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Author: David P. Twomey

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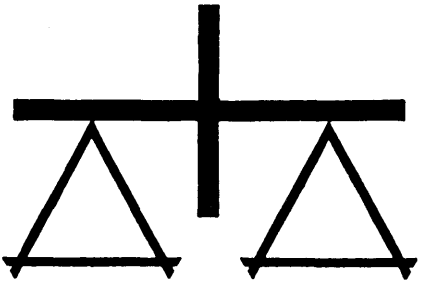

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HEALTH CARE INSTITUTIONS UNDER THE NATIONAL LABOR RELATIONS ACT

* DAVID TWOMEY

The purpose of this article is to examine the recent nonprofit hospital amendments to the National Labor Relations Act (NLRA)[1] and to place these amendments in the perspective of existing labor laws in the United States.[2] The article will first review the legislative background of the amendments and then present a study of labor relations in the health care industry under the Act. Congress left a number of statutory gaps that are currently being filled on a case-by-case basis by the National Labor Relations Board (NLRB) and by the courts. The developing case law is made a part of the presentation in order to present a complete picture of the underlying problems involved.

LEGISLATIVE BACKGROUND

The National Labor Relations Act of 1935 (Wagner Act)[3] expressly exempted governmental hospitals from its provisions, but no statutory reference was made to private, nonprofit hospitals.

* Associate Professor, Boston College.

[1] Labor Management Relations Act, 29 U.S.C. § 141 (Supp. IV 1974).

[2] The primary sources of existing labor law are the Labor Management Relations Act, as amended (specifically Title I of this Act), commonly referred to as the National Labor Relations Act or the Taft-Hartley Act, and decisions made pursuant to the Act by the National Labor Relations Board.

[3] Act of July 5, 1935, 49 Stat. 449.

In the NLRB's 1942 *Central Dispensary* decision,[4] however, the Board chose to exercise jurisdiction over a nonprofit hospital. In 1947, section 2(2) of the Act was changed by the Taft-Hartley amendments to exclude nonprofit hospitals from coverage,[5] and this exclusion remained in effect until enactment of the recent amendments.

The 1974 amendments to the National Labor Relations Act extended the coverage of the Act to some 1.5 million persons employed by private, nonprofit hospitals.[6] Congress enacted this legislation in the belief that the lack of unionization at these hospitals caused low wages, poor working conditions, and a lower standard of patient care. Testimony before Congress showed that the absence of coverage under the NLRA often resulted in recognitional strikes which disrupted patient care.[7] Coverage under the NLRA eliminates the need for any such activity, because the procedures of the Act are designed to resolve organization and recognition disputes. Congress, aware of the vulnerability of health care institutions to strikes, added amendments that apply to all nongovernmental health care institutions. These amendments set forth certain contract negotiation notices, impasse resolution procedures, priority NLRB case handling procedures, and specific strike notice requirements.

Rights of Employees Under the NLRA

The keystone of the NLRA is contained in section 7. This section specifies that all employees covered under the Act have the right to participate or refrain from participating in "concerted activities." The phrase "concerted activities" means employees acting together in an organized manner. Examples of concerted activities include organizational activities, the negotiation and ratification of collective bargaining agreements, and legal strike or picketing activities in furtherance of employee goals.

[4] 44 N.L.R.B. 533 (1942), *enforced,* 145 F.2d 852 (D.C. Cir. 1944).

[5] Section 2(2) of the Act contained the following exemption: "[A]ny corporation or association operating a hospital, if no part of the net earnings inures to the benefit of any private shareholder or individual. . . ." 29 U.S.C. § 152(2) (Supp. I 1971).

[6] 29 U.S.C. § 152 (1974).

[7] 120 Cong. Rec. 4587 (daily ed. May 30, 1974).

When a hospital banned the wearing of union insignia buttons of an organizing union, but permitted and even encouraged employees to wear "Hospital Week, Doctors' Day and St. Patrick's Day buttons, despite a dress code provision to the contrary, the NLRB concluded that the Act had been violated.[8] The Board held that enforcement of the dress code was not intended to meet any legitimate need to protect patients, but rather was designed to thwart the union's organizing campaign.[9]

JURISDICTION

The National Labor Relations Board's broad discretionary authority, based on administrative and policy considerations, is intended to establish specific monetary standards for determining whether an employer's actions have affected interstate commerce and hence are within the Board's jurisdiction.[10] Prior to the new statute, the NLRB exercised its jurisdiction over proprietary hospitals, *i.e.,* hospitals operated for a profit, where the total annual revenue was $250,000 or more. The NLRB's jurisdictional standards for proprietary nursing homes was established as $100,000. The new legislation, section 2(14), defines a health care facility as follows: "The term "health care institution" shall 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 person(s)." It is apparent that section 2(14) offers a comprehensive definition of a health care institution, and it includes profit institutions which are already under NLRB jurisdiction and nonprofit institutions. It is important to point out that employees of municipal, state, and federal health care institutions are not covered by the new law.[11] It also should be noted that the NLRB's jurisdictional

[8] St. Joseph's Hosp. v. North Cent. Tex. Laborer's Dist. Council, 225 N.L.R.B. No. 28, [1975-76] NLRB Dec. ¶16,984 at 28,148 (1976).

[9] *Id.*

[10] 29 U.S.C. § 152(6) and 152(7) (Supp. I 1971).

[11] Section 2(2) of the Act exempts "the United States or any wholly owned Government corporation . . . or any State or political subdivision thereof. . . ." *See* Camden-Clark Memorial Hosp., 221 N.L.R.B. No. 160, [1974-1975] NLRB Dec. ¶16,620 (1975).

The ramifications of public sector health care collective bargaining are beyond the scope of this paper. It should be pointed out, however, that wages, benefits, and conditions won by employees in the private sector of the health care industry are very often achieved on

standards remain unchanged for proprietary hospitals and nursing homes. In the *Shriners Hospitals* case,[12] the Board stated that it is not yet ready to set forth specific monetary standards for nonprofit hospitals.

Jurisdiction Over Supervisors

Supervisors are excluded from the provisions of the NLRA through section 2(3) of the Act as defined in section 2(11). Section 2(11) defines the term "supervisor" to mean "[a]ny individual having authority, in the interest of the employer, to hire, transfer, suspend, lay off, recall, promote . . . or discipline other employees . . . or responsibility to direct them. . . ."

In *Doctors Hospital and Ohio Nurses Association,*[13] the Board dealt with the question of whether certain registered nurses were "supervisors" and thus not employees protected under the NLRA. The union sought to represent a unit of full-time and part-time registered nurses employed at the employer hospital's two facilities. Among other matters, the employer urged that registered nurses classified as house directors and coordinators should be excluded from the unit as supervisors. The Board rejected the union's contentions that the supervisory functions of the "house directors" were exercised in the patients' interests rather than in the employer's interests and therefore house directors should not be treated as supervisors. The Board found that although the "house directors" did not have authority to hire and fire, they were salaried employees rather than hourly employees; hence, they had the power to call in additional personnel, and

a "comparability" basis by the public sector of the industry. The federal government, and an ever-increasing number of state and local governments, are accepting the concept of collective bargaining for public employees. In all but three states, public employees in the health care industry do not have the right to strike as do their counterparts in the private sector under the 1974 amendments. As a substitute for the right to strike, fact finding and, in some instances, "binding arbitration" are provided by executive order or statute. Two major countervailing factors utilized by fact finders and arbitrators to resolve impasses in public sector collective bargaining are comparisons of wages and benefits of other employees performing similar services in private employment and the ability of the public employer to pay. As society's ability to pass on the increased costs of settlements to patients and taxpayers is reached, the ability of public sector health care employees to achieve comparable economic benefits without resort to strikes may be difficult to achieve.

[12] 217 N.L.R.B. No. 138, [1974-1975] NLRB Dec. ¶ 15,701 (1975).

[13] 217 N.L.R.B. No. 87, [1974-1975] NLRB Dec. ¶ 15,688 (1975).

their recommendations with regard to disciplinary action were often followed by higher authorities. "House directors" were thus excluded from the unit as supervisors. The Board considered the position of "coordinators" to be nonsupervisory and included them in the bargaining unit with registered nurses because they lacked effective power to discipline or to make recommendations concerning section (11) criteria.

Section 14(a) should also be referred to in assessing the implications of the section 2(3) exclusion. Section 14(a) points out that nothing in the Act prohibits a supervisor from joining a labor union or remaining a member of one; however, employers are not compelled by law to recognize or to bargain with them. The rationale for this exclusion is based on the concept that supervisors are management representatives and, as such, owe their primary loyalties to management.

Jurisdiction: Hospital Housestaff

The NLRB, in the *Cedars-Sinai Medical Center* decision,[14] found that a medical center's housestaff personnel, including interns, residents and clinical fellows, were primarily students engaged in graduate educational training, and hence were not granted rights under the NLRA. The Board concluded that interns, residents, and clinical fellows are not "employees" within the meaning of section 2(3) of the Act.[15] The Board recognized that they possess certain employee characteristics, but found that the housestaff participated in the hospital programs principally as a prerequisite to the practice of medicine and not to earn a living; therefore, their stipends were deemed to be mere living allowances and not compensation for hours worked.[16]

Preemption

Generally, the doctrine of preemption means that if the federal government acts in a particular area where it has authority to act, then the states are precluded from acting in that same area. The

[14] Cedars-Sinai Medical Center and Cedars Sinai Housestaff Ass'n, 223 N.L.R.B. No. 57, [1975-1976] NLRB Dec. ¶ 16,690 at 27,511 (1976).

[15] *Id.*

[16] *Id.* at 27,509 and 27,511.

NLRA has consistently been viewed as preempting existing state laws.[17] The General Counsel of the NLRB addressed the preemption issue in the *Guidelines Issued by the General Counsel for Use of Board Regional Offices in Unfair Labor Practices Arising under the 1974 Nonprofit Hospital Amendment to the Taft Hartley Act.*[18] It is the General Counsel's view that all state labor relations laws concerning health care institutions must yield to the new federal law.[19] The result will be a uniform policy for all health care institutions throughout the country that meet the jurisdictional requirements of the Act.[20]

Remedial Powers of the Board

Under section 9 of the NLRA, the Board has authority to issue appropriate orders to remedy a broad range of violations concerning representation matters in the health care industry, including ordering a re-run election.[21] In the case where an employer's conduct is so pervasive as to render a fair re-run election unlikely, the Board may certify the union based on a prior authorization card majority.[22]

Under section 10(j) of the Act, the Board has discretionary authority to seek temporary injunctive relief in a federal district court to maintain the status quo in unfair labor practice cases while the parties are awaiting the resolution of their basic dispute before the Board. Section 10(1) requires the Board to seek temporary injunctive relief in matters involving secondary boycotts and recognitional picketing.

Under section 10(c) of the Act, the Board is given power to order that wrongfully discharged employees be reinstated with or

[17] *See, e.g.*, San Diego Building Trades Council v. Garmon, 359 U.S. 236 (1959), Myers v. Bethlehem Shipbuilding Corp., 303 U.S. 41, (1938). *See generally* Motor Coach Employees v. Lockridge, 403 U.S. 274 (1971); Letter Carriers v. Austin, 86 LRRM 2740 (1974).

[18] 4Lab. L. Rep. (CCH) ¶ 9046 (1976) [hereinafter cited as *Guidelines*].

[19] *Id.* at 15,102.

[20] Section 10(a) continues to empower the NLRB to grant jurisdiction over "cases in any industry" to states with consistent provisions in their state laws. The Board could then, at its discretion, return jurisdiction over health care institutions to selected states. Minnesota's Charitable Hospital Act has, for example, had great success over a period of 27 years.

[21] Restaurant Associates, 194 L.L.R.B. No. 172 (1972).

[22] NLRB v. Gissel Packing Co., 395 U.S. 575 (1969).

without back pay. The Board is also empowered under this section to require employers to post notices that the employer will not engage in further discriminatory activity.[23] The Board, however, may not order a party who has committed an unfair labor practice to agree to specific contractual items.[24]

In his *Guidelines*, the General Counsel recognized that Congress intended that controversies arising in the health care industry were to receive priority handling before the Board; therefore, he set up priority procedures for Board personnel to follow.[25]

An Overview of Representation Case Procedures

Section 9 of the NLRA provides the administrative machinery for certification of a majority representative in an appropriate unit. A "representation case" begins when an employee, group of employees, or an individual labor organization files a petition for certification with the appropriate regional director of the Board. The petition contains a description of the collective bargaining unit sought or in being, the nature of the employer's business (health care institution), the approximate number of employees in the unit, and the names of all interested unions who may claim to represent employees. The petitioning party must present satisfactory evidence to the Board that at least 30% of the group involved has shown some support for the request to hold an election. Such support is usually indicated in the signed and dated "authorization cards."

After a petition is filed, the Board decides whether its jurisdictional requirements have been met, whether the required 30% showing of interest by employees has been met, and whether the bargaining unit involved is appropriate. If the Board concludes that the above requirements have been met and thus finds the petition valid, the Board itself will conduct a union certification election. If a majority of the employees in the designated unit vote to be represented by the union, the Board then certifies the union as the bargaining agent for the employees.[26] Problems often

[23] Phelps Dodge Corp. v. NLRB, 313 U.S. 177 (1941).
[24] H.K. Porter Co., v. NLRB., 397 U.S. 99 (1970).
[25] *Guidelines*, *supra* note 18 at 15,102.
[26] Section 19 of the Act provides for an exemption freeing individuals from joining or

arise concerning the appropriateness of the bargaining unit and the election conduct of the parties involved. These topics are considered in the following two sections.

The Appropriate Bargaining Unit

A union will often urge the appropriateness of a unit that it believes has the best chance to win a majority. By contrast, an employer will often argue that a particular unit is appropriate when it knows that the union cannot achieve a majority therein. In the absence of an agreement between the parties, the NLRB determines the appropriateness of the bargaining unit. In *Barnert Memorial Hospital,*[27] however, the Board held that it will not honor stipulations of the parties that are contrary to its policy. It concluded that licensed practical nurses are "technical" employees who must be included in such a unit even though the parties stipulated that they be excluded.

In the past, the Board has utilized a number of factors to decide the appropriate unit. When deciding whether a multifacility employer should be aggregated into one unit or be constituted as separate units, the Board has considered, among others, the following factors:

1. Physical location and degree of common ownership.
2. Managerial integration.
3. The extent of organization, *i.e.*, the degree to which employees, working in individual facilities of a multifacility employer, are currently organized.
4. The degree of skill required by the particular job under consideration.
5. The community of interest of the employees.
6. The collective bargaining history of the employer, and the history and practice of collective bargaining in the industry as a whole.

The Board has unique flexibility when determining the appropriateness of bargaining units in the health care industry. Hospitals and other types of health care institutions are especially vulnerable to a multiplicity of bargaining units due to the many

supporting a labor organization where such individuals' religious convictions are contrary to such support and participation. The individuals must, however, donate an equivalent amount, via a statutory selection process, to a charitable fund.

[27] 217 N.L.R.B. No. 132, [1974-1975] NLRB Dec. ¶ 15,692 (1975).

professions and job classifications involved in the delivery of health care services. The principal thrust of the legislative history of the health care amendments to the Act admonishes the Board to avoid undue proliferation of bargaining units in the health care industry.[28] The Senate Committee Report emphasizes that

> Due consideration . . . be given by the Board to preventing proliferation of bargaining units in the health care industry. In this connection the Committee notes with approval the recent Board decisions . . . as well as the trend towards broader units enunciated in *Extendicare of West Virginia,* 203 N.L.R.B. 1232 (1973).[29]

With this Congressional intent in mind, the Board has recently decided a number of cases dealing with appropriate bargaining units. A pattern has emerged from the Board decisions that sets forth criteria for ascertaining the appropriateness of bargaining units involving professional, technical, clerical, service and maintenance, and security employees.

Two essential characteristics of professional work as set forth in section 2(12) of the NLRA are advanced training and the exercise of discretion. In *Mercy Hospitals of Sacramento, Inc.,*[30] the Board approved a separate professional unit of registered nurses, noting that it is of great significance that registered nurses have a history of separate bargaining and representation, often as a result of voluntary recognition. Other factors in the Board's decision were that, unlike most professionals, nurses are required to be on call 24 hours a day. Also, nurses are licensed by the states and all hiring, firing, and regulation of working conditions occurs in the confines of the department of nursing. In its *New York University Medical Center* decision,[31] the Board found that psychiatrists employed at a mental health facility were not an appropriate unit. Among the factors that would necessitate their inclusion with other physicians, and perhaps other health care professionals, were the congressional limitation on bargaining units for the health care industry and the similarity of working conditions for all physicians.

In the health care field, the Board continues to approve sepa-

[28] S. REP. No. 766, 93d Cong., 2d Sess. 5 (1974).
[29] *Id.*
[30] 217 N.L.R.B No. 131, [1974-1975] NLRB Dec. ¶ 15,702 (1975).
[31] 217 N.L.R.B No. 116 [1974-1975] NLRB Dec. ¶ 15,669 (1975).

rate units of technical employees. In *Barnert Hospital,*[32] the Board defined technical employees as those whose specialized training, skills, education, and job requirements establish a community of interest not shared by other service or maintenance employees. A separate community of interest is frequently evidenced by the fact that such employees are licensed or certified. Examples of "technical" job classifications that make up a "technical" unit are psychiatric technicians, X-ray technicians, respiratory care technicians, licensed practical nurses, and laboratory technicians.[33] Examples of job classifications not included in "technical" units are EKG technicians, EEG technicians, and dark room technicians. The reason for this is that their training usually takes place on the job, continues for a short period of time, and requires no independent judgement.[34]

In the *Mercy Hospitals of Sacramento*[35] and *Sisters of St. Joseph of Peace*[36] decisions, the Board held that business office clerical employees, including switchboard operators, admitting employees, patient billing employees, credit department employees, accounts payable clerks, business office cashiers, and data processing coordinators constituted an appropriate unit.[37] The Board stated in *Mercy Hospitals* that "in the health care field it will continue to recognize a distinction between business office clerical employees, performing mainly business type functions, and other types of clerical employees whose work is more closely related to the function performed by personnel in the service and maintenance unit.[38]" Examples of the latter include medical records clerks, pharmacy clerks, and ward clerks.

Service and maintenance units commonly include all employ-

[32] Barnert Hosp., *supra* note 27, at 26,057. For further analysis of technical employee units, see Newington Children's Hosp., 217 N.L.R.B. No. 134, [1974-1975] NLRB Dec. ¶ 15,696 (1975).

[33] Barnert Hosp., *supra* note 27, at 26,057. *See also* Pinecrest Convalescent Home, 222 N.L.R.B. No. 10 [1975-1976] NLRB Dec. ¶ 16,891 (1976).

[34] Barnert Hosp., *supra* note 27, at 26,057.

[35] Note 30 *supra.*

[36] 217 N.L.R.B. No. 135, [1974-1975] NLRB Dec. ¶ 15,693 (1975).

[37] *See also* St. Catherine's Hosp., 217 N.L.R.B. No. 133, [1974-1975] NLRB Dec. ¶ 15,691 (1975).

[38] Note 30 *supra,* at 26,073. *See also* Mercy Hosps., 224 N.L.R.B. No. 58, 5 LAB. L. REP. (CCH) ¶ 16,885 (1976).

ees who are not technicals, professionals or office clericals.[39] In the situation of employees at a university hospital where there was a university-wide maintenance bargaining unit prior to the 1974 amendments, the hospital employees were entitled to vote on whether they wish to be consolidated into the university-wide unit or be certified as a separate unit.[40]

Under section 9(b) of the Act, the Board may not include hospital guards in a unit with other employees. If the duties of a watchman or janitor include any significant part of guard duties, the employee may not be included in a service and maintenance unit.[41]

Election Conduct

The Btard has developed a body of rules that impose restrictions on the pre-election activities of the parties. Any violation of these rules may be grounds for setting aside an election. No electioneering acivities are permitted at polling places.[42] A "24-hour rule" prohibits both unions and employers from delivering captive audience speeches within 24 hours of an election.[43] The Board's "Excelsior Rule" requires employers to provide interested unions with the names and addresses of all employees qualified to vote.[44] The rationale is that the union as well as the employer should have an opportunity to expose every employee to all arguments concerning the advantages and disadvantages of unionization. Where there is a pre-election misrepresentation of facts by an employer or by a union, the Board will apply the *Hollywood Ceramics*[45] tests and, where satisfied, set aside the

[39] *See* St. Catherine's Hosp., *supra* note 37.

[40] *See* Duke University, 217 N.L.R.B. No. 136, [1974-1975] NLRB Dec. ¶ 15,694 (1975). See also West Suburban Hosp., 224 N.L.R.B. No. 100, [1975-1976] NLRB Dec. ¶ 16,958 (1976).

[41] *See* North American Aviation, 161 N.L.R.B. 297 (1966).

[42] Michelm, Inc., 170 N.L.R.B. 46 (1968); Alliance Ware, Inc., 92 N.L.R.B. 55 (1950).

[43] Peerless Plywood Co., 107 N.L.R.B. 427 (1953).

[44] Excelsior Underwear, Inc., 156 N.L.R.B. 1236 (1966). *See also* Brotman Memorial Hosp., 217 N.L.R.B. 558 (1975), where the Board refused to set aside an election where 12% of the addresses on the Excelsior list were incorrect but where the original list was based on the best information available to the employer.

[45] Hollywood Ceramics Co., 140 N.L.R.B. 221 (1962). *See also* Bauch and Lomb, Inc. v. NLRB, 451 F.2d 873 (2d Cir. 1971).

election. Those tests include: whether (1) the misstatement was of a material fact; (2) the opposition did not have time to reply; (3) the perpetrator was in a position to have "special knowledge" of the facts; and (4) the employees lacked independent knowledge of the true facts.

Notice Requirement of the New Amendments

Section 8(d) of the Act imposes a mandatory duty upon the parties to negotiate in good faith to reach an agreement concerning wages, hours, and other terms and conditions of employment. The Labor Management Relations Act of 1947 established the Federal Mediation and Conciliation Service (FMCS) to assist the parties to resolve any impasse concerning the achievement of initial agreements or the renegotiation of existing agreements. Prior to the 1974 amendments, the parties were not required to engage in mediation. The new nonprofit health care amendments extend the required 8(d)(1) 60-day notice to the non-initiating party in contract renegotiation situations to 90 days in the health care industry.[46] The 8(d)(3) 30-day notice to the FMCS is extended to 60 days.[47] In matters involving bargaining for an initial agreement, the initiating party must render a 30-day notice to the FMCS.[48] Section 8(d)(C) requires the FMCS, upon receipt of notice, to communicate promptly with the parties and attempt by mediation to bring them to an agreement. The General Counsel's *Guidelines* indicate that should any party refuse to participate fully and promptly in meetings undertaken by the FMCS, it will be an 8(a)(5) "refusal to bargain" unfair labor practice.[49] During all of the above-mentioned notice periods, the parties are prohibited from resorting to strikes or lockouts.[50] Section 8(g) adds an additional time limitation of 10 days onto the previous notice requirements. It requires that a 10-day notice be given to the institution and the FMCS be advised of a labor organization's intent to strike or picket. The notice is intended to provide the institution with advance warning of strike and picketing activity

[46] 29 U.S.C. §158(d)(A) (Supp. IV 1974).
[47] *Id.*
[48] 29 U.S.C. §158(d)(B) (Supp. IV 1974).
[49] *Guidelines, supra* note 18, at 15,076.
[50] 29 U.S.C. §158(d) (Supp. IV 1974).

so that the institution can make arrangements for the continued care of patients.

The purpose of the above provisions is to offer ample time and mediation talent to enable the parties to reach an agreement. If no agreement can be reached, then planning and implementation time is provided in order to insure continuity of patient care in the event of a strike.

Fact Finding Under the New Amendments

The 1974 law adds an entirely new section, section 213, which gives the Director of the FMCS the authority to establish an impartial Board of Inquiry when a threatened or actual strike has the capability of substantially interrupting the delivery of health care service in a community. In practice, the Board of Inquiry consists of one neutral person sitting as a fact finder, who conducts hearings during which the opposing parties define the issues in dispute and offer their prospective resolutions with supporting evidence and argument. A written report by the fact finder containing findings of facts and recommendations is required within 15 days after the establishment of the Board. In writing his or her report, the fact finder typically considers such major factors as (1) a comparison of the annual income of employees in question with the annual income of employees working in similar size enterprises in the same locality and state; (2) adequate provisions for job security and fringe benefits, including health care, pensions, vacations, sick leave, and holidays; and (3) cost of living considerations.[51]

The time constraints of section 213(a) make the use of the fact finding boards quite difficult. The Boards must be established within the first 30 days of the mandatory mediation period, or, in the initial contract situation, within the first 10 days of the period.[52] The FMCS then has just 10 to 30 days to process and

[51] Congressman Thompson, a co-sponsor of the original House version of the amendments, described eight factors to be considered and discussed by fact finders in their reports. In addition to the three factors set forth in the body of the article, they are career advancement, equal employment opportunity, equal pay, provisions for resolution of grievances without strikes, and job training and skills. 120 Cong. Rec. 6392 (daily ed. July 11, 1974). An additional crucial factor is the employer's ability to pay.

[52] LMRA § 213(a), 29 U.S.C.A. § 183(a) (Supp. V 1975).

appoint a fact finder.[53] Within 15 days after the initial appointment, the fact finder must contact the parties, set a hearing date, conduct proceedings in a manner which will allow all the parties to fully present their evidence and arguments, study the written submissions of the parties, which very often contain extensive economic data for comparability purposes, and then write a report with recommendations. The fact finder has little advance notice of his or her appointment to a Board of Inquiry and, more than likely has made other professional commitments during the 15 day period. The 15 day period is so constrained that many highly competent fact finders will not accept appointments to boards of inquiry. If section 213 were amended to allow for reasonable extensions of this 15 day requirement by the agreement of the parties and with the approval of the designee of the Director of the FMCS, it would give the fact finding process some much needed flexibility to accommodate the differing degrees of complexity in each case and the scheduling difficulties of both the parties and the fact finders. As the process presently operates, the 15 day period causes very many neutrals to refuse appointments, which, in turn, makes it very difficult for the FMCS to administer the appointment process within the statutory 10 to 30 day period.

Reinstatement Rights of Strikers

Reinstatement rights of strikers vary depending on the cause of the strike and the status of individual strikers. Section 8(d) of the Act, as amended, provides that "any employee who engages in a strike within any notice period . . . or who engages in any strike within the appropriate period specified in subsection (g) of this Section, shall lose his status as an employee. . . ." An individual who has lost his or her employee status, where there is no "serious" or "flagrant" employer unfair labor practice present or no 8(g) related "undermining of the bargaining relationship" by

[53] Appointments are made from the roster of arbitrators maintained by FMCS Office of Arbitration Services. This roster contains the names of individuals who engage in arbitrating grievances in both the public and private sector. Many of the individuals listed on this roster schedule grievance arbitration cases weeks and months in advance, thus precluding their availability for service as fact finders. A sufficient number of highly qualified, impartial individuals with backgrounds in law, education, public administration and finance, however, are available to serve as fact finders.

the employer, has no reinstatement rights whatsoever.[54] Thus, all the notice requirements outlined in the previous section are most significant and must be followed carefully by the labor organization. Otherwise, employees involved in strike activity may lose their status as employees.[55]

The legislative history of section 8(g) makes it clear that where a health care institution engages in "serious" or "flagrant" unfair labor practices,[56] a un on's protest of such unfair labor practices by the use of strikes or picketing would be viewed as privileged, despite the absence of proper 8(g) notices.[57] Employees engaging in a so-called "unfair labor practice strike" have an unlimited right to reinstatement. In addition to reinstatement, the Board has authority to order back pay awards.[58]

Employees who engage in an "economic strike, "*i.e.*, a legal strike to obtain improved wages, hours, or conditions of employment, have more modest reinstatement rights. An employer may hire permanent replacements for economic strikers.[59] If their jobs are not taken by "permanent replacements" during the period of the strike, then they are entitled to reinstatement. Based on the Board's "Laidlaw Rule," economic strikers not rehired at the temination of a strike because their positions have been filled by permanent replacements, remain employees and are entitled to full reinstatement upon the departure of their replacements.[60]

[54] *See* GENERAL COUNSEL'S THIRD MONTHLY HOSPITAL REPORT, 88 LAB. REL. REP. (BNA) 182 (1975).

[55] Employees who engage in picketing contrary to section 8(g) do not lose their status as employees. See GENERAL COUNSEL'S SECOND MONTHLY HOSPITAL REPORT, 88 LAB. REL. REP. (BNA) 104 (1975).

[56] The employer unfair labor practices are defined in sections 8(a)(1) through (5) of the Act. The following is prohibited: interference, restraint, and coercion of employees as to their section 7 rights [§ 8(a)(1)]; domination of unions, including employer interference with the administration of, or the furnishing of financial assistance to, labor organizations [§ 8(a)(2)]; discrimination against employees for union activity by affecting employees' terms of hire, tenure, and working conditions [§ 8(a)(4)]; refusal to bargain with the authorized representative of the employees [§ 8(a)(5)].

[57] *See* GENERAL COUNSEL'S SECOND MONTHLY HOSPITAL REPORT, *supra* note 55; GENERAL COUNSEL'S FOURTH MONTHLY HOSPITAL REPORT, 88 LAB. REL. REP. (BNA) 283 (1975).

[58] Mastro Plastics Corp. v. NLRB, 350 U.S. 270 (1956).

[59] NLRB v. MacKay Radio and Telegraph Co., 304 U.S. 333 (1938).

[60] Laidlaw Corporation, 171 N.L.R.B. 175 (1968).

THE "ALLY" DOCTRINE

Section 8(b)(4) of the Act protects unoffending, innocent, or neutral third parties from labor disputes which are not their affair. It is well-settled that an employer who performs the "struck work" of a primary employer is not an innocent or neutral third party and hence is not protected under section 8(b)(4).[61] As outlined above, the Act imposes notice and mediation requirements on labor organizations before they may legally strike or picket in order to insure that emergency plans can be worked out for the continuity of health care to the community. The question is then raised whether an institution that provides assistance to another institution that is currently engaged in a strike or is about to be struck enmeshes the assisting institution into the primary dispute, rendering it an "ally" of the other. The Senate Committee concluded that certain assistance to a health care institution that was about to be struck would not cause a secondary employer to lose its neutral status.[62] In the General Counsel's *Guidelines* it is provided that retention of "neutral" status is preserved by an institution that accepts patients from the primary employer or supplies critical help to the primary employer. In this manner, the public health of the community can be maintained. However, if the "neutral" supplies noncritical personnel, it loses its status.[63] It is the General Counsel's opinion that an "ally" institution is nevertheless entitled to an 8(g) 10-day strike notice to make and implement emergency plans to care for its patients.[64]

CONCLUSION

The 1974 amendments to the NLRA were intended to include under the Act all nongovernmental employees in the health care industry. The law provides for the orderly recognition of bargaining units. It also sets forth impasse resolution machinery and, if a strike situation should occur, a special strike notice is required

[61] Douds v. Metropolitan Fed'n, 78 F. Supp. 672 (S.D.N.Y. 1948).

[62] 119 CONG. REC. 6,941 (daily ed. May 2, 1974); 120 CONG. REC. 12,105 (daily ed. July 10, 1974).

[63] *Guidelines, supra* note 18, at 15,096.

[64] *Id.* at 15,082. *See also* J. Fleming, *Is the Good Samaritan an Ally,* 49 FLA. B.J. 97 (1975).

to provide time to plan for the continuity of patient care.

As expected by many, a surge to organize employees of nonprofit hospitals is now taking place. In the first year under the Act, 1,659 representation petitions from the health care sector were filed with the NLRB, up from 461 from the profit-making sector of the industry during the privious year.[65] Unions won 62.5% of elections conducted by the NLRB in the hospital sector during the first year, as compared with a 50% success rate for all industries in the United States during the same period.[66]

The success or failure of the nonprofit hospital amendments will be judged by the frequency and seriousness of interruptions to patient care because of strikes. Indeed, if a patten of frequent and serious strikes develops, Congress will most likely place additional limitations on a union's right to strike. Although the nature of a health care industry strike is such that it may become a major national news item,[67] the information available at this time concerning strikes throughout the industry is quite favorable. For example, 20 strikes occurred in hospitals from August 1974 through July 1975 and all but one occurred during negotiation impasses.[68] During the first year, work stoppages involved only 4% of all health care bargaining negotiations, in contrast with 15% for all other industries.[69] It is too early to assume that the 1974 amendments to the Act have been a stunning success; however, if labor unions and hospital administrations continue to pursue responsible collective bargaining, the future appears structurally sound for meaningful and peaceful labor relations in the health care industry.

[65] Rosmann, *One Year Under Taft-Hartley,* HOSPITALS, Dec. 1975, at 64.

[66] *Id.*

[67] *E.g.*, the 11-day strike of 57 hospitals and nursing homes in New York City by 37,000 Workers in July, 1976. The strike ended when the union and hospitals agreed to submit the unresolved issues to binding arbitration. The hospitals had resisted binding arbitration, contending that the state, in holding down reimbursement rates from Medicaid and Blue Cross, made it impossible for the institutions to pay any wage increases that an arbitrator might order. A major negative aspect of the strike, other than the expected curtailment of health care services, was that 130 strikers were arrested in picket-line incidents. *See* New York Times, July 18, 1976, § 1, at 1, col. 6 and at 36, col. 4.

[68] Rosmann, *supra* note 65, at 67.

[69] *Id.*