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Nearly 400,000 people are employed in the more than 900 Catholic-sponsored hospitals, nursing homes, extended care facilities, and specialty health care institutions. These employees range from highly paid, highly skilled physicians to scrub women and janitors at the bottom of the wage and skill category. The human relations problems in bringing all of these diverse groups together in a work effort is nearly as complex as the end product of that work effort, human life itself.

Catholic health care facilities, except in their philosophy toward the purposes and preservation of life, do not substantially differ from similar health institutions with which they must relate, and, in some cases, even compete. They are subject to the same economic pulls and restraints. They are engulfed in the same sociopolitical morass which has entwined the American health care delivery system. They are buffeted by strong-willed physician groups on the one hand and bureaucratic redtape on the other. Their fiscal integrity and economic future are subject to forces beyond their control. And most recently, they have been faced with concentrated attempts at employee organization and unionization.

Originally covered by the National Labor Relations Act of 1935, not-for-profit hospitals have always had a separate colume in the history of federal labor law in this country. Because of the many divergent job categories existent in a hospital, because of the social dedication of so many of its employees, and because the product of health care delivery was so very different from that provided by other industries, the health care industry had never been subjected, except in a few isolated areas of the Northeast and northern California, to very intense unionization pressure. Following World War II, this tacit distinction became a formalized one when the not-for-profit hospital industry was singled out and excluded by the Taft-Hartley amendments from coverage under the NLRA.

In the years following the change, hospital labor organization was haphazard at best and nearly impotent at worst. In a few states local legislation or court decisions had opened the nonprofit industry to organi-

zation under state labor laws.[1] In some of these areas, notably New York, Connecticut, and Massachusetts, labor organization in the hospital field became quite extensive and very militant, especially among blue collar nonprofessionals. On the whole, however, nearly 2 million employees remained unorganized by any of the modern American industrial unions.

Unfortunately, but for historically sound reasons, employees in the health sector of the nation's economy have been traditionally among the lowest paid. This has been true at all levels, including some highly skilled professional areas, with the one notable exception of the physician. In the past, health workers were assumed to be motivated more by their social service dedication. Hospitals were financially dependent upon charity and volunteer services, both additional factors breeding a low-pay mentality. Over the years these inequities bred discontent and pressure to change the existing legal structures.

Catholic health facilities were not immune to these pressures. In fact, if anything, the social service motivation of a Catholic-sponsored facility may have led in some cases to even greater dichotomies and potential inequity. As the movement toward a change in the law accelerated, hospital trade associations were forced to speak out more and more on the subject in an attempt to preserve the special treatment accorded their member hospitals. Faced with these same pressures and challenged by a Catholic theological teaching on social justice, Catholic hospitals took an early position supporting the right of health workers to organize, but at the same time attempting to distinguish the uniqueness of the industry, its product (human life), and its obligations to provide uninterrupted health care.

In 1967, a statement was issued by The Catholic Hospital Association which attempted to incorporate all of the apparently divergent views into a single, cohesive policy to govern Catholic health care facilities, in relation to this issue.[2] That statement continues to be as valid today as it was in 1967. It is a view which can provide a workable solution to the problem which, in all too many cases, has erupted into embarassing and potentially disastrous situations.

In effect, Catholic hospitals did not oppose the removal of the Taft-Hartley amendment, excluding not-for-profit hospitals from NLRA coverage. They recognized the rights of their employees, in particular circumstances, to come together for collective bargaining purposes and to seek representation by a labor union. They also sought to strike a balance to

[1] *See* Kahn, *The NLRB and Higher Education: The Failure of Policymaking Through Adjudication*, 21 U.C.L.A.L. REV. 63 (1973); *cf.* Finkin, *The NLRB in Higher Education*, 5 TOLEDO L. REV. 608 (1974).

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protect the patient and the civic communities serviced by the hospitals from being endangered by strikes and work stoppages. From the very beginning in the legislative process, which ultimately was to lead to a change in the law and a removal of the exemption, Catholic hospitals supported the workers' right to organize, but, at the same time, sought to limit the possibility of disruption and potentially fatal work stoppages.

The Catholic Hospital Association had hoped that the proposed changes in the federal labor law could be accomplished along the following lines:

> 1. A recognition of employee rights and coverage under the National Labor Relations Act for all employees in the health care industry, including employees in Catholic-sponsored facilities;
> 2. A limitation, including, under certain circumstances, an absolute prohibition on the right of health care employees from engaging in certain types of picketing, work stoppages, and strikes;
> 3. A limitation on the number and classification of bargaining units which might be deemed appropriate in the health care industry;
> 4. An extension and liberalization on all notice periods and mediation requirements under the Act; and
> 5. A relaxation of the NLRB's so-called "ally doctrine" which would have prohibited mutual aid agreements between hospitals for the maintenance of critically needed supplies and services.

The Congressional deliberations on the issue of coverage for hospital employees extended over several years. In 1973, it became obvious to other hospital representatives that the loss of the exemption was inevitable. Strategy began to shift and the CHA position became more acceptable to a general hospital industry which had earlier opposed any change in the status quo. By 1974, Congress was ready to act.

The changes in the NLRA, which became effective August 25, 1974 (the Health Care Amendments of 1974, Public Law 93-360), did not meet the criteria spelled out by The Catholic Hospital Association. The health care industry, except for a few minor exceptions, was equated with all other industries in total disregard for its uniqueness, both in structure and in product. With the exception of a provision protecting certain religious beliefs of conscientious objection to union membership, no specific special handling was accorded religious hospitals. The new law makes only the following distinctions for health care facilities:

> 1. Provides for a 90-day notice by the employer or labor organization of intent to renew or modify a contract (instead of a 60-day notice, which is required of other industries);
> 2. Mandates involvement by the Federal Mediation and Conciliation Services (FMCS) and lengthens the notice requirements (no such mandatory FMCS participation is required of other industries);
> 3. Provides that any labor organization must give a written 10-day notice to the health care institution and to the FMCS of its intent to picket, strike

and/or engage in any other concerted refusal to work (strikes and picketing are permitted subject only to a 10-day notice); and

4. Provides that the director of FMCS may, at his discretion, establish "impartial boards of inquiry" to investigate labor/management disputes and to make written reports and recommendations (no corresponding authority exists for any other industry).

In addition to these items specifically delineated in the law, Congress, in an unfortunate exercise of timidity, sought to "clarify" certain other matters, not by forceful action in the law itself, but by rather vague statements of "congressional intent." In the Senate Committee Report accompanying the bill, "advice" was given to the National Labor Relations Board on how to interpret the new law. The Board was to:

1. Avoid the fragmentation of bargaining units in health care institutions;
2. Establish a system to give priority handling to cases involving health care facilities; and
3. Allow certain transfers of patients and exchange of services from a struck or threatened health care institution to another without jeopardy of secondary strikes or boycotts (ally doctrine).

It is still too early to measure the effect of these changes on the health care industry. Increased union acitivity is clearly evidenced. Catholic facilities have, in some areas, been singled out for special treatment. Perhaps because the expectation level is higher for them or perhaps because Catholic hospitals are considered especially vulnerable, for whatever the reason, unique pressures are being brought to bear on the Catholic hospital as distinguished from their neighboring facilities.

The Catholic attitude toward labor organization has always been basically supportive. In many cases, the Church's teaching on social justice could only be accomplished through the intervention of collective bargaining mechanisms. It is important to note, however, that the Church teaches "social justice," not pro-unionism. These terms, in specific situations, cannot ever be considered coextensive nor are they synonymous. In some cases, they may even be mutually exclusive.

Yet, we are faced with a recent history of Church-supported union activism (*i.e.*, the grape and lettuce boycotts). Issues tend to become polarized in tones of black and white, right and wrong. Emotions may be allowed to sway important determinations. In a few instances Catholic hospitals have been faced with direct intervention by Church officials and confrontations with members of other Church apostolates. Industrial unions seeking to represent hospital employees have attempted to use these situations to gain leverage over the Catholic hospital and to gain recognition without first demonstrating majority support among employees. Catholic hospitals have been lumped together with the growers of California employing migrant workers. Without first reviewing the facts, certain Church-related activists have predetermined that unions are necessary in

Catholic health facilities and have put a special kind of pressure on these facilities—a situation which can only be described as being uniquely Catholic in nature.

The spector of parochial school students being shepherded by sister-religious from the educational apostolate "picketing" a Catholic hospital in support of a labor union would be humorous if it weren't already a factual event. The vision of a bishop "ordering" the hospital administration to recognize a union without a certification election is all too real. The popular press and public media exult in such situations and the issues are never as simple as they might otherwise appear.

Catholic health care facilities and the entire health care apostolate fulfill a vital role in the mission of the Church. Like other religious entities, they have their civil law dimensions as well. In this respect, the position Catholic hospitals must and will take toward labor organization is essentially pragmatic and attempts to protect, as best as is possible, the interests of the hospital, its patients, and its employees.

Catholic facilities will follow the dictates of the federal labor law. They will fairly recognize the rights of employees to organize, but at the same time will exercise appropriate management mechanisms to educate and motivate employees to the problems of health care administration, of public service, and of the financial realities of the industry. Under some conditions, they will actively oppose the unionization of their employees and, to this end, will use all reasonable means permitted under the law to achieve that end. They will recognize the right of employees *not* to participate in a labor organization.

Catholic health care facilities will support those activities of the rest of the health care industry which is seeking legislative and administrative restraints on the disruptive and divisive aspects of unionization in the industry. To this end, specifically, limitations on the right to strike and on the number and fragmentation of bargaining units in the hospital will be sought. Court and administrative appeals of adverse decisions may be sought wherever deemed appropriate.

Catholic institutions will insist that before a union be permitted to represent its employees it must first demonstrate in a fairly contested, NLRB-supervised election, that a majority of the employees in a properly established bargaining unit do, in fact, want to be so represented. Outside pressure, especially from other Church apostolates, for recognition without election cannot be tolerated. Lines of communication and cooperation between Catholic health care facilities and other Church organizations must, therefore, be improved and strengthened.

The goals of social justice can be accommodated within a Christian environment which also guarantees protection to the health care patient and the civic community which depends upon the services of the hospital or other health care institution.

# ADDENDUM

## STATEMENT BY THE CHA BOARD OF TRUSTEES CONCERNING EMPLOYER-EMPLOYEE RELATIONS

### Introduction

Catholic hospitals provide a unique opportunity for the fulfillment of the Christian Apostolate of the care of the injured and infirm. They are a vital and integral part of the work of the Church.

The primary purpose of Catholic hospitals is to relieve suffering and restore health in a Christian manner which demands competence, mercy, love, and respect. Such purpose and philosophy require special dedication to the patient and his welfare on the part of all who participate and contribute to his care. To achieve this mission, Catholic hospitals are to be guided by the social teaching of the Church. They should, in a spirit of justice and respect for human dignity, recognize their responsibility to provide an opportunity for happiness, personal achievement, and security for those who participate in this form of Christian service.

This statement by the Board of Trustees is not to suggest that hospitals should seek unions or encourage their employees to form a union. The unionization or nonunionization is the decision of the employees themselves. This statement concerns some of the basic principles which must be considered in hospital labor-management relations.

### Statement of Basic Principles

#### Employer-Employee Relations

*We believe*:

1. Hospitals have an obligation to furnish equitable terms and conditions of employment for their employees.
2. Hospital employee practices should conform to all standards established by competent public authority.
3. Remuneration and benefits furnished employees should compare favorably with those that prevail for the community for comparable occupations.
4. Hospitals should adopt and observe standards of enlightened personnel practices.
5. Hospitals should recognize that employees have a right to form or join a union or association of their own choosing for the purpose of representation in bargaining with their employers and, further, that employees should be free of any reprisal for the exercise of such rights. Hospitals should likewise recognize the right of employees to choose not to be represented by a union.

6. Hospitals should be prepared to deal with such unions or associations should the employees elect to be represented by them.

*We further believe that collective bargaining with employee unions or associations must recognize the following rights of hospitals:*

1. Hospitals have the right and obligation to determine that the union or association does in fact represent a majority of the employees.
2. Hospitals have the right to expect that the unit of representation is appropriate for representation.
3. Hospitals have the right and the obligation to determine that the organization representing employees recognizes the character of service hospitals provide, and the implied responsibilities that flow therefrom, particularly the necessity of affording uninterrupted service.
4. Hospitals have the obligation to have that kind of counsel which alerts them to the implications of different types of labor provisions and assists them in avoiding those errors in contract language which would make their task of operating the hospital more difficult.
5. Hospitals have the right to be represented by competent industrial relations counsel and/or form associations with other hospitals in a community for the purpose of doing joint collective bargaining.