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UNIONIZATION, COLLECTIVE BARGAINING AND THE NON-PROFIT HOSPITAL

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FOREWORD

In recent years the American trade union movement has been searching for new avenues of growth. Unions have become very active among employes in the public sector. A development that perhaps has attracted less notice has been increased union activity in organizing hospital employees. Several unions have been making intensive efforts in this area. Among them are the Teamsters; the Service Employees; and Local 1199, an affiliate of the Retail Wholesale and Department Store Workers. The Nurses Association has engaged in activities that are very similar to those of unions.

With this background in mind, Mr. Dennis Pointer has written a monograph which deals with public policy toward labor relations in non-profit hospitals. On the basis of his research, he makes specific suggestions for change in the National Labor Relations Act.

The Center for Labor and Management is pleased to publish this monograph. It represents a contribution to what promises to be a lively discussion in the years to come. Mr. Pointer's conclusions may generate heat as well as light. If his work serves as the basis for reasoned discussion, the Center will be well rewarded.

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TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

CHAPTER I

INTRODUCTION

Long ago we stated the reason for labor organizations. We said that they were organized out of the necessities of the situation; that a single employee was helpless in dealing with an employer . . . that the union was essential to give laborers opportunities to deal on equity with their employer.

Chief Justice Charles Evans Hughes
NLRB v. Jones and Laughlin Steel, Corp., 301 US 1 at 33.

Collective bargaining and unionization have only recently come into widespread public and professional attention with respect to the non-profit segment of the health-care arena. Hospital employee strikes and attempts to unionize have become well publicized in the last year due to major walkouts and organizational efforts in New York, Chicago and other metropolitan areas.[1] The drive for union organization of non-profit hospital employees and subsequent collective bargaining efforts parallels the unionization of industry during the 1930s.

As a greater proportion of industrial workers have come under union agreements, the unions themselves have become increasingly interested in attempting to organize the "fringe areas" of American labor. Some of the factors inhibiting union growth in the hospital sector in the past have been: (1) the preoccupation of unions with organizing more lucrative areas; (2) the low density of hospitals and the relatively small number of employees per hospital; (3) the unstable nature of the hospital labor force due to the relatively large number of women employees; (4) the multiplicity of professional and semiprofessional employees; and (5) the greater number and variety of skills in the hospital setting.[2]

Concerted efforts of unions in attempting organizational drives focused on clerical, professional, and hospital workers are illustrative of a relatively new trend. So long as the American labor force was essentially manual in nature, American unionism could look upon itself as the modern social

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[1] Note: "Strikes Threaten Four Chicago Hospitals," *Hospitals*, Vol. 42, No. 3 (February 1, 1968), p. 27; and, "3400 Workers End Strike of 25 Kaiser Facilities," *Hospitals*, Vol. 43, No. 2 (January 16, 1969), p. 37.

[2] Leo B. Osterhaus, "The Effect of Unions on Hospital Management," Part 2, "Factors Stimulating and Inhibiting Unions," *Hospital Progress*, Vol. 48 (July, 1967), p. 78.

mass movement.[3] It is clear, however, considering the proportional decline of the "blue-collar" worker in the labor force,[4] that unless the union movement increases its enrollment density in the expanding job categories, the union's central social, economic, and political position as a power in modern society could be substantially weakened.

Hospital administrators, in general, have decided to ignore the problems and implications of union organization in the health-care sector. Illustrative of this attitude is the policy formulated by the American Hospital Association, spokesman for the industry.[5]

> The American Hospital Association further believes that such institutions [non-profit hospitals] *should be exempted from all legislative acts, federal or state requiring health care institutions to bargain collectively* with any union or professional groups of their employees.[6] (emphasis added).

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[3] Everett M. Kasslow, "Occupational Frontiers of Trade Unionism," *Proceedings of the Industrial Relations Research Association*, St. Louis, Missouri (December, 1960), p. 189.

[4] The number of white-collar workers in the American labor force has increased steadily since 1900 with the largest gains coming in the late 50s and early 60s. From 1900-1950 the gains in the proportion of white-collar workers were primarily at the expense of the drastically declining farm population which has never been highly unionized. However, data indicate that since 1950 the relative increase of white-collar workers has been due to a shift from manual labor (the most highly unionized segment of the labor force). See: *Ibid.*, p. 189. The following table illustrates this observation.

Average Absolute Change of the Number of Workers
In Various Sectors of the American Labor Market
1910-1967°

Period	Agricultural Sector	Production Workers	Selected Service Industries
1910-1930	— 52.9	n.a.	n.a.
1930-1950	—128.5	n.a.	n.a.
1950-1955	—309.0	285.2	238.2
1955-1960	—264.8	181.2	76.4
1960-1967	—300.5	179.2	265.7

°Figures expressed are the average increase or decrease of workers per year (in thousands) for the period indicated.

Source: Data were extracted from, *Handbook of Labor Statistics 1968*, U.S. Department of Labor, Bureau of Labor Statistics, Bulletin No. 1600, passim 67-73.

[5] In a nationwide sample of 479 hospital administrators, approximately 80 per cent of the respondents agreed with the AHA policy promoting the continued exclusion of hospitals from federal or state labor law coverage.

This information was extracted from data gathered by Michael Hynes, "A Measurement of the Responsiveness of the American Hospital Association to Its Membership," unpublished Master's thesis, Iowa City, Iowa: The University of Iowa, 1969, unpresented data.

[6] Association Section, "Statement On Collective Bargaining in Health Care Institutions," *Hospitals*, Vol. 42, No. 2 (January 16, 1968), p. 112.

Antithetical to this attitude is the perspective adopted by unions making a concerted effort to organize the non-profit hospital industry. A spokesman for Local 1199 (New York) of the Drug and Hospital Employees Union, AFL-CIO[7] has confirmed a *Wall Street Journal* report that the union has invested $350,000 in an organizational structure designed to stimulate a nationwide unionization drive among hospital workers.[8] Similarly officials of HELP, the Hospital Employees Labor Program, a two-union combination,[9] last year announced its intentions of organizing all Chicago area hospital personnel "from top to bottom."[10, 11]

Upon initial investigation it appears that the hospital sector is faced with much the same situation, with respect to unionization, as industry as a whole was during the first forty years of the twentieth century. It is the purpose of this monograph to examine the development and status of the collective bargaining and unionization efforts of *nonprofessional employees* of voluntary (non-profit) hospitals, generate some observations regarding relative bargaining power and the right to strike, and provide several alternatives for action that will hopefully prevent, or at least soften, the impending "collision" of union organizers and hospital management. The first step in this task is to examine certain aspects of federal and state labor law as they apply to non-profit hospitals.

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[7] Local 1199 originally represented pharmacy workers and began organizational efforts in the hospital field during 1959. Its parent organization is the Retail Wholesale and Department Store Union, an AFL-CIO affiliate.

[8] "New York Union Planning Nationwide Hospital Drive," *Hospitals,* Vol. 43, No. 3 (February 1, 1969), p. 117.

[9] HELP is a joint effort of Local 73, Service Employees International Union (AFL-CIO) and Local 743, International Brotherhood of Teamsters.

[10] "HELP Wins First Victory, Represents 1000 Workers," *Hospitals,* Vol. 42, No. 2 (January 16, 1968), p. 124.

[11] Note: In thirteen elections during the last two years HELP has won eight, lost two, and experienced two ties. It now represents 4,000 of Chicago's 40,000 hospital employees. "HELP Two Years Later," *Hospitals,* Vol. 43, No. 5 (March 1, 1969), p. 105.

CHAPTER II

THE LABOR LAW STATUS OF NON-PROFIT HOSPITALS

Federal Legal Environment 1930-1947

During the last few years, with hospital employee strikes in most major cities, the public and some health professionals have expressed surprise that the union movement is expanding into the non-profit hospital sector.[12] Yet the union organizational effort directed toward the employees of non-profit hospitals has a traceable history beginning in the middle part of the 1930s. In 1936 the American Federation of Labor (AFL) successfully organized a group of hospital engineers and nonprofessional workers in ten San Francisco institutions.[13] A somewhat similar organizational effort occurred in New York City during 1937; however, it met with considerable resistance and a strike ensued.[14]

The National Labor Relations Act (1935), more commonly known as the Wagner Act, did not specifically provide for the exemption of charitable, religious or educational institutions. Generally speaking, the courts in several cases also denoted no implied exemption with respect to non-profit institutions as a whole based on considerations stemming from impact on interstate commerce.[15]

Eight years after the law was enacted the New York Court of Appeals upheld the legality of the National Labor Relations Board (NLRB) to assert jurisdiction over a labor dispute involving a hospital's attempt to gain an injunction to prohibit a threatened strike (*Central Dispensary and Emergency Hospital v. NLRB*).[16] The NLRB ruled that non-profit hospitals were exempt from the provisions of the Wagner Act because of their charitable status.[17] In this particular instance the court decided that the non-profit hospital was engaged in interstate commerce due to its purchase of supplies across state lines, thus making the hospital susceptible to pro-

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[12] Leonard Berlow, "Are Unions the Answer to Collective Bargaining?" *Hospital Topics* (May, 1961), p. 36.

[13] Leo B. Osterhaus, *op. cit.*, p. 75.

[14] Ester Weismann, "Non-Profit Hospitals and Labor Unions," *Cleveland-Marshall Law Review*, Vol. 8, No. 3 (September, 1959), p. 482.

[15] Note: *NLRB v. Polish National Alliance*, 322 V.S. 643 (1922); *American Medical Association v. United States*, 130 F. 2d 233 (D.C. Cir. 1942) and, *Christian Board of Publications v. NLRB*, 113 F. 2d 753 (7th Cir. 1940).

[16] *Central Dispensary and Emergency Hospital v. NLRB*, 57 NLRB 393 (1943), enfor'd 145 F. 2d 852 (D.C. Cir. 1944), cert. denied, 324 U.S. 827 (1945).

[17] The NLRB has tended to treat non-profit institutions that are not charitable like any other employer. See: *Walnut Hills Country Club*, 145 NLRB 81.

visions in the National Labor Relations Act, had participation in interstate commerce been the only criteria.

In the final analysis, since the National Labor Relations Act did not specifically either include or exclude non-profit hospitals, the interpretation of the legislative intent was left to the discretion of the courts. As it developed, the Central Dispensary and Emergency Hospital case proved to be the exception to the majority of court rulings with respect to the application of the Wagner Act to non-profit hospitals. In 1938 the Jewish Hospital of Brooklyn sought an injunction against its employees to halt a recognitional strike. The hospital argued that the Wagner Act was not intended to cover "not for profit institutions" engaged in the delivery of health-care and cure services, and that an injunction should be granted.[18] The court granted the injunction, but not on the reasoning provided by the plaintiff. The court ruled, in this important decision, that the parties must be engaged in an industry or trade where one party was motivated to secure a livelihood and the other by a desire to earn a profit. The employees fulfilled the requirements of the former, but neither was ruled to be motivated by monetary considerations.[19]

The general intention of the courts in response to perceived public sentiment is illustrated by a 1941 ruling of a Pennsylvania court:[20]

> [Operations of hospitals] would be impossible, should we hold the Labor Act applicable with all its attending ramifications, interpretations and possible cessations of service due to labor disputes. . . . Surely the legislature had no such intentions. . . .[21]

Most other rulings tended to follow this general line of reasoning as courts concluded that (1) the intent of the Wagner Act was not to extend coverage to the workers of non-profit charitable institutions, and (2) making them susceptible to the act was not in the public interest. Additionally, the rationale for excluding non-profit hospitals from the provisions of the labor laws centered on a distinction between those who were in business for personal gain and those who were not.[22] A New York court stated that

> the character of such employers [non-profit, charitable institutions] . . .

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[18] The Norris-La Guardia Act (1932) specifically limited the granting of injunctions in labor disputes unless coercion or force on the part of either party was clearly demonstrated.

[19] *Jewish Hospital of Brooklyn v. John Doe*, 252 app. Div. 581 (1938).

[20] The Pennsylvania Labor Relations Law was modeled after the Wagner Act and the arguments presented against hospital inclusion under this act typify the rationale that was being presented for federal exemption.

[21] *Western Pennsylvania v. Lichliter*, 340 Pa. 382, 17A, 2d 206 (1941).

[22] Judith Vladeck, "Collective Bargaining in Voluntary Hospitals and Other Non-Profit Operations," *Proceedings of New York University 19th Annual Conference on Labor*. Thomas G. S. Christensen (ed.), Washington, D.C.: Bureau of National Affairs, Inc., 1966, p. 223.

was sufficient assurance of fair dealing with their employees to render unnecessary the protection of the Labor Relations Act.[23]

Neil W. Chamberlain and James W. Kuhn state that labor law can best be understood if "one thinks of the courts as an instrument of society's adjusting to changed social conditions."[24] As we will note, the environment created by the preceding court decisions formed the foundation for a statutory enactment that embodied the prevailing mood of the public.

Federal Legal Environment 1947 to Present

With the passage of the National Labor Relations Act of 1947 (Taft-Hartley Act), non-profit hospitals were *specifically* excluded from federal labor law coverage. The law states that

> The term 'employer' includes any person acting as an agent of an employer, directly or indirectly, but shall not include . . . any corporation or association operating a hospital, if no part of the net earnings inures to the benefit of any private shareholder or individual. . . .[25]

This was the statutory directive that encompassed the climate the courts had created prior to 1947. The Taft-Hartley Act stands today as the nation's major piece of labor legislation.

The debate surrounding the adoption of the amendment specifically excluding non-profit hospitals from coverage (introduced by Senator Tydings) focused on two related factors. First, Congress expected that the National Labor Relations Board would continue to decline jurisdiction over most cases dealing with charitable institutions, and that guidelines should be drawn so that *only* non-profit hospitals would be exempted.[26] Secondly, there seems to have been concern over whether hospitals were engaged in commerce, especially interstate commerce, and that subsequent regulation should be left to local authorities.[27] Additionally, the legislative history of the Taft-Hartley Amendments denoted concern that charitable hospitals were primarily a matter of local interest because they were executing a quasi-governmental function.[28] Succinctly stated, the Congress

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[23] *Trustees of Columbia University v. Herzog*, 269 app. Div. 24 aff'd., 295 N.Y. 605 (1945).

Also there seemed to be some concern that if non-profit institutions were requested to bargain collectively, much charitable contribution would be withdrawn.

[24] Neil W. Chamberlain and James W. Kuhn, *Collective Bargaining*, second edition, New York: McGraw-Hill Book Company, 1965, p. 279.

[25] *National Labor Relations Act, 1947;* Public 2.101, 80th Congress, 1st Session, as amended by Public L. 188, 82nd Congress, 1st Session. Section 2 (2) subquoted from: Stephen A. Schlossberg, *Organizing and the Law,* Washington, D.C.: The Bureau of National Affairs, Inc., 1967, p. 4.

[26] Judith Vladeck, *op. cit.*, p. 225.

[27] Michael Hynes, "The Union Movement In the Non-Profit Hospital," unpublished mimeo, Iowa City, Iowa: The University of Iowa, 1969, p. 7.

[28] Albert X. Bader, Jr., "The Present Labor Law Status of Non-Profit Institutions,"

believed that charitable hospitals were doing something that the states wanted done, and would otherwise have to do themselves.[29] The foundation for this line of reasoning can be noted in *Western Pennsylvania Hospital v. Lichliter*[30] where the Pennsylvania Labor Relations Act was not held applicable to hospitals because the court ruled that hospitals were not employers under the act. They were supported in part by state funds, and thus were considered agencies of the Commonwealth of Pennsylvania.[31]

The implication of the exemption of non-profit hospitals from the provisions of the Taft-Hartley Act is clear. Section 8 (a) (5), reaffirmed the Wagner Act and stated that it was an unfair labor practice for an employer to refuse to collectively bargain in good faith with his employees or their representatives. Additionally, it was made an unfair labor practice to fire employees for union activities or to discriminate against union members in any way.[32] Thus in the absence of any state statute which specifically includes non-profit hospital employees, such hospitals have no legal obligations, under the law, to recognize or deal with their employees on a collective basis. Additionally, the hospital management can engage in direct action to halt or limit union activity (e.g., removing organizers or limiting promotions to employees sympathetic to the union cause). In this manner, unions attempting to organize prospective employee groups are essentially barred from the hospital, at least in the eyes of federal legislation. One other implication, although more general in nature but equally important, should be mentioned. The exemption of non-profit hospitals from federal labor law coverage has been cited in state courts as a declaration of desirable public policy with respect to interpreting state laws which neither specifically include nor exclude non-profit hospitals.

One example of a court proceeding based on a judgment stemming from considerations derived from the Taft-Hartley Act will demonstrate the line of thought incorporated by most judiciaries after 1947.

In 1960, the Colorado Supreme Court ruled that St. Luke's Hospital was not required to recognize or collectively bargain with representatives chosen by its employees. The Court ruled that the State Labor Relations Act, which was modeled after the Taft-Hartley Act, did not entitle hospital

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Proceedings of New York University 19th Annual Conference on Labor. Thomas G. S. Christensen (ed.), Washington, D.C.: Bureau of National Affairs, Inc., 1966, p. 240.

[29] In essence, the Congress was considering non-profit hospitals to be an extended arm of the state government (which were exempt from provisions of the Taft-Hartley Act).

[30] *Western Pennsylvania v. Lichliter*, 340 Pa. 382, 17A, 2d 206 (1941).

[31] Albert X. Bader, Jr., *op. cit.*, p. 14.

[32] These points were originally stated in the Wagner Act which the Taft-Hartley Act amended.

employees protection under its provisions.[33] The reasoning of the court with respect to this decision was that: (1) state policy was against the disruption of critically important hospital functions by concerted efforts of employees, and (2) the law imposes duty on these people to care for the ill.[34]

Reflecting on the development of the federal labor law status of non-profit hospitals, several conclusions can be drawn. It appears that judges and legislatures have expected the employees of non-profit hospitals to share in that institution's charity. Proprietary hospitals are not exempted from Taft-Hartley thus the exclusion of non-profit health-care institutions is due to their charitable status rather than being hospitals *per se*. Additionally, it has been assumed that since these institutions are by definition charitable, and noting that "charity begins at home," employees of these establishments would be treated equitably as a matter of course.[35] Traditionally this has not been the case.

Employees of non-profit hospitals have been considered along with government employees, with respect to their exclusion from protection of the labor laws, although they possess none of the benefits of public employment (e.g., guaranteed tenure, promotion review boards, job security provisions and adequate pension plans).[36] This logic does not parallel the rationale of hospitals providing a quasi-governmental function, one of the factors considered when excluding health-care institutions from Taft-Hartley coverage. Additionally, in many instances, hospital workers, under the jurisdiction of state labor relations laws, have been held to a level of conduct not required of other employee groups. For example, several state legislatures have severely limited the right of hospital employees to strike or picket while not requiring employers to recognize or bargain collectively with said employees.[37]

Since the Taft-Hartley Act makes no provision for dealing with non-profit hospitals, this duty is automatically left open to the states' discretion. The Constitution of the United States holds that any duty not specifically assumed by the federal government reverts to the states.[38] Thus it be-

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33 *St. Luke's Hospital v. Industrial Commission of Colorado,* 45 LRRM 2953 (1960).

34 *Ibid.*

35 Note the rationale provided in *Trustees of Columbia University v. Herzog* mentioned earlier.

36 Judith Vladeck, *op. cit.*, p. 222.

37 Massachusetts does not require hospital management to bargain with its employees although the state has the power to enjoin strikes.

38 The jurisdiction of state law with respect to the labor relations of non-profit hospitals has been upheld in several cases. Note: *Utah Valley v. Industrial Comm'r of Utah,* 199 F. 2d 60 (10 Cir. 1952) and, *Utah Labor Relations Board v. Utah Valley Hospital,* 120 Utah 463, 235 P. 2d 520 (1951).

comes necessary to briefly analyze applicable state labor laws. Before doing this, however, it would prove beneficial to examine the single piece of federal labor legislation that, by implication, includes non-profit hospitals in its coverage.

The Labor-Management Reporting and Disclosure Act (1959) places controls on the internal affairs of labor unions and on the conduct of the union-management relationship. Specifically, the act requires that employers report:

1. promises to make, or the making of payments or loans to officials or other representatives of labor organizations.
2. payments to employees for the purpose of causing them to persuade other employees to exercise or not to exercise, or as to the manner of exercising, their rights to organize and bargain collectively.
3. payments to labor relations consultants under such circumstances to interfere with certain employee rights.[39]

Reports of these actions must be filed with the Secretary of Labor. Penalties for failure to file such reports or filing false reports, include fines up to a maximum of $10,000 and/or imprisonment for one year.

The object of enacting requirements for filing reports on the aforementioned activities is to restrict such behavior. It was assumed that employers would not want to make such actions known through the public filing of reports, nor would they want to run the risk of engaging in such behavior and not filing, thus becoming susceptible to the penalties. Hospitals engaged in such dealings that limit the employees rights to organize and bargain collectively must, therefore, choose between two undesirable alternatives or desist from such practices.[40]

The Applicability of State Labor Laws to Non-Profit Hospitals

As noted earlier the individual states have usually decided to leave the regulation and control of labor management relations to the federal government. Presently seventeen states and one territory have enacted legislation dealing specifically with labor relations. In most cases, these laws are modeled closely after the Taft-Hartley Act, with several exceptions; one notable difference is the treatment of non-profit hospitals.

Table 1 provides an analysis of the eighteen state labor laws with respect to their consideration of non-profit hospitals.[41] Table 2 denotes those activities that are deemed unfair labor practices under these respective laws

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39 *Hospital Law Manual,* "Labor-Management Reporting and Disclosure Act," section 2-2, The University of Pittsburgh: Health Law Center (Supplement; February, 1960), pp. 3-4.

40 *Ibid.*

41 The specific citations of these acts are presented in Appendix One.

Table 1

The State Labor Law Status
of Non-Profit Hospitals

	expressly exempt	implied exemption	expressly included	implied inclusion	status uncertain	applicable to R.N.'s and L.P.N.'s only	statutes to prohibit or prevent strikes
Colorado		X[a]					X[h]
Connecticut	X						X[h]
Hawaii					X		
Kansas					X		
Massachusetts		X[b]				X	X[g]
Michigan				X[c]			X[g]
Minnesota			X				X[g]
Montana						X	
North Dakota	X						
New Jersey				X[d]			
New York			X				X[g]
Oregon					X	X	
Pennsylvania		X[e]					X[h]
Rhode Island	X						X[h]
Utah	X						X[h]
Vermont	X						
Wisconsin				X[f]			
Puerto Rico					X		

[a]*St. Luke's Hospital v. Industrial Comm'r of Colo.*, 142 Colo. 28, 349 P. 2d 995 (1960).

[b]Nonprofessional employees are excluded under the act, while licensed professional and practical nurses are included. See: *St. Luke's Hospital v. Labor Relations Commission*, 320 Mass. 467, 70 N.E. 2d 10 (1946).

(only fourteen states are listed here as some states do not specifically denote such practices). It can be observed that six states (Connecticut, Colorado, North Dakota, Pennsylvania, Utah, and Rhode Island) deem it illegal for hospital employees to strike but provide that employers are *not* subject to the general provisions of the law; i.e., they are not required to recognize or bargain collectively with their employees. Three states provide protective regulations for licensed professional and practical nurses but exempt non-professional personnel.[42] Thus in eight of the eighteen states having labor laws,[c] non-profit hospitals are not required to recognize or bargain collectively with their employees, where the employees themselves are placed under specific regulation in six of these eight states severely limiting their relative bargaining power (i.e., their right to strike).

> The . . . [thirty-three] remaining states do not have labor relations laws. The absence of legislation does not make hospital union activity illegal in these states. Such activity is left unprotected, and union and management disputants may battle freely over acceptance or rejection of collective bargaining. To this extent, the legal status of hospital employees in these [thirty-three] states is similar to that of non-profit hospital employees in the states where non-profit hospitals are exempt from coverage of state labor laws.[43]

We may therefore note that in forty-four states non-profit hospitals are in no way required to recognize or bargain collectively with their employees. In general the courts have analyzed pertinent federal and state

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[c] *Local No. 1644 v. Oakbrook Hospital Corporation*, 367 Mich. 79, 116 N.W. 2d 314 (1962).

[d] *Johnson v. Christ Hospital*, 45 N.J. 108, 211 A. 2d 376 (1965).

[e] *Western Pennsylvania Hospital v. Lichliter*, 340 Pa. 382, 17A. 2d 206 (1941).

[f] *Wisconsin Employment Relations Board v. Evangelical Deconess Society*, 242 Wisc. 78, 7 N.W. 2d 590 (1943).

[g] Emergency machinery to prevent or prohibit hospital employee strikes.

[h] Prohibits hospital employee strikes expressly with no machinery for dispute resolution.

Sources: (1) Albert Bader, Jr., "The Present Labor Law Status of Non-Profit Institutions," *Proceedings of New York University Nineteenth Annual Conference on Labor* (1966), pp. 236-238; (2) *Hospital Law Manual* (August, 1967), p. L-A; (3) Respective state labor laws and court decisions.

[42] Generally, nursing personnel are in somewhat of a unique position with regard to their bargaining attempts with management. Since they are in extremely short supply, their bargaining power, in a relative sense, is higher than that of nonprofessional hospital employees. In states that prohibit hospital employee strikes, nursing personnel can resign en masse and be rather confident that the management could not hire replacements—nonprofessional employees do not have this assurance. As noted in the introduction, this paper will not deal specifically with the unionization and collective bargaining efforts of professional hospital personnel.

[43] Estelle Hepton, *Battle For The Hospitals: A Study of Unionization In Non-Profit Hospitals*, Bulletin No. 49, New York State School of Industrial and Labor Relations; Ithaca, New York (March, 1963), p. 8.

Table 2

State Unfair Labor Practices

For Employers	Colorado	Connecticut	Hawaii	Kansas	Massachusetts	Michigan	Minnesota	New York	Oregon (1)	Pennsylvania	Rhode Island	Utah	Wisconsin	Puerto Rico
Interference	X	X	X	X	X	X		X	X	X	X	X	X	X
Domination of union	X	X	X	X	X	X		X	X	X	X	X	X	X
Discrimination for union activity	X	X	X		X	X	X	X	X	X	X	X	X	X
Discrimination for testifying	X	X	X	X	X	X	X	X		X	X	X	X	X
Refusal to bargain	X	X	X		X			X	X	X	X	X	X	X
Espionage	X	X	X	X			X	X			X		X	
Blacklisting employees	X	X	X				X	X			X		X	
Deduct dues not authorized individually	X		X	X						X			X	
Breach of contract	X		X				X						X	X
Bargaining with minority			X									X	X	X
Lockout contrary to agreement							X		X					
Ignoring final determination of tribunal	X		X										X	
Secondary boycott	X		X	X			X			X		X	X	

Table 2 (Continued)

For Employees or Unions	Colorado	Connecticut	Hawaii	Kansas	Massachusetts	Michigan	Minnesota	New York	Oregon (1)	Pennsylvania	Rhode Island	Utah	Wisconsin	Puerto Rico
Picketing in minority strike	X		X	X								X	X	
Coercing employees	X		X	X	X	X	X			X		X	X	X
Coercing employers to join in interference	X		X									X	X	
Ignoring final determination of tribunal	X		X										X	
Breach of contract	X		X	X			X						X	X
Sit down strike	X		X	X	X	X	X		X	X		X	X	
Mass or violent picketing	X		X	X		X	X					X	X	
Intimidating employees or employees' family	X			X			X			X		X	X	
Picketing beyond industry				X										
Insistence on hiring standby employee	X													
Acting as union agent without license				X										
Forcing union membership	X		X	X	X	X				X			X	
Jurisdictional strike				X						X			X	

[1] Applicable to licensed professional and practical nurses employed in health-care facilities.

Source: *Hospital Law Manual*, University of Pittsburgh: Health Law Center, (February, 1962), p. C-2.

(when in existence) legislation and have noted that it is desirable public policy to prevent the disruption of critical hospital services because of employee strikes. In most instances, the individual states have felt the best way to accomplish this would be to passively discourage unionization through legislation hampering organizational efforts in hospitals (exemption from state labor law coverage). Additionally some states actively limit the bargaining power of already established hospital unions by eliminating non-profit hospitals from coverage under the respective state's anti-injunction legislation.

The federal government and twenty-four states have enacted anti-injunction legislation. Generally these acts limit the power of courts to grant injunctions to prohibit such actions as strikes and picketing unless coercion or force can be clearly demonstrated on the part of the union. All federal courts are bound by the Norris-La Guardia Act (1932) which severely limits the granting of injunctions in labor disputes. A categorization of the state anti-injunction acts can be found in Appendix 2. Some states specifically exclude non-profit hospitals from inclusion under these acts; in these cases injunctions are more easily obtainable.[44]

The remainder of this chapter will focus on the examination of four states that have chosen to encourage collective bargaining in the non-profit hospital sector but also limit or prohibit the employees right to strike. These states are New York, Michigan, Minnesota, and the somewhat unique situation of Massachusetts.

Although New York has had a rather long history of collective bargaining and unionization in the private sector, non-profit hospital employees have only recently adopted these techniques and then only somewhat sporadically throughout the state. Prior to 1963, New York did not include non-profit hospitals under the coverage of the State Labor Relations Law. Through the period 1960-1962, there were several bitter strikes at New York City hospitals. This development caused Governor Nelson Rockefeller to commit himself to advocating the removal of the exemption of non-profit hospitals under section 715 of the State Labor Law. In 1963, the law was amended to include the employees of non-profit hospitals located in New York City only.[45] Section 713 of the act declared that strikes by the employees of non-profit hospitals were illegal and section 716 established fact finding, mediation and binding arbitration for the resolution of disputes not settled through the process of joint union-management negotiation.[46]

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44 *Hospital Law Manual* (November, 1968), pp. 7-8.

45 Albert X. Bader, Jr., *op. cit.*, passim 241-247.

46 Synopsis of New York State Labor Relations Act, Sections 713 to 716, effective October 1, 1963.

Even before the formal initiation of the act, problems concerning the appropriate delineation of the bargaining unit arose. The New York State Labor Board conducted hearings concerning the configuration of the bargaining units and denoted five classifications: registered nurses, licensed practical nurses, clerical employees, and maintenance and service workers. After some disagreement with this structure by several unions, the board consented to allow "globe" elections[47] to determine whether maintenance and service employees would be considered as single or separate units.[48]

During the later part of 1964, Local 1199 of the Drug and Hospital Employees Union began organizing outside New York City proper. Several strikes ensued which prompted the legislature to extend the State Labor Law coverage to remaining portions of the state in May of 1965.[49]

The Michigan Labor Mediations Act entitles the employees of nonprofit hospitals the right to bargain collectively with their respective employers over wages, hours, and working conditions. Section 13a (3) (a) states that:

> The parties to a hospital or public utility dispute shall be obligated under this act to bargain collectively at all times.[50]

The union selected by the employees as their representative can be designated through voluntary recognition if the hospital is certain that it represents a majority of the workers in the unit or through elections conducted by the State Labor Board.

The Act stipulates that if collective bargaining breaks down (either the original negotiation of the contract or the grievance procedure), one of two procedures may be followed depending upon the specific circumstances. If there is a settlement procedure stipulated in the contract, it must be followed. If, however, there is no collective agreement in existence or if the contract contains no specifically delineated settlement procedure, the following steps must be undertaken.[51]

1. Notice of the dispute must be filed with the Labor Mediations Board at least 30 days before a strike or lockout can be instigated.
2. If the dispute has not been settled within 30 days, the case transfers to the governor who then submits it to a special commission.
3. The commission issues a special report which summarizes its recommendations for settling the dispute. This statement is only suggestive and is not binding on either party.

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47 Globe elections are held to determine who shall vote in the representational election that decides if the union shall represent a specific group or groups of employees.

48 Albert X. Bader, Jr., *op. cit.*, p. 245.

49 *Ibid.*, p. 246.

50 Michigan Labor Mediations Act (Bonnie-Tripp Act) subquoted from: Estelle Hepton, *op. cit.*, p. 9.

51 Synopsis of Michigan Labor Mediations Act (Bonnie-Tripp Act) Sections 423-1 to 423.25 in the Compiled Laws of 1948; approved and made effective May 31, 1949.

4. If the dispute can still not be settled, and either party notifies the Labor Mediations Board that negotiations have stalemated, a strike election is conducted. A majority vote must be obtained to call a strike.

The Act states that no slowdowns are permitted during the negotiation period, but the employees are in no way prohibited from terminating their employment "individually." Throughout the course of the four-step process, both parties are urged to submit the dispute to compulsory arbitration and are required to bargain in "good faith" with respect to the issues at hand. Fact-finding commissions have been appointed in eleven hospitals during the period 1959-1962, and there have been no strikes in any of Michigan's non-profit hospitals since shortly after World War II.[52]

The Minnesota Charitable Hospitals Act of 1947 prohibits strikes and lockouts and requires compulsory and binding arbitration on disputable issues. Procedure for the settlement of disputes between parties is stated as follows:

> Sec. 179.38 Arbitration Mandatory.—In the event of the existence of any labor dispute which cannot be settled by negotiation between the charitable hospital employers and their employees, either such employers or employees may petition and avail themselves of the facilities of the department of labor as provided in Minnesota Statutes, Sections 179.01 to 179.17, insofar as sections are not inconsistent with the provisions [of these sections]. If such dispute is not settled within 10 days after submission to conciliation, any unsettled issue of maximum hours of work and minimum hourly wage rates shall, upon service of written notice by either party upon the other party and the State Labor Conciliator, be submitted to the determination of a Board of Arbitrators whose determination shall be final and binding upon the parties.[53]

A district court ruling in 1951 and a Supreme Court decision in 1954 have upheld the constitutionality of the law.[54] Before the statute's enactment, nonprofessional hospital employers had struck on several occasions, but since 1954, when the law's constitutionality was upheld, there have been no disruptions. In general, the law has proven to be a sound mechanism for keeping hospitals free from strikes.[55]

In 1946, the Massachusetts Supreme Court held non-profit hospitals exempt from its labor relations law, thus denying employees the guaranteed right to collectively bargain with and be formally recognized by their

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[52] Estelle Hepton, *op. cit.*, p. 10.

[53] Minnesota Charitable Hospitals Act of 1947, Section 179.38, subquoted from: Estelle Hepton, *op. cit.*, p. 11.

[54] *Fairview Hospital Association v. Public Building Service Union, Local 113*, 22 Labor Arbitration 279 (1954).

[55] Averill G. Marcus, "Collective Bargaining in Non-Profit Hospitals," *I.L.R. Research*, Vol. 13, No. 1 (May, 1967), p. 5.

employers.[56] This law seemed applicable to all employers of charitable hospitals until a 1964 decision guaranteed the bargaining rights of professional and practical nurses;[57] nonprofessional workers were excluded from coverage. Although not given the protection of labor law coverage, nonprofessional hospital employees were included under the auspices of the Emergency Labor Disputes Act of 1947. This act establishes mechanisms to settle disputes threatening the "public health and safety." The policy of the act is stated in part as follows:

> . . . primary responsibility [is placed] upon the employers and representatives freely designated or selected by employees for the avoidance of any interruption in the production or distribution of food, fuel, water, electric light and power, gas or hospital or medical services resulting from differences concerning wages, hours and other terms and conditions of employment. . . .[58]

Under the act the governor may choose among several alternative ways in which to bring about an end to a strike covered by the provisions of the legislation. In an unsettled dispute the governor may

1. *appoint* a moderator who will attempt to reconcile the parties through mediation and conciliation, and will release findings to the public.
2. *request* the parties to submit the dispute to a board of inquiry which will recommend settlement terms.
3. *require* both parties to continue production, or
4. *seize* the plant or facility and operate it in the manner he sees fit to safeguard the public health and safety.[59]

Although Massachusetts is not highly unionized in the hospital sector, there has never been a strike of non-profit hospital employees.

In summary, we may note that generally the states have chosen to follow the federal guidelines with respect to the regulation of labor-management relations. Eighteen states have enacted labor laws. Of these eighteen states only four include hospital employees under labor law coverage. In total, forty-four states do not require hospitals to recognize or bargain collectively with their employees, while eight of these states require behavior of hospital employees not expected of employees in general (i.e., they are denied the right to strike). The implications of federal and state legislative enactments with respect to non-profit hospital labor-management relations will be discussed in the following chapters of this monograph.

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[56] *St. Luke's Hospital v. Labor Relations Comm'r*, 320 Mass. 467, 70 N.E. 2d 10 (1946).

[57] Albert X. Bader, Jr., *op. cit.*, pp. 237-238.

[58] Section 1 of the Massachusetts Emergency Labor Disputes Act (1947), subquoted from: Estelle Hepton, *op. cit.*, p. 14.

[59] *Ibid.*, p. 15.

CHAPTER III

HOSPITAL EMPLOYEE UNIONS: SOME MAJOR OBJECTIONS

Labor-management relations can be analyzed by noting that unions and the organization as an employer are essentially dichotomous entities, occupying the same operational space, encompassing only small areas of goal overlap and then only in a uni-directional sense. The union's primary objective is maximum job security,[60] where the organization's goal is to achieve maximum flexibility and greatest latitude of management prerogatives so that delineated objectives may be reached.[61] The union is forced to accept certain goals of the organization of which it is a part in order to insure its own existence (e.g., the economic viability of the specific industry is of particular importance to the union in order for it to be able to secure employment for its members). Historically, however, management has not been required, out of economic necessity, to accept the goals of the union that has organized its industry. This condition has changed somewhat with the extension of union security clauses, but few organizational bylaws state that one of the objectives of the firm is to increase the well-being of its employees. On the other hand the union's interest in the "health" of the organization, of which it is a part, is implicit.

As noted previously, the American Hospital Association has stated that non-profit hospitals should remain exempt from all legislative acts (federal or state) that require health-care institutions to recognize or bargain collectively with their employees. A recent nationwide survey of 479 hospital administrators has revealed that approximately 80 per cent of the selected sample agree with this policy.[62] Generally, hospital administrators have expressed their reasoning for disapproval of unionization efforts in the non-profit health-care arena by focusing on five major objections.[63]

1. The non-profit hospital is not a commercial enterprise with profits over which to bargain.[64]

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60 The concept of maximum job security as an objective of the union movement forms the foundation for Selig Perlman's theory of the "manualist psychology." See: Selig Perlman, *A Theory of the Labor Movement*, New York: The Macmillan Company, 1949.

61 Robert Tannenbaum denotes eight primary ways in which the manager seeks to increase the rationality of the organization by attempting to expand his decision-making authority. In all cases the expansion of decision-making authority increases the management's flexibility and scope of prerogatives. See: Robert Tannenbaum, "Managerial Decision-Making," *The Journal of Business*, Vol. 23 (January, 1950), pp. 33-37.

62 Hynes, *op. cit.*, unpresented data.

63 This configuration of objections is subquoted from Estelle Hepton, *op. cit.*, pp. 3-5.

64 Leonard Berlow, "Are Unions the Answer to Collective Bargaining?" *Hospital Topics* (May, 1961), p. 38.

2. Unionization leads to insubordination among employees, which cannot be tolerated in a hospital.[65]
3. Collective bargaining infringes upon management prerogatives, rights and responsibilities to deliver health care.[66]
4. Unions do not provide any benefits to employees which the hospitals themselves cannot provide.[67]
5. The recognition of a union is a direct invitation to strikes.[68]

The logic of these objections when considered in total is unclear. It is of some importance to note that the objections raised concern the appropriateness of unions and their right to organize hospitals *per se*. In this regard, why then are proprietary hospitals treated differently (they are covered under the Taft-Hartley Act) than non-profit institutions? In the legislative and legal sense the same set of objections should be equally applicable to both profit and non-profit hospitals. As Hepton has noted, the obvious answer is that legislators have realized that there is no substantive uniqueness to the operations of *all* hospitals;[69] the main criteria seems to be the charitable status of the institution under consideration. Subsequently we may note that charitable institutions generally are not exempt from Taft-Hartley; the exemption of non-profit hospitals seems to be due to the interaction effect of the two factors—the "non-profit" orientation on one hand and being a "hospital" on the other. The questions remaining are: (1) is this exemption, considering the objections and analysis provided, justifiable, and (2) what are the alternate contingencies if the present classification is disregarded?

Although the list of objections raised by hospital administrators to hospital unions, as presented, is not a complete enumeration, a discussion of these objections will facilitate the answering of question one. The author will then be in a position to present thought regarding alternative contingencies and policy determination (this will be the emphasis of Chapter Four).

No Profits Over Which to Bargain

The assertion that non-profit hospitals do not have profits over which to bargain is in itself a valid statement; this, however, does not establish that terms of employment (including wages) are, in fact, not bargainable. The non-profit hospital must pay the standard rate for material commodities that it purchases; why then is the acquisition of labor resources any

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[65] David R. Kochery and George Strauss, "The Non-Profit Hospital and the Union," *Buffalo Law Review* (Winter, 1960), p. 273.

[66] "Hospital Strike," *Modern Hospital* (June, 1959), pp. 63-64.

[67] Kochery and Strauss, *op. cit.*, pp. 277-278.

[68] Martin R. Stienberg, "Unions and Voluntary Hospitals," *Hospital Management* (June 1959), p. 25.

[69] Estelle Hepton, *op. cit.*, p. 6.

different? Hospital employees can no longer be expected to share the hospitals' charity as they have been forced to do in the past. The hospital has switched from employing marginal labor to attempting to retain a stable and skilled nonprofessional work force. This change is clearly noted by Temple Burling, M.D., when he describes hospital labor policies in transition:

> The transition hospitals have been making between ancient and modern personnel practices is nowhere more clearly revealed than in its policies toward unskilled employees. Traditionally hospitals kept their costs down by hiring workers at less than prevailing wages. In order to get workers at such low rates, they accepted the otherwise unemployable: the handicapped, the aged, the derelict. Hospital employment came to be seen as a form of charity, a way to give a modicum of self-respect to people who could not find work elsewhere.[70]

Since approximately two-thirds of the average hospitals' operating budget is accounted for by payroll expense, increasing the labor bill forces hospital costs upward and directly affects the prospective patients' ability to purchase health-care services. Since the patient receives the benefit of a more sophisticated work force (indirectly), it is only natural that he or the community as a whole rather than the worker assume the cost. Hospital costs have been increasing about 12 per cent per year over the last half decade, but generally, wages are still lagging behind comparable categories in the remainder of the work force[71] (see Table 3, page 28).

Increased Insubordination and Erosion of Management Prerogatives

The critical nature of the services rendered by the hospital, management contends, necessitates immediate unquestioning obedience on the part of subordinates. Additionally, the demand for specific services of the institution is highly variable, and management requires the prerogative to rearrange the work assignments and reporting times of its employees. It is contended that unionization would unnecessarily hamper both of these "strategic" requirements.

Union officials in both the non-profit hospital and industrial sector have stressed that orders should be carried out explicitly as required by the superior. If an employee believes that an infringement on his rights has

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[70] Temple Burling, Edith M. Lentz and Robert M. Wilson, *The Give and Take In Hospitals: A Study of Human Organization in Hospitals*, New York: G. P. Putnam's Sons, 1956, p. 162.

[71] "American Hospital Association Guide Issue," *Hospitals*, Vol. 42, No. 15, Part 2 (August 1, 1968), p. 444.

occurred, a grievance can be filed after the fact.[72] The hospital management's desire for maximum flexibility within reasonable limits is a demonstrable need. This same requirement has been voiced in the industrial sector and unions have strived to accommodate it; the hospital environment should be no exception.

Often the organization denotes that union demands requiring a worker voice in specified areas of management decision making (staffing, job classification, productivity requirements, etc.) infringes on the property rights of the corporation. It must be remembered that the corporation's "property rights" carry no duty on the part of others to be managed. The fallacy of the property rights concept of management prerogatives is that property rights give command only over things. When the particular "business" assumes a corporate form and requires the cooperation of a large number of individuals performing specialized functions, control over things ceases to be sufficient. Chamberlain and Kuhn note that:

> Cooperation, without which the property right is reduced to a power of disposition, cannot be commanded. It can be won only by consent . . . thus the right to manage and direct others does not flow out of legal right but must be granted by those very people who are managed and directed; the price of the grant may be that management must yield its independence in certain matters of business operation.[73]

Too often management views unions with respect to the rigidity they sometimes demand rather than considering the flexibility they can initiate. Given mutual union-management cooperation, the problems of organizational prerogatives unique to the hospital environment can be circumvented.

Unions Provide No Substantive Gains

One objection of many hospital administrators to unionization efforts has been that the employees do not need a union; all that can be done is being done.[74] In the discussion regarding the federal labor law status of non-profit hospitals, it was noted that one of the reasons hospitals were exempted from the coverage of Taft-Hartley was that the Congress believed that charitable institutions would look after the welfare of their employees as a matter of course. Traditionally, this has not been the case as the workers of non-profit institutions have been expected to subsidize

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[72] Interview with Peter Ottley, President, Local 144, Hotel and Allied Service Employees' Union (BSEIU), September 9, 1962. Subquoted from: Estelle Hepton, *op. cit.*, p. 4.

[73] Chamberlain and Kuhn, *op. cit.*, p. 90.

[74] This viewpoint was expressed in Kochery and Strauss, *op. cit.*, pp. 277-278.

their employers' philanthropy. As has already been mentioned in the discussion of the first objection, hospital wages have traditionally been less than those accruing to comparable positions in industry.[75] Additionally, employees have viewed the union mechanism as a means of gaining recognition and representation as a viable and potentially contributory segment of the organization. Chris Argyris in *Integrating the Individual and the Organization* has stated that unions typically attempt to fulfill the desire of the employee for purpose and worth because management has failed to utilize the worker's full potential as a human being.[76] Due to increasing specialization and tightened managerial controls, complemented by the employee's lack of recognition and feeling of worth, the worker engages in the adaptive mechanisms of absenteeism, turnover, and aggression.

> If these activities are not adequate to help them adapt to the frustration and conflict, the employees may take other action. One step is to attempt to decrease the degree of personal and institutional dependency and submissiveness that they feel toward management. This may be done by bringing in a trade union which will not only represent their interest and back them up with appropriate weapons (for example, strikes), *but will tend to ask for some voice in such practices as job rates, job changes, layoffs, discharges and so on.*[77] (emphasis added)

Since employees in other segments of the economy have been granted the *right* of recognition and representation, hospital employees justifiably argue that they should not be treated differently. To differentiate between the two groups is to invite conflict.

Invitation to Strikes

Virtually every discussion of the objections to the unionization of hospital employees eventually focuses on the problem of actual or threatened strikes. Legislatures and courts presenting their rationale for exempting hospitals from labor law coverage allude to the "intolerable conditions" that would be created if critical hospital services were substantially curtailed or eliminated completely due to a strike. The power of this objection lies both in its inherent validity and the strong public sentiment it arouses.

With respect to the issue of strike action by hospital employees, the central concept of primary attention is one of bargaining power. Administrators contend that due to the critical nature of the services the hospital provides and the consequences that would occur if these services were

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[75] A more thorough discussion of the hospital wage structure is provided in Chapter Four of this monograph. Data denoting comparative wage scales are presented in Table 3.

[76] Chris Argyris, *Integrating the Individual and the Organization*, New York: John Wiley and Sons, 1964, especially Chapter Three.

[77] *Ibid.*, p. 61.

curtailed, unionized hospital employees are provided with an inordinate amount of bargaining power with which to coerce management to accept their demands. Additionally, this action (the strike) harms not the institution from which gains are being sought, but rather the public whom the institution serves. Secondary rather than primary participants are made party to the dispute even though they did not help to formulate the situation causing the disruption, nor can they substantially aid in the dispute settlement.

The area of bargaining power theory and the associated concepts of wage determination are complex and cannot be treated even superficially in this monograph.[78] However, realizing this factor, the author will attempt to address the subject generally so that several preliminary conclusions can be drawn with regard to the relative bargaining power of hospitals and hospital employees.

A succinct statement of the concept of bargaining power is provided by A. C. Pigou.[79] Pigou assumes that when a union and management bargain about a change in the wage rate, there is a given wage above which the union will not demand for fear that unemployment will result.[80] Complementarily, there is a wage rate below which the employer will not press for fear that his labor force will be lost and production will be halted. The fact that an inordinate wage demand will decrease the demand for labor while an excessive wage decrease will lessen the supply of labor will set rather specific limits to the bargaining space.[81, 82] The factors stimulating an agreement between the parties are: (1) the fear of curtailed production while fixed cost must be assumed, thus decreasing the organization's profit; and (2) decreased earnings on the part of the employees.

J. R. Hicks has diagramed this relationship in his model of the bargaining schedule presented in Figure 1.[83] OE represents the wage rate

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78 The interested reader is directed to sources indicated in the footnotes of this discussion for a more detailed treatment of bargaining power and wage determination theory.

79 A. C. Pigou, *Economics of Welfare*, fourth edition, London: Macmillan and Company, Ltd., 1938, especially pp. 451-461.

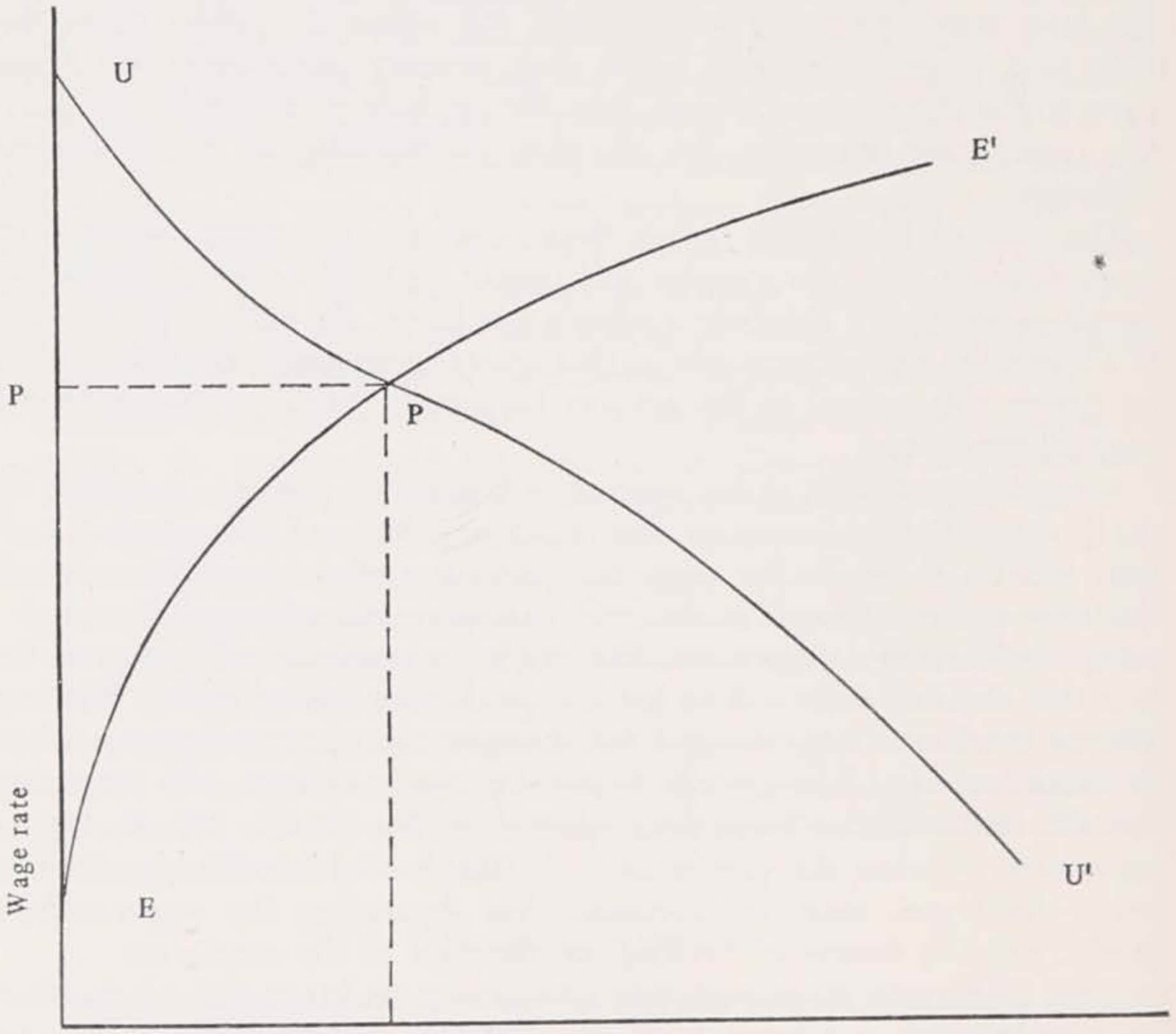
80 One of the major defects of Pigou's theory is that it deals only with wage determination. The theory can be conceptually extended to cover the determination of the total bargainable package (i.e., wages plus fringes, union security agreements, work scheduling, etc.).

81 Chamberlain and Kuhn, *op. cit.*, pp. 162-163.

82 This statement is an oversimplification in the sense that it assumes a fixed supply of labor. Given a constant fund of dollars allocated to wages, wage rates can be increased by reducing the number of workers. The United Mine Workers general wage policy is a case in point.

83 J. R. Hicks, *Theory of Wages*, New York: The Macmillan Company, 1932, especially Chapter Seven.

Figure 1
Bargaining Schedule Model



Source: J. R. Hicks, *A Theory of Wages*, New York: The Macmillan Company, 1932, pp. 144-145.

which management would have undertaken in the absence of union pressure, EE' is the management concession curve over time. The employer's wage offering increases as his cost of keeping the firm inoperable increases. UU' is the union resistance curve, at any point on which the cost of accepting a lower wage rate equals the cost of striking for the indicated period of time. OP depicts the best possible bargain for both parties, i.e., where the union resistance curve and the management concession curve meet. It is at this point the bargain will be made.

The actual duration of the strike, the mutually agreeable wage rate, and the relative bargaining power of both negotiating participants depend upon the slopes of both the management concession and the union resistance curves. Three of the more important factors affecting the slopes of these

curves are (1) the elasticity of demand of the final product, (2) the ease of substituting other factors of production for the labor engaged in the dispute, and (3) the size of the group under consideration compared to the total employment of the given facility. Generally, in instances where the demand for the product is inelastic, substitutability is not easily accomplished and the size of the specific bargaining unit is large relative to the total employment,[84] the union possesses a greater amount of bargaining power relative to management, all other things being equal.

An analysis of the model and the aforementioned considerations would tend to indicate that the hospital's concession curve is much steeper than the employees' resistance curve generally. Klarman states that ". . . the demand for hospital care is not likely to respond to variations in price"[85] (hence the demand for hospital care is inelastic). Additionally, hospitals have been traditionally labor factor oriented; this conclusion is demonstrated in part by the fact that the personnel-to-patient ratio has been increasing over the last decade.[86] In the final analysis a substantial measure of the relatively large amount of bargaining power possessed by hospital employees is due to the critical nature of the hospital's services and the public pressure that could be brought to bear on both parties to settle the dispute. It appears that the environmental and structural pressures stimulating dispute settlement in the hospital arena are such that strikes will be ended quickly.[87] Given the short time duration of the strike action and the pressures to resume "production," the hospital's cost of disagreement with the union's terms is considerably greater than the union's cost of disagreement with the management's terms. With respect to the Hicks bargaining schedule model, it can be noted that the union, relative to the management, has a greater amount of bargaining power and thus should be able to enforce more of its demands in a shorter period of time. The statement that management cannot win strikes of short duration, while unions cannot benefit from long strikes seems to have particular relevance

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[84] With respect to the size of the bargaining unit and its effect upon the amount of bargaining power, two opposing considerations are important. First, absolute size gives the union a greater measure of control over the total production process. On the other hand, a small number of organized workers can often have considerable negotiating strength since their wage demands are but a small part of the total wage package (this is especially true of small groups of highly skilled workers).

[85] Herbert Klarman, *The Economics of Health*, New York: Columbia University Press, 1969, p. 24.

[86] See: "Guide Issue," *Hospitals*, Vol. 42, No. 15, Part 2 (August 1, 1968), p. 445.

[87] A survey of hospital strikes reported in *Hospitals*, The Journal of The American Hospital Association, between January, 1960, and May, 1969, denoted that the median length of hospital disputes was six days. In the industrial sector the average duration of strikes was 23.4 days during the period 1960-1966 (*Handbook of Labor Statistics 1968*, U.S. Department of Labor, Bureau of Labor Statistics, Bulletin No. 1600, p. 67.).

to the hospital situation where disputes, according to theory, are settled quickly.

Succinctly stated, bargaining power is the ability to secure another's agreement on one's own terms. A union's bargaining power at any one point in time depends upon management's willingness or unwillingness to meet the union's terms. On the other hand, management's willingness depends upon the cost of disagreeing with the union's terms, relative to the cost of agreeing to them. This definition provides for the interaction of a host of variables affecting relative bargaining power.[88]

Contingent to the considerations discussed above regarding bargaining power, several questions can be proposed that will, hopefully, organize the thought presented with respect to the legal status of non-profit hospital unions and the major objections raised by administrators when faced with organizational efforts in their facilities. These questions, in the author's opinion, form the core policy considerations the non-profit hospital sector must face and attempt to resolve, given the probability of increased organizational activity.

1. Disregarding the considerations presented regarding relative bargaining power, is it advisable to allow hospital employee representatives to be recognized by and negotiate with hospital management?
2. To what extent have strikes by the employees of hospitals actually severely disrupted operations as to threaten the health and safety of patients rather than merely cause organizational inconvenience?
3. To what extent have hospital strikes been avoided by the exclusion of non-profit health-care institutions from coverage under federal and state labor legislation?
4. What are the inherent causes of hospital strikes? Are they primarily actions aimed at gaining recognition of the union or are they terms of employment strikes (wages, hours, and working conditions)?
5. In the final analysis, if it is agreed that hospital strikes are detrimental to the general public welfare, what are the contingent alternatives available to avoid such strikes but still allow employees representation?
6. What is the future of labor-management relations in the non-profit hospital arena?

It is the purpose of the concluding chapter of this monograph to address these questions.

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[88] Chamberlain and Kuhn, *op. cit.*, p. 172.

CHAPTER IV

HOSPITAL UNIONIZATION: SOME POLICY CONSIDERATIONS

The Advisability and Equity of Employee Representation

The major objections raised against hospital unions are not unique to the health arena. Since the thrust of union organization began during the 1930s, managers have raised the same objections to unions as hospital administrators are now raising when faced with similar developments thirty years later. These arguments are primarily the ones presented in the preceding chapter: (1) unionization leads to the insubordination of the work force, (2) union representation will not gain anything for the employees that management acting alone would not instigate, and (3) collective bargaining infringes on management's right to manage.

Sweeping the floor of a hospital is little different than doing relatively the same job in the private sector—why then should employees of hospitals be denied the right of organization accorded to other workers? Additionally, it is difficult to argue that hospital employees should subsidize the health-care costs of the community by working for less than wages provided comparable positions in the private sector. The American Hospital Association has noted that:

> Despite . . . substantial salary increases over the last two years, hospital workers remain among the lower paid groups in the national economy. In comparison to manufacturing workers, hospital workers have made gains in recent years, but by 1967 the average hospital worker received only 75 per cent as much as his counterpart in manufacturing.[89]

This statement is substantiated by the data presented in Table 3, comparing the average annual wage of workers in hospitals and industry.

Like governmental employees, until recently hospital workers have been denied their right of representation. But unlike workers in the government sector they are not provided with the same protective mechanisms (the structure of the civil service regulations). If the rights of representation and negotiation are to be denied hospital employees, it seems that these rights should be replaced by other benefits accruing to the individual worker.

Again, disregarding the threat of hospital strikes, the administrator may find that the union-management relationship could actually be beneficial

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89 "American Hospital Guide Issue," *Hospitals,* Vol. 42, No. 15, Part 2 (August 1, 1968), p. 444.

to the organization as a whole. Chamberlain and Kuhn describe union-management interaction as an evolving relationship. Initially, the collective agreement is viewed as a contract for the sale of labor encompassing the perception and behavior of self-centered interest on the part of both parties.

Table 3

Average Annual Wage of Hospital and Manufacturing Employees for Selected Years, 1950-1967

Year	Hospital	Manufacturing	Ratio
1950	$1,817	$3,033	59.9
1955	2,526	3,936	64.2
1960	3,240	4,665	69.5
1965	4,072	5,592	72.8
1966	4,235	5,841	72.5
1967	4,476	5,975	74.9

Source: "Guide Issue," *Hospitals*, Vol. 42, No. 15, Part 2 (August 1, 1968), p. 444.

Next the relationship moves into a phase that may be characterized as mutual governance where the contract is considered a constitution and the related grievance procedure as a judicial-legislative mechanism. Finally, the union-management agreement may come to be perceived as a framework establishing the boundaries for cooperative decision-making.[90] The latter phase is no doubt somewhat of an idealistic picture, but a picture not without merit. Several scholars engaged in the study of human behavior in organizations have formulated conceptualizations that, when integrated, form a hypothesis regarding evolution of the union-management relationship over time.

Abraham Maslow has developed what he denotes as the concept of motivational hierarchy.[91] Fundamental to this model of human needs is the thought that satisfactions come in not one general but rather several specific units. Human behavior with respect to work is motivated by a hierarchy of needs in ascending order: physical, safety, social, ego, and creative. Higher, less basic needs, do not provide motivation unless lower needs are satisfied, and as soon as a basic need is satisfied it no longer motivates.

> Physical needs are the most fundamental, but once a reasonable . . . level of physical need satisfaction is obtained (largely through pay), individuals become relatively more concerned with other needs. First they seek to satisfy their security needs (through seniority, fringe benefits, and so forth). When

90 Chamberlain and Kuhn, *op. cit.*, pp. 121-126.

91 Abraham Maslow, *Motivation and Personality*, New York: Harper and Row, 1954.

these, too, are reasonably satisfied social needs (friendship, group support, and so forth) take first priority. And so forth. Thus, for example, hungry men have little interest in whether or not they belong to strong social groups; relatively well-off individuals are more anxious for good human relations.[92]

For the most part, man's relative affluence in the United States has lifted him above the lower level needs (physical and safety); thus they alone can no longer be a primary source of motivation. Much research has indicated that participation, in a real sense, in the organization fulfills the requirement of a higher level motivator.[93]

Concomitant with Maslow's formulation are the empirical investigations of Frederick Herzberg.[94] Herzberg postulated that dissatisfactions are not simply the opposites of satisfactions (i.e., being satisfied and not being dissatisfied are different experiences). Dissatisfiers are those elements of the work environment that when fulfilled do not motivate the individual but rather cause no immediate dissatisfaction (e.g., low pay or physical conditions of the work place). On the other hand, satisfiers are those elements of the work environment that are motivating factors (e.g., intrinsic challenges of the task). Job satisfiers can be categorized as growth components and dissatisfiers as deficiency components. Via Maslow's typology, the former are higher-level needs while the latter are lower-level needs.

The conceptualizations of Maslow, Herzberg, and Chamberlain and Kuhn can be integrated so that a model can be formulated to describe the evolution of the union-management relationship over time. The model, presented in Figure 2, suggests that during the contract phase of the relationship, as described by Chamberlain and Kuhn, union demands focus on the physical and safety needs (i.e., monetary compensation, working conditions, union security, etc.). The fulfillment of these needs reduces dissatisfaction but does not stimulate satisfaction and thus motivation; the growth component is small relative to the deficiency component. After the lower-level needs have been satiated, or some zone of indifference has been reached, the union will attempt to fulfill higher-level needs because lower-level needs are no longer motivators of behavior nor are they elements

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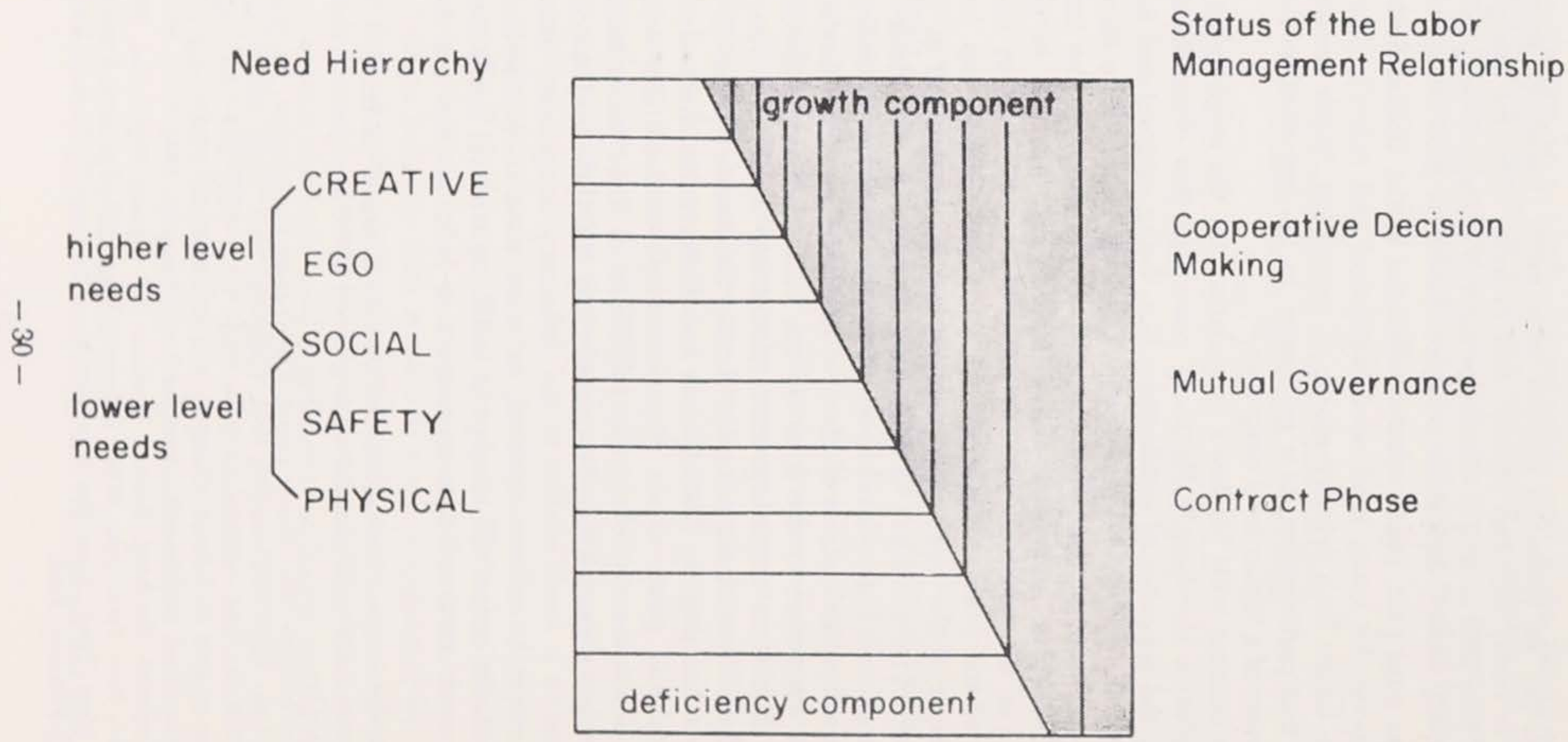
[92] George Strauss, "Some Notes On Power Equalization," in Harold J. Leavitt (ed.), *The Social Science of Organizations,* Englewood Cliffs, New Jersey: Prentice-Hall, Inc., 1963, p. 41.

[93] For instance note: Rensis Likert, *The Human Organization, Its Management and Value,* New York: McGraw-Hill Book Company, 1967. Chris Argyris, *Integrating The Individual and The Organization,* New York: John Wiley and Sons, Inc., 1964. S. E. Seashore and D. G. Bowers, *Changing The Structure and Functioning of an Organization,* Ann Arbor, Michigan: Institute for Social Research, 1963.

[94] Frederick Herzberg, Bernard Mausner and Barbara Snyderman, *The Motivation to Work,* New York: John Wiley and Sons, Inc., 1959. See also: Frederick Herzberg, "One More Time: How Do You Motivate Employees?" *Harvard Business Review,* January-February, 1968.

Figure 2

Union-Management Relationship
Evolution Model



causing satisfaction. Here union demands are focused on creating an environment where collective and individual participation and recognition of worth are realized. Argyris denotes that the organization can create an environment that will allow for the fusing of union-individual and organizational goals.[95] Workers can increase their individual growth component (the realization of higher-level need fulfillment) while engaging in behavior that will further organizational objectives.

It must be emphasized that the evolutionary development suggested by the model may not be a completely continuous and uni-directional process. Some facets of union-management relations will mature while others will not; some will progress only to revert to an earlier stage of development. The model, however, does provide some glimmer of hope for labor-management peace as the higher levels of development should lead to greater elements of cooperation due to the fusion of divergent group objectives.[96]

In the author's opinion, one of the major precipitates of the model as formulated is the realization that the use of higher-level motivators by management may be ineffective in an organization that denies recognition of and attempts to bargain by the employees' chosen representatives. Such recognition and subsequent bargaining should establish the foundation for a more conducive organizational climate if these factors were desired by a majority of the employees. Union recognition can be viewed as a primary need (and to some extent a safety need) on which higher levels of need fulfillment and subsequent motivation can be stimulated.

The Disruption of Critical Hospital Services Due to Employee Strikes

One of the major considerations of hospital administrators, other health professionals, and concerned laymen when addressing the problems of hospital unionization has been the threat of critical service disruption due to walkouts by employees. The primary question here revolves around the issue of to what extent strikes have actually threatened the welfare or lives of patients rather than merely caused administrative or organizational inconvenience. Although a definitive answer will be unavailable until specific research in this area is undertaken, speculation based on general observation can be informative.

Nearly every state has at least one hospital with a collective bargaining

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95 Argyris, *op. cit.*

96 The general conceptualization presented in the model could be tested by assessing the aggregate of workers' perceived needs and demands longitudinally in the unionized organizational structure. If validated, the theory could provide useful insight with regard to facilitating the development of higher-level stages of the relationship more quickly and with less dysfunction.

agreement,[97] although hospital strikes have been concentrated in only a few of these states. Hepton has noted, after a survey of the effects of several hospital strikes in diverse areas of the country, that generally where labor disputes have occurred, patient care has not been jeopardized. She notes that

> Surely, inconvenience is suffered by the administration of the hospitals, by their employees, and their patients, but the essential functions of the hospital are carried on without hindrance.[98]

The author has reached similar conclusions after a review of labor-management disputes as covered by *Hospitals*, the Journal of the American Hospital Association. Although the review was neither an inclusive nor entirely random sample of hospital strikes, the Journal, acutely aware of the interest generated by administrators about hospital labor disputes, provides adequate coverage of such events.

Generally, the strike of nonprofessional employees, not directly associated with the support of the patient, does not tend to cause hospital services to be eliminated altogether but rather necessitates some curtailment in areas deemed nonessential, reassignment of remaining personnel and/or the enlistment of volunteer workers. A week-long strike by 3,400 nonprofessional employees of twenty-five Kaiser Foundation Hospitals demonstrated this typical pattern.

> The hospitals and clinic, serving 870,000 members of the Kaiser Permanente Medical Care Program, curtailed elective surgery and routine check-ups but otherwise continued services throughout the strike.[99]

Volunteers, including many physicians' wives, substituted for absent personnel. Additionally, the picket line established by striking employees allowed deliveries to be made to the facilities.[100]

It is an unusual case where the struck hospital is not able to transfer its expected patient load to other nonaffected facilities in the area, while maintaining services for patients that remain or for some medical reason cannot be moved. During a strike by employees of Adelphi Hospital in New York City, "all but 10 of the hospital's 70 patients were transferred or discharged after a representational dispute. . . ."[101]

It must be recognized, however, that a strike in a hospital which is the

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97 Estelle Hepton, *op. cit.*, p. 17. Subquoted from: Richard D. Vanderworker, "Speech before the University of Michigan Third Annual Institute for Hospital Administrators," *Services Labor Report*, No. 318 (March 29, 1960), p. A-7.

98 *Ibid.*, p. 22.

99 "3400 Workers End Strike of 25 Kaiser Facilities," *Hospitals*, Vol. 43, No. 2 (January 16, 1969), p. 34.

100 *Ibid.*, p. 37.

101 "Struck Hospital Strikes Back," *Hospitals*, Vol. 43, No. 4 (February 16, 1969), p. 120.

only health facility in a given service area would presumably work some hardship on the area's potential patient population due to the difficulty of patient transfer and service deferment to other facilities. At least, until recently, it is these single hospital service areas that have not been highly unionized; the main thrust of organizational effort has been in larger population areas where the difficulties enumerated above are not present.

The Effect of Labor Law Coverage on Strikes: Recognition vs. Terms of Employment

If, in the absence of specific state legislation prohibiting the employees of non-profit hospitals from striking, it could be shown that the recognition of and collective bargaining with employee groups would lower the probability of strikes, the resistance of management to unionization would be greatly reduced. The decision would be to recognize unions with the hope that this recognition would reduce, if not completely eliminate, strike action.

In the industrial sector the most bitterly fought strikes before World War II were usually the result of worker attempts to gain recognition and the right to bargain collectively with their respective employers.[102] After recognition had been gained, the "business minded" union leaders emphasized that the main thrust of activity would be to avoid strikes and reach peaceful settlements. The obvious way to avoid strikes, they reasoned, was for employers to recognize employees and engage in collective bargaining with them. The main focus of this argument was incorporated in the Wagner Act (1935) and restated in the Taft-Hartley Act (1947):

> The denial by some employers of the right of employees to organize and the refusal by some employers to accept the procedure of collective bargaining lead to strikes and other forms of industrial strife or unrest, which have the intent or the necessary effect of burdening or obstructing commerce. . . .[103]

Whether or not the requirements placed on management to recognize and bargain in "good faith" with their employees have appreciably decreased the number and/or severity of strikes is difficult to detect.

Chamberlain and Kuhn note that strikes have several dimensions on which they can be measured and not all of these indices have changed in the same direction.[104] They point out that the frequency of strikes has generally declined while the duration of, participation in, and economic loss from strikes has remained the same or decreased slightly over time.[105] Only

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102 Chamberlain and Kuhn, *op. cit.*, p. 393.

103 *National Labor Relations Act, 1947;* Public L. 101, 80th Congress, 1st Session, as amended by Public L. 188, 82nd Congress, 1st Session. Section 1.

104 Chamberlain and Kuhn, *op. cit.*, p. 395.

105 *Ibid.*, passim, 195-401.

in the last few years have these indicative statistics borne out the confidence displayed in the intent of enacted federal legislation (see Table 4).

Table 4

Trends of Strikes in the United States: The Private Sector

Period or Year	Duration[a]	Frequency[b]	Participation[c]	Loss[d]
1895-1900	22.2	1.340	3.8	n.a.
1935-1940	22.6	1.133	4.2	0.24
1955-1960	20.7	0.872	4.3	0.28
1961-1963	23.8	0.720	2.6	0.14
1964	22.9	0.710	3.4	0.18
1965	25.0	0.713	3.1	0.18
1966	22.2	0.722	3.7	0.19

[a]Duration: Average duration in calendar days. Figures are simple averages; each stoppage is given the same weight regardless of size.

[b]Frequency: Number of strikes per 10,000 employed.

[c]Participation: Workers involved in work stoppages as a per cent of total employed.

[d]Loss: Man hours idle during year as a per cent of estimated total working time.

Sources: Neil W. Chamberlain and James Kuhn, *Collective Bargaining*, second edition, New York: McGraw-Hill Book Company, 1965, pp. 397-399; *Handbook of Labor Statistics 1968*, U.S. Department of Labor, Bureau of Labor Statistics, Bulletin No. 1600, p. 301.

The pertinent question, therefore, is to ask what would have been the effect had no legislation been enacted?

The effect of management recognition of unions in the hospital sector, with respect to the indices of strike severity, is even harder to isolate due to the short duration of concentrated union activity in this environment. Although no hard data are yet available, several indicative trends are discernible. Of the eighteen states that have enacted state labor legislation, four states insure the right of non-profit hospital employees to be recognized by and bargain collectively with their employers while protecting their right to strike. What has been the trend of non-profit hospital strikes in these states?

In Wisconsin, hospital employees are protected and granted the right to strike under provisions of the State Employment Relations Act. Essentially, employees in the non-profit hospital arena are accorded the same labor law status as are employees in the private sector. As of June 30, 1968, thirty-five non-profit hospital bargaining units, the first of which was recognized in 1941, have been certified by the Wisconsin Employment Relations Commission (WERC). Morris Slavney, Chairman of WERC, notes that "there have been no strikes in the state of Wisconsin among hospital employees which have affected the operation of the hospitals.

. . ."[106] In Michigan employees of non-profit hospitals are allowed the alternative of strike action only after submitting to a compulsory mediation process administered by the state. Yet, given the final alternative of strike action, there have been no walkouts since shortly after World War II.[107] Although California does not have a state labor relations law, the concerted effort of unions to organize hospitals has been widespread. Hepton notes that

> Strikes in California's hospitals have been few and most of these have occurred over recognition. Only three strikes have occurred in the past fifteen years.[108]

In contrast to these examples, when other states are examined that do not guarantee employee recognition and bargaining rights, one finds that exclusion from coverage has not eliminated strikes in hospitals.[109] Examples of this situation are the states of Illinois, Ohio, Washington, and Pennsylvania. New York, prior to 1963, did not protect employees' right to unionize and experienced a multitude of recognitional strikes. It must be noted that recognitional strikes are one-time events; if won, they can never happen again. However, once recognition has been gained there can be many terms of employment strikes (disputes focused on wages, hours, and working conditions). Thus, by definition, terms of employment strikes are more probable than recognitional strikes. This factor complicates the procedure of merely classifying and counting disputes to determine the effect of labor law coverage between states on the type of strike action that predominates.

In summary, it appears that state labor laws which guarantee hospital employees the rights of recognition and collective bargaining may tend to curtail strike action generally. Conversely, evidence indicates that where there is exclusion of hospitals from state labor law coverage, or where there is a lack of such a law, hospital strikes have not been eliminated or even reduced. Additionally, it would appear that a large number of hospital disputes arise from recognitional efforts by unions rather than deriving directly from negotiations regarding terms of employment.

It must be emphasized that these conclusions are, at most, only tentative and that directed research in this area must be undertaken before any firm relationships can be established. A nationwide survey of union activity in the hospital environment would be an important contribution at this time. A properly executed study could more accurately determine the effect of differing labor law structure on union growth and strike activity.

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[106] Letter from: Morris Slavney, Chairman, Wisconsin Employment Relations Commission, dated May 6, 1969.

[107] Estelle Hepton, *op. cit.*, p. 26.

[108] *Ibid.*, p. 28.

[109] *Ibid.*, p. 25.

The Prevention of Strike Action in Non-Profit Hospitals

If one accepts the notion that strikes by the employees of non-profit hospitals are detrimental to the public welfare (this notion has not been proven), what alternative policy considerations are available to prevent such strikes? Generally, six mechanisms have been implemented in varying degrees by the several states.

Mediation

As mentioned previously, Michigan insures the right of hospital employees to strike only after the dispute has progressed through a five stage mediation process. At no time is a settlement imposed, but rather the process insures that all alternatives are employed before a strike occurs. Although subject to much discussion, the system has kept Michigan relatively free of strikes. The success of this program, however, may be due to the low concentration of hospital union activity in the state; with a greater number of bargaining units the machinery might easily become overloaded and hence inoperable.

The primary advantage of the mediation process is that it respects the continuity of the labor-management relationships. Since no solution is imposed, the framework is laid for a mutual resolution of problems—a factor that is extremely important noting that after the dispute is settled the parties must continue to deal with one another.

Compulsory Binding Arbitration

Under the system of compulsory binding arbitration, the ultimate authority in the decision-making process rests with the appointed arbitrator or judge. Minnesota provides the best example of enforced compulsory arbitration in the hospital environment. If a dispute cannot be settled by mediation, the disputants must submit the problem to arbitration where the award will be determined.

Several problems are inherent in this attempt to eliminate strikes. First, there is a tendency to rely on the arbitration process as the only means to a solution. Consequently, compulsory arbitration may make preliminary negotiation and mediation efforts meaningless. Between 1953 and 1965, only one agreement in the Twin City area of Minnesota was settled by negotiation, while all the others were brought to final arbitration.[110] Second, the aspirations of good collective bargaining tend to be supplanted. Parties have the tendency to demand much more than they believe they could get normally, hoping that the arbitrator will split the middle in order

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[110] Duane R. Carlson, "Minnesota's Pioneer Labor Act: Model or Mistake?" *Modern Hospital,* Vol. 104, No. 5 (May, 1965), p. 107.

that a compromise may be reached. Finally, with respect to major issues, the dispute is rarely settled but rather postponed until another day.

Injunction

An injunction is a court order designed to terminate a threatened or executed action. One of the more recent examples of an injunction in the hospital arena transpired in the Chicago area in 1968 when a State Circuit Court enjoined HELP (Hospital Employee's Labor Program) from striking South Chicago Community and Norwegian-American Hospital.[111] Although the employees were ordered to continue work, nothing would have prevented them from terminating employment "individually."

In essence, the injunction rarely accomplishes anything of substantive value. The main purpose of the injunction is usually to insure that critical services will be provided while other means of resolving the dispute are attempted. Since the injunction, when granted, completely eliminates the threat of a strike, at least for the moment, employees discover other ways by which to make their objections known (i.e., mass resignation, slowdown, etc.).

Fact Finding

Fact finding has been used successfully in aiding the resolution of public employment disputes in Wisconsin since 1962. The Wisconsin statute states that either party to the dispute may request implementation of the fact-finding mechanism. The procedure followed in most fact-finding hearings is similar to that used in grievance arbitration (somewhat like a regular court hearing). Both disputant parties present cases to and are open to questioning by the neutral. After the presentations have been presented and examined, the fact finder prepares a decision and sends it to the parties.[112] Additionally, the enacted award and accompanying rationale is distributed to local newspapers for publication.

Although procedures vary, fact finding does not impose acceptance of the award as determined by the fact finder. It is assumed that the parties, after examining the dispute in a logical manner, will resolve their differences voluntarily. Additionally it is assumed that dissemination of the pertinent facts of the situation and the neutral's award will spur public sentiment to request, if not demand, a settlement.

In Wisconsin twenty-eight cases requested fact-finding from June, 1962 to June, 1965; generally the system worked well.[113] Complaints center

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111 "Court Lacks Power to Order Collective Bargaining, Illinois Appelate Court Rules," *Hospitals*, Vol. 42, No. 2 (January 16, 1968), p. 33.

112 James Stern, "The Wisconsin Public Employee Fact Finding Procedure," *Industrial and Labor Relations Review*, Vol. 20, No. 1 (October, 1966), pp. 3-5.

113 *Ibid.*, pp. 4-6.

around (1) the length of time required for final decisions (the shortest case took three months from start to finish), (2) the relatively high cost of the procedure, and (3) the highly subjective criteria used for making the award. Additionally, in situations where employees are granted the right to strike, prohibition of strikes is not accomplished. Sometimes strikes can be prevented by airing and discussing pertinent facts. Public sentiment can be created to stimulate a settlement by releasing information about the dispute and by making an award (the decision of the neutral as to who should get what). But in the end analysis settlement is left to the individual parties—a stalemate is still possible.

Seizure

Seizure is probably the most straightforward method of insuring that labor-management disputes do not end in strikes. In Massachusetts the Emergency Labor Disputes Act allows the governor the option, among other alternatives, to seize a facility engaged in a strike threatening the public welfare or safety and operate it as he sees fit. Additionally, the governor may require the striking facility to continue operating under its own management; this action parallels the injunction process. Although Massachusetts is not highly unionized in the health care sector, there has never been a hospital strike.[114]

Do-Nothing Approach

The do-nothing approach, with respect to hospital labor-management relations, has been adequately described in the preceding pages of this monograph. It involves the exclusion of hospitals from coverage under state labor law, if one exists, and not requiring employers either to recognize or to bargain collectively with their employees. As noted earlier this approach does not decrease, and may even tend to increase, the incidence of hospital strikes. Few problems have been solved solely because they have been ignored; labor-management relations in the hospital environment, the author believes, will be no exception.

Government intervention focused on the elimination of hospital strikes must be viewed in a cost-benefit frame of reference; compared to the sum total of all costs, both direct and indirect, what are the benefits of alternative courses of action? On one hand it has been noted that strikes by hospital employees *may* be detrimental to the public health and safety; on the other, employees in the hospital sector are being denied rights granted to their counterparts in the industrial sector. The relative merits of these two factors should establish the frame of reference by which the decision will be made as to whether or not hospital employees should be allowed the right

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114 Estelle Hepton, *op. cit.*, p. 14.

to strike. If, however, under certain circumstances strikes are deemed detrimental in the hospital environment, what contingencies are available to prevent them if it is agreed that (1) hospital employees should be allowed to be recognized by and collectively bargain with their employer and, (2) the methods of strike prevention already enumerated, when considered individually, are inadequate.

The industrial sector of the economy has been and is facing the same problems as the hospital sector in its attempt to combat strikes that are detrimental to national welfare (emergency disputes). They also have found that each of the alternatives mentioned above possesses defects that tend toward dysfunction. The problem is to develop a system that will capitalize on each alternative's inherent strength while eliminating its weakness. Additionally, it would be beneficial to lessen the probability of strikes in instances where patient welfare is not in jeopardy and completely eliminate strikes where such action is clearly detrimental to noncontestant third parties. The ultimate worth of any such system largely depends on the extent to which it safeguards the public while, at the same time, protecting the rights of workers and management. An independent study group addressing itself to the problems of national labor policy stated that

> Agreement by the parties is our basic method for reaching fundamental settlements to labor disputes. Even in cases involving large numbers of workers or the threat of an emergency, in our view, the principle of ultimate private agreement must guide the design and use of government procedures for dispute settlement. Nevertheless, we must recognize that the use of economic force by the parties in certain vital industries or at certain critical times can inflict serious harm on the public interest. Some protective instruments must be placed in the hands of the government.[115]

What may be needed is an *arsenal of weapons approach*[116] that provides a responsible authority (possibly the governor with the aid of the state labor department) a series of alternatives that may be implemented in the hospital environment to either reduce or eliminate the possibility of strikes. The governor, under this system, would have the option of using any mechanism or package of mechanisms depending upon the specific situation. The alternatives might include:

1. Do nothing
2. Creation of a fact-finding commission
3. Compulsory mediation
4. Compulsory and binding arbitration
5. Injunction

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115 Clark Kerr, *et al.*, *The Public Interest in National Labor Policy*, New York: Committee for Economic Development, 1961, p. 95.

116 This general typology has been suggested for use in the industrial sector for the resolution of emergency strikes. See: Kerr, *et al.*, *op. cit.*, pp. 95-104.

As one proceeds down the list of alternatives, the severity of the action increases. For the "harder" mechanisms (compulsory arbitration and injunction) to be implemented, clear evidence of threatened or actual detriment to the public's welfare and safety should be demonstrated. If, however, detrimental consequences could not be substantiated, less stringent mechanisms should be applied so that the probability of strike activity is reduced. This action would range from doing nothing to requiring the parties to mediate the dispute. None of the foregoing moves by the "responsible authority" would be mandatory. Nothing could be done (alternative one) or after one method had been tried, there would be no restriction on trying another. This system would allow constant assessment and appraisal of the situation in the light of emerging developments.

Because of the strong sense of uncertainty on the part of both parties as to which element or package of elements would be employed in a given instance, the negotiation process of the disputants before governmental intervention would not be sabotaged.

> We must . . . be exceedingly careful not to introduce procedures in our eagerness to provide protection for the public welfare, which will in themselves interfere with the parties' ability to arrive at a voluntary agreement. Experience has shown that, at both the state and federal levels, the very existence of legal procedures that can be invoked when the parties fail to agree in collective bargaining tends to promote such failures.[117]

Clearly the choice of whether to implement "hard" or "soft" mechanisms must hinge solely on whether detriment to patient welfare, either actual or threatened, can be positively demonstrated. Such decisions should not be made on the basis of probable organizational inconvenience, bargaining power or other such considerations. Since demonstrated or hypothesized threat to patient welfare is the *sine qua non* for prohibiting strikes by nonprofit hospital employees, clear evidence of this threat should be present when such rights are suspended.

The arsenal approach is not without defects. First, it will prove difficult to quantify the conditions that would determine whether or not any given threatened or actual strike would be detrimental to patient welfare. Preliminary guidelines would have to be delineated in general terms so that they could be applied to specific situations. Secondly, there is always the possibility that the "hard" mechanisms would be utilized more than circumstances warrant.

> Study after study has shown that the emergency potential of a given labor dispute is always grossly exaggerated at the moment it occurs. Dire conjectures about "what would happen if" seldom become reality.[118]

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[117] *Ibid.*, p. 99.
[118] *Ibid.*, p. 96.

The excessive use of "hard" mechanisms would render the total arsenal of weapons approach useless, since expectancy would be built into the system. Disputant parties usually have the capacity for behavior that takes account of essential public needs. Additionally, the resiliency and flexibility of freely conducted negotiations are impressive. These considerations suggest that compulsory and binding arbitration and/or injunction should be used with utmost caution and reluctance.[119]

It appears that the arsenal of weapons approach would *prohibit* hospital strikes when they would clearly endanger the health or welfare of the patient and would allow the implementation of mechanisms that would *lessen the probability* of strikes in situations where detriment could not be demonstrated. Both the public's health and the workers' rights would be guaranteed.

The Future of Labor Relations in the Health Care Sector

The future of labor-management of the nation's economy depends to a large degree on the alternatives health professionals, legislators, unions and the general public choose to undertake. The first three groups seem to play the most vital part in this directional determination.

Union leaders have pledged themselves to organize the non-profit hospital sector. HELP, a two-union combination, after two years has organized seven Chicago area hospitals. This union has also pledged to organize Chicago hospitals "top to bottom.'[120] Local 1199 of the Drug and Hospital Union has invested $350,000 to implement a committee that will organize a nationwide drive among hospital workers. The union has named Mrs. Martin Luther King, Jr., as honorary chairman and is using the Southern Christian Leadership Conference (S.C.L.C.) as organizers in the south.[121] The Reverend Ralph Abernathy has led the Local 1199 B strike in Charleston, South Carolina, to gain employee recognition and the guarantee of $1.50 minimum wage for all area hospital workers. Abernathy has stated that the S.C.L.C. is determined to make a stand in Charleston because the majority of the area's nonprofessional hospital employees are black as is the case in most southern states.[122] Generally, it appears that:

(1) unions are committed to organizing hospital workers and this activity should be expected to increase in the next few years.

(2) the union movement, especially in the South and inner city areas of

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119 *Ibid.*, p. 96.

120 "HELP Two Years Later: 7 Won 2 Lost, 3 Tied," *Hospitals*, Vol. 43, No. 5 (March 1, 1969), p. 105.

121 "New York Union Planning Nationwide Hospital Drive," *Hospitals*, Vol. 43, No. 3 (February 1, 1969), p. 117.

122 "Abernathy in Charleston," *CBS Evening News*. April 22, 1969.

> large cities, will become increasingly intertwined with the cause of civil rights. If this occurs more militancy should be expected.

The American Hospital Association, on the other hand, believes that non-profit hospitals should not be required to recognize or collectively bargain with their employees.[123] A nationwide sample of hospital administrators has shown that approximately 80 per cent of this group agree with the A.H.A. stand.[124]

> It appears that, at least for a while, hospitals will continue to oppose the employees right to be recognized and bargain collectively with their respective employers.

Several trends seem to be emerging that would indicate a slight reversal of the hospital's historically solid stand opposing unions. First, the Catholic Hospital Association has endorsed the employee's right to join a union and collectively bargain with their respective hospital's management. The Catholic Hospital Association's board of trustees has noted that

> 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.[125] (emphasis added)

Secondly, it appears that there is a significant reversal in the opposition to union organization by hospital administrators in states that are relatively highly organized in the health care sector. Data collected in a nationwide sample of 479 hospital administrators indicate that the percentage of respondents that agree with the A.H.A. policy regarding unions is significantly less than expected (chi square, $p<.01$) in regions one, two, four, six, and nine (see Figure 3 and Table 5).[126] Most of these states are more highly organized in the hospital sector than the nation as a whole (the exception is region six).

Additionally, it would appear that considering the trend toward increasing educational requirements for hospital administrators, as a group they will come to be more receptive toward unionization efforts. In part, the change should occur because of the increasing involvement of prospective administrators in formal course work dealing with collective bargaining and labor relations. There also appears to be some evidence that continuing education programs sponsored by universities for practicing hospital administrators are beginning to focus on the problems of labor-management

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123 This policy is presented in "Association Section," *Hospitals*, Vol. 42, No. 2 (January 16, 1968), p. 112. Supra footnote no. 6.

124 Michael Hynes, *op. cit.*, unanalyzed data.

125 "Catholic Group Endorses the Right to Join Union," *Hospitals*, Vol. 42, No. 2 (January 16, 1968), p. 124.

126 Michael Hynes, *op. cit.*, unpresented data.

relations and unionization in the hospital sector to a greater extent.[127]

In the last analysis, given a measure of public and professional support,

Figure 3

Classification of Hospitals by Region

1. *New England*
   Connecticut
   Maine
   Massachusetts
   New Hampshire
   Rhode Island
   Vermont

2. *Middle Atlantic*
   New Jersey
   New York
   Pennsylvania

3. *South Atlantic*
   Delaware
   District of Columbia
   Florida
   Georgia
   Maryland
   North Carolina
   South Carolina
   Virginia
   West Virginia

4. *East North Central*
   Illinois
   Indiana
   Michigan
   Ohio
   Wisconsin

5. *East South Central*
   Alabama
   Kentucky
   Mississippi
   Tennessee

6. *West North Central*
   Iowa
   Kansas
   Minnesota
   Missouri
   Nebraska
   North Dakota
   South Dakota

7. *West South Central*
   Arkansas
   Louisiana
   Oklahoma
   Texas

8. *Mountain*
   Arizona
   Colorado
   Idaho
   Montana
   Nevada
   New Mexico
   Utah
   Wyoming

9. *Pacific*
   Alaska
   California
   Hawaii
   Oregon
   Washington

Source: "Guide Issue," *Hospitals*, Vol. 42, No. 15 (August 1, 1968), p. 434.

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[127] A recent postgraduate conference held by the Graduate Program in Hospital and Health Administration, The University of Iowa, devoted one-half day to the subject.

it is the state and federal legislatures that will precipitate the actual change in the labor-management relations of non-profit hospitals. These changes can occur at one or both of two levels, state and/or federal. The elimination

Table 5

Per Cent of Hospital Administrators
Agreeing and Disagreeing With AHA
Policy Position on Collective Bargaining

Non-profit hospitals should be exempted from all legislative acts, federal or state, requiring health-care institutions to bargain collectively with any union or professional group of their employees.

	Region of Hospital Location								
	1	2	3	4	5	6	7	8	9
agree	63.4	72.2	84.6	74.8	100.0	66.1	96.0	88.6	67.6
disagree	36.6	27.8	15.4	25.2	00.0	33.9	4.0	11.4	32.4

$P < .01$

Source: Data extracted from: Michael Hynes, *op. cit.*, unpresented data.

of hospitals from exemption under federal labor legislation thus insuring the employees' right to be recognized by and collectively bargain with their employers can be accomplished by eliminating section 2(2) of the Taft-Hartley Act. This action's main value would be derived from its comprehensiveness and uniformity. If, however, the individual states desire to attempt to decrease the probability of strike action detrimental to public welfare, they should be given some initial latitude with respect to the implementation of the arsenal of weapons approach. If the considerations presented are taken into account, the arsenal approach should prove to be a beneficial supplement to the recognition and collective bargaining that would be mandatory under Taft-Hartley.

Conclusion

> 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.[128]

128 *National Labor Relations Act, 1947;* Public Law 101, 80th Congress, 1st Session, as amended by Public Law 188, 82nd Congress, 1st Session. Section 1.

BIBLIOGRAPHY

Books and Monographs

Argyris, Chris. *Integrating the Individual and the Organization*, New York: John Wiley and Sons, 1964.

Beal, Edwin and Wickersham, Edward. *The Practice of Collective Bargaining*, Homewood, Illinois: Richard D. Irwin Co., 1963.

Burling, Temple, *et al. The Give and Take In Hospitals: A Study of Human Organization In Hospitals*, New York: G. P. Putnam's Sons, 1956.

Chamberlain, Neil W. and Kuhn, James W. *Collective Bargaining*, New York: McGraw-Hill Book Company, 1965.

Dubin, Robert (ed.). *Human Relations In Administration*, third edition, Englewood Cliffs, New Jersey: Prentice-Hall, Inc., 1968.

Dunlop, John T. and Chamberlain, Neil (eds.). *Frontiers of Collective Bargaining*, New York: Harper and Row, 1967.

Falcone, Nicholas S. *Labor Law*, New York: John Wiley and Sons, Inc., 1962.

Graham, Harry. "Public Employees and Collective Negotiations," *Collective Bargaining in the Iowa Public Sector*, Iowa City, Iowa: Center for Labor and Management, Conference Series No. 14, 1969.

Health Law Center, *Problems in Hospital Law*, Pittsburgh, Pennsylvania: The Aspen Corporation, 1968.

Hepton, Estelle. *Battle For The Hospitals*, Cornell University: New York State School of Industrial and Labor Relations, Bulletin No. 49, 1965.

Herzberg, Frederick; Mausner, Bernard; and Snyderman, Barbara. *The Motivation to Work*, New York: John Wiley and Sons, 1959.

Hicks, J. R. *Theory of Wages*, New York: The Macmillan Co., 1932.

Hospital Law Manual, University of Pittsburgh: The Health Law Center (Supplements, 1962-1968).

Katz, Daniel and Kahn, Robert T. *The Social Psychology of Organizations*, New York: John Wiley and Sons, Inc., 1966.

Kerr, Clark, *et al. The Public Interest In National Labor Policy*, New York: Committee for Economic Development, 1961.

Klarman, Herbert E. *The Economics of Health*, New York: Columbia University Press, 1967.

Likert, Rensis. *The Human Organization: Its Management and Value*, New York: McGraw-Hill Book Company, 1967.

Maslow, Abraham. *Motivation and Personality*, New York: Harper and Row Publishers, 1954.

Miernyk, William H. *The Economics of Labor and Collective Bargaining*, Boston: D. C. Heath and Company, 1965.

Myers, A. Howard. *Labor Law and Legislation*, fourth edition, Cincinnati, Ohio: South-Western Publishing Company, 1968.

Perlman, Selig. *A Theory of The Labor Movement*, New York: The Macmillan Company, 1949.

Pigou, A. C. *Economics of Welfare*, fourth edition, London: Macmillan and Company, Ltd., 1938.

Rees, Albert. *Economics of Trade Unions*, Chicago: The University of Chicago Press, 1962.

Ross, Arthur M. and Hartman, Paul. *Changing Patterns of Industrial Conflict*, New York: John Wiley and Sons, 1960.

Rowen, Richard T. and Northrup, Herbert R. (eds.). *Readings in Labor Economics and Labor Relations,* Homewood, Illinois: Richard D. Irwin, 1968.
Seashore, S. E. and Bowers, D. G. *Changing the Structure and Functioning of an Organization,* Ann Arbor, Michigan: Institute For Social Research, 1963.
Schlossberg, Stephen I. *Organizing and the Law,* Washington, D.C.: The Bureau of National Affairs, Inc., 1967.
Somers, Herman M. and Somers, Anne. *Doctors, Patients and Health Insurance,* Washington, D.C.: The Brookings Institution, 1961.
Strauss, George. "Some Notes On Power Equalization," in Harold J. Leavitt (ed.), *The Social Science of Organizations,* Englewood Cliffs, New Jersey: Prentice-Hall, Inc., 1963.
Sturmthal, Adolf (ed.). *White Collar Unions: Contemporary Development In Industrial Societies,* Champaign-Urbana, Illinois: The University of Illinois Press, 1966.
Taft, Philip. *Organized Labor in American History,* New York: Harper and Row, 1964.
Ulman, Lloyd (ed.). *Challenges to Collective Bargaining,* Englewood Cliffs, New Jersey: Prentice-Hall, Inc., 1967.
Wirtz, Willard W. *Labor and the Public Interest,* New York: Harper and Row, 1963.

Cases and Legislation

American Medical Association v. United States, 130 F. 2d 233 (D.C. Cir. 1942).
Central Dispensary and Emergency Hospital v. NLRB, 57 NLRB 393 (1943).
Christian Board of Publication v. NLRB, 113 F. 2d 753 (7th Cir. 1940).
Donald Peters, et al. v. South Chicago Community Hospital; Donald Peters, et al. v. Norwegian-American Hospital. Ill. Ct. App., Case Nos. 52946, 52947 (March 27, 1969).
Jewish Hospital of Brooklyn v. John Doe, 252 App. Division 581 (1938).
National Labor Relations Act, 1947; Public Law 101, 80th Congress, 1st Session, as amended by Public Law 188, 82nd Congress, 1st Session.
NLRB v. Jones and Laughlin Steel Company, 301 US 1 at 33.
NLRB v. Polish National Alliance, 322 US 643 (1922).
Prospect Heights Hospital v. Davis, 45 LRRM 3193 (1960).
Pennsylvania Labor Relations Board v. Mid Valley, 385 Pa. 344, 124A. 2d 108 (1956).
Society of New York Hospitals v. Hansom, 60 N.Y.S. 2d 589 (1945).
St. Luke's Hospital v. Industrial Commission of Colorado, 45 LRRM 2953 (1960).
Synopsis of Charitable Hospital Act of 1947, Minnesota State Chapter 335, Sections 179.35-179.39.
Synopsis of Michigan Labor Mediations Act, Sections 421.1 to 423.5 (1948).
Synopsis of New York State Labor Relations Act, Sections 713-716 (1963).
Trustees of Columbia University v. Herzog, 269 App. Div. 24 aff'd., 295 N.Y. 605 (1945).
Utah Labor Relations Board v. Utah Valley Hospital, 120 Utah 463, 235 P. 2d 520 (1951).
Utah Valley Hospital v. Industrial Comm'r of Utah, 199 F. 2d 60 (10th Cir. 1952).
Walnut Hills Country Club, 145 NLRB 81.
Western Pennsylvania Hospital v. Lichliter, 340 Pa. 382, 17A 2d 206 (1941).

Journal Articles

"American Hospital Association Guide Issue," *Hospitals,* Vol. 42, No. 15, Part 2 (August 1, 1968).
Arthurs, H. W. and Crispo, John. "A Closer Look at Compulsory Arbitration," *Canadian Hospital,* Vol. 41 (February, 1964), pp. 49-54.

Association Section. "Statement on Collective Bargaining in Health Care Institutions," *Hospitals*, Vol. 42, No. 2 (January 16, 1968), p. 112.

Bader, Albert X. "The Present Labor Law Status of Non-Profit Institutions," *Proceedings of New York University 19th Annual Conference on Labor*, Thomas G. S. Christensen (ed.), Washington, D.C.: Bureau of National Affairs, Inc., 1966, pp. 235-263.

Bergkist, Gunborg. "Collective Bargaining in Sweden," *International Nursing Review*, Vol. 15, No. 1 (January, 1968), pp. 67-73.

Berlow, Leonard. "Are Unions the Answer to Collective Bargaining?" *Hospital Topics*, (May, 1961), pp. 36-39.

Brown, James Douglas. "The Right to Strike: Government Employees," *Personnel*, Vol. 44 (July-August, 1967), pp. 39-43.

Burke, Walter J. "Are There Practical Alternatives to Strikes?" *Wisconsin Bar Bulletin*, Vol. 39 (June, 1966), pp. 16-30.

Carlson, Duane R. "Minnesota's Pioneer Hospital Act: Model or Mistake?" *Modern Hospital*, Vol. 104, No. 5 (May, 1965), pp. 106-110.

"Catholic Group Endorses Right to Join Union," *Hospitals*, Vol. 42, No. 2 (January 16, 1968), p. 124.

Chamberlain, Neil W. "Strikes In Contemporary Context," *Industrial and Labor Relations Review*, Vol. 20, No. 4 (July, 1967), pp. 602-616.

Colfax, David J. "Labor Responds to Compulsory Arbitration: Organization Correlates of Protest and Acquiescence," *Industrial and Labor Relations Review*, Vol. 20, No. 1 (October, 1966), pp. 77-87.

"Court Lacks Power to Order Collective Bargaining, Illinois Appellate Court Rules," *Hospitals*, Vol. 42, No. 4 (February 16, 1968), p. 33.

Daykin, Walter L. "The Hospital and Employee Organizations," *Hospital Administration*, Vol. 3 (Fall, 1958), pp. 6-14.

Gershenfeld, Walter J. "Organization and Bargaining in Hospitals," *Monthly Labor Review*, Vol. 91 (July, 1968), pp. 51-52.

"HELP Two Years Later; 7 Won, 2 Lost and 3 Tied," *Hospitals*, Vol. 43, No. 6 (March 1, 1969), p. 105.

"HELP Wins First Victory, Represents 1000 Workers," *Hospitals*, Vol. 42, No. 2 (January 16, 1968), p. 124.

Herzberg, Frederick. "One More Time: How Do You Motivate Employees?" *Harvard Business Review*, January-February, 1968.

Hoover, Earl R. "At Common Law—The Hospital," *Labor Law Journal* (August, 1967), pp. 460-467.

"Hospital Strike," *Modern Hospital* (June, 1959), p. 63.

"Illinois Court Says Hospital Union May Picket But Not Strike, Cites Important Social Interest," *Daily Labor Reporter*, No. 65 (April 4, 1969), pp. A2-A3.

Kasslow, Everett M. "Occupational Frontiers of Trade Unionism," *Proceedings of the Industrial Relations Research Association*, St. Louis, Missouri (December, 1960), pp. 180-195.

Klungartner, Archie. "Nurses, Collective Bargaining and Labor Legislation," *Labor Law Journal* (April, 1967), pp. 236-245.

Kochery, David R. and Strauss, George. "The Non-Profit Hospital and the Union," *Buffalo Law Review*, Vol. 9, No. 2 (Winter, 1960), pp. 255-282.

Kuhn, James W. "Does Collective Bargaining Usurp The Managers Right To Manage?" *Modern Hospital*, Vol. 98, No. 1 (July, 1968), pp. 70-73.

Marcus, Averill G. "Collective Bargaining in Non-Profit Hospitals," *I.L.R. Research*, Vol. 13, No. 1 (May, 1967), pp. 3-34.

McCarthy, Bernard. "Collective Bargaining, The Experience of Hospitals in Ontario," *Canadian Hospital,* Vol. 39 (May, 1962), p. 38.

McKersie, Robert B. and Brown, Montague. "Nonprofessional Hospital Workers and a Union Organizing Drive," *Quarterly Journal of Economics* (August, 1963), pp. 372-404.

Metzger, Norman. "The Case Against Compulsory Arbitration of Hospital Labor Disputes," *Hospitals,* Vol. 41, No. 1 (January 1, 1967), pp. 42-45.

Miller, Ronald L. "Collective Bargaining In Hospitals," *Hospital Administration,* Vol. 12 (Summer, 1967), pp. 60-68.

"New Jersey Public Employment Relations Law," *Government Employee Relations Report,* No. 264 (September 30, 1968), pp. F1-F4.

"New York Union Planning Nationwide Hospital Drive," *Hospitals,* Vol. 43, No. 3 (February 1, 1969), pp. 117-118.

Osterhaus, Leo B. "The Effect of Unions On Hospital Management," *Hospital Progress.* Vol. 48 (July, 1967), pp. 75-88.

Parker, Hyman. "The Laws Governing Labor-Management Relations In Michigan Hospitals," *Labor Law Journal* (October, 1961), pp. 972-990.

Parker, Hyman. "The Laws Governing Labor-Management Relations In Michigan Hospitals," *Labor Relations In Hospitals,* Ann Arbor, Michigan: Bureau of Hospital Administration, The University of Michigan, 1960, pp. 5-27.

Shister, Joseph. "The Direction of Unionism 1947-1967: Thrust or Drift?" *Industrial and Labor Relations Review,* Vol. 20, No. 4 (July, 1967), pp. 578-601.

Spencer, Vernon. "Association Bargaining: The Dilemma of The Organized Hospital," *Hospital Management,* Vol. 105 (April, 1968), pp. 68-72.

Steinberg, Martin R. "Unions and Voluntary Hospitals," *Hospital Management* (June, 1959), pp. 23-27.

Stern, James L. "The Wisconsin Public Employee Fact-Finding Procedure," *Industrial and Labor Relations Review,* Vol. 20, No. 1 (October, 1966), pp. 3-29.

"Strikes Threaten Four Chicago Hospitals," *Hospitals,* Vol. 42, No. 3 (February 1, 1968), p. 27.

"Struck Hospital Strikes Back," *Hospitals,* Vol. 43, No. 4 (February 16, 1969), p. 120.

Tannenbaum, Robert. "Management Decision Making," *The Journal of Business,* Vol. 23 (January, 1950), pp. 33-37.

Taylor, George W. "Public Employment: Strikes or Procedures?" *Industrial and Labor Relations Review,* Vol. 20, No. 4 (July, 1967), pp. 617-636.

Vladeck, Judith. "Collective Bargaining In Voluntary Hospitals and Other Non-Profit Operations," *Proceeding of New York University 19th Annual Conference on Labor.* Thomas G. S. Christensen (ed.), Washington, D.C.: Bureau of National Affairs, Inc., 1966, pp. 221-234.

Weismann, Ester. "Non-Profit Hospital and Labor Unions," *Cleveland-Marshall Law Review,* Vol. 8, No. 3 (September, 1959), pp. 482-491.

Wood, Donald. "They Live and Learn With Unions," *Modern Hospital,* Vol. 93, No. 1 (July, 1959), pp. 73-75.

"3400 Workers End Strike of 25 Kaiser Facilities," *Hospitals,* Vol. 43, No. 2 (January 16, 1969), p. 37.

Unpublished Material and Other Sources

Abernathy In Charleston, "Civil Rights and Hospital Unionization," *CBS Evening News,* April 22, 1969.

Council of Economic Advisors. *Annual Report,* 1968.

Graham, Harry. *Lecture Notes: Collective Bargaining* (Winter-Spring, 1969), The University of Iowa.

Handbook of Labor Statistics 1968. U.S. Department of Labor, Bureau of Labor Statistics, Bulletin No. 1600.

Hawley, Karen Sue. "Economics of Collective Bargaining by Nurses," *unpublished Master's Thesis,* Ames, Iowa: Iowa State University ,1967.

Hynes, Michael. "A Measurement of The Responsiveness of The American Hospital Association to Its Membership," *Unpublished Master's Thesis,* Iowa City, Iowa: The University of Iowa, 1969.

Hynes, Michael. "The Union Movement In The Non-Profit Hospital," *Unpublished Mimeo,* Iowa City, Iowa: The University of Iowa, 1969.

Serrill, George. "The Question of The Right To Strike In Non-Profit Hospitals," *Unpublished Mimeo,* Iowa City, Iowa: The University of Iowa, 1969.

Slavney, Morris. Personal Communication dated May 6, 1969.

APPENDIX 1

State Labor Relations Acts Citations

State	*Citation*
Colorado	Colo. Rev. Stat. Ann. Sect. 80-4-1 to -22 (1964)
Connecticut	Conn. Gen. Stat. Ann. Sect. 31-101 to -111 (1960) as amended Supp. 1966)
Hawaii	Hawaii Rev. Laws c90 (1955, as amended Supp. 1965)
Kansas	Kan. Gen. Stat. Ann. Sect. 44-801 to -817 (1949 as amended Supp. 1961)
Massachusetts	Mass. Gen. Laws Ann. c105 A (1958, as amended Supp. 1966)
Michigan	Mich. Stat. Ann. Sect. 17.454(1)-17.454(27) (Rev. Vol., 1960)
Minnesota	Minn. Stat. Ann. Sect. 179.01-179.17, 179.35-.39 (1966)
Montana	Mont. H.B. No. 100, Laws, 1967
North Dakota	No. Dak. Cent. Code Sect. 34-12-01 to -14
New Jersey	N.J. Const. Art. 1, Sect. 19
New York	N.Y. Labor Law Art. 20 (McKinney 1965, as amended Supp. 1966)
Oregon	Ore. Rev. Stat. Sect. 662.505-.795, (1964)
Pennsylvania	Pa. Stat. Ann. tit. 43, Sect. 211.1-.13 (1964)
Rhode Island	R.I. Gen. Laws Ann. Sect. 28-7-1 to -47 (1957 as amended Supp. 1966)
Utah	Utah Code Ann. Sect. 34-1-1 to -15 (1966)
Vermont	Vt. S.B. No. 1004 Laws, 1967
Wisconsin	Wisc. Stat. Ann. Sect. 111.01 to .19 (1957 as amended Supp. 1967)
Puerto Rico	P.R. Laws Ann. tit. 29, Sect. 61-76 (1966)

Source: *Hospital Law Manual*, The University of Pittsburgh: Health Law Center (August, 1967), p. L-A.

APPENDIX 2

State Anti-Injunction Legislation

State and Citations	*Similar To Norris-La Guardia*	*Other*
Arizona Ariz. Rev. Stat. Ann. Sect. 12-1808 (1956)		X
Colorado Colo. Rev. Stat. Ann. Sect. 80-5-16 (1953)	X	
Connecticut Conn. Gen. Stat. Sects. 31-112 to -118 (Rev. 1958)	X	
Hawaii Senate Bill No. 545, Laws (1963)	X	
Idaho Idaho Code Ann. tit. 44, c. 7 (1947)	X	
Illinois Ill. Ann. Stat. c. 48, Sect. 2a (Smith-Hurd 1950)		X
Indiana Ind. Ann. Stat. tit. 40, c. 5 (Repl. Vol. 1952)	X	
Kansas Kans. Gen. Stat. Ann. Sects. 60-1104 to -1107 (1949)		X
Louisiana La. Rev. Stat. Ann. Sects. 23-821, 23-841 to -849 (1951)	X	
Maine Me. Rev. Stat. Ann. c. 107, Sects. 36, 37 (1954)		X
Maryland Md. Ann. Code art. 100, Sects. 63-75 (1957)	X	
Massachusetts Mass. Gen. Laws Ann. c. 149, Sects. 20B, 20C, 24; c. 214, Sects. 1, 9, 9A, 9B; c. 220, Sects. 13A, 13B (1958)	X	
Minnesota Minn. Stat. Ann. Sects. 185.01-185.22 (1945)	X	

Appendix 2 (continued)

State and Citation	*Similar to Norris-LaGuardia*	*Other*
New Jersey N.J. Stat. Ann. Sects. 2A:15-51 to -58 (1952)	X	
New Mexico N.M. Stat. Ann. c. 59, art. 2 (1953)		X
New York N.Y. Civ. Prac. Art. Sect. 876a	X	
North Dakota N.D. Rev. Code c. 34-08 (1943)	X	
Oregon Ore. Rev. Stat. Sects. 662.010-662.130 (1953)	X	
Pennsylvania Pa. Stat. Ann. tit. 43, Sects. 206a-206r (1952)	X	
Rhode Island R.I. Gen. Laws Ann. Sects. 28-60-2 to -6 (1956)	X	
Utah Utah Code Ann. Sects. 34-1-23 to 34; 34-2-1 to -6 (1953)	X	X
Washington Wash. Rev. Code Sects. 49.32.010-49.32.100 (1956)	X	
Wisconsin Wis. Stat. Ann. Sects. 103.51-103.62; 133.07 (1957)	X	X
Wyoming Wyo. Comp. Stat. Ann. Sects. 54-501 to -507 (1945)	X	

Source: *Hospital Law Manual,* The University of Pittsburgh, Health Law Center (November, 1962), pp. C1-C2.

APPENDIX 3

Right To Work Laws And Union Security Contracts

"Labor organizations frequently seek to enter into union security contracts with employers. Such contracts are usually of three types: The closed shop contract which provides that only members of a particular union may be hired; the union shop contract which makes continued employment dependent upon membership in a union; and the agency shop contract which requires non-union employees to pay amounts to the union equal to the dues paid by members.

"Union security contracts have been absolutely prohibited in some instances and strictly regulated in others. The closed shop contract is the only union security device which is prohibited by the Labor Management Relations Act. However, while both the union shop contract and the agency shop contract are under certain conditions permitted, the Labor Management Relations Act provides that the various states may regulate or prohibit such union security arrangements.

"Thus, in a state which prohibits certain types of union security agreements, all hospitals, including those proprietary hospitals which are covered by the Labor Management Relations Act, would be prohibited from entering into union security agreements proscribed by state law. Where a state does not prohibit union security contracts, but subjects them to stricter regulations than those contained in the Labor Management Relations Act, all hospitals must adhere to the more rigorous state requirement.

"By statute, many states have made union security contracts unlawful. Statutes forbidding such contracts are usually called 'right to work' laws on the theory that they protect the employee's 'right to work,' even if he refuses to join a union. Several other states have statutes or decisions which purport to restrict union security contracts, or provide for specified procedures designed to evidence employee approval before such agreements may be made.

"Although a union security contract may be legal in the state in which the hospital is located, the hospital is not required to enter into such a contract. However, a hospital may be obligated to discuss inclusion of a union security clause in a contract in those states where a union security contract is legal and the hospital has a duty to bargain in good faith with its employees' representative under the state labor relations act."

Source: *Hospital Law Manual*, University of Pittsburgh: Health Law Center (November, 1968), p. 9.

APPENDIX 4

Statutory Provisions Restricting Union Security Agreements

State and Citations	*Closed Shop*	*Union Shop*
Alabama Ala. Code Ann. tit. 26, art. 4 (Supp. 1953)	X	X
Arizona Ariz. Const. art. XXV; Ariz. Rev. Stat. Ann. tit. 23, c. 8, art. 1 (1956)	X	X
Arkansas Ark. Const. Amend. No. 34; Ark. Stat. Ann. tit. 81, c. 2 (1947)	X	X
Colorado Colo. Rev. Stat. Ann. Sects. 80-5-6(1) (c), 80-5-6(1) (3) (1953)	(1)	
Florida Fla. Const. Declaration of Rights, Sect. 12.	X	X
Georgia Ga. Code Ann. Sects. 54-901 to -908 (Supp. 1958)	X	X
Indiana Ind. Ann. Stat. tit. 40, c. 27 (Supp. 1957)	X	X
Iowa Iowa Code Ann. c. 736A (1950)	X	X
Kansas Kan. Const. Sect. 12	X	X
Louisiana (2) La. Rev. Stat. Ann. tit. 23, c. 8, part IV (Supp. 1957)	X	X
Mississippi Miss. Code Ann. Sect. 6984.5 (Supp. 1956)	X	X
Nebraska Neb. Const. art. XV, Sects. 13-15; Neb. Rev. Stat. Sects. 48-217 to -219 (Reissue 1952)	X	X
Nevada Nev. Rev. Stat. Sects. 613.230-613.300 (1956)	X	X
North Carolina N.C. Gen. Stat. c. 95, art. 10 (Repl. Vol. 1958)	X	X
North Dakota N.D. Rev. Code Sect. 34-0114 (Supp. 1957)	X	X

Appendix 4 (continued)

State and Citations	*Closed Shop*	*Union Shop*
South Carolina S.C. Code Sects. 40-46.1-40-46.11 (Supp. 1957)	X	X
South Dakota S.D. Code Sect. 17.1101 (Supp. 1952)	X	X
Tennessee Tenn. Code Ann. Sects. 50-208 to -210 (1957)	X	X
Texas Te. Rev. Civ. Stat. Ann. art. 5207a (1947)	X	X
Utah Utah Code Ann. tit. 34, c. 16 (Supp. 1957)	X	X
Virginia Va. Code Ann. tit. 40, c. 4, art. 3 (1950, as amended Supp. 1958)	X	X
Wisconsin Wis. Stat. Ann. Sect. 111.06(1) (c) (1) (1957)	(3)	

[1] All union shop is permitted by a 3/4 vote of the employees in the unit.
[2] Does not apply to hospital workers.
[3] All union shop is permitted by a 2/3 vote of the employees in the unit.

Source: *Hospital Law Manual*, The University of Pittsburgh: Health Law Center, p. D-1.

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