Ten Years After: A Legal Framework of Collective Bargaining in the Hospital Industry

Michael J. Stapp

Follow this and additional works at: http://scholarlycommons.law.hofstra.edu/hlelj

Part of the Law Commons

Recommended Citation
Available at: http://scholarlycommons.law.hofstra.edu/hlelj/vol2/iss1/3
TEN YEARS AFTER: A LEGAL FRAMEWORK OF COLLECTIVE BARGAINING IN THE HOSPITAL INDUSTRY

Michael J. Stapp*

INTRODUCTION

Under the original National Labor Relations Act (NLRA), collective action by hospital workers was protected. However, as part of the Taft-Hartley Act in 1947, Congress excluded non-profit hospital workers from protection under the NLRA.

Between the years of 1947 and 1974, the labor rights of non-profit hospital workers were governed solely by state laws. During that time only twelve states permitted any kind of labor organization by non-profit hospital workers. Of these states, only four permitted any kind of work stoppage whatsoever; the remainder allowed non-profit hospital workers to organize, but the final step in bargaining was either fact finding, mediation, arbitration or some combination of these.

In 1974, Congress enacted the 1974 Health Care Amendments which established, among other things, the right of non-profit hospital workers to organize and strike. The purpose of the amendments was twofold: to grant non-profit hospital workers the benefit of collective organization

---

* B.S., University of Kansas; M.B.A., J.D., University of Kansas; Blake and Uhlig, Kansas City, Kansas.

The author gratefully acknowledges the assistance of Jean Baderschneider, former Professor of Business, University of Kansas and Elinor Schroeder, Professor of Law, University of Kansas, in the research and preparation of this article.

Editors' Note: As this article went to press, the Eleventh Circuit decided NLRB v. Walker County Medical Center, 722 F.2d 1535 (11th Cir. 1984) and the Board decided St. Francis Hospital, 271 N.L.R.B. No. 160, 116 L.R.R.M. 1465 (1984). These cases are, therefore, discussed only in footnotes at appropriate points throughout the article.

4. Id. at 33-44.
and bargaining, and at the same time to try to assure the continued supply of quality health care.\(^6\)

During the ten years that have elapsed since the 1974 Amendments were enacted, a large body of Board and court law has been created to deal with those amendments. One object of this article is to present a comprehensive framework of that law. Although commentators have addressed many of the issues presented in this article, few have considered the 1974 Amendments as a whole.

The ultimate design of this article is to explore whether the original purposes of the 1974 Amendments are served by the Board and court decisions. This exploration will examine the law in the hospital industry, and also analyze the effect that law has on employee rights and the availability of health care. This normative approach to the law provides a vehicle through which the success of these amendments can be evaluated. Concurrently, various suggestions have been made to improve the law in order for it to better achieve the goals set forth in 1974.

Finally, this article attempts to address some of the areas of labor conflict that may arise in the industry. Anticipating these problems may prove helpful in shaping the law in the future. This approach of identifying and addressing these various conflicts should produce a body of law responsive to the needs of the public, employers and employees.

**Summary of the 1974 Health Care Amendments**

In 1974 the National Labor Relations Act was amended to include all health care institutions in the United States.\(^7\) In addition to extending coverage under the Taft-Hartley Act to non-profit health care institutions, the 1974 Amendments added several provisions that relate to the health care industry.

The phrase “health care institution” is defined under the new section 2(14) of the Act to “include any hospital, convalescent hospital, health maintenance organization, health clinic, nursing home, extended care facility or other institution devoted to the care of sick, infirm, or aged persons.”\(^8\)

Three new subsections that apply specifically to the health care industry were added to Section 8(d). First, Section 8(d)(A) requires any party in the health care industry that intends to change an existing labor contract to give the other party written notice ninety days prior to the
proposed change, as opposed to the conventional sixty days, during which time the contract remains in effect. Second, Section 8(d)(B) requires any labor organization that is involved in an initial contract dispute to give the proper state mediation agency, when there is one, and the Federal Mediation and Conciliation Service (FMCS) thirty days notice before any work action is taken. Finally, under Section 8(d)(C) mediation is mandated once notice is served under either Section 8(d)(A) or (B).

The 1974 Amendments also added Section 8(g), which requires any labor organization that engages in any “strike, picketing, or other concerted refusal to work” in the health care industry to give the affected employer ten days written notice prior to engaging in the activity.

Section 213 of the new Act established the Board of Inquiry (BOI), whose purpose is to function as a fact finder in situations where the Director of the FMCS feels a BOI could help in preventing a strike in a health care institution.

All these amendments have had varying degrees of impact on collective bargaining in the health care industry. The impact on collective bargaining of each of these amendments and the 1974 Amendments as a whole will be discussed in the following sections of this article.

THE SCOPE OF THE 1974 HEALTH CARE AMENDMENTS

An individual’s status as a supervisor will affect his or her membership in a bargaining unit. The NLRA provides that bargaining units must not include supervisory personnel. These provisions may have signifi-
cant impact on the American Nurses Association (ANA), which has many members who are considered supervisors under §2(11) of the Act. The Fourth Circuit has refused to certify a State Nurses Association because one-third of its members in the hospital in question were supervisors. In response to that decision, the Board issued a supplemental decision and order in the case of Sierra Vista Hospital, Inc., in which it stated that it would not certify a labor organization which represented supervisory nurses who actively participate in the activities of the organization. This could drastically affect the ANA by forcing it to choose between the role of a professional organization and that of a traditional labor union.

To date, the Sierra Vista Hospital decision has been applied in such a manner that most state nursing associations do qualify as labor organizations. The Board will not disqualify a state nurses association unless the employer “meet[s] the ‘heavy burden’ of showing that the participation of supervisors presents a ‘clear and present danger’ of a conflict of interest which compromises the labor organization’s bargaining integrity.” Moreover, the Board requires that there be active participation by the complaining employer’s supervisory employees in the internal affairs of the labor organization.

Hospitals that are political subdivisions are not “employers” as defined by Section 2(2) of the NLRA. This means that public hospital workers are not protected under the Act. Consequently, it is not surprising that the determination of which hospitals are political subdivisions has become a major issue of contention.

19. See Kessler Institute for Rehabilitation, 255 N.L.R.B. 990, 107 L.R.R.M. 1040 (1981); Ojai Valley Community Hosp., 254 N.L.R.B. 1354, 106 L.R.R.M. 1278 (1981); French Hosp. Medical Center, 254 N.L.R.B. 711, 106 L.R.R.M. 1149 (1981); Arlington Hosp., 246 N.L.R.B. 992, 103 L.R.R.M. 1093 (1979). However, the Second Circuit has criticized the Board’s Sierra Vista decision for its narrow inquiry into what influence is actually exerted by supervisors over a state nurses association. NLRB v. North Shore Univ. Hosp., 724 F.2d 269 (2d Cir. 1983). The Eleventh Circuit recently enforced a Board ruling that a state nurses association would be considered a labor organization, despite the fact that a number of the directors of the association were supervisors. NLRB v. Walker County Medical Center, 722 F.2d 1535 (11th Cir. 1984). Relying on the Sierra Vista Hospital standard, the Eleventh Circuit found that the employer had not met its heavy burden of showing a clear and present danger of conflict of interest. This conclusion was based on the Board’s finding that the bargaining units were sufficiently insulated “to negate the probability of conflict of interest.” Id. at 1541. Moreover, the court noted that should a conflict arise, the unit members would be free to invoke the Board’s unfair labor practice proceedings.
The United States Supreme Court, in *NLRB v. Natural Gas Utility District*, set forth the standard for determining whether an entity will be considered an "employer" or a "political subdivision" under Section 2(2). In *Natural Gas Utility District*, the Court voiced its approval of the two-pronged test applied by the Board to determine whether an entity is a political subdivision. The Court noted that the Board has limited its exemption for political subdivisions to situations where the entity is "(1) created directly by the state, so as to constitute departments or administrative arms of the government, or (2) administered by individuals who are responsible to public officials or to the general electorate." 

The Board and the courts have consistently applied this standard to hospitals to determine whether a hospital is an "employer" as defined by Section 2(2). In *Camden-Clark Memorial Hospital*, the Board found that Camden-Clark Hospital was created as an agency of the state so as to constitute an administrative body of the government. However, the majority of cases which addressed the issue rejected the notion that the respective health care institution was an arm of the government.

The Board and courts are likely to find that the hospital qualifies as a political entity because the state exerts the necessary degree of control over the hospital. Thus, where a majority of the hospital's directors were appointed by a state agency, the hospital was considered a political entity. However, where a city financed or provided the facilities for...
the hospital, the Board did not find the requisite control. In situations where the political status of a hospital is unclear, the Board will often look to see who exercises control over labor management relations in deciding whether to assert jurisdiction.\(^3\)

Hospital house staffs\(^4\) are not "employees" as defined in Section 2(3) of the NLRA.\(^5\) The Board first addressed this issue in Cedars-Sinai Medical Center,\(^6\) where it found that "interns, and clinical fellows are primarily students . . . (and) . . . that they are not employees within the meaning . . . of the Act."\(^7\) The Board based its decision on the manner in which the Cedars-Sinai program was conducted. First, the Board noted that house staff service is "prescribed by the accrediting bodies and specialties boards which govern graduate medical education."\(^8\) Second, the Board concluded that house staff compensation was primarily in the nature of a stipend and was in no way related to the amount of patient care provided or hours worked.\(^9\) Finally, the Board noted that the length of service of a house staff member is closely related to the program of study the individual is pursuing, and few students become Cedars-Sinai employees after the completion of their training.\(^10\) The Board specifically limited its decision to cases where the house staff are treated the same way as the house staff at Cedars-Sinai.\(^11\)

The Board clarified its position on the house staff issue in St. Clare's Hospital and Health Care Center.\(^12\) In that case, the Board pointed out

---

\(^3\) Grey Nuns of Sacred Heart, 221 N.L.R.B. 1215, 91 L.R.R.M. 1099 (1975). Despite the fact that the borough owned the hospital facilities, the Board found that the provision of health care was not essential to the operation of the local government, and therefore, the Board would not decline to assert jurisdiction. Id. at 1215-16, 91 L.R.R.M. at 1099. See also Crestline Memorial Hosp. Ass'n v. N.L.R.B., 668 F.2d 243 (6th Cir. 1982).

\(^4\) Where the hospital itself exercises decision making power over such issues as hiring, firing, and salaries, the Board will assert jurisdiction. Buffalo General Hosp., 218 N.L.R.B. 1090, 89 L.R.R.M. 1626 (1975). In situations where the governmental body exercises the decision making power over such terms and conditions of employment, the Board will not assert jurisdiction. Toledo Dist. Nurses Ass'n, 216 N.L.R.B. 251, 88 L.R.R.M. 1392 (1975).

\(^5\) Cedars-Sinai Medical Center, 223 N.L.R.B. 251, 91 L.R.R.M. 1398 (1976), defines the term "house staff" to include interns, residents and clinical fellows, all of whom are medical students who must serve a period of training in a hospital.

\(^6\) Cedars Sinai, 223 N.L.R.B. at 251, 91 L.R.R.M. at 1398.

\(^7\) Id. at 253, 91 L.R.R.M. at 1400.

\(^8\) Id. at 252, 91 L.R.R.M. at 1399.

\(^9\) Id.

\(^10\) Id.

\(^11\) Id.

\(^12\) 229 N.L.R.B. 1000, 95 L.R.R.M. 1180 (1979).
that there are primarily four categories of students: (1) “students employed by a commercial employer in a capacity unrelated to the student’s course of study,” (2) “students . . . employed by their own educational institutions in a capacity unrelated to their course of study,” (3) “students . . . employed by a commercial employer in a capacity which is related to the student’s course of study,” and (4) students who “perform services at their educational institutions which are directly related to their educational program.” The Board found that hospital house staffs fall into the fourth category. It concluded that students who were house staff members did not have bargaining privileges under the Act. The Board reasoned that the mutual interests of the students and the educational institution are predominately academic, not economic. Services rendered are directly related to their educational program. Moreover, the Board retained jurisdiction over hospital house staffs, which precludes house staffs from coverage under state labor laws.

The most recent case to consider the status of hospital house staffs is Physicians National House Staff Association v. Fanning. There, the court concluded that the determination of whether a house staff member is an employee as defined by the NLRA must be resolved by the Board on the facts of each individual case. The court found that the legislative history of the 1974 Amendments, and the defeat in the 96th Congress by the House of Representatives of a bill which would have specifically included house staffs under the NLRA, indicated a congressional intent not to include house staff members under the NLRA definition of employees. The court’s mandate of a case-by-case review is likely to generate significant litigation and heated labor disputes over this issue in many hospitals. Controversy can be expected to arise most frequently in hospitals which deviate from the Cedars-Sinai treatment of house staffs.

43. Id. at 1000-02, 95 L.R.R.M. at 1181-82.
44. Id. at 1002, 95 L.R.R.M. at 1183.
45. Id. at 1003-04, 95 L.R.R.M. at 1184-85.
46. Id. at 1002, 95 L.R.R.M. at 1183.
49. Id.
50. Id. at 498-99. An extensive review of the legislative history of §152 and this case is provided in Comment, NLRB Does Not Exceed its Authority in Holding that House Staff are not Employees within the meaning of the NLRA—Physicians Nat’l House Staff Ass’n v. Fanning, 642 F.2d 492 (D.C. Cir. 1980), 56 Notre Dame Law. 314 (1980).
In addition to the statutory restrictions the 1974 Amendments placed on the Board's jurisdiction over hospital labor disputes, the Board applies its own discretionary jurisdictional standards. In *East Oakland Community Health Alliance, Inc.*, the Board concluded that it would not review labor disputes in nursing homes and related facilities if annual gross revenues did not exceed one hundred thousand dollars or in any other type of health care institution if annual gross revenues did not exceed two hundred fifty thousand dollars. As a result, hospital workers in small hospitals will not be accorded the same rights as hospital workers in hospitals with gross revenues exceeding two hundred fifty thousand dollars.

**APPROPRIATE HOSPITAL BARGAINING UNITS**

Prior to the enactment of the 1974 Health Care Amendments, Congress noted its desire to prevent the proliferation of health care bargaining units. It feared that proliferation would cause: (1) small units closing down a whole facility, (2) jurisdictional disputes, (3) interference with health care team work, and (4) excessive administrative costs. With these restrictions in mind, Congress left the decision as to what constitutes an appropriate bargaining unit within the "sound discretion of the Board." To date, the Board has established the following seven units in the health care industry: (1) a technical employees unit, (2) a unit for regis-

53. It would appear that the reasoning in NLRB v. Comm. of Interns and Residents, 566 F.2d 810 (2d Cir. 1977), cert. denied, 435 U.S. 904 (1978), is equally applicable to this situation. Accordingly, where the Board has not asserted jurisdiction because of a voluntary monetary limitation but has not ceded jurisdiction to the state, workers would be unprotected by virtue of federal preemption.
55. IMPACT, supra note 3, at 394.
56. Presbyterian/St. Luke's Medical Center v. NLRB, 653 F.2d 450, 454 (10th Cir. 1981) (applying 29 U.S.C §159(b) (1976)).
57. The Board has also certified units for chauffeur-drivers, Michael Reese Hosp. Medical Center, 242 N.L.R.B. 322, 101 L.R.R.M. 1157 (1979), and for guards, Schlesinger Geriatric Center, 267 N.L.R.B. No. 212, 114 L.R.R.M. 1221 (1983). The chauffeur-drivers unit certified in *Michael Reese* worked for an "external transportation department" which had its own budget and its own separate system of hiring and firing, distinguishing this from the typical hospital bargaining unit. As noted in the *Schlesinger* decision, guards are always to have their own bargaining unit under 29 U.S.C. §159(b)(3).
tered nurses, 59 (3) a unit for licensed practical nurses, 60 (4) a unit for physicians, 61 (5) a clerical workers unit, 62 (6) a maintenance department unit, and (7) a residual unit for professional employees. 64 Although the Board has not always been clear in outlining its justification for establishing various units, there seem to be several factors which influence the Board's decisions.

The Board’s recent decision in St. Francis Hospital 65 outlines its basic approach to unit determinations in the hospital industry. The Board

65. 265 N.L.R.B. No. 120, 112 L.R.R.M. 1153 (1982). Even more recent than St. Francis Hospital is the Board's decision in St. Francis Hosp. 271 N.L.R.B. No. 160, 116 L.R.R.M. 1465 (1984) (St. Francis II). This decision is indicative of the political bias of the current Board, and demonstrates the length to which the Board will go to abrogate employee organizational rights.

In St. Francis II the Board has adopted the so-called "disparity of interests" test, citing the circuit courts' disagreement with the Board's previous approach to this issue. Noting the Second Circuit's disapproval of a "rigid disparity of interest" test, as advocated by the Ninth and Tenth Circuits, the Board instead created a "refined disparity of interests" test. 271 N.L.R.B. No. 160 at 13, 116 L.R.R.M. at 1469-70. However, the only guidance the Board provides to distinguish these two tests is the obtuse reference in Footnote 45 of St. Francis II to "a disparity of interests analysis using community of interest elements." Id. at 18, 116 L.R.R.M. at 1471.

In an illuminating dissent, member Zimmerman points out of the gross deficiencies of the current Board's approach to this problem. Id. at 23-33, 116 L.R.R.M. at 1472-75. Perhaps the most telling criticism from a practitioner's view is that the Board provides no guidance as to when the traditional "community of interest" factors become significant enough to be considered a "disparity of interest." Id. at 26-27, 116 L.R.R.M. at 1473.

In the decision, the Board states that:

[T]he phrase 'disparity of interest' properly emphasizes that more is required to justify a separate unit in a health care institution than in a traditional industrial or commercial facility. That is to say, the appropriateness of the petition for a unit is judged in terms of normal criteria, but sharper than usual differences (or 'disparities') between the wages, hours, and working conditions, etc., of the requested employees and those in an overall professional or non-professional unit must be established to grant the unit. Requiring greater disparities than the usual community of interest elements to accord health care employees separate representation must necessarily result in fewer units and will thus reflect meaningful application of the congressional injunction against unit fragmentation.

Id at 15, 116 L.R.R.M. at 1470 (footnotes omitted).

From a lawmaker's position, the most important criticism is the total lack of authority in the legislative history of the Act for such a test. Member Zimmerman notes the Eleventh Circuit's decision in NLRB v. Walker County Medical Center, 722 F.2d 1535 (11th Cir. 1984), which concludes that the "disparity of interest" test is not more than a stricter application of the "community of interest" test. 271 N.L.R.B. No. 160 at 27, 116 L.R.R.M. at 1473. Regardless of what nomenclature is used to describe the Board's current approach, it is clear that that approach does not do justice to the goals of the 1974 amendments.

The two primary goals of the Amendments were to provide non-profit hospital workers the benefits of collective organization and bargaining, and to minimize patient care disruptions. See supra note 6 and accompanying text. Where these two goals conflict the conflict must be dealt with directly, not by simply making it more difficult for employees to organize. While bargaining unit proliferation

Published by Scholarly Commons at Hofstra Law, 1984
indicated it used a two-tiered approach to hospital bargaining unit determinations. The first tier is a determination of whether the unit sought falls into one of the seven units the Board has recognized as valid in the hospital industry. The seven units the Board has delineated that may be appropriate units in a hospital are: "Physicians, registered nurses, other professional employees, technical employees, business office clerical employees, service and maintenance employees, and skilled maintenance employees."

The Board maintains that this initial step in the unit determination process is responsive to the congressional admonition against unit proliferation. Furthermore, the Board, citing its decision in *Newton-Wellesley*

may increase the likelihood of patient care disruptions, the creation of a particular bargaining unit does not per se constitute "undue proliferation". Hospital bargaining unit proliferation is not inherently evil if it does not result in an increased risk of patient care disruptions. Rather than follow the *St. Francis II* approach, the Board must instead balance the employees' rights to collective action against what it determines to be the propensity for patient care disruptions in the particular bargaining unit, on a case by case basis. To blindly adhere to the congressional admonition against hospital bargaining unit proliferation ignores the reasoning behind that admonition, and defeats the purposes of the Act.

Such an approach could be utilized to provide the guidance lacking in the current Board approach. A rulemaking approach could easily be adopted to determine the propensity for patient care disruptions. Factors to be considered in determining the likelihood of patient care disruptions would include the total number of authorization cards signed in the proposed unit; the different facilities in the proposed unit; the likelihood that a strike by one particular bargaining unit would be debilitating to the hospital; the likelihood that other employees would cross picket lines should a strike occur in the proposed unit; the authorization card support of the various job classifications within the bargaining unit; and the past history of labor unrest in the facility (e.g., wildcat strikes).

At the same time, the Board could utilize the "community of interests" test, as it has in the past, to determine how to maximize the employees' rights to collective action. Once these two separate and distinct determinations have been made, the Board must then balance the actual threat of patient care disruptions against employee rights, to make the ultimate decision as to whether undue proliferation will result.

Unless the Supreme Court acts in this area, the Board's decision in *St. Francis II* has guaranteed a second decade of litigation and labor unrest. *Health Care Unions Hit NLRB Ruling*, AFL-CIO News, Oct. 13, 1984, at 3, col. 1. Instead of following the congressional admonition to give "due consideration" to the unit proliferation issue, the Board has given undue consideration to that issue. Disregarding the rationale behind that congressional admonition could ultimately defeat the whole purpose of the 1974 amendments. The Board seems to be ignoring the fact that if employees in the hospital industry are not afforded adequate employment rights under the law, they will exercise those rights regardless of the law. This is a consideration which at least implicitly underlies all labor legislation. This problem can be dealt with by balancing the likelihood of undue proliferation against employee organizational rights. Undue proliferation would not be found where the likelihood of patient care disruptions is remote or uncertain and employee organizational rights would be promoted by a large number of bargaining units. Conversely, undue proliferation would be found where the likelihood of patient care disruptions is high and employee organizational rights would not be significantly furthered by increasing the number of bargaining units. What the Board must understand is that the ultimate bargaining unit determination is a function of these two interdependent factors.

66. *Id.*
67. *Id.*, slip op. at 15, 112 L.R.R.M. at 1157.
68. *Id.*, slip op. at 14, 112 L.R.R.M. at 1158. As Congress indicated:

Due consideration should be given by the Board to preventing proliferation of
Hospital notes that it has regularly departed from the traditional community of interest test in the hospital industry. In short, the Board has concluded, based on its prior experience in hospital unit determinations, that it is complying with the congressional admonition by limiting hospital units to these seven units.

Once the Board has reached a determination that the desired unit falls into one of the appropriate seven, it will apply the traditional "community of interest test" to determine whether the employees should be represented separately. This traditional community of interest test has been very important, despite judicial condemnation. In several decisions the Board had established a bargaining unit based on the community of interest shared by the employees. The Board had attempted to establish an irrebuttable presumption that nurses are always a separate unit based on the community of interest test. The Ninth Circuit rebuked the Board for doing so, and the Board has returned to finding separate nursing units based on the community of interest in the particular case.

In the past the Board has also considered the separation of professional and non-professional employees, as mandated by Section 9(b)(1) of the NLRA, an important factor in the determination of bargaining units in the health care industry. In this connection, the Committee notes with approval the recent Board decisions in Four Seasons Nursing Center, 208 N.L.R.B. 403, 85 L.R.R.M. 1093 (1974), and Woodland Park Hosp., 205 N.L.R.B. 888, 84 L.R.R.M. 1075 (1973), as well as the trend toward broader units enunciated in Extendicare of West Virginia, 203 N.L.R.B. 1232, 83 L.R.R.M. 1242 (1973).


69. 250 N.L.R.B. 409, 413 n.16, 104 L.R.R.M. 1384, 1388 n.16 (1980).
70. St. Francis I, 265 N.L.R.B. No. 120, slip op. at 14 n.27, 112 L.R.R.M. at 1157 n. 27.
71. Id., slip op. at 16, 112 L.R.R.M. at 1158. The Board did state that under "extraordinary and compelling facts" it would certify units smaller than these seven.
72. As stated by the Board when defining community of interest:
Factors which warranted consideration in determining the existence of substantial differences in interests and working conditions included: a difference in method of wages or compensation; different hours of work; different employment benefits; separate supervision; the degree of dissimilar qualifications, training, and skills; differences in job functions and amount of working time spent away from the employment or plant situs under State and Federal regulations; the infrequency or lack of contact with other employees; lack of integration with the work functions of other employees or interchange with them; and the history of bargaining.
73. NLRB v. Mercy Hosp. Ass'n, 606 F.2d 22 (2d Cir. 1979), cert. denied, 445 U.S. 971 (1980); General Hosp. v. NLRB, 608 F.2d 965 (3d Cir. 1979); NLRB v. Frederick Memorial Hosp., 691 F.2d 191 (4th Cir. 1982); NLRB v. West Suburban Hosp., 570 F.2d 213 (7th Cir. 1978); NLRB v. St. Francis Hosp. of Lynwood, 601 F.2d 404 (9th Cir. 1979); and Presbyterian/St. Luke's Medical Center v. NLRB, 653 F.2d 450 (10th Cir. 1981).
74. See generally cases cited in notes 57-64.
75. NLRB v. St. Francis Hosp. of Lynwood, 601 F.2d 404 (9th Cir. 1979).
76. Id.
The Board, in *Mercy Hospital of Sacramento, Inc.*, began with the premise that professionals are to be kept separate from non-professionals in bargaining units. The Ninth Circuit, when dealing with the hospital industry, has taken a somewhat different view of the presumption that professionals and non-professionals should have separate bargaining units. In *NLRB v. HMO International/California Medical Group Health Plan, Inc.*, the court was asked to determine whether a bargaining unit that included both licensed vocational nurses and registered nurses would be appropriate. The court concluded that it would be appropriate to include these professionals and non-professionals in the same unit after a *Sonotone* election. Further, the court suggested that due to the congressional concern with unit proliferation, the Board should first certify the joint unit of professionals and non-professionals and then at some future date hold a *Sonotone* election.

Resolving the inherent conflict between the congressional admonition against unit proliferation and the Board's application of the community of interest test has given rise to heated disputes among the various circuits and the Board. Of the eleven circuits that have reviewed health care bargaining unit cases, six have chastised the Board for its dogmatic

79. In *St. Francis I*, the Board stated that only registered nurses and physicians "have been regularly granted units, apart from other health care professional employees." 265 N.L.R.B. No. 120, slip op. at 12, 112 L.R.R.M. 1153, 1157 (citing Newton-Wellesley Hosp., 250 N.L.R.B. 409, 104 L.R.R.M. 1384 (1980)). This would suggest that the Board has abandoned this approach to hospital unit determinations. However, a careful reading of *Newton-Wellesley* reveals that the Board, while perhaps abandoning strict adherence to this policy, gives it great consideration in making its determination of whether the requisite community of interests exists. See also *NLRB v. Community Health Services, Inc.*, 705 F.2d 18, 20 (1st Cir. 1983).


81. 678 F.2d 806 (9th Cir. 1982).

82. *Id.* at 811 n.15. Where it is proper to certify two groups of professionals as separate bargaining units based on community of interest, the two groups can be certified as one unit where the employees are given an opportunity to vote to be in one unit. *Sonotone Corp.*, 90 N.L.R.B. 1236, 26 L.R.R.M. 1354 (1950).

83. *HMO Int'l*, 678 F.2d 806.


adherence to the community of interest test. These courts have repeatedly emphasized that the community of interest doctrine is not appropriate in the hospital industry where the focus of a unit determination should be on the proliferation issue. The Fifth, Sixth, Eighth and Eleventh Circuits are the only courts to approve the Board’s application of the community of interest test in the hospital sector. However, these circuits’ approval came only after each concluded that the use of the community of interest test would not result in unit proliferation.

In addressing the hospital bargaining unit question, both the Ninth and Tenth Circuits adopted what has come to be known as the “disparity-of-interest” test. In *NLRB v. St. Francis Hospital*, the Ninth Circuit stated that: “[b]y focusing upon the disparity of interest between employee groups which would prohibit or inhibit fair representation of employee interests, a balance can be made between the congressional directive and the employees’ right to representation.”

This disparity-of-interest test is further explicated by the Tenth Circuit in *Presbyterian/St. Luke’s Medical Center v. NLRB*:

“[i]t is not the similarity of employee’s training, hours, conditions and activities which determine the appropriateness of the unit. It is, rather, the dissimilarity of interests relevant to the collective bargaining process that determines which employees are not to be included in a proposed unit. The proper approach is to begin with a broad proposed unit and then exclude employees with disparate interests.”

This test flows from the Ninth Circuit’s premise that the employees’ community of interest is subordinate to the admonition against unit proliferation. The effect of the test is that the party desiring a smaller unit has the burden of proving that the smaller unit is appropriate.

---

86. See *Supra* note 85.
87. *NLRB v. Sweetwater Hosp. Ass'n*, 604 F.2d 454 (6th Cir. 1979); *Vicksburg Hosp., Inc. v. NLRB*, 653 F.2d 1070 (5th Cir. 1981); *Watson Memorial Hosp. v. NLRB*, 711 F.2d 848 (8th Cir. 1983); *NLRB v. Walker County Medical Center*, 722 F.2d 1535 (11th Cir. 1984).
88. See *supra* note 87.
89. *NLRB v. St. Francis Hosp. of Lynwood*, 601 F.2d 404 (9th Cir. 1979); *NLRB v. HMO Int’l/Cal. Medical Group Health Plan, Inc.*, 678 F.2d 806 (9th Cir. 1982); *Presbyterian/St. Luke’s Medical Center v. NLRB*, 653 F.2d 450 (10th Cir. 1981).
90. 601 F.2d 404 (9th Cir. 1979).
91. Citing Senator Williams’ statement that “a notable disparity of interest between employees in different job classifications...could sometimes require a number of bargaining units.” *Id.* at 419.
92. 653 F.2d 450 (10th Cir. 1981).
93. *Id.* at 458 n.6. This explanation was embraced by the Ninth Circuit in *NLRB v. HMO Int’l*, 678 F.2d 806, 812 n.17 (9th Cir. 1982).
The Board's vituperative denouncement of the disparity-of-interest test in *St. Francis Hospital*96 points out the basic philosophical differences it has with the Ninth and Tenth Circuits. The Board would not relegate its traditional community of interest test to a subordinate position to the unit proliferation issue, but would balance these two policies to make the ultimate unit determination. The Board points out that Congress did not indicate that the Board should abandon the community of interest test, nor did Congress abrogate the section 9(b) duty to establish units which allow the employee the fullest freedom to exercise his or her section 7 rights.97 Accordingly, the Board would apply its two-tiered approach as explained in *St. Francis Hospital*.

The dispute among the various circuits and the Board seems to stem from their philosophical differences regarding the relative status of the community of interest test and the unit proliferation issue. The Board's position that these two concerns must be balanced to make the ultimate bargaining unit determination seems to comport best with congressional intent. On the one hand, Congress wished to ensure continued health care to the public by limiting health care bargaining units.98 Yet, Congress was also concerned with extending the advantages of collective bargaining to employees in the hospital industry.99 If anything is clear from the labyrinth of legislative history surrounding the 1974 Amendments, these were the two primary concerns Congress had when enacting that legislation.

The best approach would be to balance these two concerns, not to subordinate one to the other. The Ninth and Tenth Circuits' approach admittedly would subordinate an employee's section 7 rights to the public's right to uninterrupted health care. The Board's approach has the ultimate effect of subordinating the public's right to that of employees.100 It would appear that neither of these rights should be subordinated to the other, but each should be weighed in the given circumstances.

---

96. In *St. Francis I*, the Board stated that: "We believe that while the HMO decision represents the most extreme example of misrepresentation of the Legislative History to the health care amendments, it is the inevitable result of placing more importance upon a congressional admonition than upon sound principles of statutory construction." 265 N.L.R.B. No. 120, slip op. at 17 n.29, 112 L.R.R.M. 1153, 1158 n. 29.

97. Id.

98. House Report, supra note 6; Senate Report, supra note 6.

99. Id.

100. The Board adamantly denies that the first tier of its two-tiered test creates a presumption of validity for the seven delineated units. *St. Francis Hosp.*, 265 N.L.R.B. No. 120, slip op. at 17, 112 L.R.R.M. 1153, 1160. However, this first tier does, in fact, create the presumption that there is no undue proliferation for the seven units. As stated by the Board, these employee groups *may* be proper if they meet the community of interest test. Thus, under the Board approach, all seven units are presumed not to cause undue proliferation.
Such an approach seems to be advocated by the Second Circuit in *Trustees of Masonic Hall v. NLRB*. In Masonic Hall, the court specifically stated that it was balancing the “employees’ right to exercise section 7 rights with the congressional admonition against unit proliferation.” The balancing approach will achieve a “finely tuned balance of competing considerations and philosophies to develop a procedure that will, at the same time, protect labor and management rights and promote good health care.” It would seem as if this approach treats unit proliferation and community of interest as coequal considerations, without subordinating one to the other.

The Second Circuit seems to at least implicitly reject both the disparity-of-interest test and the Board’s two-tiered approach. The court specifically spurned the disparity-of-interest test, citing the above-quoted remarks for the proposition that the two competing interests should be balanced. While the court concluded that the issue of disparity is at least addressed when making a community of interest determination, it also concluded that strict adherence to the disparity-of-interest test would not be appropriate.

The Masonic Hall court expressly reserved opinion on the recently decided Board decision in *St. Francis Hospital*. However, it would appear that the Second Circuit has at least implicitly overruled the first tier of the Board’s two-tiered approach. The court specifically stated that there should be neither a presumption in favor of small units nor a

---

101. 669 F.2d 626 (2d Cir. 1983).
102. Id. at 633.
103. Id. at 641.
104. Id.
105. Id.
106. Id. at 627 n.1.
presumption in favor of large units. Moreover, the court would require the Board to evaluate each case on its individual facts to determine the appropriateness of the units. This would appear to be the case-by-case balancing approach advocated earlier.

It is not clear which of these three approaches the other circuits will prefer regarding the unit proliferation issue. The First Circuit's recent decision in Community Health Services, Inc. simply states that under any standard the unit in question would not result in undue proliferation. The court did not extend its decision beyond the particular facts of the case. The Third Circuit would appear to align with the Second Circuit since it uses balancing language and cites the Second Circuit's Mercy Hospital decision favorably. The Fourth Circuit clearly favors a case-by-case analysis and explicit treatment of the proliferation issue, but it is unclear with which circuit it is in accord, since it cites the Second, Ninth and Tenth Circuits. The Fifth Circuit makes no reference whatsoever to any other circuit's decisions on this issue. The Sixth Circuit cites cases from the Second, Third, Seventh, Ninth and Tenth Circuits favorably; however, the court ambiguously enunciated the standard it used to reach its ultimate determination, as it simply stated that the two units certified would not lead to undue proliferation. The Eighth Circuit has specifically rejected the disparity-of-interest test, but it is not clear whether it is adopting the Board's two-tiered approach or some other approach.
Finally, the Seventh Circuit's recent decision in *NLRB v. Res-Care, Inc.*,\(^{116}\) appears to have applied a balancing approach even though it also cited *HMO International*.\(^{117}\) The Seventh Circuit took a somewhat different approach than those previously mentioned. Although it recognized the need to balance the proliferation issue and the employees' organizational rights, the *Res-Care* decision focused more on whether the proliferation is *undue*.\(^{118}\) The court suggested that *undue* proliferation refers, in all likelihood, both to the absolute number of units and the number relative to the size of the institution.\(^{119}\) The court then concluded that a limit of two bargaining units in one health care facility can in no manner be considered *undue* proliferation.\(^{120}\) Accordingly, the court reasoned that deference should be given to the Board's determination that community of interest mandated two units.

An additional factor that affects the determination of a hospital bargaining unit is the supervisory status of the members within the proposed unit. As noted in the previous section, the membership of supervisory personnel in an organization will affect whether that organization can represent employees under the Act. This is also a consideration when the Board determines the appropriate bargaining unit.

Inclusion or exclusion of a particular employee from a bargaining unit in turn depends on the definition of a supervisor. The term supervisor is defined under the Act as:

> [A]ny individual having authority, in the interest of the employer, to hire, transfer, suspend, lay off, recall, promote, discharge, assign, reward, or discipline other employees, or responsibly to direct them, or to adjust their grievances, or effectively to recommend such action, if in connection with the foregoing the exercise of such authority is not of a merely routine or clerical nature, but requires the use of independent judgment.\(^{121}\)

Congress made specific reference to this section when enacting the 1974 Amendments and noted with approval the Board's careful avoidance of the application of the term supervisor "to a health care professional who gives direction to other employees in the exercise of professional judg-

\(^{116}\) 705 F.2d 1461 (7th Cir. 1983).

\(^{117}\) *Id.* at 1470.

\(^{118}\) *Id.* at 1469-71.

\(^{119}\) *Id.* at 1470. The court concedes that undue proliferation may also refer to the number of units relative to the heterogeneity of the work force, but doubts the likelihood that heterogeneity was intended as a consideration: *Id.* at 1470-71.

\(^{120}\) *Id.* at 1471.

ment, which direction is incidental [to] the professional’s treatment of patients. 122

The Board has generally looked to see if the individual in question has the power to hire, fire or promote an individual, or to effectively recommend these actions. 123 In Ojai Valley Hospital, 124 the Board considered the following four factors to be important when determining supervisory status: (1) responsibility for the operation of a particular unit, (2) authority to assign work, transfer, train and evaluate, (3) responsibility for hiring, and (4) responsibility for firing. 125

The Board has recently been criticized by several circuits for its determination of supervisory status in the hospital sector. The Sixth Circuit in Beverly Enterprises v. NLRB 126 refused to enforce a Board order defining seven Licensed Practical Nurses (L.P.N.) as bargaining unit employees. That court concluded that that part of the Board’s decision regarding its determination of the L.P.N.’s supervisory status was confusing. 127 The court ruled that the Board must clearly articulate that the L.P.N.’s are not supervisors because they do not exercise independent judgment, or they exercise professional judgment not in the interest of the employer. 128 The result of the court’s decision, therefore, is that a hospital employee who exercises independent professional judgment merely in conjunction with supervisory responsibilities is considered a supervisor.

The Fourth Circuit in NLRB v. St. Mary’s Home, Inc. 129 has also refused to enforce a Board finding that an L.P.N. was not a supervisor.


125. Id. at 1358, 106 L.R.R.M. at 1283. Apparently, the wearing of habits also connotes supervisory authority to the Board. Mercy Hosp. of Buffalo, 266 N.L.R.B. No 168, 113 L.R.R.M. 1574 (1983).

126. 661 F.2d 1095 (6th Cir. 1981).

127. Id. at 1101. The Third Circuit seems to be in accord in Tressler Lutheran Home for Children v. NLRB, 667 F.2d 302, 307 (3d Cir. 1982).

128. The court stated that: “[t]he Regional Director failed to clearly articulate whether he had determined that L.P.N. activities respecting patient care either did not involve independent judgment, or did involve independent professional judgment not in the interest of the employer, thereby leaving the impression that he considered the ‘conjunction with patient care’ alone sufficient for non-supervisory status.” Beverly Enters. v. NLRB, 661 F.2d 1095, 1101 (6th Cir. 1981). On remand, the Board found that the L.P.N.’s did not exercise independent judgment in the employer’s interest. Beverly Manor, 264 N.L.R.B. No. 128, 111 L.R.R.M. 1336 (1982).

129. 640 F.2d 1062 (4th Cir. 1982).
The Court found that one of the most important factors in determining supervisory status is whether the employee is the highest ranking employee on the job site to which other employees look for direction.\textsuperscript{130} Relying heavily on this test, the court ruled that the L.P.N. in question must be considered a supervisor.\textsuperscript{131}

The Seventh Circuit, in \textit{NLRB v. Res-Care, Inc.},\textsuperscript{132} also criticized the Board’s application of the term supervisor in the health care industry. The court maintained that a supervisor, as defined under section 2(11), has control over employee job tenure and other conditions of employment.\textsuperscript{133} In \textit{Res-Care}, the court noted the Board’s apparent inconsistent application of the term supervisor, but agreed that the L.P.N.’s in question had no authority to “effectively recommend promotion or discharge” of employees and were, thus, not supervisors.\textsuperscript{134}

In the companion case of \textit{NLRB v. American Medical Services, Inc.},\textsuperscript{135} the court held the Board’s classification of seventeen registered nurses as non-supervisory to be improper. The court considered three factors to be instrumental in distinguishing the \textit{Res-Care} situation from \textit{American Medical Services}. First, the enforcement of the Board’s order would result in an extremely low ratio of supervisors to employees at the American Medical Services facility.\textsuperscript{136} Second, there were at least two examples of registered nurses exercising the authority to discharge employees at the American facility.\textsuperscript{137} Finally, the American Medical Services’ Registered Nurses exercised discretion as to who would be working. The court went on to find that all these factors were present in \textit{American Medical Services} but absent in \textit{Res-Care}, which justified its denial of enforcement.\textsuperscript{138}

The final factor that seems to affect hospital bargaining unit decisions is the scope of the bargaining unit. The Board has established a

\begin{itemize}
\item \textsuperscript{130} \textit{Id.} at 1066.
\item \textsuperscript{131} \textit{Id.} at 1067 (citing the Board’s decisions in Northwoods Manor, Inc., 260 N.L.R.B. 854, 109 L.R.R.M. 1226 (1982) and Clark Manor Nursing Homes Corp., 254 N.L.R.B. 455, 106 L.R.R.M. 1231 (1981)).
\item \textsuperscript{132} 705 F.2d 1461 (7th Cir. 1983).
\item \textsuperscript{133} \textit{Id.} at 1465.
\item \textsuperscript{134} \textit{Id.} at 1468.
\item \textsuperscript{135} 705 F.2d 1472 (7th Cir. 1983).
\item \textsuperscript{136} \textit{Id.} at 1474.
\item \textsuperscript{137} \textit{Id.}
\item \textsuperscript{138} \textit{Id.} The Eleventh Circuit in \textit{Walker County}, 722 F.2d 1535 (1984), however, found merit in the Board’s approach to the supervisory status of hospital workers. The court relied on the fact that, although assistant unit coordinators and charge nurses, in the hospital in question, performed some of the same duties as supervisors, these individuals were primarily engaged in patient care. The court, therefore, did not consider them to be supervisors. \textit{Id.} at 1542. Thus, the exercise of independent professional judgment is not enough to support the conclusion that an individual is a supervisor.
\end{itemize}
presumption that single-hospital bargaining units are most appropriate.\textsuperscript{139} The two circuits that have ruled on this issue have refused to enforce the Board’s decisions that are based on this presumption.\textsuperscript{140} Both circuits emphasized the importance of considering the proliferation issue in both unit composition decisions and unit scope decisions.\textsuperscript{141} Accordingly, the Board must expressly find that a single hospital unit will not cause fragmentation where a single employer operates multiple facilities.

Regardless of the outcome of this feud between the courts and the Board, it is clear that the desire to limit the number of bargaining units in hospitals will play a role in future unit determinations. It is also clear that the determination of a bargaining unit can have significant effects on collective bargaining in the hospital industry. Unit determinations that result in broad units could affect collective bargaining in the hospital industry in many ways.\textsuperscript{142} The determination of a unit can determine the outcome of an election; unions representing broad units have a more difficult time winning elections.\textsuperscript{143} Broad bargaining units seem to strike more often because of internal problems.\textsuperscript{144} The tendency of broad units to strike more often seems to hold true in the hospital industry where larger hospital units strike more often than do smaller units.\textsuperscript{145} Broad bargaining units also disrupt the internal political structure of unions and lead to a decentralized bargaining structure.\textsuperscript{146} Broad units, however, can be expected to negotiate better compensation packages for union members because larger unions are usually more powerful than smaller unions.\textsuperscript{147} There should also be a shift in compensation packages for broad unions toward wages as opposed to fringe benefits.\textsuperscript{148}


\textsuperscript{141} Presbyterian/St. Luke’s, 653 F.2d at 454; Long Island Jewish, 685 F.2d at 34.

\textsuperscript{142} T. Kochar, \textit{Collective Bargaining and International Relations} 94 (1980). The term “broad” is used in the sense that the bargaining unit encompasses a large and varied number of job classifications.

\textsuperscript{143} \textit{Id.} at 109-10.

\textsuperscript{144} \textit{Id.} at 111.

\textsuperscript{145} \textit{Impact}, supra note 3, at 329.

\textsuperscript{146} Kochar, \textit{ supra} note 142, at 103 (citing \textit{The Structure Of Collective Bargaining} 18-20 (A. Weber ed. 1960)).

\textsuperscript{147} Miller, \textit{The Impact Of Collective Bargaining On Hospitals} 43 (1979).

The establishment of narrow units should have effects which are the opposite of those mentioned above. Unions representing narrow bargaining units will probably be more successful at winning elections.\textsuperscript{149} Narrow units are less powerful and, consequently, obtain poorer compensation packages than large units.\textsuperscript{150} However, narrow units are more cohesive and are probably better able to take their members out on strike, when they do strike.\textsuperscript{151} Narrow bargaining units comprised of professionals should shift worker compensation packages away from wages toward working conditions.\textsuperscript{152} This is partially borne out by the evidence that professional hospital employees are greatly concerned about patient care issues.\textsuperscript{153}

In short, the final resolution of the bargaining unit controversy will significantly impact on collective bargaining in the hospital industry. Not only will that resolution affect the bargaining power of the unions and employees,\textsuperscript{154} it will also affect the nature of the issues that are discussed at the bargaining table.\textsuperscript{155}

\textbf{UNFAIR LABOR PRACTICES UNDER SECTION 8(g) OF THE NLRA}

As previously stated, section 8(g) of the NLRA requires a labor organization to give a hospital ten days notice prior to striking or picketing that hospital.\textsuperscript{156} Congress enacted section 8(g) with the express purpose of allowing hospitals to provide alternative patient care in order to "insure the continuity of health care to the community."\textsuperscript{157} Congress also specifically indicated that any violation of section 8(g) would be considered an unfair labor practice punishable under section 10(j) of the Act.\textsuperscript{158}

Beyond outlining the purpose of the Act, Congress specifically indicated some of the acts which would and would not be considered unfair labor practices under section 8(g). Although strikes or picketing need not begin exactly ten days from service of notice, they must begin within seventy-two hours of that time.\textsuperscript{159} In addition, the employer must receive

\begin{itemize}
  \item \textsuperscript{149} KOCHAN, supra note 142, at 85.
  \item \textsuperscript{150} Feuille, supra note 148, at 51.
  \item \textsuperscript{151} KOCHAN, supra note 142, at 85.
  \item \textsuperscript{152} Feuille, supra note 148, at 51.
  \item \textsuperscript{153} Metzger, \textit{Hospital Labor Scene Marked By Union Issues}, \textit{HOSPITALS}, Apr. 1, 1980, at 106.
  \item \textsuperscript{154} Feheley, \textit{Amendments to National Labor Relations Act: Health Care Institute}, 36 \textit{OHIO ST. L.J.} 234 (1975).
  \item \textsuperscript{155} Feuille, supra note 148, at 51.
  \item \textsuperscript{156} 29 U.S.C. §158(g).
  \item \textsuperscript{157} HOUSE REPORT, supra note 6, at 5; SENATE REPORT, supra note 6, at 4.
  \item \textsuperscript{158} \textit{Id}.
  \item \textsuperscript{159} \textit{Id}.
\end{itemize}
twelve hours advance notice of the impending strike or picketing. Accordingly, once the union serves notice on the employer it must wait ten days to strike; however, if it waits more than ten days, it must give the employer twelve hours notice, and in any event, it cannot take action more than seventy-two hours after the ten day period is over. Congress specifically provided that repeated service of the ten day notice upon the employer would be considered a refusal to bargain in good faith. More importantly, Congress specifically adopted the holding in *Mastro Plastics Corporation v. NLRB*, that a labor organization need not serve notice on the employer if the strike is an unfair labor practice strike. Congress also pointed out that while an employer is “free to take whatever action is necessary to maintain health care” it is not free “to use the ten day period to undermine the bargaining relationship.”

The courts and the Board have been faced with further questions of interpretation involving section 8(g). The courts and the Board have held that section 8(g) specifically grants hospital workers the right to strike, despite state laws prohibiting hospital workers from striking. The Board has determined that a section 8(g) violation coupled with subsequent termination of employment will disqualify an employee as a voter in a representation election. The courts have also been faced with applying section 8(g) to the particular acts and particular entities discussed in the next subsections.

**The Application Of Section 8(g) to Particular Entities**

In *Walker Methodist Residence*, the Board addressed the issue of whether two unorganized employees were required to give the ten day

---

160. *Id.*
161. *Id.*
163. *House Report, supra* note 6, at 6; *Senate Report, supra* note 6, at 4. This seems to punish the wrong people for the ULP. Since § 8(g) is designed to protect the community, it does not seem logical to withdraw that protection because of something the employer has done. Congressional intent was to assure that healthcare employees be accorded the same treatment under the law as other employees. However, on balance, there appears to be no alternative method to prevent the employer's violations.
164. *Id.*
165. *Ascot Nursing Center, 216 N.L.R.B. 680, 88 L.R.R.M. 1606 (1975)* (short walkout by six nurses aides, protesting "shortchanged" paychecks); *Methodist Hosp. of Ky., Inc. v. NLRB, 619 F.2d 563 (6th Cir. 1980)* (it is not necessary to give ten days notice for a strike begun before the 1974 Amendments were enacted).
notice under section 8(g). In concluding they are not, the Board found that section 8(g) on its face does not apply to unorganized workers. Moreover, the Board found that Congress had been concerned with massive strikes that might disrupt patient care when it enacted section 8(g), and that Congress did not intend to apply section 8(g) to unorganized workers. This rule has been extended to situations where six unorganized employees engaged in job actions. The Board has repeatedly refused to apply section 8(g) to hospital workers absent action by a labor organization. The courts have refused to apply section 8(g) to unrepresented employees who strike and then later, during the strike, become members of a union.

The Ninth Circuit has refused to apply section 8(g) to unorganized workers in Kapialani Hospital v. NLRB, where the court held that unrepresented employees who engage in a work action in support of union employees need not give the ten days notice. Further justification for this position was found in Montefiore Hospital and Medical Center v. NLRB, where the court pointed out that a hospital could lawfully question unrepresented employees as to whether they intended to strike once notice has been served by a union, or enact a rule requiring all hospital personnel to give ten days notice before engaging in work action.

The Board and the courts have also refused to enforce section 8(g) against labor organizations who do not represent health care workers. In

---

169. Id. at 1631, 94 L.R.R.M. at 1518.
170. Id. This is questionable logic in light of the fact that a few key hospital employees could disrupt patient care at a hospital.
171. Mercy Hosp. Ass'n, Inc., 235 N.L.R.B. 681, 98 L.R.R.M. 1077 (1978) (six unorganized nurses aides engaged in unannounced work stoppage to protest understaffing; however, there was no evidence that patient health was jeopardized).
172. Long Beach Youth Center, 230 N.L.R.B. 648, 95 L.R.R.M. 1451, enforced, 591 F.2d 1276 (9th Cir. 1979), (citing Kapialani Hosp. v. NLRB, 681 F.2d 230 (9th Cir. 1978), for the proposition that unorganized workers are not required to give notice under section 8(g). There was some controversy in the Long Beach decision as to whether the workers were organized. The court found that despite the fact that the employees signed authorization cards contemporaneous with the organizational meeting, the employees were not organized).
173. Long Beach Youth Center, 230 N.L.R.B. 648, 95 L.R.R.M. 1451, enforced, 591 F.2d 1276 (9th Cir. 1979); Mercy Hosp. Ass'n, Inc., 235 N.L.R.B. 681, 98 L.R.R.M. 1077 (1978). Consider whether this policy complies with congressional intent where no labor organization is involved, but work action is taken by a large number of employees who disrupt patient care.
174. Long Beach, 581 F.2d 230 (9th Cir. 1978).
175. 581 F.2d 230 (9th Cir. 1978).
176. Id. at 233.
177. 621 F.2d 510 (2d Cir. 1980).
178. Id. at 515.
179. Id. at 516.
Laborers International Union v. NLRB, the court refused to apply section 8(g) to labor organizations striking hospital subcontractors engaged in construction and renovation of hospital facilities, even though such activities might endanger patient lives. This doctrine has even been extended to situations where non-hospital labor organizations have picketed hospitals, a topic to be addressed in the next subsection.

The Application Of Section 8(g) To Particular Acts

A threat to strike does not require notice under section 8(g); there must actually be a strike. A brief work stoppage, e.g., for thirty minutes, apparently does not require ten days notice. Picketing requires section 8(g) notice, but there may be different rules governing different forms of picketing.

Informational picketing of a hospital by non-health care employees does not require section 8(g) notice, as long as the picketing is not directed toward the hospital. However, informational picketing involving off duty hospital employees directed at a hospital is subject to the section 8(g) notice requirements. The conventional rules of common situs picketing apparently do apply to the hospital industry. Sympathy picketing by

180. 567 F.2d 1006 (D.C. Cir. 1977).
181. Id. at 1009.
182. Laborer's Local 1253 (St. Mary's Hosp. of Roswell), 248 N.L.R.B. 244, 103 L.R.R.M. 1526 (1980) (union not required to give notice since picketing was directed towards construction contractor and the picket signs clearly stated at whom the dispute was directed); NLRB v. Int'l Bhd. of Electrical Workers, 548 F.2d 704 (7th Cir. 1977) (electricians not required to give notice for area standards picket, as activity was directed towards electrical contractor).
183. District 1199-E, RWSDU (Greater Pennsylvania Avenue Nursing Center), 227 N.L.R.B. 132, 94 L.R.R.M. 1083 (1976) (quoting heavily the HOUSE REPORT, supra note 6, and the SENATE REPORT, supra note 6).
185. District 1199-E, Hosp. and Health Care Employees (Federal Hill Nursing Center), 243 N.L.R.B. 23, 101 L.R.R.M. 1346 (1979) (union violated Section 8(g) by beginning picketing eighty and one-half hours after time stated in 10-day notice without notifying the employer); Painters Dist. Council, 243 N.L.R.B. 609, 101 L.R.R.M. 1456 (1979) (picketing of hospital entrance without notice is a violation regardless of the fact that patient care interruption was not intended).
187. Dist. 1199, Nat'l Union of Hosp. and Health Care Employees (United Hosps. of Newark), 232 N.L.R.B. 443, 96 L.R.R.M. 1404, 1406 n.12 (1977) (citing the HOUSE REPORT, supra note 6, and the SENATE REPORT, supra note 6, for the proposition that picketing of a health care institution would in itself constitute unusual circumstances under section 8(b)(7)(C) warranting a period of time less than 30 days).
188. Laborers' Local 1253, 248 N.L.R.B. 244, 247, 103 L.R.R.M. 1526, 1528 (1980).
unrepresented employees need not be preceded by section 8(g) notice.\textsuperscript{189} Sympathy picketing by any other union has been held by the Board to require section 8(g) notice,\textsuperscript{190} however, enforcement of that decision was denied by the Second Circuit.\textsuperscript{191} The Board, in a recent decision on point, maintains that section 8(g) applies to all forms of picketing.\textsuperscript{192} It is not clear what the ultimate resolution of this issue will be, but it is clear that the courts are willing to recognize different rules for different forms of picketing.

\textit{Employer Activities Under Section 8(g)}

While an employer may prepare for a strike during the notice period, it may not impair the bargaining relationship.\textsuperscript{193} There are five factors relevant to determining the appropriateness of employer behavior: "(1) the number of replacements being interviewed and/or hired; (2) the permanence of the replacements (hired in anticipation of the strike); (3) the number and types of supplies ordered (in anticipation of a strike); (4) the nature of patients’ illnesses; and (5) the willingness of the union to permit the passage of supplies and personnel through its picket lines.”\textsuperscript{194} In addition, the NLRB General Counsel has indicated that employers may question workers as to whether they intend to strike, but the employer must: "(1) indicate the purpose of the inquiry; (2) assure the employee’s participation in the conversation on a voluntary basis; and (3) indicate that the conversations are free from employer hostility toward union organization.”\textsuperscript{195}

\textsuperscript{189}. Montefiore Hosp. and Medical Center v. NLRB, 621 F.2d 510 (2d Cir. 1980).
\textsuperscript{190}. Dist. 1199, Nat’l Union of Hosp. Employees (First Healthcare Corp.), 222 N.L.R.B. 212, 91 L.R.R.M. 1097 (1976) (Chairman Murphy and Member Fanning dissenting on grounds that one and one-half hour sympathy picket by four union members did not fall within the intent of section 8(g), as their presence did not change character of picketing, did not broaden their objectives and did not generate any economic pressure on the employer).
\textsuperscript{191}. 556 F.2d 558 (2d Cir. 1976).
\textsuperscript{192}. Dist. 1199, Hosp. and Health Care Employees (South Nassau Hosp.), 256 N.L.R.B. 74, 107 L.R.R.M. 1190 (1981). Although the Board agreed with the Administrative Law Judge’s (ALJ) finding, Chairman Fanning found it unnecessary to rely on First Healthcare Corp. in which he dissented. Member Zimmerman found it unnecessary to pass on First Healthcare Corp. since he was not a Board Member at the time and since this case involved primary activity. Member Jenkins agreed that there was a violation of section 8(g), although he did not rely on Dist. 1199, Nat’l Union of Hosp. and Health Care Employees (United Hosps. of Newark), 232 N.L.R.B. 443, 96 L.R.R.M. 1404 (1977), which the ALJ cited in support of finding a violation here. Jenkins adhered to his dissent in that case, but found that decision factually distinguishable from the instant case. 256 N.L.R.B. 74, n.1.
\textsuperscript{193}. HOUSE REPORT, supra note 6, at 6; SENATE REPORT, supra note 6, at 4.
\textsuperscript{194}. IMPACT, supra note 3, at 416-17.
\textsuperscript{195}. Id. at 417.
It is a general feeling among practitioners that unions attempt to comply with section 8(g) notice requirements. Accordingly, once the parameters of this issue are defined, there should be less litigation in this area. However, in the near future, the issue of employer conduct during this notice period may prove to be fertile ground for conflict.

HOSPITAL SOLICITATION RULES

The courts first addressed a post-1974 amendments hospital solicitation rule in *St. John's Hospital and Nursing Home, Inc. v. NLRB.* The court upheld a regulation restricting union solicitations to employee-only areas. The *St. John's* court concluded that hospitals, much like retail establishments, have an interest in protecting consumers from union solicitations and, accordingly, the hospital could prohibit all union solicitations in gift shops, cafeterias, hospital corridors, lounges and patient rooms.

In *Beth Israel Hospital v. NLRB,* a seemingly contradictory case, the First Circuit prohibited a hospital from precluding union solicitations in hospital cafeterias and coffee shops. However, the Supreme Court found these two cases compatible and affirmed *Beth Israel.* Based on these cases, the Supreme Court concluded, in its affirmation of *Beth Israel,* that "the Board's general approach to requiring health care facilities to permit employee solicitations and distribution during non-working time in non-working areas, where the facility has not justified the prohibition as necessary to avoid disruption of health care operations or disturbance of patients, is consistent with the Act."

*NLRB v. Baptist Hospital, Inc.*

The Supreme Court clarified its position on hospital solicitation rules in *NLRB v. Baptist Hospital, Inc.* In *Baptist Hospital,* the Supreme Court formulated four rules regarding union solicitation prohibitions in hospitals.

---

196. Id. at 418.
197. 557 F.2d 1368 (10th Cir. 1977).
198. Id.
199. Id. at 1375.
201. Id.
203. 437 U.S. at 507.
First, the Board will be allowed to make the presumption that no-solicitation rules in non-immediate patient care areas are invalid. The Court also acknowledged the Board's St. John's decision that immediate patient care areas include patients' rooms, operating rooms, and treatment rooms, such as x-ray and therapy areas.

Second, employees will be allowed to overcome this presumption by proving that such solicitations are not an interference with patient care. Baptist Hospital was able to demonstrate that the sitting rooms and corridors were an integral part of proper patient care. Consequently, the Court found that the employer had overcome this presumption.

Third, evidence that the hospital allows union solicitations in certain parts of the hospital will weigh in favor of a no-solicitation rule in other areas. Baptist Hospital presented evidence that solicitations were allowed at nurses stations and adjacent utility rooms, employee lounges and the maintenance and laundry buildings; all these alternative means of solicitations were considered important in determining the validity of the no-solicitation rule.

Finally, the Court pointed out that the functions of hospitals are unique and that these functions must be considered when evaluating the legality of a solicitations rule. More specifically, the Board must consider the patient care issue and revise its rulings if patient care is jeopardized.

The Application of Baptist Hospital

In response to the Baptist Hospital decision, the NLRB General Counsel formulated guidelines setting out the Board's position on no-solicitation rules in specific areas of hospitals. Under those guidelines, the Board will consider no-solicitation rules in the following areas to be presumptively valid: (1) patient rooms, (2) operating rooms, (3) treatment

---

205. Id. at 778.
206. Id. at 780. The court specifically reserved the question of whether corridors and sitting rooms on patient floors can be presumed to be non-patient care areas. However, the tenor of the decision makes it seem as if the court would rule against this presumption.
207. Id. at 781.
208. This proof was based primarily on testimony that patient health depended to a large extent on tranquil surroundings and that union solicitations which disrupt this tranquility might harm patients. Id. at 783.
209. Id. at 782-87.
210. Id. at 785 (citing Beth Israel Hosp., 437 U.S. at 505).
211. Id. at 784-85.
212. Id. at 789-90.
213. Id.
rooms, (4) corridors and sitting rooms on patient floors which are accessible to and used by patients, and (5) elevators and stairways that are used frequently to transport patients. Solicitation bans on nurses stations will carry no presumption, and the validity will be determined on the basis of patient care considerations. Finally, bans on public areas, such as cafeterias and gift shops, and areas to which only employees have access will be presumed invalid.

In its first hospital solicitation case since Baptist Hospital, the Board concluded that a room, although adjacent to an operating room and occasionally used by doctors conferring with relatives of patients, was not an "immediate patient care area" because "the room was not generally accessible to patients or visitors." Pursuant to an enforcement request by the Board, the Ninth Circuit found that the room in question was primarily used by employees as a lounge and never used by patients. Accordingly, the court held that since the room was not an "immediate patient care area," it was the hospital's burden to prove that the union representative's "complete prohibition [from the room] was necessary to prevent disruption of patient care." The court went on to find that while there was limited evidence of one instance of patient disruption, this could not outweigh the evidence that the room had been used as an employee lounge for one year without patient disturbance and that the employer had alternate means of assuring that patients were not disturbed. Based on these factors, the court concluded that the Board's presumption had not been overcome and, therefore, enforced the Board's order.

The latest cases concerning the hospital solicitation issue are Dallas Association of Community Organizations for Reform Now v. Dallas County Hospital District and Eastern Maine Medical Center v. NLRB. While these cases reached different results on the validity of the solicitation rules, both courts focused their analyses on the same factors.

215. Id. at 15,936-37.
216. Id. at 15,937.
217. Id. at 15,937-38.
218. Los Angeles New Hosp., 244 N.L.R.B. 960, 102 L.R.R.M. 1189 (1979). However, there was evidence that doctors occasionally used the room for discussions with patients' relatives.
220. Id. at 1021.
221. The specific incident in question gave rise to a level of noise that could be discerned from the operating area. Nevertheless, the Board properly concluded the hospital should have exercised the less restrictive option of asking the employees to be quiet. Id. at 1021-22.
222. Id. at 1022.
223. 656 F.2d 1175 (5th Cir. 1981), rev'd on other grounds, 670 F.2d 629 (5th Cir. 1982).
224. 658 F.2d 1 (1st Cir. 1981).
In *Dallas County Hospital*, no labor solicitation was involved and the decision was based on constitutional grounds. However, the court specifically discussed *Baptist Hospital* in the context of solicitations in a hospital. The court went on to find that because of the extremely crowded conditions, the hospital corridors and entryways were patient care areas. If applied in a labor relations context, this case could prohibit solicitations in hospitals that are forced to use non-traditional patient care areas.

In *Eastern Maine Medical Center*, the court also applied the *Baptist* patient care standard to a hospital corridor to determine the validity of a solicitation rule. The court found that the employer had failed to prove that a solicitation ban was necessary to avoid patient care disruptions. Accordingly, the court concluded that the hospital’s no-solicitation rule was overly broad and presumptively invalid.

**Hospital Mediation and Fact Finding Requirements**

Under the new section 8(d) of the Act, a party must serve written notice on the other party 90 days prior to the proposed modification or termination of an existing labor contract. If the labor dispute is not resolved within 60 days prior to the termination of the contract, the party must serve notice on the Federal Mediation and Conciliation Service (FMCS). If there is no existing contract, notice must be served on the FMCS thirty days prior to a job action. Once notice has been served on the FMCS, mediation proceedings must begin and the parties must participate. Should the parties refuse to participate, a violation of section 8(a)(5) or 8(b)(3) will be found. In the event mediation fails, the Director of the FMCS is authorized to appoint a board of inquiry (BOI) to avert an interruption of health care.
Appointment of a BOI is within the discretion of the Director of the FMCS. While selection of a BOI is within the discretion of the FMCS, the FMCS has formulated some rules to decide when a BOI is appropriate. The following data is considered relevant when determining whether a BOI should be appointed:

The type of facilities; the number of beds and occupancy rates in the facility and in other similar facilities in the locality; the number of employees in the bargaining unit and the facility as a whole; the number of employees in other unions at the facility and their likely response to a picket line; whether the facility provides any emergency or other special services not adequately available elsewhere; and any other data relevant to what the impact of a strike by the particular union would be on the operation of the facility and the delivery of health care in the locality.

The appointment of a BOI must be made within thirty days of the receipt of notice, regardless of when the contract terminates. Once the BOI is convened, its purpose is to investigate the issues involved in the dispute and make a written report containing findings of fact and recommendations for settling the dispute in a prompt, peaceful and just manner, all within fifteen days. The FMCS has, however, found one way to circumvent the thirty day appointment rule. By getting both parties to sign a written stipulation, the FMCS is able to avoid the statutory time requirements and still appoint a BOI.

Mediation and fact finding have many perceived advantages and disadvantages. The primary advantage of these techniques is in the area of strike reduction. The primary disadvantage is that both parties, knowing they must go to mediation or fact finding, will not give negotiations

238. "In the first place there is no 'need for judicial supervision' of the exercise by the Director [FMCS] of his discretionary power 'in order to safeguard the interest of' the Hospital. The board has no substantive adjudicatory powers; its recommendations are purely advisory, without binding authority on either employer or union. The board is in effect no more than a mediating arm of the Director." Sinai Hospital of Baltimore, Inc. v. Horvitz, 621 F.2d 1267, 1270 (4th Cir. 1980).


240. Id. at 605-06; See also Sinai Hosp. of Baltimore, Inc. v. Scearce, 561 F.2d 547 (4th Cir. 1977); Sinai Hosp. of Baltimore v. Horvitz, 621 F.2d 1267, 1270 (appointment of a board beyond the 30 day period is not within Director's power); Affiliated Hosps. of San Francisco v. Scearce, 583 F.2d 1097 (9th Cir. 1978) (overturning the FMCS's position that a board can be appointed anytime between 60 and 30 days preceding contract termination).

241. GC Guidelines, supra note 234, at 15,092.

242. IMPACT, supra note 3, at 183. Apparently, the courts will enforce these agreements and regulate them according to the statutory BOI rules. Southwest Louisiana Hosp. Ass'n v. Local Union No. 87, 664 F.2d 1321 (5th Cir.), reh'g denied, 669 F.2d 729 (5th Cir. 1982).

243. KOCHAN, supra note 142, at 291.
their best effort. Empirically, it is very difficult to evaluate whether the 
parties give negotiations their best effort; however, it should not be diffi-
cult to evaluate the success of these techniques in strike reduction.

First, it is helpful to point out how these techniques reduce strikes. 
Fact finders in the health care sector have the following positive com-
ments about the process: "(1) parties were forced to develop supportive 
data for their positions; (2) the Board served as a face-saving device; (3) at 
times the Board acts as a catalyst to get the parties to start negotiations or 
move off dead center; and (4) the threat of a Board may prompt the 
parties to settle before it is convened or issues recommendations." A 
majority of both labor and management negotiators involved in BOI's 
found them to be helpful.

Apparently, mandatory mediation in the health care industry is 
effective: strikes are frequently postponed in the interest of further medi-
tion. Moreover, the FMCS seems to be on the average more successful 
in the health care industry than in all other industries as a whole. 
However, there are costs involved in this success. The FMCS spends 
more time and energy proportionately on the health care industry than it 
does on any other industry.

Fact finding also seems to be successful in the health care industry. 
Strikes occurred in fifteen percent of the BOI fact finder situations from 
1974 through 1977. While this rate is higher than the rate for non-BOI 
situations, it is still impressive when one considers the fact that BOI 
situations are the least likely to be resolved peacefully.

SUMMARY

The Impact And Success Of The 1974 Health Care Amendments

1. Strike Activity—During the period from 1974 until 1979, strike 
activity has risen in the health care sector overall. The mean weighted 
duration of hospital strikes, twenty-seven days, is essentially the same as 
that for industries as a whole. While strikes in hospitals occur in all

244. IMPACT, supra note 3, at 173-74.
245. Id. at 268.
246. Id. at 268-70.
247. Id. at 332.
248. Id.
249. Id. at 331.
250. Id. at 341.
251. Id. The rate for non-BOI situations is 4.6 percent.
252. See IMPACT, supra note 3, at 319-22.
253. Id. at 324-25.
parts of the country, four states, New York, Michigan, California and Washington, accounted for fifty percent of work days lost due to strikes.\textsuperscript{254} The average number of workers involved in each strike is 248.\textsuperscript{255} However, data reveals that strikes tend to occur more frequently in the larger hospital units.\textsuperscript{256} Over three-fourths of hospital strikes end in the formation of a formal agreement between the union and the hospital, which is slightly lower than the percentage for United States industries as a whole.\textsuperscript{257} In sixty percent of hospital strikes, the primary issues involved were monetary.\textsuperscript{258} Only five percent of hospital strikes were based on the union recognition issue.\textsuperscript{259}

At first, it would seem that the 1974 Amendments have not accomplished the congressional goal of keeping hospital strikes low. As noted by one commentator, this may be expected to continue through the 1980s as unions intensify hospital organizing efforts.\textsuperscript{260} This may, however, be a temporary phenomenon, due to the relatively new use of collective bargaining in the hospital industry, as compared to other industries which have been protected under the NLRA for almost fifty years. Once both hospitals and unions become accustomed to each other, strike activity may subside in the hospital sector.

It would not be surprising for strike activity in the hospital industry to fall below the all-industry national average. Such a decline is a possibility, considering the special provisions in the 1974 Amendments designed to reduce strike activity in hospitals. As previously pointed out, both mediation and fact finding seem to have been a success in reducing strikes in the health care industry. However, the 1974 Amendments have failed in one respect: the 90 day notice requirement has not promoted bargaining as Congress had hoped.\textsuperscript{261} Moreover, the congressional hope was to reduce organizational strikes which interrupt patient care in rural areas.\textsuperscript{262} The data clearly indicates that most strikes are not in rural areas.\textsuperscript{263} To

\begin{itemize}
  \item \textsuperscript{254} Id. at 325.
  \item \textsuperscript{255} Id. at 328.
  \item \textsuperscript{256} Id.
  \item \textsuperscript{257} Id. at 355.
  \item \textsuperscript{258} Id. at 338.
  \item \textsuperscript{259} Id.
  \item \textsuperscript{260} Elliot, \textit{Hospitals Must Face Heavy Unionization Drives in 80's — Part 1}, \textit{HOSPITALS}, June 16, 1981, at 58. \textit{See also} Mulcahy & Rader, \textit{Trends in Hospital Labor Relations}, 31 LAB L.J. 100 (1980).
  \item \textsuperscript{261} Impact, \textit{supra} note 3, at 245, 339-40.
  \item \textsuperscript{262} Id. at 327; Senate Report, \textit{supra} note 6, at 6; House Report, \textit{supra} note 6, at 6.
  \item \textsuperscript{263} Impact, \textit{supra} note 3, at 328. An analysis of strikes throughout the United States showed that while almost fifty percent of all strikes took place in big cities, only six percent occurred in rural areas.
\end{itemize}
date, it seems that the 1974 Amendments have at least partially met the congressional goal of preventing patient care interruptions.

2. Employee Wages and Benefits—The average hourly wage rate in the hospital industry is below the average hourly wage rate in most other industries.\textsuperscript{264} However, the gap between the hospital industry and United States industries as a whole dropped to twenty percent during the period from 1974 to 1976, because of large increases in the wages of hospital workers.\textsuperscript{265} Only thirty-one percent of hospital contracts contain discipline and discharge grievance procedures compared to fifty-nine percent for all United States industries as a whole.\textsuperscript{266} Moreover, hospital contracts provide management with greater flexibility than the contracts in United States industries as a whole.\textsuperscript{267}

The relatively new implementation of collective bargaining in the hospital sector may also account for the fact that hospital workers do not have as attractive compensation packages as other industries. This is even more likely when one considers the intense opposition hospitals have toward unions. This recent adoption of bargaining and the weakness of hospital unions may account for the relatively short duration of hospital contracts.\textsuperscript{268} As employers become more experienced and unions become more powerful, we can expect contract terms to lengthen.

One of the original purposes of the 1974 Amendments was to extend the benefits of collective action to non-profit hospital employees.\textsuperscript{269} With this goal in mind, the 1974 Amendments were enacted in an attempt to balance the relative power of labor and management. Granting hospital employees the right to strike had a tremendous impact on the bargaining power of hospital unions. It is not unusual to see an increase in wages in the hospital industry, commensurate with the increase in union bargaining power. Apparently, the 1974 Amendments have accomplished the congressional purpose of making the benefits of organized labor available to hospital workers.

3. Unfair Labor Practices—Unfair labor practice cases in the hospital industry increased 213 percent during the period from 1974 to 1976.\textsuperscript{270} The majority of these cases were filed against employers, even to a greater

\begin{itemize}
\item \textsuperscript{264} Id. at 153.
\item \textsuperscript{265} Id.
\item \textsuperscript{266} MILLER, supra note 147, at 122.
\item \textsuperscript{267} Id. at 70.
\item \textsuperscript{268} Id.
\item \textsuperscript{269} SENATE REPORT, supra note 6, reprinted in 1974 U.S. CODE CONG. & AD. NEWS 3946, 3948.
\item \textsuperscript{270} IMPACT, supra note 3, at 410.
\end{itemize}
Unfair labor practice cases may serve as an indication of the willingness and ability of bargaining parties to function under the NLRA. Apparently, hospitals have difficulty under the new labor relations system. However, this does not necessarily mean the system is unworkable. Frequently, parties that are new to collective bargaining have a tendency to test the outer limits of permissible action. If the high number of unfair labor practice cases in the hospital industry is due to the newness of collective bargaining, we should see a decrease in unfair labor practice cases in the near future. Support for this conclusion may be found in the fact that most of the unfair labor practice cases are filed against employers who are less experienced than unions at collective bargaining.272

Alternatives To the NLRA As It Now Applies To Hospitals

The first obvious alternative to the Act, as it now stands, is to no longer protect non-profit hospital employees under the Act. This may very well be the best alternative, though perhaps not politically acceptable, if the system Congress designed cannot guarantee the availability of patient care. However, if the hypothesis about the decline in hospital strikes proves true, then there is no reason to accept this alternative, given the benefits hospital employees enjoy under the Act.

A second possible alternative to the Act is to drop the current section 8(g). The only purpose for that section, as previously noted, is to give hospitals adequate time to provide patient care in the event of a strike. This in turn depends on two factors: (1) whether unions observe the ten day notice requirement, and (2) whether hospitals are able to find alternative patient care. Though there is no empirical evidence on the subject, the consensus among professionals in the hospital collective bargaining field is that unions try to comply in good faith with this notice requirement.273 Almost ninety percent of hospitals who are served with section 8(g) notice took some action toward providing alternate patient care.274 In addition to serving the congressional purpose of continuous patient care, section 8(g) also serves as the catalyst to start serious bargaining.275 In fact, mediators have suggested that this provision be extended to other sectors of collective bargaining.276 Clearly, the elimination of section 8(g) would be unwarranted.

271. Id. While U.S. employers as a whole have more ULP's filed against them than U.S. unions as a whole, the percentage of ULP's filed against hospitals is even higher than the percentage for employers as a group.
272. Id.
273. Id. at 418.
274. Id. at 333-34.
275. Id. at 277.
276. Id.
The final suggestion to change the present system involves the mediation and fact finding process currently in use. However, before any suggestions can be made, an evaluation of the present system must be undertaken. There are at least five problems that may arise from the present system: (1) strikes, (2) the chilling effect,\(^2\) (3) the narcotic effect,\(^2\) (4) the half-life effect,\(^2\) and (5) the skewing of results to favor one party.\(^2\) The strike issue has already been dealt with and it has been concluded that this system has at least some effect on the reduction of strikes.\(^2\) There is at least some evidence that fact finding does have a chilling effect on the parties; however, it is not conclusive.\(^2\) No clear evidence exists as to the narcotic or half-life effects of this system. Finally, there is limited evidence that fact finding may be biased in favor of the hospitals, but this evidence is sketchy at best.\(^2\) This process seems to be fairly effective in the hospital sector; strikes are reduced and the parties seem to favor the process.\(^2\) There are, however, additional changes which could be implemented to improve the system.

First, a board of inquiry should be appointed at any time, at the discretion of the Director of the FMCS. This has the advantage of allowing the Director to appoint a board at a later time when the parties have narrowed the issues\(^2\) and, thus, the fact finder can be more effective.\(^2\) This also has the advantage of stimulating bargaining or enhancing mediator success because the specter of fact finding will always be present.\(^2\) This change is supported by a majority of mediators and fact finders.\(^2\)

---

277. The term “chilling effect” refers to the fact that the incentive to bargain may be reduced (chilled) when the parties know that alternative mechanisms are available. KOCHAN, supra note 142, at 291.

278. The term “narcotic effect” refers to the fact that parties may become addicted to and overdependent upon the process. Id. at 292.

279. The term “half-life” refers to the fact that the parties may not use the process over time because it is not acceptable for resolving their disputes, and thus they turn to other alternatives. Id.

280. “Biasing of the parties” refers to the hypothesis that the procedures may be inherently conservative and would, therefore, favor the party seeking the fewest deviations from the status quo. Id.

281. See supra notes 247-51 and accompanying text.

282. IMPACT, supra note 3, at 249. In thirty-seven percent of the cases in which a fact-finding board was appointed it was found that one or both parties had delayed bargaining in anticipation of a fact-finding board.

283. Although fact-finders tend to favor hospital management on such issues as wages and vacations, they tend to favor the unions on other issues such as union security and pensions. Id. at 264.

284. Fifty-seven percent of the mediators and sixty-five percent of fact-finders expressed positive reactions to the mediation and fact-finding procedures. In addition, fifty-eight percent of management and fifty-nine percent of union negotiators found the procedures useful. Id. at 266-68.

285. Id. at 230.

286. Id. at 278-79; KOCHAN, supra note 142, at 278-79.

287. IMPACT, supra note 3, at 175, 268; KOCHAN, supra note 142, at 278-79.

288. All of the parties, including the mediators, fact-finders, and labor and management
Second, labor and management negotiators should have some input into who is selected as a mediator and who is selected as a fact finder. This has a three-fold advantage: it allows the parties to select someone they can work with; it allows the parties to select someone who has knowledge of the field; and it is a change sought by both labor and management negotiators.289

Legal Issues That May Arise In The Future Regarding Hospital Labor Relations

One major area with the potential for future conflict is the applicability of section 8(b)(7)(C) to hospitals.290 Both the Senate and House reports maintain that picketing of a hospital would in itself be considered an unusual circumstance; consequently, any picketing of a hospital without prior filing of a representation petition would be prohibited under the "reasonable period of time" clause of section 8(b)(7)(C).291 As the Board pointed out in its General Counsel guidelines on health care institutions, however, legislative history on this subject is inconclusive as to whether Congress intended to allow any organizational picketing of hospitals where the labor organization has not filed a petition.292 The Board concluded that such picketing will not be considered in the "same light as comparable conduct in other industries."293 The Board went on to elicit two factors to be considered when determining what constitutes a "reasonable time" for picketing a hospital without filing a petition. First, "the nature of the illness being treated at the picketed institution"294 is important, since presumably, more serious illnesses would justify a shor-
ter time period. The second factor is "the effects of the picketing on the institution's ability to treat its patients." Therefore, the Board concluded that case by case adjudication will be necessary to provide firmer standards by which to evaluate a "reasonable time period."

A second controversy which may arise in the future is the application of the *Mastro Plastics* doctrine to the new section 8(d) notice requirements. As previously mentioned, both the House and Senate reports specifically apply *Mastro Plastics* to section 8(g); however, neither report mentions the application of that doctrine to the section 8(d) notice requirements. It would seem that such specific reference to section 8(g) and no reference to section 8(d) is an expression of congressional intent not to apply *Mastro Plastics* to section 8(d). Moreover, it would seem as if the purpose of section 8(d), preventing patient care interruptions, could be better served by such an interpretation. The Board, however, has not taken this view and will apply *Mastro Plastics* to section 8(d). The Board justifies this application by the fact that the Supreme Court in *Mastro Plastics* specifically applied its decision to the preamendment section 8(d). It hardly seems persuasive that Congress intended this result in situations where the interest of patient care would be better served by not applying *Mastro Plastics*, particularly when no reference was made by Congress to section 8(d) and the application of *Mastro Plastics*.

A third problematic area which may arise in the future is the scope of bargaining topics to be considered mandatory bargaining issues in the hospital industry. As previously mentioned, the professional employee is concerned with many patient care issues. The problem with this is that patient care issues may be considered subjects which are reserved as management rights. Clearly, both parties in terms of legal liability and professional ethics have a stake in any decision involving patient care. The only case to date concerning the question of what a mandatory bargaining issue is for a hospital concluded that the special nature of the health care industry did not justify an exception to the general rule that interest arbitration is only a permitted bargaining subject. Whether or not

---

295. Id.
296. Id.
301. *NLRB v. Massachusetts Nurses Ass'n*, 557 F.2d 894 (1st Cir. 1977). Several decisions have addressed the issue of mandatory bargaining in a hospital, but the issue involved was not unique to hospitals, so there was no focus on the unique circumstances of the industry. See, e.g., *St. Mary's Hosp.*, 260 N.L.R.B. 1237, 109 L.R.R.M. 1343 (1982); *Briareliff Pavilion for Specialized Care*, 260 N.L.R.B. 1374, 109 L.R.R.M. 1383 (1982).
patient care issues will be considered mandatory issues is still unresolved. It is apparent in the hospital industry that the line between mandatory and permissive bargaining issues is indistinct.

Another issue which is sure to trouble health care institutions as employers is the application of the ally doctrine. Although the ally doctrine is clearly applicable to hospitals, it is not clear exactly how the doctrine will be applied in the hospital industry. The Board, in interpreting congressional intent, has concluded that: (1) secondary hospitals which supply critical personnel to take care of patients to maintain public health will be considered "neutral", and (2) secondary hospitals which supply non-critical help will be considered "allies." The real controversy, as yet to be resolved, is which help will be considered critical and which will be considered non-critical. Surely, in a modern hospital every employee's job is considered an integral part of assuring patients the best care. The difficulty will be in separating the necessary functions from those that are purely superfluous.

An additional source of potential conflict concerns the application of the Board's decision not to apply section 8(g) notice requirements to unorganized employees. As previously indicated, this decision has been extended to a situation where seventeen unorganized workers picketed. The real problem arises when large numbers of unorganized workers picket or when just a few unorganized pickets disrupt patient care. Clearly, a blind application of this Board rule could circumvent the congressional purpose in section 8(g) of assuring continuous patient care. One alternative would be to apply section 8(g) to unorganized employees only when patient health is endangered; this would balance the two congressional objectives of patient care and ease of expression for unorganized hospital workers. This very argument, however, was rejected in East Chicago Rehabilitation Center v. NLRB. Although the court in East Chicago recognized the merit of this argument, it correctly pointed out that the argument is addressed to the wrong body. The court further stated that this section was the product of legislative compromise, and a

---

302. Under the ally doctrine, certain neutral employers who perform the work of a struck primary employer become primary employers for the purposes of determining whether a section 8(b)(4)(B) violation (prohibition against secondary picketing) has been committed. For further explanation, see C.J. Morris, The Developing Labor Law 1165 (2d ed. 1983); GC Guidelines, supra note 236, at 15,096.

303. GC Guidelines, supra note 234, at 15,096.

304. Id. at 15,097.


306. See supra note 172 and accompanying text.

307. Long Beach Youth Center, 230 N.L.R.B. 648, 95 L.R.R.M. 1451 (1977) (the Board found no sacrifice of protected status under the Act, as section 8(g) does not apply to work stoppages by unrepresented employees).

308. 710 F.2d 397 (7th Cir. 1983).

309. Id. at 403.
Collective Bargaining in the Hospital Industry

Congress which explicitly applied section 8(g) only to labor organizations. Judge Coffey, in his dissenting opinion, aptly illustrated the various problems that can result when the application of section 8(g) is so restricted. Yet, if the hospital is truly concerned with patient care, it can implement a work rule requiring ten days notice, as recommended in Montefiore Hospital.

The First Circuit's recent decision in Massachusetts Nurses Ass'n v. Dukakis illustrates another area of concern for organized labor in the hospital industry. The court found that a Massachusetts statute limiting medical payment reimbursements was not preempted by the National Labor Relations Act. The court's decision was based on its conclusion that the state's police power encompassed medical cost payment plans. This decision could result in the effective abrogation of hospital employee collective bargaining rights. The court did state that "any pretextual, arbitrary, or capricious invocation of Chapter 372 as an excuse for refusal to bargain over wages or working conditions would present quite a different case, subject to different principles." Yet, regardless of the motive an employer might have for invoking the statute, the impact of federally created employee collective bargaining rights is the same; those rights are destroyed by state law.

CONCLUSION

The 1974 Amendments appear to have been successful in achieving much that was desired by Congress. No widespread patient care interruptions have arisen, and many hospital employees have taken advantage of the collective bargaining process. Despite this apparent success, the inherent conflict of these juxtapositional goals will continue.

The importance of balancing these concerns is illustrated by the current dispute regarding bargaining unit determinations. Once the Board and the courts recognize the need to balance the concerns of patient care and employee rights, a congruous system of bargaining unit determinations will evolve. It is important that neither of these concerns be ignored if the purposes of the 1974 Amendments are to be served.

Both the Board and the courts must be explicitly cognizant of the reasoning behind the Amendments and the varying effects a particular ruling may have on achieving the desired goals. This article has attempted to illustrate the conflicts that have arisen and those that may arise in the future. Various suggestions regarding ways to resolve these conflicts have also been made, with an eye toward better effectuating congressional policies.

310. Id.
311. Id. at 405.
312. See supra notes 177-79 and accompanying text.
313. 726 F.2d 41, (1st Cir. 1984).
314. Id. at 45.