percent of the hospitals receiving recognition requests and 75.0 percent of the hospitals having negotiated contracts.

The high incidence of conflict in State and local facilities is somewhat surprising, however, since a majority of the States that grant public employees organizational and collective bargaining rights also prohibit strikes.²² This prohibition is often overcome, of course, by the use of mass resignations and "sick-outs." In the mid-1960's the American Nurses' Association (ANA) revoked its no-strike pledge and began using these two techniques on a wide scale to gain representation in hospitals. During this period, the organizational activity of the ANA, and thus the use of these tools, was heavily concentrated in State and locally controlled facilities.²³

Across all control categories, approximately 13 percent of hospitals with negotiated agreements have experienced work stoppages, while 21 percent of those with requests for recognition have experienced some form of conflict:

	With agreement	With recognition request
Total	12.8	20.9
State and local	11.3	28.9
Voluntary	16.9	18.9
Proprietary	11.1	20.0
Federal	1.1	0

The patterns presented thus far suggest that the hospital industry as a whole has faced a rather limited demand for collective bargaining representation but that once a recognition request was forwarded the probability of conflict increased drastically. The higher incidence of labor-management conflict in health care facilities with recognition requests (but without signed contracts) tends to indicate that relatively more work stoppages are precipitated by recognition demands than by the negotiation of terms and conditions of employment.

The data indicate that the incidence of work stoppages is highly associated with facility size. Hospitals with fewer than 100 beds account for 14.4 percent of the total number of hospitals with recognition requests and 25.1 percent of those with negotiated agreements. On the other hand, hospitals with more than 400 beds account for 36.1 percent of the total number of hospitals receiving recognition requests and 25.6 percent of those with negotiated agreements.

Tabulation of the data on the percentage of hospitals experiencing work stoppages that have had requests for recognition and that have negotiated agreements shows that the incidence of work stoppages is greater with a request for recognition than with an agreement:

²⁰ Economywide data for this comparison was gathered from *Handbook of Labor Statistics, 1968* (SBL Bulletin 1600, 1968), p. 315.

²¹ 69 Stat. 624 (1955).

²² Advisory Commission on Intergovernmental Relations, op. cit., pp. 12-24.

²³ See Dennis D. Pointer, "Employee Organization in Health Care Facilities: An Exploratory Analysis and Evaluation" (unpublished Ph. D. thesis, the University of Iowa, 1970), pp. 266, 319.

Number of beds	With agreement	With recognition request
Total	12.8	20.9
Under 25	0	25.0
25 to 49	10.3	43.8
50 to 99	10.6	22.2
100 to 199	12.4	25.0
200 to 299	11.5	12.5
300 to 399	29.0	17.0
400 to 499	17.6	25.8
500 or more	12.0	18.7

This difference, however, is greater in smaller hospitals than in larger ones. That is, as hospital size increases so does the probability of having a work stoppage associated with terms of employment demands. Further, as hospital size increases, the probability of having a work stoppage related to demands for employee organization decreases. Apparently smaller hospitals are more willing, relatively, to take a stand against collective employee activity in the initial stages (demands for recognition), but once recognition is achieved the probability of a work stoppage stemming from agreement negotiation is reduced. Larger hospitals seem to be less willing (or less able) to take a stand against employee organization recognition activity (leading to a strike), but once recognition is achieved, the probability of work stoppages related to terms of employment issues increases.

Mr. METZGER. Again I will not burden you with the statistics. Dr. Pointer is the statistician in the team. I am the negotiator. But it seems to us—and those of us in New York are deeply concerned over orderly procedures—that the National Labor Relations Act provides an orderly procedure. We can argue on whether the passage of the law brings unions into the hospitals. I happen to feel that this is an argument that is not one that can be settled on the basis of emotionality.

If we look at the record of organizations throughout the country, we find that about 25 to 27 percent of workers in the United States are in unions after years of experience under the National Labor Relations Act. We forecast that the hospital industry might well reach this 25 percent, although it is about 12 percent now. But we maintain that it will reach this percentage with or without a law and that, therefore, if we are to experience the organizational drives that the rest of the country has experienced, that we should have an orderly procedure.

We are deeply concerned with several aspects of the procedure. I mention in my testimony that we are concerned with the careful enunciation.

Mr. THOMPSON. I neglected to introduce the gentleman accompanying you.

Mr. METZGER. Morton M. Maneker, an attorney with the firm of Proskauer, Rose, Getz & Mendelsohn, with extensive experience in the labor relations field. He is here in his capacity as adviser both to me and the Greater New York Hospital Association.

Mr. THOMPSON. He is probably more comfortable today than if he were a partner in Nixon-Mudge.

Mr. METZGER. No comment. Mine is a very ecumenical posture.

I must tell you that I understand completely the concern of the people in my industry who preceded me here. They speak not from emotion. They speak from deep concern that we do maintain a position where we can deliver patient care. Theirs is just as sincere as mine.

Mr. THOMPSON. I, too, share that concern. I think that obviously inclusion in the act includes the right to collective bargaining and

includes the right to strike. It is perfectly reasonable for them to have a degree of apprehension. I think they are a bit overapprehensive, however.

History shows that, with the major contracts made, there would be far fewer strikes were they included under the act than there would be if they are not, because inevitably, as you suggest, the process or the efforts to unionize this industry are going to continue.

Mr. METZGER. Notwithstanding what you do.

Mr. THOMPSON. That is right.

Mr. METZGER. Notwithstanding what you do, it will continue.

By the way, their apprehension is, I think, understandable. If you were going into the arena with Muhammed Ali, you would be concerned also.

Mr. THOMPSON. A little less today than a couple of years ago.

Mr. METZGER. I would advise you to be as concerned.

Mr. THOMPSON. I will take your advice.

Mr. METZGER. We feel the National Labor Relations Board has demonstrated a reasonable and workable approach. It is not a panacea. None of us maintain that, if we come under the act, it is going to be all a bowl of cherries. But they have demonstrated a reasonable and workable approach to the unique problem of bargaining units in profit-making hospitals; and, as you pointed out, profitmaking hospitals have some of the problems we have certainly in maintaining patient care.

They have maintained a workable approach to profitmaking nursing homes in recent years, to nonprofit long term care facilities, including nursing homes, over which the Board now exercises jurisdiction.

Thus, the problem of balancing the desires of groups of employees with the necessity of avoiding overfragmentation of hospitals with a multiplicity of unions is particularly within the expertise of the Board.

We in New York are deeply concerned over this fractionization. We are concerned with the inclusion of supervisors, with guards being in the same units as other employees.

What I maintain is something I maintained the last time I saw you. We want the same protection that you have afforded, the Congress has afforded, to General Motors and General Electric. We feel we want the same orderly procedures.

Approaching in this decade the possibility of being the largest industry in the United States, it is difficult to comprehend how anyone could speak about excluding us from a national labor policy. I do not think that it is an opportune time to speak about where changes should be made in that policy. Sometime in the future I may be testifying before this committee in different circumstances.

Mr. THOMPSON. I hope I will be here at that time in the future.

Mr. METZGER. I am not a resident of New Jersey, so I cannot assure you of this.

We feel at this time the National Labor Relations Act provides us with some semblance of order, first in the area of recognition strikes; second, exclusion of supervisors; third, in the clear demarcation of guard units; fourth, in the procedures, election procedures; 12-month waiting periods, show of interest; all very technical but very important.

We have our own problems in the East; there is no question about it. But I feel as strongly about the rest of the country and the need for this orderly approach. My statements for the various groups I represent point this out.

I think the best approach now would be to answer any questions you might have.

Mr. THOMPSON. I wonder if Mr. Maneker has any comment.

Mr. MANEKER. One thing I may be able to contribute to the extent the committee is interested is some experience in the operation of the New York State prohibition against strikes and its compulsory arbitration provisions and some of the differences that Mr. Metzger alluded to between New York State's labor policy and the national policy; where you commented, before, you felt there was a one-sided situation in other States, as employers we feel we have a local situation which is one-sided.

Given the size of this industry, its impact on interstate commerce and its special relationship to the health of the people it serves, that the national policy of protecting employer interests to a greater extent, that the State of New York now does in the area Mr. Metzger alluded to are important.

Mr. THOMPSON. Am I correct in my recollection that initially the New York State law applied only to New York City?

Mr. METZGER. The history of that is: The amendment was passed in 1963 to bring us under the quilt of the Labor Act. It was limited to municipalities of 1 million or more. Simply stated, it is a euphemism for "New York City" in New York State. It was later amended, in 1965, to include the entire State—nonprofit voluntary hospitals in the entire State.

Mr. MANEKER. I think I can comment in two aspects on the New York labor law, first the general labor law applying to hospitals and then the special provisions of the labor law applying only to hospitals.

Briefly stated, New York's general labor law is in the situation of the National Labor Relations Act before the Taft-Hartley amendment. New York passed a little Wagner Act in the thirties when the national Wagner Act was passed but never passed anything comparable to the Taft-Hartley Act.

That means, in practical sense, several things which are important in our day-to-day relations with unions, in our ability to meet the problem of potential strikes, and in the striking of a reasonable bargaining balance.

First, supervisors are not excluded from bargaining units, as they were by the Taft-Hartley amendment. So that a bargaining unit as certified by the New York State Labor Relations Board to include supervisors and representative and part of the same union as our rank and file employees, for all the same reasons that Congress extended the protection to employers of having their own supervisors, their own arm, an extension of their management ability to be excluded from the bargaining unit of the people they were to supervise, hospitals in the State of New York do not have that protection.

We think the extension of national labor policy in that respect would be an important way of balancing the relationship that we now have with unions, which is quite one-sided.

The second thing, which directly relates to the security of the hospital, the New York State Labor Board will certify a unit including the security guards of a hospital. The national act under Taft-Hartley amendment specifically excluded guards from being part of the unit or even being represented by a union in any way affiliated with a union which represents other employees than guards.

So that when you do have demonstrations or disruptions due to labor unrest at a hospital, the guards go out at a very time you need them most. This represents a very specific danger to hospital physical security.

Secondly, we have no union unfair labor practices in the State of New York. As you said, it was one-sided, where an employer could haul a union into court or before the Board over something; the union can haul a hospital before the Board on unfair labor practice charges, but nothing is defined as a union unfair labor practice. That contributes, I think, to the imbalance of bargaining power.

Similarly there are other matters, relating to the frequency of elections and the need for showing of interest which give more stability to national election processes than to our State processes.

So, in the area of our general labor policy, you have a local policy permitted to govern institutions engaged in interstate commerce in a large way, services patients from throughout the State, and hospital services are helpful to millions in the New York metropolitan tri-State area, and there is no reason why the national policy should not be in effect there. It is direly needed in this respect.

In the other half of New York State's labor policy, we have a special hospital labor law which has two features which I know are controversial and have been discussed in connection with H.R. 1236. That is a prohibition against the right to strike and compulsory arbitration, both of basic bargaining disputes over wages, hours, and conditions of employment and of grievances arising during the terms of contracts.

Our basic position there is that this bill should not be burdened with those controversial measures. They are of dubious value. I am not saying they are without significance, but our experience in 10 or 15 years of living with them indicates that they are probably not of great advantage in solving the basic problem of assuring continuity of hospital care.

I may have gotten more labor injunctions under the New York State hospital labor laws than any other lawyer in the State, representing, as I do, the association of hospitals in the city of New York. None of them have ever been effective to stop a strike or work stoppage or give assurance that a threatened strike would not occur.

The compulsory arbitration provision is not greatly used and probably an impediment to full bargaining and exploration because everybody is bargaining with the view toward the bargaining that will occur and probably reserve a position.

In any event, we do not think the supplanting of those provisions by the national act would constitute an impediment to peaceful labor relations and orderly labor relations. They have not made a great contribution. Some may differ with me. I don't think the union will. The union has never accepted the compulsory arbitration provisions and the prohibition against the right to strike as a way of life in the State of New York.

But, whatever difference of opinion there may be about more or less value in those things, to burden this bill with those problems for something of dubious value and which would impair the passage of the bill we don't think to be right.

Mr. THOMPSON. I can't conceive of this subcommittee or the full committee or indeed the Congress passing compulsory arbitration statutes. We had what amounted to one last year after the fact,

really, of a strike, the west coast dock strike, when the Committee on Rules, in a totally unique action, without any hearing reported out a bill ostensibly designed to settle that strike after this committee had reported a bill short of compulsory arbitration. The President signed the bill reported by Rules in Peking. I thought that was, in that free society, an appropriate place to sign a compulsory arbitration statute.

Let us assume for the moment that H.R. 1236 doesn't pass. What do you foresee in the hospital industry?

Mr. METZGER. I pointed out before and I would like to reiterate something. It is in my written testimony. It is almost a chimerical idea that, by denying systematic procedure to hospital workers, you will stifle their will to organize. I foresee organization throughout the country.

I have maintained, for so many years, that unions do not organize hospitals but hospital managements, by poor practices, tend to drive people into unions.

Without the law, I believe we will—of course, in New York City—suffer under an antediluvian State law if the law has not been amended to meet our needs, but the rest of the country will face unionization. Without a doubt, unionization will go on. The passage of the law will not in any way affect this growth in unionization of the country.

Basically, I think, hospitals have addressed themselves to some of the problems that you mentioned before. I would categorically state that, if you were to conduct a statistical analysis of wages—Dr. Gehrig's point was well taken—they have gone up in hospitals. They have moved into the 20th century, if you will.

I think they ought to be commended. Whether it was defensive or not, whether it was altruistic or not, is not the point. They are to be commended. But organization will go on in the hospital system.

I believe, for that reason, serious consideration of the passage of this amendment would be necessary to provide orderly procedures.

Mr. THOMPSON. Well, I have no further questions, Mr. Metzger except to thank you very much for coming.

Mr. METZGER. Thank you for the opportunity.

Mr. MANEKER. Thank you for the opportunity.

Mr. THOMPSON. We did not have scheduled, but, at the request of the former distinguished Speaker of the House, we have a few minutes, and just a few minutes, to hear from Mr. John Painter, the chairman of the Committee on Labor Relations of the Hospital Council of the National Capitol Area. Will you introduce the gentleman accompanying you?

STATEMENT OF JOHN PAINTER OF THE HOSPITAL COUNCIL OF THE NATIONAL CAPITAL AREA, INC., ACCOMPANIED BY ROBERT J. HICKEY, COUNSEL FOR THE HOSPITAL COUNCIL COMMITTEE ON LABOR RELATIONS

Mr. PAINTER. Thank you.

The gentleman with me is Robert J. Hickey, counsel for our Committee on Labor Relations. Mr. Hickey and I are prepared to answer any questions which the committee might have regarding the presentation we are about to make, and the formal statement filed with the committee.

I want to express our sincere appreciation to you for this opportunity to testify. We are indeed truly grateful. Because the committee

has already gone through extensive hearings on the predecessor H.R. 11357 and considerable hearings on this bill we will try not to duplicate the views expressed by the other hospital associations.

The details are expressed in our formal statement.

Mr. THOMPSON. If I may interrupt you, without objection your full statement and the appendix will be made a part of the record. Unhappily, I don't have time for you to read it in full. So if you would summarize it, that would be most useful.

[The statement referred to follows:]

STATEMENT OF JOHN PAINTER OF THE HOSPITAL COUNCIL OF THE NATIONAL CAPITAL AREA, INC.

Mr. Chairman and Members of the Subcommittee: This statement is prepared by John Painter, Chairman of the Committee on Labor Relations of the Hospital Council of the National Capital Area, Inc., and by Robert J. Hickey, our attorney, on behalf of the twenty-eight metropolitan Washington, D.C. hospitals which are members of the Hospital Council.

We want to thank the Chairman and members of the Committee for the opportunity to appear and testify in regard to H.R. 1236 which would amend the National Labor Relations Act by deleting the exemption for nonprofit hospitals. The effect of this bill, if enacted in its present form, would be to put hospitals on the same footing as other industries subject to the Act.

It is our opinion that a distinction does exist between hospitals and other enterprises subject to the Act's coverage. Our position is that hospitals are not grocery stores, amusement parks, or other enterprises that are regulated by the NLRB. They are unique enterprises with unique problems which cannot be automatically lumped with commercial enterprises. The broad array of services 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 regard 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.

If the only concern of hospitals in preventing passage of HR 1236 in its present form were the added costs, it is unlikely that Congress would be very sympathetic to our plight. Many businesses subject to the National Labor Relations Act are forced to pay wages and benefits they cannot afford. Indeed, many have gone out, or are going out, of existence because of unionization. Despite this, Congress has deemed that overall economic stabilization can be achieved only through coverage by the Act. A legitimate argument could be made that because of its nonprofit character, a hospital should be treated differently. However, because the Act applies to other nonprofit enterprises, this characteristic by itself would be insufficient to justify an exemption from the Act's coverage.

But there is more to hospitals' concern than mere costs. 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 businesses 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, affecting its very existence. If unsuccessful, it succeeds only in interrupting the care of patients, which affects the life and death of those involved. The nonprofit hospital cannot survive such unpredictable and costly disruptions and continue to serve the community and the needs of patients who demand immediate care.

Some might disagree that strikes and economic coercion by unions will have the impact we mention. Others might believe that even if these things do occur, the

protections afforded by coverage of the National Labor Relations Act more than offset the harm caused by coverage. As to the first, we want to point out that one of the leading hospital unions, Local 1199, has stated that absent the strike weapon, there would be no Local 1199, and it has no intention of giving that weapon up even if it means violating the law. Thus, without protection from strikes, hospitals must be prepared for a future of intimidation.

For the last three months, our Committee has been conducting research into the impact of strikes on hospitals. While all the results are not in, our preliminary reports do show that union activity consisting of strikes, picketing, sickouts, sick-in harassment, and violence have occurred and are occurring across the country. The objectives of the unions include recognition, collective bargaining agreements, grievances and jurisdictional disputes. The strikes have ranged from one day to sixty-seven days. While the impact of the union activities has varied, several hospitals have been forced to close down part of their facilities.

We would like to mention only two strikes which recently appeared in the news. The first concerns Ingalls Memorial Hospital in Harvey, Illinois, where the hospital was forced to accept only emergency patients after a strike by its nurses. The dispute involved the reduction in the amount of a shift differential for nurses to be hired in the future. The second involved a strike by 220,000 hospital workers in Great Britain which affected 750 hospitals. As a result of the strike, patients, some of whom required surgery, were sent home. (Incidentally, a city-wide strike of hospital workers recently averted in Philadelphia. It was to be part of a sympathy strike for teachers.) We singled out both of these strikes because they demonstrate how employees under union control was willing to strike over conditions of employment of other individuals not currently employed by hospitals.

This brings us to the question of whether coverage by the National Labor Relations Act will prevent this type of union pressure. The NLRA only limits certain types of strike activity such as recognition strikes, jurisdictional strikes, and secondary boycotts. The Act does not prevent strikes over new contracts or grievances. Where the Act prohibits strikes under certain circumstances, it will take a median of 12 days to secure an injunction but more likely 30 days. In the case of a strike over recognition, time involved in securing an injunction will probably be closer to 60 days. Because few hospitals can survive union pressure that long, the Act's prohibition against strikes becomes meaningless. While the Act contains provisions restricting (*not* prohibiting) national emergency disputes, few, if any, strikes would come within the ambit of the protection and even if they did qualify, the Act only delays the time in which a union can absent special legislation being passed by Congress.

As can be seen from the foregoing, we believe that a bill regulating labor relations in health care institutions must contain, as a minimum, protection against economic pressure by unions, which causes disruption in patient care.

Accordingly, we have prepared the attached bill which would effectively prohibit both strikes and the causes of strikes in hospitals. While compromises in the language of the draft are acceptable, we strongly oppose any compromise in the objectives themselves. Where the public's health is concerned, there can obviously be no compromise.

Among the major items included in the proposed substituted bill are the following:

(1) The impact of a strike on patient care is the same at all health care institutions. As a consequence, the protections afforded by the proposed substituted amendments are extended to all health care institutions, which are defined in proposed Section 2(14). A question is raised as to how to treat contractors doing business both *at* institutions and *with* institutions. Coverage of the first group is obviously needed. If a union can effectively shut down an operation at the health care institution solely because it is not owned by the institution itself, the protections afforded by the amendments are insignificant. Every major health care institution today has at least one operation which is performed by a subcontractor. At present, this ranges from food services and maintenance to such specialties as pharmacy and payroll, with the trend definitely towards even greater subcontracting of specialties.

If the institution cannot provide a key service, whether food services or payroll, it will soon cease to function. Even if replacements can be found, it would take days, perhaps weeks, before they are secured. In the meantime, the juggling of supervisors and other employees to perform these duties must come at the expense of patient care. Accordingly, we have included "subcontractors performing work at such institutions" in the proposed definition of "health care institution".

The treatment afforded subcontractors and suppliers doing business with a health care institution is only slightly better. While Section 8(b)(4)(B) of the present Act prohibits secondary boycotts, it does not contain procedures for the *expeditious* obtainment of a temporary restraining order and a preliminary injunction against such activity. It makes little difference to the health care institution that it is not receiving essential services because a subcontractor, rather than the institution itself, is faced with a strike and is unable to operate. Consequently, under our proposed Section 8(b)(8) such subcontractors, insofar as they are victims of secondary boycotts directed towards health care facilities, are afforded the same protection and remedies as the health care institutions themselves.

It should be noted that this proposal would not protect a health care institution from the loss of essential services due to a strike by the employees of a subcontractor not performing work at a health care institution directed towards the subcontractor in regard to the terms and conditions of their own employment. It is hoped that in this latter situation, the union might be amenable to providing services to the institution despite the strike.

(2) Having taken from the employees the right to strike, we recognize that some procedure must be substituted for the settlement of legitimate employee grievances over the conditions of their employment. What those procedures will be depends on whether the Act imposes an absolute or limited prohibition on the right to strike. If a limited right to strike is given, then the bill should contain: (a) an extended step procedure, consisting of fact finding, voluntary arbitration, final offer vote, and a strike vote; and (b) the right of a state or federal agency to obtain an injunction against the strike if it affects the safety or health of the community in which the institution is located.

It is our view that all strikes are inconsistent with the moral mandate imposed on a health care institution to continue operations for the benefit of the ill and suffering. Thus, we believe the only acceptable solution is either some form of compulsory arbitration or final offer selection. Moreover, because there exists a large number of small health care institutions who would be unable to engage in any complex and costly procedures for the resolution of strikes, any mechanism adopted must be relatively simple to administer. We believe that proposed Section 8(d)(3) accomplishes these objectives. While our proposal calls for compulsory arbitration, we have no objection to the principle of final offer selection as an alternative method for resolving these disputes. However, if a final offer selection is used, it cannot be as complex as the one proposed by the administration in its emergency disputes bill.

The Committee will note that under our proposed Section 8(d)(3)(D) the mediator, not the parties, would have authority to determine when the dispute should proceed to the final step, whether it be arbitration or final offer selection. The reason for this is that in any dispute, one party benefits from the dispute being expedited through the Act's procedures. If that party happens to be recalcitrant in bargaining, the mediator, by holding on to the dispute, can force it to bargain in good faith before proceeding. This uncertainty should contribute to the fostering of collective bargaining among the parties, rather than to their dependence on governmental machinery to resolve their disputes. This proposal is in keeping with the Administration's recommendation to include a holding period for mediation in the national emergency disputes bill.

The proposed substituted amendments also offer protection against strikes over grievances arising during the term of a collective bargaining contract. Under our Section 8(d)(3)(F), the parties are given an alternative of adopting their own procedure for final resolution of these disputes or of following arbitration procedures established for breaking bargaining impasses.

Unlike other employers, a health care institution must possess maximum flexibility in regard to the assignment and scheduling of its work force. Employees must be assigned when and where emergencies arise. This cannot be negotiated with unions either in a contract or with a union steward when an emergency occurs. To solve this problem, we have recommended in proposed Section 8(d)(1) that assignment and scheduling of employment not be matters over which the health care institution must bargain.

(3) The proposed substitution permits, in Section 10(n), a health care institution to seek an injunction without having to first proceed to the National Labor Relations Board. This proposal is extremely beneficial in bypassing the administrative delays in the normal Board processes for obtaining an injunction. Under this section, a court would be required to grant the restraining order without regard to affidavits or testimony but solely upon verification by a party or its

attorney that a strike is taking place. This proposal requires a court to dispense with affidavits and/or the testimony of witnesses before granting a temporary restraining order, which, as a practical matter, might allow strikes to continue for a minimum of one working day before being stopped. However, the parties would still be permitted to present witnesses or affidavits at a hearing to be held on a preliminary or permanent injunction.

Section 10(n) also includes a proviso requiring the mandatory imposition of fines caused by unlawful work stoppages. We recognize that such a procedure imposes a severe burden on unions and other concerted groups and that such a course should not be taken lightly. However, the history of labor disputes in health care institutions in states (particularly New York) with "no strike" laws has shown that such laws are usually not effective, because the unions are able to force the institutions to capitulate before they are found in contempt, or they are able to have institutions waive fines imposed in a contempt proceeding as the price for uninterrupted care in the future following the strike. In some respects, the imposition of fines might work to the advantage of unions. This would occur where a militant minority in the union is able to strike without regard to the union leadership. By imposing mandatory fines, the union leadership might be able to convince this group that such an approach would prove costly and would thereby prevent them from taking this course of action.

It has been suggested that a union engaging in a prohibited strike lose its status as a labor organization for a one-year period. We have no objection to this proposal as an *additional* remedy, and have so provided in Section 2(4). As the Committee must realize, such an approach does not necessarily mean that the union will be without bargaining power. There are many unions today without certification which are bargaining with employers, and which, in fact, might only be a representative of a minority of the employees. Also, during the 1950's when similar restrictions were imposed on Communist unions, these unions were able to continue to bargain with certain employers because of their leverage. We submit that many a health care institution caught in a squeeze by a powerful union will capitulate, even though the law declares that organization has no bargaining rights. Because this, we do not believe that the loss of representative status will, in all instances, be an effective remedy against strikes.

Another remedy which is imposed on Section 8(d)(4) is the mandatory loss of seniority and benefits based on seniority for the period in which the employee is on strike. This will have an effect on employees who might not care whether or not a union is fined or loses its representational status. It is hoped that if the employees themselves are affected by their unlawful conduct, they might decide it is not worth this slight loss in benefits to engage in prohibited activity.

(4) Based on our experience, one of the major causes of disruption in health care institutions is organizational campaigns conducted on the property by employees. Almost all administrators who have faced an organizational campaign can testify as to one or more incidents of employee organizers leaving a patient or some important task to discuss union activity. (Of course, where conversations are involved, several employees might be diverted from their patient care responsibilities.) Accordingly, we would suggest that these activities which lead to a lessening of patient care be restricted. We recognize that the present NLRB rules on organizing activities are based on a balancing of interests tested against organizational tactics conducted over a thirty-year period and that this experience should not be lightly disregarded. However, this balancing of interests has occurred in a context not relevant to the health care industry. It is our opinion that the ability of a health care facility to function without disruption clearly outweighs the employees' interest in organizing on the property. Consequently, our amendment to Section 8(a)(1) eliminates all solicitation and distribution within the confines of the institution's building. This amendment would leave to the National Labor Relations Board the determination of whether this prohibition should be extended to parking lots and similar areas adjacent to the buildings. In this latter situation, the Board could weigh the organizational benefits to the union against any harm caused by delay in the ingress to the institution by both patients and hospital personnel. With the exception of this limitation on solicitation and distribution in the buildings, all other NLRB organizational rules would be applicable to health care institutions.

(5) One of the most important items considered in the proposed substituted amendment concerns the character of the bargaining units appropriate to a health care institution under Section 9(b) of the Act. Health care institutions, 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 con-

ceivable that, as a result of their internal organization and existing NLRB precedent, institutions of the future will be confronted by numerous unions representing small numbers of employees, each of which would be attempting to outdo another. Moreover, a multitude of unions would make the institution 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 we have proposed, in Section 9(b), four basic units, consisting of: (1) all professional employees, (2) all technical employees, (3) all clerical employees, and (4) all other employees. It should be noted that this approach conforms to broad organizational campaigns of the two principal hospital unions: SEIU and Local 1199.

(6) One subject not discussed in our proposed amendments concerns the unionization of supervisors. The American Nursing Association has requested that the Act be amended to redefine the term "supervisors" to allow inclusion of low-level nursing supervisors in the bargaining units. It should be noted that the National Labor Relations Board has, as a practical matter, redefined the definition so that low-level nursing supervisors who have the power to assign and supervise non-nursing employees are probably included in bargaining units, e.g., *New Fern Restorium*, 175 NLRB No. 142 (1969). The American Nursing Association wants to extend this redefinition to encompass low-level supervisors having supervision of other nurses. We believe that all supervisors should be excluded from collective bargaining units. The reason is a simple one: An individual is either a supervisor or an employee. She cannot be both. If she attempts to occupy a dual capacity, she will soon meet with frustration. If a supervisor is part of a bargaining unit, she cannot be expected to discipline her co-employees or to implement other management instructions. Conversely, if an employee is part of supervision, her inclusion in a unit will breed distrust among other employees who will assume that she is a spy for hospital management. Neither the institution nor the employees should be placed in this situation. If an individual is a supervisor, she would be excluded from a bargaining unit without regard to what level of supervision is being exercised.

If it is decided that a redefinition of supervisor is necessary in order to obtain passage of no-strike legislation, we would recommend that an approach similar to that under the Pennsylvania law be followed. Under Section 604 of that State's law, low-level supervisors may form their own separate homogeneous units. (They cannot be included in a unit with other employees.) Section 704 of the same Act grants to such units of first-level supervision the right to meet and discuss matters which are otherwise bargainable. This is a limited right which is not coextensive with the bargaining rights given to other employees.

CONCLUSION

As stated more fully above, it is the position of the Hospital Council of the National Capital Area, Inc., that nonprofit hospitals should only be included within the coverage of the National Labor Relations Act if the Act is further amended to provide protection against strikes and other disruptive activities, and is framed to accommodate the special needs of hospitals. While the Hospital Council believes that its proposed substitute legislation accomplishes these purposes, it would agree to any other alternate legislation which would meet these objectives.

AMENDMENT

(IN THE NATURE OF A SUBSTITUTE)

Intended to be proposed by
to S. _____, a bill
H.R. 1236, an Act

To amend the National Labor Relations Act to extend its coverage and protection to employees of nonprofit hospitals, and for other purposes.

Section 1.

That Section 1 of the National Labor Relations Act is amended by adding at the end thereof the following new paragraph:

"It is also declared to be the policy of the United States to eliminate labor disputes in health care institutions where such disputes interrupt or interfere with patient care."

Section 2.

(a) Section 2(2) of such Act is amended by striking out 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,".

(b) Section 2(4) of such Act is amended by changing the period after the word "organization" to a semicolon and adding the following:

"*Provided*, that an individual or organization which assists or participates in a violation of section 8(b)(8) of this Act shall for a period of one year lose its status as a labor organization under this Act with respect to the employees of the health care institution or institutions affected by such violation."

(c) Section 2(5) of such Act is amended by changing the period after the word "work" to a comma and adding the following language: "and which is not excluded from status as a representative under section 2(4) above."

(d) Section 2 of such Act is amended by adding at the end thereof the following new subsection (14):

"The term 'health care institution' shall include any hospital, convalescent hospital, nursing home, extended care facility, clinic, institution devoted to the care of the aged, or any other health maintenance organization, or any subcontractors performing work at such institution."

Section 3.

Section 8(a)(1) of such Act is amended by changing the semicolon after the number (7) to a colon and adding the following:

"*Provided* that all solicitation and distribution is prohibited within a health care institution."

Section 5.

Section 8(b) of such Act is amended by adding at the end thereof the following new section (8):

"To engage or participate in, authorize, sanction, threaten, or to induce or encourage any individual or person to engage or participate in a strike, picketing, or work stoppage, or for any reason whatsoever, (i) against a health care institution, or (ii) against any persons doing business with such institution where an object thereof is prohibited by subsection (4) of this section: *Provided*, That nothing contained in this subsection shall prohibit publicity other than picketing for the purpose of truthfully advising the public of the existence of a dispute with said health care institution unless any effect of such publicity is to induce any individual or person to refuse to pick up, deliver or transport goods, or to perform services: *Provided further*, That nothing contained herein shall be construed to permit a health care institution to engage in a lockout of its employees."

Section 6.

Section 8(d) of such Act is amended as follows:

(a) The paragraph commencing with the phrase "For the purpose of" and ending with the phrase "require the making of a concession:" shall form a new subsection (1). After the word "concession", the following shall be added:

"*Provided*, That health care institutions 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 standards of service, assignment, selection, scheduling and direction of personnel, and the utilization of technology."

(b) That portion of the Section 8(d), commencing with "Provided that" and ending with "whichever occurs later:" in subparagraph (4) shall form a new subsection (2), except that the words "Provided that" shall be deleted and a period shall follow "later" in lieu of the present colon. Subparagraphs 1 through 4 shall be renumbered A through D.

(c) Following the new subsection (2) and prior to the phrase commencing with "The duties imposed . . .", the following new subsection (3) shall be added:

"(A) When a collective bargaining agreement is in effect between a health care institution and a labor organization, the agreement shall continue in full force and effect without recourse to strikes, picketing, work stoppages, or lockouts, and in negotiations for a renewal of such agreement the following procedures shall apply.

"(B) 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 prior to the proposed effective date of such termination or modification, whichever date is later.

"(C) During the first 80 days of the 90-day notice period, the party desiring such termination or modification shall offer to and shall meet within 15 days of the offer and shall confer with the other party at reasonable times in an effort to satisfy the requirements of section 8(d).

"(D) 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. If in the discretion of the 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.

"(E) Upon expiration of mediation, if an agreement has not been reached and the parties have not mutually agreed upon a procedure for a binding resolution of their dispute, the Director of the Service shall forthwith provide the parties with a list of five persons from which list the parties shall each alternately strike one name until only one name remains. The party who served the notice of contract termination or modification shall be the first to strike a name. The person whose name remains shall consider and determine the dispute. 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.

"(F) If during the terms of a collective bargaining a dispute arises over the interpretation or application of the agreement, which is not subject to final adjustment under the terms of the agreement, without resort to economic activity by one of the parties, the procedures set forth in subsection (E) shall be followed to resolve the dispute."

(d) That portion of Section 8(d) commencing with "The duties imposed . . ." and terminating with the phrase "reemployed by such employer", shall form a new subsection (4) with the following modification. The first part of the first sentence shall be modified to read: "The duties imposed by employers, health care institutions, employees, and labor organizations by subparagraphs (2) and (3) . . ." The last sentence is modified by deleting the period and substituting a comma and the following phrase: "except that an employee who violates Section 8(b)(8) and who is reemployed shall not be entitled to any compensation, seniority, or benefits based on seniority for the period in which he was engaged in unlawful activity."

Section 7.

Section 9 of such Act is amended by adding at the end thereof the following new subsection (f):

"The only appropriate units in a health care institution shall consist of one of the following units, or combination thereof: (1) all professional employees; (2) all technical employees; (3) all clerical employees; and (4) all other employees: *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 other than those set forth above may be voluntarily agreed to by the health care institution and the labor organization."

Section 8.

Section 10 of such Act is amended in the following manner:

(a) Section 10(1) of such Act is amended by striking the period at the end of the first sentence and adding ", and cases given priority under subsection (n)."

(b) Section 10(m) of such Act is amended by striking the period and adding "or (n)."

(c) Section 10 of such Act is amended by adding at the end thereof the following new subsection (n):

"Whenever it is charged that any person has engaged in an unfair labor practice within the meaning of section 8(b)(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 court in the United States having jurisdiction of the parties for appropriate injunctive relief pending the final adjudication of such matter. Upon the filing of any such petition the court shall have jurisdiction to and shall grant a temporary restraining order without regard to the facts or legal issues involved so long as the petition is accompanied by a verified statement from an officer of the institution or its attorney that a

strike, picketing or work stoppage is occurring. The temporary restraining order shall issue for a period of 15 days and may be extended for an additional 15 days. Upon filing of any such petition the court 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. No later than 30 days after the issuance of the temporary restraining order, the court should hold hearings on whether a preliminary injunction should issue and under what conditions. The court shall retain jurisdiction to determine whether the injunction should become permanent.

If it is determined that there is a violation of Section 8(b)(8) by a labor organization, the court must impose upon the labor organization a fine of not less than \$1,000 for each day on which a violation occurs, which fine cannot be waived by agreement of the parties.

For the purposes of this subsection a court shall be deemed to have jurisdiction of a labor organization (i) in the district in which such organization maintains its principal office, or (ii) 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."

Section 9.

(a) Section 303(a) of the Labor Management Relations Act is amended by inserting "or 8(b)(8)" between "8(b)(4)" and "of".

(b) Section 303 of the Labor Management Relations Act is amended by adding at the end thereof the following new subsection (c):

"Any health care institution, labor organization or patient or other occupant of a health care institution injured by reason of violation of section 8(b)(8) of the National Labor Relations Act may sue in a United States District Court or in any other court having jurisdiction of the parties in the same manner as provided in section 303(b). In such an action, the court may award both actual and punitive damages for injury to property and to the person, including suffering, and the costs of the suit. In the determination of liability, the existence of a violation of section 8(b)(8) of the National Labor Relations Act shall constitute *prima facie* evidence that such violation was the proximate cause of the injury."

MR. PAINTER. I think, Congressman, that the main thing we are here for is really in the interest of the patient. We are here because we feel that the patient needs protection. We feel that the amendment as proposed does not provide that necessary protection.

A minute ago Mr. Metzger spoke about he would like to have the protection that is afforded General Motors. I think hospitals deserve more protection than is afforded under the law to General Motors. The problem here is, if a strike involves the lower level of employees, we may be able to continue in a favorable climate; but if it involves the technical or professional employees there is no chance. We must yield to the union.

We did begin studies last November, which we have been conducting since that time, of hospital strikes throughout the country. It has been our experience that the hospitals experience the same economic pressures that are brought to bear against other forms of industries. That is, some strikes were peaceful, some involved violence, intimidation and harassment. In one strike right here in the District of Columbia in a nursing home, patients were given an overdose of laxatives by employees sympathetic to the striking union, which resulted in two patients having to be taken to the hospital. In the same strike, the unions made use of stench bombs, which has a severe effect on patients, those suffering from emphysema.

We are not saying that happens in all strikes, but we are saying when people become overheated it is apt to happen. Today we are reading about the strike not only right here in Maryland of four State hospitals, but in England 750 hospitals were shut down by 220,000 some employees. Those hospitals were forced to send patients

home, even those facing surgery. Possibly you don't believe that it would happen here.

Mr. THOMPSON. I don't.

Mr. PAINTER. But the gentleman earlier today, Mr. Godoff, made the same threats to the hospitals in New York, and has made it every time they come to an impasse on negotiations.

Mr. THOMPSON. Of course you would stop such things.

Mr. PAINTER. The local in Philadelphia was prepared to support the teachers, in their strike, and they threatened to shut down every hospital where they had representation in Philadelphia.

I have discussed this point to eliminate the idea that strikes will not happen in hospitals. They will, unless there is some statutory mechanism for preventing strikes, or stopping them as soon as they occur.

We have outlined in our statement various procedures which we believe should be followed in eliminating economic pressures against hospitals. We are not wedded to any particular formula either for the elimination of the strikes or the causes leading to the strikes. We hope that our proposed amendments will provide the basis for an intelligent discussion of the needs of hospitals.

Mr. Hickey will be prepared to answer any questions you might have regarding that amendment.

I think in the interest of time I might skip over to the fact of the question of the supervisory nurses that was brought up in the first hearing by the American Nursing Association. It would appear that they and the committee have not taken into account the fact that there was the NLRB decision in the *New Fern Restorium*, 175 NLRB 142 (1969), which did involve licensed practical nurses and most low level nursing supervisors being included in units composed of the other nurses. Thus the ANA proposal is aimed at the nurses in the upper echelons of supervision, so that they would be in the same unit with the people they supervise.

If this is granted both hospitals and nursing employees would suffer. The hospitals obviously cannot rely upon a supervisor who has aligned herself with the people over which she is to exercise discipline. On the other hand, employees don't feel good when they know the nurse is going to go back and report the things that happen to management. On the whole it is an unwholesome situation which we think should be rejected by the committee.

In conclusion, I want to thank the committee for allowing me to make this brief presentation.

Mr. THOMPSON. I want to thank you for coming. We had felt earlier that our schedule was such that we could not include you. We have had a considerable body of hearings, this legislation being identical to the legislation of last year which passed the House by more than 70 percent of the vote.

I just have one or two questions. How many hospitals in the Greater Capital area have unions?

Mr. PAINTER. I would say three or four.

Mr. HICKEY. It varies. There are probably three or four that have unions throughout the hospital. There are several others which have different groups within the hospital unionized.

Mr. THOMPSON. I see. Have there been any recognition strikes in the area?

Mr. HICKEY. There has been picketing. The worse situation was on a nursing home that was covered by the act.

Mr. THOMPSON. A proprietary nursing home?

Mr. HICKEY. That is correct. As far as true recognition picketing, we have not really seen too much of that. If it has happened it is a sporadic thing which comes and goes.

Mr. THOMPSON. Are you affiliated with the American Hospital Association?

Mr. PAINTER. Yes.

Mr. HICKEY. I don't want to take up too much of the committee's time. But I do feel this is worth while. I was a former employee of the National Labor Relations Board. I have sat through several of the hearings and have heard quite a bit of testimony on section 8(b)(7)(C), which is the recognition picketing section. I handled quite a few of the cases when I was at the Board and since then, I think the protection that this committee believes 8(b)(7)(C) affords is highly overstated. All you have to do is read the Board cases to come to that conclusion.

First of all 8(b)(7)(C) doesn't prohibit all recognition picketing. A union can engage in publicity picketing without being stopped unless, of course, there is a work stoppage. If it engages in true recognition picketing it has up to 30 days.

Now the Board can step in in less than 30 days, but the Board only does so where there is violence. I had a strike where the company was suffering a million dollars a day, and the Board refused to step in. They will only step in where there is going to be violence.

Assuming the 30 days runs, the median time on the Board and with all reports is 12 days. That is the quickest without any problem at all. The normal situation is 30 days, more than likely 60 days, if you have any legal problem. If you add up all the time, and you can do this in any strike, you can pick and choose your choice under 8(b)(7)(C), you will find out the average time in getting an injunction under 8(b)(7)(C) will run you from 60 to 90 days.

If you are a hospital in an area where there are no other hospitals you can't move patients. You cannot subcontract. It means as a practical matter, you don't have a strike.

The absence of strikes doesn't prove how the legislation will work. It just proves how easy it is for a hospital to cave in. They are extremely easy. How many will face closing down and having patients sue them for hospitalization. It happened in England. That wasn't a strike over recognition. All of the English hospital workers are unionized. It happened over a sympathy strike in favor of other workers, and they were willing to shut down all the hospitals and patients were sent home.

I think if the committee wants to find out exactly what happens in a strike like that, it is very, very easy. I think it would be worthwhile for the committee to write to the equivalent of this Labor Committee to find out what has happened.

Mr. THOMPSON. Well, interestingly enough, the committee, 2 years ago, went to Europe and did a comparative study of the labor laws in Italy, France, and the United Kingdom. I happened to have some friends in Parliament, and had something of a hand in drafting of the British labor law, which is only 2 years old. Much of it was drawn from the Canadian law, and much was drawn from our law.

But I remember very well warning them that they were, in my judgment, inadequately prepared to deal with problems which would arise under their act, particularly 8(a)(3) type violations.

It was really almost amusing to see that they had established a staff of under 50 to administer that law, which on its surface was impossible. The law is not by any means completely analogous to ours, nor is the labor-management structure in the United Kingdom like ours. I studied it rather intensively. It was based largely on the common law. Employees have rights there which far exceed the rights of American workers in many instances.

Knowing what I do of the British law, and incidentally, this committee printed a rather extensive report of those comparisons, I see no possibility of an analogous situation in the United States. I hope to be going back there, and at such time I will look into it. But I am afraid that I will go back there after this passes the House.

So with that I will thank you very much for coming.

The subcommittee will adjourn.

[Whereupon, at 12:20 p.m. the subcommittee adjourned.]

[The following material was submitted for the record:]

STATEMENT OF HENRY T. WILSON, ASSOCIATE COUNSEL, FEDERAL-PUBLIC SERVICE DIVISION, LABORERS' INTERNATIONAL UNION OF NORTH AMERICA

Mr. Chairman and Members of the Subcommittee: We would like to thank the Chairman, Representative Thompson, and members of the Subcommittee for the opportunity of submitting for the record a statement in support of H.R. 1236. Even though H.R. 1236, 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.

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 Laborer's International Union 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 NONPROFIT 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 H.R. 1236.

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 from 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 H.R. 1236 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 Laborers' 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 1236 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 1236. 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.

KENTUCKY HOSPITAL ASSOCIATION,
Louisville, Ky. April 26, 1973.

HON. CARL D. PERKINS,
U.S. House of Representatives,
Rayburn House Office Building, Washington, D.C.

DEAR CONGRESSMAN PERKINS: Please recall our previous correspondence outlining this Association's opposition to H.R. 1236 (Amendment to the National Labor Relations Act) which is identical to H.R. 11357 in the last Congress, both of which were introduced by Congressman Thompson from New Jersey, Chairman of the Special Subcommittee on Labor. H.R. 1236 would remove the existing exemption of not-for-profit hospitals from the Act.

Our Association requested an opportunity to appear before the Subcommittee, but Congressman Thompson advised that there was no time available for testimony and invited us to submit a statement for the record. This we have done.

The Kentucky Hospital Association opposes H.R. 1236 on essentially the same basis as that set forth in testimony by American Hospital Association representatives to the Subcommittee on April 19, 1973. In the interest of brevity we are enclosing a copy of the AHA statement which was presented to the Subcommittee. (See testimony on p. 90.)

We have carefully reviewed the record of the Subcommittee hearings held during the last session of Congress. The bill moved rather quickly in the House last year, as the record will show. We do hope that our views will receive serious consideration by the full Committee on Education and Labor after it is reported by Congressman Thompson's Subcommittee. Moreover, we would hope that the debate on the floor of the House would clearly indicate our views on this piece of legislation.

The work stoppages in Kentucky hospitals as the result of recognition or collective bargaining attempts have been few and far between. As you realize, most of our hospitals are small and located in rural areas. Should hospitals services be curtailed or stopped in those communities, there is no nearby place for the patients to be transferred to. In fact, even in the few urban areas in the Commonwealth the transfer of patients from one institution to another would be almost impossible, should the *welfare of the patient* be considered as the most important factor in the case of an institution which might experience a work stoppage.

This Association has for many years worked with its member institutions to insure that hospital personnel policies, salaries and fringe benefits were in line with the economic realities of the communities in which they provide service. State and Federal minimum wage requirements, other Federal statutes and the usual factors of supply and demand require that hospitals meet their obligations and responsibilities to their employees as in any other industry. We believe that unemotional consideration of the facts in the case support our viewpoint.

H.R. 1236 appears simple enough, but as outlined in the AHA Statement, the National Labor Relations Act, as presently written, would not deal with the inadequacies of the act as applied to health care institutions. We simply must insure that every effort is made to protect the patients in hospitals under any and all circumstances. Our institutions have done this since the beginning. Should Congress in its wisdom take action to bring nonprofit hospitals under the National Labor Relations Act, then legislation must be included in the act to protect patients from the results of strikes or work interruptions which involve life and death situations.

We appreciate this opportunity to present our views to you and the Subcommittee for the record.

Sincerely yours,

HASTY W. RIDDLE,
Executive Vice President.

GREATER GRAND RAPIDS HOSPITAL COUNCIL INC.,
Grand Rapids, Mich., April 17, 1973.

Re H.R. 1236 Amendments to the National Labor Relations Act.

Representative JAMES O'HARA,
House Office Building,
Washington, D.C.

DEAR REPRESENTATIVE O'HARA: In reference to the above legislation, Grand Rapids Hospitals are concerned about including provisions dealing with strikes, picketing, impasse resolutions and bargaining unit fragmentation in such a manner as to protect the continuity of patient care.

We are making a specific request that our concerns be included in the official printed hearing record on the bill.

If there are to be changes in the existing law, we solicit your support of amendments attached as promulgated by the American Hospital Association as being in the best interest of our patients and their continuing care.

However, we do recognize that Michigan has a good labor relations law, and therefore, we are opposed to having this law pre-empted by changes in Taft-Hartley.

Michigan law does not allow the right to strike and cases can be settled in Michigan instead of involving the U.S. Courts and the backlog of NLRB cases.

Yours truly,

W. B. MARSHALL,
Executive Director.

Enclosures.

PROPOSED AMENDMENTS TO NATIONAL LABOR RELATIONS ACT WITH COMMENTARY

Approved by Board of Trustees November 16, 1972

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:

"(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.

Eliminates the exemption for not-for-profit hospitals.

Defines "health care institutions" broadly so that all 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.

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).

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.

"(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 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.

"(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; 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 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 handbills and similar advertising that 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 termination and modification procedures set forth in subsection (d) of this section 8."

5. Section 9 is amended by adding a new subsection (f) as follows:

"(f) 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 that (1) includes professional employees, unless all 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 the technical employees employed in such institution by the employer operating such institution are included therein; or (3) includes clerical employees, unless all 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 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 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 that is agreed upon by the employer and the bargaining representative."

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:

Technical amendment. Makes the inconsistent termination and modification 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 work force 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 NLRA § 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.

COMMENTS

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 proved that, even in priority cases, the board cannot respond swiftly enough in obtaining temporary injunctive relief to prevent irreparable injury.

Provides additional protection for health care institutions from illegal strikes and picketing by creating a cause of action for damages.

AMENDMENT

"(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 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)."

CALIFORNIA HOSPITAL ASSOCIATION,
Sacramento, Calif., April 23, 1973.

Re H.R. 1236.

Hon. FRANK THOMPSON, Jr.,
Chairman, House Special Subcommittee on Labor,
Rayburn House Office Building, Washington, D.C.

DEAR CONGRESSMAN THOMPSON: This is in response to your invitation to the California Hospital Association to submit a statement for the record on H.R. 1236. This bill would extend coverage of the National Labor Relations Act to nonprofit hospitals.

The California Hospital Association represents some 600 acute general hospitals. Some of our members in the San Francisco Bay Area have had collective bargaining agreements for more than 30 years. At least 125 of our member institutions have collective bargaining agreements, and many of these hospitals deal with from six to nine different unions in one institution.

The California Hospital Association is opposed to H.R. 1236 because we believe—for reasons expressed in the current and previous hearings by the American Hospital Association and others—that this bill would be detrimental to hospitals, patients and the communities which are served. However, we do not intend merely to repeat what others have said in this regard. Our purpose in submitting this statement is 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 that amendments be adopted which would remedy those deficiencies in the event the Committee concludes that nonprofit hospitals should be covered under the Act. We believe that if hospitals are to provide adequate patient care services while covered under the National Labor Relations Act, amendments must be adopted to provide solutions for two major problems—(1) strikes, picketing and impasse resolution in hospitals and (2) the fragmentation of hospitals into numerous bargaining units.

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 above, 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 amendments be adopted to deal with collective bargaining impasses.

Although the right to strike should be preserved, the right to exercise that option should be severely limited for hospitals and other groups, such as public employees. In an acute health care institution, a strike has its chief impact on acutely ill patients not on the employer or the employees. Similarly, a strike against a government agency has its major effect on the public rather than the participants in the dispute. This is recognized in a bill which was recently introduced in the California State Legislature by Assembly Speaker Bob Moretti proposing a state labor relations law for public employees. The bill resulted from the recommendations of an Advisory Council on Public Employee Relations, which consisted of five prominent labor relations experts.

In an effort to minimize the thrust of disrupted government service due to unresolved employee grievances, the proposed bill provides for mandatory mediation, non-binding fact finding and cooling-off periods prior to resorting to a strike or lock-out to resolve labor disputes. The need to resolve impasses short of a strike where the public interest is involved apparently was the motivation for President Nixon's recent appointment of "The National Commission for Industrial Peace" whose charter is to explore ways for management and labor to resolve their differences through collective bargaining "consistent with the public interest."

In addition to an impasse resolution procedure, amendments are essential to prohibit other types 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, the proposed amendments should 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. The proposed amendments should 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, X-ray 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, and that amendments be adopted which are designed to prevent any further fragmentation of health care institutions into small units. Such amendments should 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 should include separate units for (1) professional employees, (2) technical employees, (3) clerical employees and (4) service and maintenance employees. A hospital should be allowed to agree to a smaller unit if appropriate to do so in any given case, but smaller units should not be imposed upon hospitals.

We believe that the amendments suggested above 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.

Sincerely yours,

WILLIAM M. WHELAN,
Executive Director.

AMERICAN OSTEOPATHIC HOSPITAL ASSOCIATION,
April 27, 1973.

HON. FRANK THOMPSON, Jr.,
*Chairman, Special Subcommittee on Labor, Committee on Education and Labor,
Rayburn House Office Building, Washington, D.C.*

DEAR MR. THOMPSON. 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 being considered in the bill H.R. 1236.

The American Osteopathic Hospital Association 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 exists between them and the hospital's management. The ever-rising cost of hospital health 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 care costs, there would be difficulty in justifying the additional costs that would result from collective bargaining units in non-profit hospitals.

The implications of the Taft-Hartley Act, and the very nature of the non-profit hospital cannot be overlooked in this discussion. Collective bargaining in its usual sense cannot be applied to non-profit hospitals. The non-profit community hospital is not a factory or a store; in fact, it has no analogy in private industry. It does not manufacture or sell products. On the contrary, it deals with the preservation of human life, the facing of life and death situations. No part of its net earnings inures to the benefit of any private share holder or individual. The hospital exists only for the good of the patient, not to produce a product or make a profit.

The essential relationship of hospital workers to quality care of patients also clearly differentiates hospitals from business and industry. In delivering patient care services, health care institutions are wholly dependent upon their employees. This unique relationship must not be tampered with by anyone or any outside influence, if hospitals are to provide and maintain uninterrupted and constantly available high quality health care.

Implicit in the collective bargaining process under the National Labor Relations Act are strikes, picketing, and work stoppages. Toleration of such activities by an institution which is devoted to quality, constant health care is ludicrous. Yet, under the NLRA, unions are permitted to engage in recognition strikes and picketing. Apart from the recognition strikes and picketing, NLRA 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.

In the final analysis, the persons who would suffer the most from the strike situation would be the one who could least afford the risk—the PATIENT.

Sincerely,

Mr. E. R. LINK, Jr.,
Executive Director,
American Osteopathic Hospital Association.

STATEMENT OF THE KENTUCKY HOSPITAL ASSOCIATION

The Kentucky Hospital Association opposes H.R. 1236 on essentially the same basis as that set forth in testimony by American Hospital Association representatives to the Special Subcommittee on Labor on April 19, 1973.

The work stoppages in Kentucky hospitals as the result of recognition or collective bargaining attempts have been few and far between. Most of our hospitals are small and located in rural areas. Should hospital services be curtailed or stopped in those communities, there is no nearby place for the patients to be transferred to. In fact, even in the few urban areas in the Commonwealth the transfer of patients from one institution to another would be almost impossible, should the *welfare of the patient* be considered as the most important factor in the case of an institution which might experience a work stoppage.

This Association has for many years worked with its member institutions to insure that hospital personnel policies, salaries and fringe benefits were in line with the economic realities of the communities in which they provide service. State and Federal minimum wage requirements, other Federal statutes and the usual factors of supply and demand require that hospitals meet their obligations and responsibilities to their employees as in any other industry. We believe that unemotional consideration of the facts in the case support our viewpoint.

H.R. 1236 appears simple enough, but as outlined in the AHA Statement, the National Labor Relations Act, as presently written, would not deal with the inadequacies of the act as applied to health care institutions. We simply must insure that every effort is made to protect the patients in hospitals under any

and all circumstances. Our institutions have done this since the beginning. Should Congress in its wisdom take action to bring nonprofit hospitals under the National Labor Relations Act, then legislation must be included in the act to protect patients from the results of strikes or work interruptions which involve life and death situations.

(Submitted by Hon. Romano L. Mazzoli.)

THE AMERICAN SOCIETY OF RADIOLOGIC TECHNOLOGISTS,
Chicago, Ill., April 20, 1973.

Hon. FRANK THOMPSON, Jr.,
House of Representatives,
Washington, D.C.

DEAR MR. THOMPSON: By the time I learned that Hearings were being held on H.R. 1236, it was too late to prepare and present testimony on this legislation. However, our Board of Directors has taken a position in favor of the passage of this bill.

Employees of not-for-profit hospitals need the protection provided by the NLRA from arbitrary and capricious management. Although the protections provided by this Act may not be needed in every not-for-profit hospital, where they are needed, they are needed badly.

The testimony of hospital associations tends to make it appear that the quality and quantity of patient care would suffer if H.R. 1236 is passed. Actually, the opposite is true. When employees are harassed and disgruntled and they perceive no reasonable means for remedy, is it likely that their motivation would be as high as it would be if they were not burdened with concerns induced by conditions of their employment?

As employers not-for-profit hospitals have the same obligations to their employees as clinics, for-profit hospitals and nursing homes which are covered by the Act. Therefore, the current exemption from the Act for not-for-profit hospitals should be eliminated.

Sincerely,

ROBERT C. BEST,
Executive Director.

STATEMENT OF THE SOUTHERN STATES INDUSTRIAL COUNCIL

The Southern States Industrial Council, representing approximately 3,000 employers and 3,000,000 employees, wishes to register strong opposition to H.R. 1236, a bill which would extend coverage of the National Labor Relations Act to the employees of non-profit hospitals.

We have submitted testimony to this subcommittee in the past stating that reform of our national labor law is long overdue and urging that the NLRA be given a complete overhaul. It is highly disturbing to our members that instead of consideration being given to the reforms so urgently needed, it is rather being given to a proposal for bringing an additional 1.4 million employees under the act.

Furthermore, the proposal under consideration would extend all the abuses which have been the outgrowth of our national labor law to service institutions which, above all others, should be free from strikes, slowdowns, picketing and violence. In the case of industrial plants, disruption of operations by concerted action of labor unions usually causes financial loss and personal inconvenience to a substantial number of people. But in the case of hospitals, union-formulated disruptions and disturbances can cause suffering and even death.

Our labor law gives unions so many special privileges and saddles employers with so many handicaps that it has enabled unions to develop excessive, monopolistic power. Unions have used this power to artificially inflate wages and at the same time reduce productivity. The result is high labor costs which, in the case of non-profit hospitals, must be added to charges to patients which already are at a level so high as to cause financial crises among countless families when hit by serious illness and prolonged hospitalization.

Enactment of H.R. 1236 would have tremendous repercussions throughout the entire area of labor-management relations. It would for the first time extend by legislative enactment the coverage of the NLRA beyond the limits set by Congress. Because of its significance, this legislation should be submitted to exhaustive examination. Its implications should be thoroughly explored at public hearings in which all interested parties are given an opportunity to participate.

Yet, in the 92nd Congress a bill identical to H.R. 1236 was rushed through the House after abbreviated hearings before this subcommittee. Fortunately, the bill was stalled and never reached the Senate floor after word of what was happening got around and a storm of protest arose. The same thing seems to be happening all over again in this subcommittee in the current session. After the briefest public notice, only two days of hearings were scheduled on H.R. 1236, closing out a long list of potential witnesses, highly qualified by their experience under the NLRA to appraise the effects of broadening its coverage.

Union officials keep coming back again and again to press Congress for more privileges and more power. It is, therefore, no great surprise that they should be exerting pressure so soon again to bring more workers under the NLRA—the act which has worked so much in their favor, to the detriment of employers and the rights of many individual employees who do not want union representation. The question is being asked, however, as to whether the House Special Subcommittee on Labor and the House Labor Committee should not be more resistant to union pressure. Is enough consideration being given to the needs, wishes and problems of the great majority of the labor force which is non-union, and the proper balancing of the rights of employers against the rights of unions?

Is the self-interest of unions and union officials being placed above the public interest? We believe the members of this subcommittee should ask themselves whether promoting the unionization of hospital workers, as the NLRA would do if these workers were placed under it, would be in the best interest of the people who voted them into office. The history of what has happened to industry under the NLRA—artificially high costs, strikes, slowdowns, disruptions of service, strife and violence—provides convincing proof that transplanting these abuses to the area of hospital care would be a disservice to the American people.

We have in previous testimony cited many of the flaws in the National Labor Relations Act. Both as it was written by Congress and as it has been interpreted by the National Labor Relations Board and the courts, the act has provided organizing and bargaining advantages for unions and disadvantages for employers and non-union employees. Perhaps the most serious flaw in our labor law is the privilege given to unions of “exclusive representation”, forcing employees who voted against union representation to accept it against their will. Then the law compounds this evil by authorizing labor contracts which compel employees to pay dues and fees for the unwanted union representation.

The special privileges of exclusive representation and compulsory unionism, plus the exemption of unions from the anti-trust laws, have permitted the unions to develop such monopoly power that they virtually run rampant in this country. Under the NLRA, unions have been able to circumvent secret ballot elections among employees through use of card checks; conduct secondary boycotts which supposedly are illegal; institute featherbedding and make-work practices; and deprive employers of freedom of speech in communicating with their own employees and of such basic management rights as subcontracting of work and relocation of plants. The list of abuses that have developed under the NLRA is long and the foregoing are only a few examples.

Union power developed through compulsory unionism and other flaws in the NLRA is both economic and political. The latter has made possible the pressures on Congress to which we referred earlier—pressures which some members of Congress who have accepted large amounts of union money and manpower in their election campaigns find very difficult to resist. This constitutes a compelling reason not to extend the NLRA to 1.4 million more workers since it would enable union officials to amass still more money and even greater political power.

When Congress faces up to the ills generated by the NLRA and takes the necessary steps to remedy them, it may be time to talk about extending the coverage of the act to more American workers. Until that time, members of Congress should have the fortitude to say “no” to union officials and summarily reject such proposals as H.R. 1236.

BOARD OF CHURCH AND SOCIETY
OF THE UNITED METHODIST CHURCH,
April 11, 1973.

HON. FRANK THOMPSON, Jr.,
*Chairman, Special Subcommittee on Labor,
House of Representatives, Washington, D.C.*

DEAR MR. THOMPSON: Thank you for the opportunity of submitting a statement for the record in relationship to hearings on H.R. 1236.

In April, 1972 the General Conference of The United Methodist Church, meeting in Atlanta, Georgia, adopted a "Resolution on Extension of Right to Organize and Bargain Collectively" which applies directly to H.R. 1236. The General Conference of The United Methodist Church is the highest legislative body of that church and its resolutions represent official positions taken by that church.

The resolution states:

Historically, the United Methodist Church has recognized and supported the right of workers to organize and bargain collectively over wages, hours, and conditions of labor. National policy since 1935 has codified procedures for the recognition of labor unions and for collective bargaining with the result of lessened conflict in the private industrial sector of the economy.

However, several categories of employees were excluded from the coverage of the National Labor Relations Act including (1) federal employees or employees of any political subdivision such as State or school district (2) employees of hospitals operated entirely on a nonprofit basis.

Unfortunately, social strife in the occupational markets of non-profit hospital workers and public employees has led to high social costs, including the tragedy of death. In view of this unresolved strain, the United Methodist Church requests the Congress to amend the National Labor Relations Act to include under its coverage (1) government employees, federal, state, and local, and (2) the employees of hospitals operated entirely on a nonprofit basis.

On behalf of The United Methodist Church and in keeping with the above resolution, I urge the Special Subcommittee on Labor to report H.R. 1236 favorably to The House of Representatives.

Sincerely yours,

LUTHER E. TYSON, Ph.D.,
*Director, Department of Economic Life,
 Board of Church and Society,
 the United Methodist Church.*

AMERICAN FEDERATION OF LABOR AND
 CONGRESS OF INDUSTRIAL ORGANIZATIONS,
 Washington, D.C., April 24, 1973.

HON. FRANK THOMPSON, Jr.,
*Chairman, Special Subcommittee on Labor of the Committee on Education and Labor,
 House of Representatives, Washington, D.C.*

DEAR MR. CHAIRMAN: The AFL-CIO at its last Constitutional Convention passed unanimously the enclosed resolution urging the continuation of efforts to extend the protections of the National Labor Relations Act to the employees of non-profit hospitals.

At the present time these employees are specifically exempted from coverage under the law's provisions. As a result, over 1.3 million of these workers are currently denied federal protection of such basic trade union rights as the right to organize, to bargain collectively through representatives of their own choosing and to be protected from harassment and other unfair labor practices of unscrupulous employers in the exercise of these rights.

In this regard, Mr. Chairman, and in conjunction with your subcommittees recent hearings on legislation to bring the employees of non-profit hospitals under coverage of the National Labor Relations Act, I wish to express organized labor's full support for your bill, H.R. 1236, which would accomplish this much needed change in the law. I would also respectfully request that this letter and the enclosed Convention Resolution be included in the hearing record as the official policy of the AFL-CIO on this legislation.

Thank you for your time and interest.

Sincerely yours,

ANDREW J. BIEMILLER,
Director, Department of Legislation.

Enclosure.

HOSPITALS UNDER THE NLRA

WHEREAS, While hospital charges have increased tremendously, the majority of the almost three million hospital workers in the United States remain without the protection of unionization, and

WHEREAS, The unionization of these workers—many of them paid only the federal minimum wage of \$1.60 per hour—is made more difficult by the specific exclusion of non-profit hospitals from coverage by the National Labor Relations Act, and

WHEREAS, Some hospital workers are now granted collective bargaining rights under Federal Executive Order 11491, through state and local government employment and legislation, and through decisions of the National Labor Relations Board with regard to proprietary hospitals, and

WHEREAS, This coverage makes it doubly unfair that non-profit hospital employees are still denied NLRA coverage; therefore, be it

RESOLVED: That the AFL-CIO express complete and continued support of the effort to obtain NLRA protection for the employees of non-profit hospitals.

THE CATHOLIC HOSPITAL ASSOCIATION,
St. Louis, Mo., April 17, 1973.

HON. FRANK THOMPSON, Jr.,
House of Representatives,
Washington, D.C.

DEAR MR. THOMPSON: 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 1236, 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 1236, 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 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 interrupted 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 1236 overlooks this moral and humanitarian obligation of management and labor.

The proposed amendment to and the National Labor Relations Act fails 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 1236, 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. We are concerned that, unless the right of the public for uninterrupted hospital service is given due consideration and is acted upon by you—Congressman Thompson—and your colleagues by means of amendment(s) to HR 1236, the public interest will not be served.

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 1236 protect the public's right to uninterrupted hospital service.

Sincerely,

Sister IRENE KRAUS, DC,
President.

Enclosure.

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 employees to form a union. The unionization or nonunionization is the decision of the employees 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 employees.
2. Hospital employee practices should conform to all standards established by competent public authority.

3. Remuneration and benefits furnished employees 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 employees 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 employees should be free of any reprisal for the exercise of such rights. Hospitals should likewise recognize the right of employees to choose not to be represented by a union.

6. Hospitals should be prepared to deal with such unions or associations should the employees 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 employees.

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 employees 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.

MICHIGAN NURSES ASSOCIATION,
East Lansing, Mich., March 29, 1973.

HON. JAMES G. O'HARA,
Congress of the United States,
House of Representatives, Washington, D.C.

DEAR MR. O'HARA: Michigan Nurses Association, the professional association representing R.N.'s in the State, wishes to express its support of HR 1236, introduced by Representative Frank Thompson, D., New Jersey and Representative John M. Ashbrook, R., Ohio.

As a constituent of the American Nurses' Association, MNA welcomes the opportunity to present its viewpoint on this particular piece of legislation. We urge that you support this bill because it will accord to nurses throughout the nation and other hospital workers as well, the protection of the right to organize and bargain over salaries and other conditions of employment, a right that I might add, Michigan Nurses already enjoy.

In asking for your support of this legislation, MNA does have two major concerns that must be resolved before passage of the proposed bill. These are:

1. the interpretation of the term "SUPERVISOR" as it now exists in the National Labor Relations Act.

2. a guarantee that present Michigan labor laws will not be affected.

As you may know, there is a supervisory exclusion in the Taft-Hartley Act. As we understand it, the term "supervisor" was originally intended for business and industry where the supervisor exercises considerable authority to control and direct employee work activities. Registered nurses, however, exercise independent judgment on nursing, not subject to anyone's control or direction.

From the legal standpoint, most nursing practice acts throughout the country specifically indicate that every registered nurse is responsible for his or her individual acts.

Nurse supervisors may advise and assist other registered nurses in their practice of nursing but CANNOT direct their practice. MNA, therefore, supports an amendment to include language to HR 1236 that would define supervisor as "any professional person is considered a supervisor only if administrative supervision is his or her primary duty and activity."

On point number two, we strongly recommend that states with labor laws similar to Michigan do not have their jurisdiction removed by the Federal Law taking precedence over the state law.

Precedent for recognizing unique problems of special industries in the National Labor Relations Act already exist. For example, Sections 8 (e) and (f) accommodate the special needs of the clothing and apparel industry and the construction industry. MNA in like manner feels that special accommodation needs to be made in Taft-Hartley which clearly recognizes the distinction between professional authority of registered nurses and the bureaucratic authority within the hospital setting.

MNA appreciates the assistance you have given nursing and health in the past and look forward to working with you in the future for better health care of our citizens.

We would appreciate any copies of language changes on HR 1236 that testimony produces.

Cordially,

WILLIAM E. LUDWIG,
Director, Legislation, Public Relations.

(Submitted by Congressman James G. O'Hara).

STATEMENT OF MICHAEL D. BROMBERG, DIRECTOR, WASHINGTON BUREAU, ON
BEHALF OF FEDERATION OF AMERICAN HOSPITALS

Mr. Chairman and Members of the Subcommittee, my name is Michael D. Bromberg, Director of the Washington Bureau of the Federation of American Hospitals. We would like to thank the Subcommittee for this opportunity to present the Federation's views on H.R. 1236.

The Federation of American Hospitals is a national non-profit association representing nearly 600 investor-owned (proprietary) hospitals through 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 85,000 beds in investor-owned hospitals located in 41 states and the territory 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. 1236

H.R. 1236, if passed, 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 organization 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 of H.R. 1236, 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. 1236 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 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 wage 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 increases—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-Hartley Act, has an inflationary 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.

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 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 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 Z is a series of recent newspaper articles dealing with a 21 day strike against an investor-owned hospital in Richlands, Virginia and the turmoil it caused.

As a result of two union elections in late 1972, Clinch Valley Clinic Hospital—a 135 bed, investor-owned facility at Richlands, Virginia—became the first hospital in the state to be unionized.

Three months later, more than 100 members of Local 1199, of the National Union of Hospital and Nursing Home Employees (AFL-CIO)—mostly service and maintenance workers and licensed practical nurses—went on strike. About 200 of the remaining, non-union employees stayed on the job, and the hospital was able to continue uninterrupted service to the community.

The strike ended March 6th after 21 days of tension and agony. There was picketing, charges and counter-charges—and numerous strikers were arrested for violating Virginia's right-to-work law.

The Federation recommends that this Subcommittee report legislation or include amendments, in the event that H.R. 1236 is favorably reported this year, to prohibit strikes, picketing and lockouts in all hospitals during a cooling-off period and providing for alternatives including a combination of conciliation, mediation, fact finding and non-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 services they render. For that reason we urge consistency in the application of future legislation in this area. Certain areas of our society must be protected and must be treated more sensitively than others—and hospital care is certainly one of them. We believe this legislation is necessary to guarantee the continuity of patient care which can prove fatal when interrupted.

I thank you for this opportunity to present the views of the Federation on this most crucial aspect of health care delivery.

CLINIC MANAGEMENT HANDS ULTIMATUM TO STRIKERS

(By Dee Wilson)

Striking employees of the Clinch Valley Clinic Hospital in Richlands, Va., Saturday were issued an ultimatum to return to their jobs by Friday, Mar. 2, or "it would be considered that they had voluntarily quit their jobs".

The statement was given to the Bluefield Daily Telegraph Saturday afternoon by a legal spokesman for the 135 bed hospital management.

The spokesman said that since the strike by members of National Union 1199 of the Hospital and Nursing Home Employees began on Feb. 13, the hospital has not been able to fully serve the medical needs of the community. It was pointed out that though out-patient care under striking conditions was at about normal level, staff doctors had been requested to limit the number of patients admitted to the hospital.

The hospital spokesman said that management had every intention of continuing the negotiations with the union whether the striking members of the union returned to their jobs or not.

In the same statement, the hospital refuted an earlier statement made by the union that "negotiations had been broken off by the hospital." The spokesman said that negotiations are to continue, by agreement between the union and management, next Tuesday.

"This hospital continues to be willing to negotiate at any reasonable time and place, but "marathon" sessions will not necessarily bring about a settlement," the spokesman said.

The hospital reiterated that there would have to be an agreement on basic issues and said that the union, at all times, had considered the hospital's offer, as acceptable in every respect except that the union insisted that the hospital employ the "check-off" system through the hospital payroll to collect union dues. The spokesman said the hospital did not consider it in the "best interest of all concerned" for the hospital to take over the chore of collecting these dues to be sent to the union's New York office. The hospital pointed out that the additional bookkeeping would involve much extra cost in preparing the reports and attendant office work to complete this task. The union, the spokesman contended, should collect these dues itself.

Friday, Arnold Miller, president of the United Mine Workers of America said that "the UMW is prepared to use its resources in any lawful way" to hasten a settlement of the strike.

Miller added that he "was deeply disturbed by the refusal of the hospital management to negotiate a fair settlement" with the union members.

The UMWA president said that his studies indicated that the Clinch Valley Clinic Hospital is substantially used and financed by UMWA members and their families." Miller urged UMWA members and their families to seek other institutions for medical care until the dispute is settled. "I know that all members of our union will honor the picket lines of National Union 1199 of the Hospital and Nursing Home Employees at Richlands," he added.

The hospital is one of two located in the western end of Tazewell County. The Clinch Valley Clinic is licensed as "The Bluefield Sanitarium trading as the Clinch Valley Clinic Hospital."

On Feb. 13, the day the strike began, the hospital management through its attorneys, went before Tazewell Circuit Judge Vincent L. Sexton in Tazewell and obtained an injunction against the union, which in part, prohibited any picketing at all during the labor dispute. On Feb. 16, Sexton issued an amended injunction permitting a total of 14 pickets about the hospital premises. The distribution was prescribed as six pickets at each the main entrance and main exit of the hospital, and two pickets at a passageway to the rear of the hospital.

The amended injunction followed 134 arrests of the striking union members on charges of violating the Virginia Right to Work Law, a violation of a Virginia statute not tried before a higher court prohibiting a strike at a hospital, and unlawful picketing. Over fifty of the union members, including the National Union Organizer spent time in either the Tazewell County jail or the Buchanan County jail in Grundy, Va.

Since the amended injunction was entered, there have been no more reported incidents at the hospital. Security is being maintained by a private firm, "Guardmark," hired by the hospital before the strike actually began. Municipal, County and State Police officers have continued routine patrols in the area since pickets were permitted to return to the line.

Merchants in the Richlands area have furnished the picket line with a "salamander" oil burning heater and regularly provide the strikers with sandwiches and coffee.

The hospital managed to handle a major emergency Friday when six of seven persons injured in a Tazewell County School bus crash were admitted to the hospital for treatment.

The waiting rooms in the hospital appear a packed furing most of the clinic hours, but the patients stay has been made more tolerable by non-striking dietary employees serving coffee and refreshments to the patients as they await to see the staff doctors.

Friday, an assistant hospital administrator was observed moving from waiting patient to waiting patient discussing the patients problems and explaining the cause of the delays in receiving medical care.

Each side indicated Saturday that the negotiating session scheduled for Tuesday would bring results "mutually agreeable."

[From the Richlands News-Press, Feb. 21, 1973]

PRESENT EMPLOYEE BENEFITS AVAILABLE TO CLINCH VALLEY CLINIC HOSPITAL EMPLOYEES

1. Paid sick leave each year—18 days.
2. Paid holidays—6.
3. Vacation: 1 week after 6 months; 2 weeks after 12 months; 3 weeks after 10 years of service; 4 weeks after 20 years of service.
4. Fifty percent Blue Cross-Blue Shield Plan paid for by the hospital.
5. Life insurance fully paid by employer (\$3,000).
6. Retirement plan paid for by the hospital.
7. Bereavement pay—3 days off at regular daily rate.
8. Five-day, 37½ hour workweek except for office nurses.
9. Social Security benefits.
10. Unemployment compensation benefits.
11. Workmen's compensation benefits.
12. Paid educational leave.
13. Full discount on balance of hospital bill—50 percent discount on private room difference for employees and family.
14. Free parking space.
15. Wage policy and merit increases.

16. Grievance procedure.
17. Job security.
18. Pay differential for 3 to 11 and 11 to 7 shifts.
19. Coffeekbreaks.
20. Availability of cafeteria meals at less than cost.
21. Salary advances in emergency.
22. Leaves of absence.
23. No loss in pay for jury duty.
24. Minimum beginning wage \$1.85 per hour.
25. Equal employment employer.

POLICE REPORT PICKETS AT HOSPITAL PEACEFUL

Richlands, Va., police reported Sunday night that there have been no incidents at the strike-bound Clinch Valley Clinic Hospital in that town.

Some 175 members of the National Union of Hospital and Nursing Home Employees Union No. 1199 have been involved in a work stoppage since Feb. 13. On that same day, Judge Vincent L. Sexton of the Circuit Court of Tazewell issued an injunction prohibiting any picketing "about" the hospital premises.

Enforcement of the injunction and arrests under the Virginia Right to Work Law resulted in 134 arrests of the union members until an amended injunction was entered Friday. With the amended injunction, the union was allowed a maximum of six pickets at the main entrance and six pickets at the main exit to the hospital along U.S. Rt. 460. Two additional pickets are allowed under the amended injunction at the rear passageway of the hospital.

There have been no confirmed incidents at the hospital since Judge Sexton issued the amended order.

Security at the hospital is being maintained by a private security company, bolstered with the routine patrols maintained by the Town of Richlands Police Department and the Tazewell County Sheriff's Department.

Spokesmen with both the union and the hospital management indicated that additional negotiating sessions were expected to resume early next week.

H. E. Allen, administrator of the Clinch Valley Clinic Hospital, said in a full page advertisement in Sunday's Bluefield Daily Telegraph that the hospital has made the following offers to the union members:

- 1) 50 cents an hour increase for a two year contract; 2) one extra holiday;
- 3) improved medical and hospital insurance the hospital will pay 75 percent of the medical insurance cost instead of 50 percent they are now paying; 4) protection of seniority and other rights in a written agreement that the hospital believes will protect all employees.

Paul Hudgins, the attorney for the hospital, said earlier that the .50 cents per hour increase would be given with a .30 cents per hour increase in the first year of the two year agreement, and the additional .20 cents in the second year of the contract.

The statement further stated that the union wished a "check-off" clause for union dues. This would mean that the hospital would deduct the amount of the union dues from the employee's pay and remit it to union headquarters in New York.

The union's negotiating committee is composed of 14 hospital employees, a union organizer, and a union attorney. The hospital is represented by the Bluefield law firm of Hudgins, Brewster, and Couling in the negotiations.

STATEMENT OF AMERICAN SOCIETY FOR MEDICAL TECHNOLOGY

The American Society for Medical Technology strongly supports the bill, H.R. 1236, to amend the National Labor Relations Act of extend its coverage and protection to employees of nonprofit hospitals. The Society is in complete accord with the intent of this amendment and offers the following information in support of this legislation.

The ASMT is a national, professional society dedicated to the development of higher standards in clinical laboratory methods and research: the elevation of the status of those specializing in medical laboratory techniques: the creation of a mutual understanding between the medical technologists and the physicians and all others who are employed in the interest of individual or public health:

the promotion of mutual aid and benefit of the members: and, furthering the ideals and principles of the profession of medical technology.

At the present time, ASMT is the largest organization representing laboratory personnel in the United States and currently counts among its members, more than 17,000 persons whose occupations span the entire field of medical technology including such specialties as microbiology, biochemistry, hematology, histology, immunohematology, cytology, and nuclear medical technology. These members are engaged in a broad spectrum of employment settings, however, the overwhelming majority work in hospitals.

The American Society for Medical Technology has long been cognizant of the impact of job inequity upon patient care. This concern resulted in the adoption of the following policy statement:

The philosophy of the American Society for Medical Technology requires that the profession place patient care above self-interest. Individual members are dedicated to uphold rigid standards of duty and performance. Patient care is jeopardized by working conditions which fail to provide properly trained or adequately compensated laboratory professionals. If collective bargaining becomes necessary, negotiation by ASMT and its constituent societies is consistent with the Society's responsibility to the public.

It is the national policy to guarantee employees the right to organize without fear to adverse actions by their employers. Without the protection guaranteed under the Labor Relations Act, professionals such as those represented in our membership are understandably reluctant to collectively engaged in activities which lead to more equitable socio-economic conditions. Actions taken against some health care employees in the recent serve as warning signals to those who would contemplate corrective actions. In the absence of Federal labor regulations covering the nonprofit hospitals, management of these institutions will continue to erect barriers which isolate them from the recognition of unfair employment practice complaints.

Absent the legal protection of the NLRA many job related problems arise that remain unresolved. The unresolved problems are a major contributing factor to the large employee turnover in the health field. This turnover phenomenon creates a hardship on the patient: both from the increased health care costs incurred in replacing and reorienting new employees and from the reduced quality of care which is a direct result of only lesser qualified personnel being willing to tolerate the undesirable working conditions.

To alleviate these inequities, the American Society for Medical Technology urges the immediate passage of H.R. 1236.

CHAMBER OF COMMERCE OF THE UNITED STATES,
Washington, D.C., April 26, 1973.

HON. FRANK THOMPSON, JR.,
*Chairman, Special Subcommittee on Labor, Committee on Education and Labor,
House of Representatives, Washington, D.C.*

DEAR MR. CHAIRMAN. Attached is a statement expressing the views and recommendations of the Chamber of Commerce of the United States on H.R. 1236, an amendment to the National Labor Relations Act.

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.*

Enclosure.

STATEMENT OF O. F. WENZLER¹ FOR THE CHAMBER OF COMMERCE OF THE
UNITED STATES

The Chamber of Commerce of the United States appreciates this opportunity to present our views in opposition to H.R. 1236—a bill to amend the National Labor Relations Act.

H.R. 1236 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.

¹ Labor Relations Manager, Chamber of Commerce of the United States.

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. 1236 would affect the cost and the availability of health care services to nearly every American.

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 skyhigh, 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 administration 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. 1236 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. 1236 not be reported from committee.

STATEMENT OF THE COMMUNICATIONS WORKERS OF AMERICA

The Communications Workers of America endorses the enactment of H.R. 1236, a bill that would amend the National Labor Relations Act to extend its coverage and protection to employees of nonprofit hospitals.

Employees of nonprofit hospitals were originally included under the National Labor Relations Act of 1935, but in 1947 the Taft-Hartley Act exempted these workers from coverage for two major reasons, which today are no longer valid.

The first reason is that it was believed in 1947 that the health industry did not constitute interstate commerce. This was based on the small size of the hospital industry, which then was a comparatively small operation with only 350,000 workers throughout the nation.

By contrast, today there are more than 7,000 hospitals in the United States and nearly 3 million hospital workers, almost ten times the 350,000 in 1947, when nonprofit hospitals were exempted by Taft-Hartley. Today, employment in the hospital industry exceeds the number of workers found in aircraft, textile products,

printing and publishing, chemicals and allied products, department stores, banking, hotels and other large areas of service and production.

America's hospitals have combined assets of more than \$36 billion. They spend in excess of \$25 billion in providing services to their patients and have an annual payroll of more than \$15 billion.

The nonprofit sector of the hospital industry has also experienced the extensive growth enjoyed by the entire hospital industry during the last quarter-century. Nonprofit hospitals now make up 48 percent of all hospitals, with more than 3,000 in the United States, handling 66 percent of all admissions. They employ nearly 1,400,000 workers. Nonprofit hospitals in the 1970's unlike those in the 1940's, are big business.

Because of the rapid growth of the hospital industry as a whole and particularly in the nonprofit sector, courts and administrative agencies have recently decided that hospital operations constitute interstate commerce and are subject to regulation by Congress. In 1966, the Supreme Court in *Maryland vs. Wirtz* upheld the authority of Congress to bring hospital employees under the 1966 amendments to the Fair Labor Standards Act. 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 exempted from the coverage of the National Labor Relations Act 25 years ago is that they were then considered "charitable institutions." This no longer holds true today, as has been admitted by experts in the health industry as well as administrators of nonprofit hospitals. The charitable hospital operating solely on donations from wealthy patrons for the benefit of the poor is an anachronism in America in the 1970's.

Reverend John Simmons, Administrator of the Pacoima Memorial Lutheran Hospital located in the suburbs of Los Angeles, emphasized this when he said in testimony before the Special Subcommittee on Labor last year: "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."

Extension of the coverage and protection of the National Labor Relations Act to employees of nonprofit hospitals would benefit not only those employees, but also the hospital industry in general and the public as a whole, promoting stability in the labor force.

The evidence that unionization of hospital employees results in a vast reduction of employee turnover is overwhelming. For example, at the renowned John 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.

The Mount Sinai Hospital in New York experienced 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 before unionization, but today with a union contract it is, in Reverend Simmons' words, "way under 100."

From the standpoint of equity, it is unjust that employees doing the exact same work in nonprofit hospitals as is done by their co-workers in federal hospitals, municipal and state hospitals and private hospitals should receive lower pay because they do not enjoy the privilege of organization and the right of collective bargaining that workers in other hospitals are guaranteed. Nurses, orderlies and other workers in nonprofit hospitals are discriminated against by being excluded from the protection of the National Labor Relations Act, which they would receive if they were employed in any hospital other than a nonprofit hospital.

Current law denies nonprofit hospital employees access to the National Labor Relations Board's election procedures. Because nonprofit hospitals are not under the NLRB's jurisdiction, many of them experience "recognition strikes" by employees seeking to attain status. Employers in nonprofit hospitals are not required to bargain with organizations representing the hospital employees.

The Communications Workers of America is especially concerned about 200 employees of the Methodist Hospital in Pikeville, Kentucky, who declared they want CWA representation and have been involved in a recognition strike for almost a year now, since last June 10. Almost 100 percent of the eligible workers signed membership cards, but because nonprofit hospitals are not under the coverage of the National Labor Relations Act, the hospital refused to discuss the issue with the workers and fired the leaders of the organizing effort.

The agony which these nonprofit hospital employees have undergone is highlighted by the experience of a woman employee at the Pikeville Hospital. After having worked nine straight days, and stayed up all night with her young daugh-

ter, she asked for a day off. She was told to come to work anyhow, and then she was fired. Her supervisor said to her: "You seem to think, your family is more important than this job."

The Pikeville strike is not aimed at getting higher wages or improved working conditions. It is simply a recognition strike to get the hospital authorities to accept the proven fact that more than 90 percent of the workers there voluntarily signed cards in good faith showing that they want to be represented by CWA. Nevertheless, the hospital authorities are unwilling to even talk with the workers, much less recognize their demands, after almost 11 months of striking.

During the 92nd Congress, legislation to place workers in nonprofit hospitals under the protection of the National Labor Relations Act passed the House and received the support of the Nixon Administration, but the legislation was blocked in the Senate.

During the House floor debate in the 92nd Congress, Representative John Ashbrook (R-Ohio), a supporter of the legislation, put the issue of extending coverage to nonprofit hospitals in clear perspective when he stated:

"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."

The growth and development of the hospital industry during the last quarter-century have established that nonprofit hospitals engage in interstate commerce and are no longer charitable institutions. The plain fact is that a hospital is a business enterprise, whether it is proprietary or nonprofit in terms of its organization. Since all hospitals serve the general public's health needs, they should all be governed by an evenhanded public policy.

The Communications Workers of America urges Congress to extend the coverage of the National Labor Relations Act to employees of nonprofit hospitals, a move which would end the continuance of an unwarranted anachronism and render these economically deprived employees long-overdue justice.

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
Washington, D.C., April 30, 1973.

HON. FRANK THOMPSON, Jr.,
Chairman, Special Labor Subcommittee,
Washington, D.C.

DEAR MR. CHAIRMAN: Would be grateful to you if you could have the enclosed Statement by the South Carolina Hospital Association relative to H.R. 1236 included in the Hearings for that bill.

With best regards, I am

Sincerely,

WM. JENNINGS BRYAN DORN,
Member of Congress.

Enclosure.

STATEMENT BY WILLIAM L. YATES, EXECUTIVE DIRECTOR, SOUTH CAROLINA HOSPITAL ASSOCIATION, RELATIVE TO H.R. 1236.

The South Carolina Hospital Association is opposed to H.R. 1236, legislation introduced by Congressman Frank Thompson, Jr., which would remove the existing exemption for nonprofit hospitals from the provisions of the National Labor Relations Act. Our arguments against extending Taft-Hartley Act coverage to nonprofit hospitals are based on the following:

1. Strikes can neither be justified nor tolerated in hospitals.
2. Strikes are virtually unknown in industries in which there are no unions.
3. Unions make little effort to organize workers who are not covered by the Taft-Hartley Act or similar state laws.

4. If nonprofit hospitals are covered by the Taft-Hartley Act, there will be an overwhelming effort by unions to organize the hospitals. The results will be strikes, followed by new strikes as each union competes to achieve the reputation of being the organization which can get the most for hospital workers.

The South Carolina Hospital Association is neither anti-labor nor anti-union. It simply is bound by its commitment to protect patients against disruptions in service and any other forms of diminution of the quality of patient care.

Since the problem is somewhat different in states where many hospitals are already unionized, the South Carolina Hospital Association would suggest as a compromise measure that the Taft-Hartley Act could be amended to permit the individual states to elect coverage of their nonprofit hospitals by the federal labor law.

We will appreciate your consideration of our position and your opposition to H.R. 1236.

MISSOURI HOSPITAL ASSOCIATION POSITION ON H.R. 1236

It is the position of the Missouri Hospital Association that conditions which prompted exemption of non-profit hospitals from provisions of the National Labor Relations Act have not materially changed; consequently, the exemption remains valid and should be continued.

The Missouri Hospital Association further takes the position that the National Labor Relations Act in its present form is not adequate to deal with the unique relationships of labor, management and the patient in hospital operation. The changing of a single section in the National Labor Relations Act, as proposed in H.R. 1236, would in fact place the patient in potential jeopardy while contributing nothing to the improvement of health care or operational efficiency in hospitals.

PROVIDENCE HOSPITAL,
Waco, Tex., April 19, 1973.

Hon. W. R. POAGE,
Waco, Tex.

MY DEAR CONGRESSMAN: Providence Hospital would like to go on record as strongly opposing HR 1236 for the removal of the current exemption of non-profit hospitals from the Taft-Hartley Act.

As you know, hospitals differ from industry in that we are dealing with human lives as opposed to a product with our major objective . . . better patient care. Our employees are dedicated to their work and we practice our philosophy which is respect and justice for every individual. This is evidenced in our personnel practices and policies. We are an Equal Opportunity Employer and comply with the letter and spirit of State and Federal employment requirements.

It is our contention that interference by a bargaining unit would cause insurmountable damage to a health institution as it would be the patient that would suffer . . . and it would be just that interference with the continuity of patient care.

If I may take the liberty, think about the personal impact this would have on your own family if they happened to be hospitalized when the union decided to strike. They would be the ones who would be helpless without proper nursing care. It would be disastrous in this respect and would be very costly from an economical standpoint.

The two outstanding objections we foresee are:

(1) Increased costs to hospitals which must be borne by the patients or the National Government.

(2) The possibility of work stoppage, picketing, striking, impasse resolution, and bargaining unit fragmentation which would have a detrimental impact on continued patient care.

We urge you to oppose this bill in the interests of our patients and request you to relay a copy of our position on HR 1236 to Special Labor Subcommittee Chairman, Frank Thompson, for inclusion in the official printed hearing record on the bill.

Sincerely,

SISTER AUSTIN, FACHA,
Administrator.

HALLIDAY'S APOTHECARY INC.,
Jacksonville, Fla., April 17, 1973.

To: The Committee on Education and Labor.
Re: H.R. 1236.

HONORABLE CONGRESSMAN: Employees of nonprofit hospitals have a fundamental right to form associations and through collective bargaining to acquire proper working conditions and a living wage for themselves and their families. Whenever such collective bargaining has failed to bring about a just settlement

of their grievances hospital workers have the same rights as other workers in our American Society.

Legislation which, through privilege, exception, or discrimination inhibits the formation of associations of workers is flagrantly unjust. Hospital workers should receive the same benefits and protection extended to practically every other American worker.

I strongly support H.R. 1236 as the exemption of not-for-profit hospitals from the National Labor Relations Act allows the hospital administration to harass, intimidate, and discriminate against employees who attempt to collectively bargain. I am attaching a newspaper article that I feel is a case of such discrimination against two pharmacists and myself.

Thank you for your interest and support.

Respectfully yours,

THOMAS E. LOVETT, *Pharmacist*.

[From the Jacksonville (Fla.) Chronicle, Mar. 29, 1973].

SUIT MAY BE FILED IN DISMISSAL OF THREE PHARMACISTS HERE

Three staff pharmacists who were dismissed by St. Vincent's Hospital say they were fired and were not the victims of a staff cutback as claimed by the hospital.

Attorney Lacy Mahon has been contacted by a union negotiator on behalf of the trio to consider the possibility of a suit being filed to challenge the dismissals under the Right to Work Law.

The three—Thomas E. Lovett, Mrs. Mary Ann Bell and Charles Fuller—were dismissed by the hospital March 8.

Lovett said the timing of the dismissals was interesting because that was the day the hospital administrator had promised to give an answer to a request by union negotiator Dwaine Carman of the Retail Clerks International, AFL-CIO, as to whether the hospital would recognize the union as the official representative for staff pharmacists at St. Vincent's, including the three who were dismissed.

Lovett said the pharmacist situation at St. Vincent's began in November of 1972 when the group asked, through regular administrative grievance channels, for a four-point pay package.

He said the group sought 1) an increase in base pay for pharmacists at the hospital from \$5.35 an hour to \$6.00 an hour, 2) time and a half pay for all hours over 40 worked each week, 3) a night differential pay 8½ percent greater than the day rate and 4) an increase in the salary for the position of pharmacy intern.

Lovett said the hospital finally, in January of this year, granted a base pay hike to \$5.71 an hour but rejected the other three proposals.

He added that he and the other pharmacists in turn rejected the hospital's offer and resubmitted the plan, except that the night pay differential request was changed to 15 percent, directly to the administrator, Sister Catherine.

Lovett said that on Jan. 5 the pharmacists received a letter from the hospital's chief pharmacist, Leon Robins, advising them that their request had not gone through regular grievance channels, that their "tone was out of character" and that he (Robins) would meet with the assistant administrator to discuss "wages, hours and tenure."

Lovett said he met with Sister Catherine the same day and was told the same thing that Robins had advised in the letter.

Lovett said he and the other staff pharmacists then sought help from negotiator Carman. He added that St. Vincent's is a nonprofit hospital and, as such, is exempted from the National Labor Relations Act.

Carman asked, however, that his union still be recognized as the agent for the hospital pharmacists and reportedly was told he would get an answer March 8.

At 11 a.m. that day, Lovett said he and the other two were fired and that Chief Pharmacist Robins asked them to get off the hospital premises "immediately."

Lovett said he and the other two were told verbally that they were being dismissed due to the introduction of a new unit drug dosage program that would cut back on the services needed from the hospital's pharmacy.

Lovett claimed, however, that the dismissals were not based on seniority, that part-time help in the pharmacy was not cut back, and that since the dismissals new nonprofessional help has been hired.

The Chronicle contacted Robins for his side of the story. He referred the call to the personnel administrative chief, who reportedly was out of his office at the time. The Chronicle subsequently received a call from the hospital's public relations director, who promised to look into the allegations presented by Lovett but who had not called back by press time this week.

STATEMENT OF THE NATIONAL LABOR-MANAGEMENT FOUNDATION

(By S. Rayburn Watkins, President)

The National Labor-Management Foundation wishes to thank the Committee for the opportunity to submit its views on H.R. 1236.

The National Labor-Management Foundation has offices in Washington, D.C., and Louisville, Kentucky. It was chartered in Illinois in 1947 as a non-partisan, non-profit organization to provide research, education and information to develop clearer understanding and better communication among employees, employers, and the general public in labor-management matters. The Foundation studies and supports legislation that it believes will help bring about improved labor-management relations, and better working conditions. We believe our labor laws should be designed to give every working man and woman the greatest possible opportunity to grow in his or her work and be compensated appropriately, and at the same time provide adequate safeguards for the right of employers.

By passing H.R. 1236, the House impulsively amended the National Labor Relations Act so as to extend its coverage to employees of non-profit hospitals. The National Labor-Management Foundation holds the opinion that all workers should be properly paid for work performed. However, even though the initial cost increases caused by union organization of employees may not initially be exorbitant, experience shows that wages are increased beyond economic justification. In addition, the National Labor-Management Foundation is concerned that the unions' demands for higher wages could result in drying up of employment possibilities for unskilled laborers. One of the major labor problems in the United States is that of unemployed, unskilled workers. Hospitals provide unskilled workers an opportunity to pridefully support themselves and not be dependent on welfare handouts. An amendment such as that advocated by H.R. 1236 will only reduce such opportunities for unskilled workers and would add a greater load to an already overburdened welfare program.

The free market system of supply and demand for labor does work when given the opportunity. Even though employee turnover in some nonprofit hospitals is high, the problem is more effectively corrected without government interference. The law of supply and demand is effective or else the hospital goes out of business completely. Employment levels and employment stability will not and cannot be corrected merely by amending the National Labor Relations Act.

It would be more prudent for legislators to at first consider the possibility of reforming current labor laws which are outmoded by the passage of time and changing conditions to alleviate problems arising from current legislation. Numerous requests have been made over the years to correct the defects in the National Labor Relations Act and the National Railway Labor Act. These included taking labor disputes out of the National Labor Relations Board and putting them in the Federal Courts; outlawing card checks and requiring secret ballot elections prior to union recognition; make stranger picketing illegal; revise the Landrum-Griffin Law, which has been rendered largely ineffective, so as to put real teeth into it; prohibit strikes by public employees; prohibit use of union funds, facilities and staff time on partisan political activities; and place unions under anti-trust regulations. All such requests continue to be ignored. A number of bills designed to correct weaknesses and/or inequities in labor laws are lying dormant, buried in various committees in Congress, and dying for lack of an airing.

Previously, the expansion of the National Labor Relations Act has come through assumption of jurisdiction by the National Labor Relations Board or court orders directing the National Labor Relations Board to assert jurisdiction. This action could lead to further revisions which would unduly favor labor unions and further widen the gap between management and unions.

It is hard to believe that enactment of this bill would substantially reduce hospital strikes, as some have asserted. Unionization in other fields has always resulted in more, not fewer, strikes. During the floor debate last year it was stated that union organization of hospital employees has led to a dramatic decrease in employee turnover and improved care of patients. Similar improvements have occurred in hospitals across the country which have not been organized by unions. The National Labor-Management Foundation is of the opinion that improvements in patient care result from the demand of the public for improved care. Upgrading of personnel is most often brought about through in-house training programs established by hospital administrations. What the H.R. 1236 amendment does is merely encourage growth of union power and further the imbalance between unions and management. To automatically turn over a potential 1,387,000 employees to the unions will not necessarily alleviate the employees' problems.

Instead, it will thrust upon employees the further hardship of paying union dues and the loss of income due to possible strikes. The spectre of helpless hospital patients left unattended because of a strike of hospital employees would be incredible. Hospital patients, unlike automobile parts rolling along an assembly line, would be seriously affected by a work stoppage. In addition, the general public will have higher costs for hospital care and medical insurance, without the assurance that patients will receive any more qualified care than they have now.

Sponsors say that this bill refers to a group which is heavily minority and heavily female. One reason that minorities are frustrated in their attempts to better themselves, according to the records, is that unions keep many members of minority groups out of better paying skilled jobs severely restricting their entrance into apprentice programs. A number of cases are on record where unions have restricted the upgrading of employment possibilities by making it difficult or outright refusing members of minority groups to take advantage of existing apprentice training programs.

Opening up more employee training programs in all kinds of crafts and trades to minorities by reducing the power of unions to restrict entrance to these programs can accomplish more than H.R. 1236. If Congress is serious about the nation's minority problems—slums, segregation, and unemployment—now is the time to begin. This would not be done by passing more inequitable laws, but rather by correcting defects in the current labor laws which allow these problems to persist.

Unions already enjoy too many special privileges under federal law, privileges which give them a stranglehold on many phases of our economy. To place a potential additional 1.4 million workers in the hands of union officials would just make such concentration of power that much worse.

Reform of national labor laws is long overdue. The National Labor-Management Foundation urges Congress to reject H.R. 1236 and to take action on legislation to accomplish total labor reform as a more proper move in the right direction.

STATEMENT OF J. C. TURNER, GENERAL SECRETARY-TREASURER, INTERNATIONAL UNION OF OPERATING ENGINEERS

The International Union of Operating Engineers represents a total of over 400,000 members in the U.S. and Canada. Many thousands of these members are employed in non-profit hospitals.

Employees in non-profit hospitals certainly deserve the right to utilize the benefits of coverage by the National Labor Relations Act. Many wild-cat strikes have occurred in non-profit hospitals because of the lack of an orderly collective bargaining procedure of the type that would flow from N.L.R.A. coverage.

Many years ago, the Congress of the United States decided that workers shall have the right to organize into labor unions of their own choosing and to bargain collectively through that union without interference or coercion from the employer. Non-profit hospital employees are not second-class citizens.

As you know, H.R. 1236 is identical to the Bill which passed the House in the last session of Congress, but died in the Senate.

We urge your early and favorable action of H.R. 1236.

STATEMENT OF THE NATIONAL RIGHT TO WORK COMMITTEE

This written statement is submitted in order to present the views of the National Right to Work Committee on the subject of extending coverage of the National Labor Relations Act to employees of non-profit hospitals. Legislation to affect this is contained in H.R. 1236.

In light of the gravity of the subject under consideration and the millions of persons to be influenced by passage of H.R. 1236, it is highly regrettable that the hearings were called on such very short notice and that we, along with many other groups, were denied the opportunity to make any oral presentation during the extremely limited time allocated for appearances of witnesses. It is unfortunate that this vital matter has been accorded such limited discussion and debate, for it precludes any material which might tend to offset the onesided and incomplete record of the abbreviated hearings on identical legislation—H.R. 11357—in the 92nd Congress. Further, the token hearing conducted on H.R. 1236 effectively blocks a thorough and searching study of all the ramifications of H.R. 1236, and the adverse effects this bill will have on nearly one and one-half million employees

of non-profit hospitals in the United States, and on untold millions of ill and afflicted who must rely on these institutions for succor.

The National Right to Work Committee is a single-purpose citizens organization dedicated to the principle that union membership should be voluntary. Our members and supporters represent a cross-section of individuals from all walks of life—wage earners, both union and non-union, professional people; businessmen; and others. In our view, it is wrong for any individual to be denied employment for his refusal or failure to pay money to a union boss as a condition of employment.

We share the concern of most Americans that all working men and women have the greatest possible opportunity to use their talents to the maximum extent of their ability, and that they are compensated therefor appropriately. There is no question in our minds that the right to organize and bargain collectively can be an important tool for the employee in obtaining just working conditions and wages and other benefits. There is much evidence that our national labor policy as embodied in the National Labor Relations Act has not served the best interests of our wage earners.

The authorization for compulsory unionism granted by the National Labor Relations Act has led to the creation of a staggering political imbalance, giving political power to a relatively few union czars which is far out of proportion to the number of workers whom they claim to represent. Under the National Labor Relations Act, enormous economic power has become concentrated in the hands of union officials. The rights of individual workers and employers have become subordinate to the rights of union organizers. The root cause of this unhealthy concentration of power is compulsory unionism—forced payment of tribute to a labor boss—a tyrannical practice sanctioned by the National Labor Relations Act. We seriously question the wisdom and moral justification for bringing nearly 1,500,000 employees of non-profit hospitals under a law with very serious defects.

Under the National Labor Relations Act, this nation has operated on the premise that the public interest is best served when the federal government fosters and encourages the unionization of working men and women. We urge this Congress not to revalidate, by passage of legislation such as H.R. 1236, basic errors in our national labor policy.

Our principal concern is not with the broad question of public policy. Our primary concern is that provision in the National Labor Relations Act which sanctions compulsory unionism. This provision, requiring 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 nationwide public opinion survey conducted in the summer of 1972 just prior to the National Democratic Party Convention. 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 believed their party's platform should contain such a statement. That viewpoint was shared by 68 percent of the Independents and 65 percent of the Democrats. It also was supported by 72 percent of all voters between the ages of 18 and 29, 65 percent of the voters with an annual family income under \$5,000, 56 percent of all nonwhite voters, and 58 percent of union families.

In 1971, 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 National Labor Relations Board. . . ." The sponsors of that bill obviously were not familiar with the impact of the existing law which authorizes the forced unionization of workers. Recent history is replete with examples showing clearly that widespread—and often violent—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." 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 last 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. Typical of its provisions designed to promote forced unionism, is one which 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 subjects an employer to charges of 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 is extracted from the pockets of his employees against their will. 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 employees to pay money to union officials in the form of dues, fees and assessments. Extending coverage of the National Labor Relations Act to employees of non-profit hospitals will not alleviate their problems. It will aggravate them! This bill would thrust upon a million and a half working men and women the additional hardship of paying union dues in order to continue to work.

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 H.R. 1236 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. These monopolistic compulsory privileges which were given to union officials by the National Labor Relations Act have contributed greatly to the undermining and the decline of efficiency and productivity of America. And, we submit that the Nation would be well down 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, Congress elected to amend that bill so as to guarantee postal employees freedom of choice. Manifesting an outpouring of public sentiment just before the 1970 elections, 226 members of the House of Representatives voted for voluntarism.

If it should be decided to report favorably this bill for consideration, we strongly urge this Subcommittee 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 allows the forcing of employees to pay money to a labor organization in order to hold a job.

Under the National Labor Relations Act, the federal government forces a hospital employee to accept as his bargaining representative an individual or organization he may not want. The Act permits a hospital employer to be compelled by the federal government to bargain on behalf of any employee with an individual or representative which that employee did not voluntarily designate as his agent. Additionally, arrangements are sanctioned whereby the federal government authorizes the firing of a hospital employee because he refuses to pay money to a person or organization which he did not voluntarily engage as his agent. We appeal to you not to force upon nearly 1.5 million hospital employees a policy which experience over nearly 40 years clearly shows is not in the best interest of the employer, the employee, or the country as a whole.

AMERICAN OSTEOPATHIC ASSOCIATION,
Arlington, Va., May 2, 1973.

Hon. FRANK THOMPSON, Jr.,
Chairman, Special Labor Subcommittee,
Rayburn House Office Building, Washington, D.C.

DEAR MR. CHAIRMAN: In support of the American Osteopathic Hospital Association's statement on H.R. 1236 and, particularly, on behalf of the American Osteopathic Association and the American Association of Colleges of Osteopathic

Medicine, we wish to extend our views on the proposed legislation, which would remove the current exemption of non-profit hospitals from the purview of the National Labor Relations Act (NLRA).

We deliver qualified, efficient, and uninterrupted medical treatment to thousands of patients each year through 14,000 D.O.'s and 229 osteopathic hospitals providing 25,000 beds. It is our goal, as it is with other health care institutions, to render to the sick proper professional treatment and needed hospital services.

It is our contention that a distinction does exist, contrary to the consensus of the legislation, between non-profit hospitals and industry otherwise included under NLRA. The very nature of hospitals, their function and service, does not lend itself readily to third party interference. Hospitals are extraordinary enterprises, with extraordinary problems, engaged in the delivery of extraordinary services. Consequently, what is ordinarily a workable and desirable method of solving labor relations problems is inappropriate. A superior system designed to promote employee welfare becomes intolerable when it jeopardizes human life.

We appreciate the intent of the Committee in proposing this legislation to protect individual rights of workers to enjoy the potential benefits flowing from collective bargaining. We, too, are interested in promoting and protecting individual rights. We believe that the Committee will agree with our conviction that a "preeminent right" of every American is to have available and receive, *unconditionally*, high quality health care.

While we agree that collective bargaining could provide incentive to the hospital employee and stability to the hospital staff, we suggest that the "cure" would be far worse than the "disease". It is our opinion that strikes, picketing, boycotts, and other facets of the collective bargaining process would not merely hinder hospital operations, but would actually be detrimental to the public interest. Regretfully, the proposed legislation does not provide the needed protection for the hospital patient while promoting the rights of hospital employees.

While it is certainly a secondary consideration from our point of views it would seem that at a time when vigorous efforts are being made by hospitals and the Federal government to seek a solution to the rising costs of health care, it would be inappropriate to take action which might jeopardize such progress.

Because we believe that a hospital or other health care facility has a social, moral and legal obligation to provide uninterrupted medical services of the highest caliber at all times, we do not feel that these institutions should be placed in jeopardy where the expense of health care provided would be compromised. Therefore, we strongly urge the Committee to give careful consideration to the ramifications which the enactment of this bill would have upon the quality of health care delivered to the American people.

With respectful regard,

ROBERT W. OLIVER, Ph. D.,

Executive Secretary, American Association of Colleges of Osteopathic Medicine.

ROY J. HARVEY, D.O.,

Director, American Osteopathic Association.

AMERICAN SOCIETY OF HOSPITAL PHARMACISTS,
Washington, D.C., April 27, 1973.

HON. FRANK THOMPSON, Jr.,
Chairman, Special Subcommittee on Labor,
Rayburn House Office Building, Washington, D.C.

DEAR MR. THOMPSON: We appreciate this opportunity to provide comments concerning H.R. 1236 currently under consideration by your committee. The American Society of Hospital Pharmacists is the national specialty society of pharmacists practicing in hospitals and related institutions throughout the country. Since the vast majority of our members are hospital employees, we have a direct interest in this legislation.

H.R. 1236 would amend the National Labor Relations Act to extend its coverage to employees of nonprofit hospitals. Nonprofit hospital employers may be faced with requests for recognition from labor organizations which seek to represent some or all employees. We believe the process of forming bargaining units in such a large workforce of employees should be orderly and recognize the right of self-determination for all.

In 1947 the Congress protected professional employee bargaining units by amending the National Labor Relations Act (NLRA) to include a definition of

"professional employee" in Section 2(12) and afforded these employees the opportunity to seek their own representation by means of the proviso in Section 9(b). Under this provision, the National Labor Relations Board (NLRB) permits professional employees to form bargaining units composed exclusively of the members of one profession. Furthermore, State authorities have upheld the right to exclusive professional bargaining units under State labor relations laws applicable to health care employees.

In order to provide hospital pharmacists a vehicle with which to exercise rights to exclusive pharmacist units, the American Society of Hospital Pharmacists adopted an Economic Status Program in 1971.

This program is designed to organize exclusive units of pharmacists in hospitals. It was based on an extensive study of unionization among hospital employees. (See attached article entitled, Report on Unionization of Hospital Pharmacists which appeared in the September 1969 issue of the *American Journal of Hospital Pharmacy*.)

Hospitals recognize the specialty background and education of pharmacists and place them in a department devoted almost exclusively to pharmaceutical services. As licensed practitioners under state law, pharmacists are solely responsible for many functions in the hospital which may not be assumed by other professional personnel, such as dispensing and compounding of prescriptions. The pharmacist possesses professional skills which are unique and vital to the effective operation of a hospital. The conditions of employment are separate and distinct from those of other professions. This is not to say that hospital pharmaceutical services exist in a vacuum but only that patient interests in drug use-control can best be served by pharmacists. These same kinds of consideration apply to other health professionals within hospitals.

While the characteristics of hospital pharmacy discussed above are by no means a complete picture of the responsibility of the profession, they do illustrate some of the reasons why pharmacists, as well as other professionals, should be entitled to an exclusive bargaining unit if chosen by members of the profession. Therefore, we recommend that H.R. 1236 be amended to preserve and support exclusive professional bargaining units. We suggest that H.R. 1236 be amended by adding a new section to read:

That Section 9(b) of the National Labor Relations Act is amended by adding a proviso (4) to read:

"(4) decide that any unit is appropriate for such purposes if such unit includes professional employees of various professions unless a majority of employees in each respective profession vote for inclusion in such unit."

If the committee desires to discuss our comments in further detail please feel free to call on us.

Sincerely,

JOSEPH A. ODDIS,
Executive Director.



