Core issues of unionization: Your ten most frequently asked questions answered

JEFFREY A. BROWN, MD, JD, MPH
Stamford, Connecticut

The author details unionization in terms of health professionals, with special emphasis on how today's labor relations climate impacts on nurse anesthetists.

"Should we or shouldn't we unionize?" More and more health professionals are asking themselves this question. In fact, this question has been asked so often that one would think that some clear guide to answering it already would have been found. But, alas, such is not the case. Instead, the blanket of confusion that surrounds the unionization debate seems to grow thicker and thicker as more and more people engage in it.

What follows is an attempt to help clarify at least some of this confusion by answering what seem to be the ten most frequently asked questions about unionization: (1) What is "trade-unionism"? (2) What, if any, are the differences between the health professional and factory unionism? (3) Can one be a "unionist" and a "professional" at the same time? (4) Must one join a union to be able to bargain about money and working conditions? (5) Does unionizing guarantee higher wages? (6) If we unionize, how will the 1974 National Labor Relations Act Amendments affect us? (7) If we don't unionize, will the amendments affect us anyway? (8) With whom should we bargain? (9) Against whom should we bargain? (10) How do we form a union if we want to form one?

What is "trade-unionism"?

Webster's New International Dictionary defines "trade-union" as "a voluntary association of working people organized to further their rights, privileges, and interests with respect to, [among other things] wages, hours and conditions of labor . . . education [and] mutual assistance." All that "trade-unionism" really means is that you want to pursue these mentioned goals by voluntarily joining a group whose aim also is to pursue them.

Historically, those "tradesmen" working mechanically with their hands were among the first to unionize and thereby give "trade-unionism" its name. Nonetheless, except for this historical association of unions with tradesmen, there really is nothing that limits "trade-unionism" to these people. In fact, white-collar and professional unionism in education and law, as well as health, is now among the fastest-growing sectors of the entire "trade-union" movement.

Are factory unions and health professions' unions the same?

The answer to this question is clearly not, as common sense tells you. While it is true that there is a certain degree of overlap between factory and health professionals' unions, there are two vital differences.

The first is that health professionals have significant individual power while factory workers typically do not. While unions almost always increase the power of the factory worker, they may
not necessarily do the same for the health professional. In fact, those of you who work alone in rural hospitals may have quite a bit to lose both economically and professionally if you decide to make your managements listen to what your fellow anesthetists have to say. But more on this later.

The second difference is that factory unionism has not really ever concerned itself with the quality of the factory product, whereas health professional unionism has blazed new territory by adding demands about improving patient care to its bargaining table list. Moreover, it is no accident that health professional unionism has taken the obtaining of power to determine patient care standards as one of its preeminent goals. For obtaining this power destroys forever the myth that “unionism” and “professionalism” are mutually exclusive.

Can one be both a unionist and a professional?

Of all the confusing issues surrounding the unionism controversy, the professionalism question is perhaps the worst offender. Does joining a union necessarily make one “less” of a professional? Focusing on the health care provider, part of this confusion stems from two false equations: (1) that of associating nursing professionalism with “Night- ingalism”—“the belief that one should be dutiful and deferential,” and (2) that unionism with strikes shows a callous disregard for patient well-being.

Yet, on one hand, evidence exists that militance, not deference, is becoming the professional norm for some nursing groups, and that union militance already has become valued by younger nurses from a higher status background than their colleagues. On the other hand, strikes for improved patient care have become the most commonly motivated strikes, and no clear evidence exists to date that patient care has suffered during any physician or nurse strikes so far.

Moreover, if one believes that medical sociologist Freidson’s isolation of the core factors that distinguish professionals from nonprofessionals is accurate, then health unionism clearly can be seen as increasing, not decreasing, union members’ professionalism. He notes that the core distinction—the crucial factor which makes a professional a professional—is: only the professional is seen to have “legitimate, organized autonomy.” This autonomy includes the right to control entry into the profession, the right of the profession to police itself, and the right to tell clients what is good for them.

In other words, what makes a professional more “professional” is the ability of the individual to get more power to control his or her work. Thus, the unique trend of health unions to use collective bargaining to dictate hospital hiring procedures, structure peer review committees, and set patient care standards can be viewed as part of an overall campaign to use unionism directly as a means of increasing their members’ professional power.

Must you join a union in order to bargain?

The answer to this question is no—that is, if you are either the only anesthetist working at your hospital or if no union already exists. Under the law, all collective bargaining really is, is a set of rules which govern formal bargaining between a group of employees and their employer about certain mutually agreed to issues. Informal bargaining (such as, stopping one’s hospital administrator in the cafeteria and asking for a raise or for extra vacation), or formal individual bargaining (such as, meeting with one’s administrator at a set time each year to discuss a formal agenda of contract specifics) certainly is possible and may even get the individual more money or benefits than otherwise obtainable through union bargaining.

But, individual formal or informal bargaining is not allowed over issues covered by a valid contract negotiated between one’s union and employer. In other words, if you already belong to a union, and that union has a contract with your hospital covering salary, for example, you cannot go up to the administrator and ask for either more or less than the contract specifies. Nor can the administrator make any individual deals modifying the contract terms.

Moreover, if the union is certified as the bargaining unit for your professional group under the National Labor Relations Act, you are bound by the union contract even if you personally do not even belong to the union.

Does unionizing necessarily mean more money, better working conditions, and improved patient care?

The answer to this question is no. Whether unionized bargaining gets health professionals more money, benefits, and power to better patient care largely depends on how much economic and professional power they had before unionizing. While it is true that collective bargaining does seem indicated whenever group action works better than individual action, it certainly does not follow that group action always is better.
Consider, for example, the situation of the rural nurse anesthetist who currently gets more money than her male colleague working in a hospital ten miles away. She may do better because she, in fact, is a more skilled anesthetist. Or, because her hospital administrator may not know what her colleague is earning. Or, because her hospital serves a wealthier clientele or a clientele with more generous insurance coverage. If she, her colleague, and the two administrators decided to bargain as a foursome, a perfectly legal thing to do, she might be the loser.

Consider, too, the case of ten anesthetists working in a large urban hospital. The chief surgeon may like one more than another. Or, the medical staff may think another's work is of much better quality than the others. Or, a third may far surpass his peers in "apple-polishing." Unionizing here would bring these discrepancies to light and probably would cause a leveling of salaries that our three friends might object to strenuously.

The point is that unionizing tends to homogenize salaries. Indeed, one of the major tenets of modern collective bargaining is "equal pay for equal work." This tenet in practice more often than not has translated as "equal pay for all having the same job title and seniority." Thus, one of the first consequences of this principle is the elimination of all non-title and non-seniority wage differentials, both "fair" and "unfair."

Moreover, since unions are democratic organizations (one person-one vote), they are subject to the "tyranny of the majority." Individuals who know that they are being paid substantially more than their peers should hesitate before equating unionization with financial improvement. Unfortunately, it often happens that some bargaining unit members will be sorely tempted to sacrifice their more highly paid peers financial interests as "bargaining chips." This possibility unfortunately is particularly real in bargaining units composed of a majority of one type of health professionals (such as RNs) and a minority of another, generally a better paid type (such as CRNAs).

Finally, any health professional's ability to get a hospital to improve patient care largely depends on that professional's ability to influence hospital governance. Thus, influencing patient care translates as influencing hospital administrators and/or boards of trustees and/or medical staffs. Unless the health professional group demanding more of a say in how patient care should be improved occupies such a crucial position in hospital operations as to force administrators, trustees, and medical staffs to listen, group demands may yield far less than individual requests.

How does the national labor relations act affect anesthetist unions?

The answer to this is profoundly. The July 26, 1974 amendments to this Act granted collective bargaining rights to all those employed by non-profit health facilities. Either anesthetists or their hospitals now can request the National Labor Relations Board (N.L.R.B) to hold an election to determine what organization shall have the right to be the anesthetists' exclusive bargaining representative. (The hospital, however, first would have to claim that at least one anesthetist had demanded to be recognized as this representative.)

The N.L.R.B's power in certifying "bargaining units" has far-reaching consequences for anesthetists unionized under the 1974 amendments. Perhaps the greatest of these consequences is that CRNAs could likely be forced to join bargaining units dominated by RNs or by other non-anesthetist personnel.

Why? The N.L.R.B's rulings consistently have followed that of the landmark case of *Mercy Hospitals of Sacramento*, in which the only hospital professionals allowed to have their own bargaining unit were the RNs (there were no unionized MDs). The others had to join an overall hospital professional unit. And, while it has not been settled whether or not anesthetists might be forced into the overall unit as opposed to the RN unit or vice-versa, the N.L.R.B in fact has established the precedent of deeming it "appropriate" for anesthetists to join the RN unit.

To consider what these rulings imply, review the earlier section on the "tyranny of the majority." Anesthetists bargaining as a minority part of a large unit may not do as well as their non-anesthetist colleagues. For example, a New York CRNA reported that his RN-dominated unit gained a 20% pay raise for its RNs but only a 9% raise for its anesthetists. Moreover, the dollar amounts of the RN raises was two to four times that obtained for the CRNA's.

The amendments, of course, also make all bargaining between N.L.R.B-certified units and their hospital employers subject to all the doctrines and rulings which the National Labor Relations Board has evolved over the years. This fact is of crucial importance, since the N.L.R.B had industrial, primarily factory, bargaining in mind when it handed down these rulings. It is not at all clear whether the N.L.R.B will have the flexibility to take
the unique characteristics of hospital professionals into account when it considers their unions. If the NLRB does not, these professionals, to their dismay, may find that the decisions rendered will severely damage their professional autonomy.

Nowhere is this lurking danger more serious than in the "management rights" arena. In the past, even the United States Supreme Court, in a landmark case, has allowed employers to refuse to budge from the bargaining position that they shall have the exclusive "right to select, hire, to promote, demote, discharge, discipline for cause, to maintain discipline and efficiency . . . and to determine schedules of work." Moreover, the employers also were held to have the right to insist that all the above "matters shall never be the subject of arbitration." 9

Since professionals hold the rights to control entry, police themselves, and determine the nature of their work as the very cornerstones of their right to a professional identity, much indeed is at stake should the NLRB continue to follow its "management rights" precedents. For example, the NLRB then would refuse to force hospitals to bargain with anesthetists over the latter's desires to determine work schedules; set work apportionment among anesthesiologists and anesthetists; help determine anesthesia care standards; or define the criteria by which prospective new anesthetist employees are judged.

What happens if we don't unionize?

Even if you don't unionize, the labor law changes nonetheless will affect you, since they will cover the labor relations between all nonprofit hospital unions and their hospitals.

The other unions may demand and get wage packages which will limit your hospital's ability to give you what you want. Or, the other unions, (for example, New York City's Committee of Interns and Residents) may demand and get special access to hospital governance which could result in your own political power being diminished in your institution. Or, the other unions may strike and expect your support. Regardless of your personal feelings about unionism, it will be extremely difficult to avoid being affected by the wave of hospital bargaining fostered by the 1974 amendments.

Forming a union but refusing to seek "bargaining unit" certification from the National Labor Relations Board will not be a useful compromise either. In the first place, your hospital will have the right to compel a unit election if even one anesthetist doesn't like your union.

Moreover, refusing to seek certification will deprive you of all the legal protection against employer unfair labor practices (such as, firing employees for pro-union activity) from which the National Labor Relations Act was designed to shield you. Unless you individually have sufficient professional, economic, and intra-hospital political power to get a better contract than you can get with a group, seeking bargaining unit certification under the amendments does seem indicated.

With whom should we bargain?

If anesthetists do seek bargaining unit certification, the question is, how to maximize the benefits of this type of unionization? The answer largely depends on who else will be in your bargaining unit.

Recall that recent NLRB rulings are likely to give you at least two choices: either join the RN unit or join a unit of all other hospital professionals. (The NLRB has not yet ruled on the question of a combined anesthetist-salaried anesthesiologist unit's appropriateness.)

Of these two choices, joining with the RNs would seem to be the better choice. A natural political and economic alliance exists between RNs and all "expanded role" nurses such as anesthetists, nurse midwives, and pediatric nurse practitioners. Moreover, "joint resolution agreements on jurisdiction and mutual assistance" have been promulgated by state nurses' and state nurse anesthetists' associations in, for example, Michigan and New Mexico.

On the other hand, individual or small numbers of anesthetists would have relatively little bargaining power within their units compared with those of large numbers of RNs. (Recall the situation of the New York anesthetists who fared rather poorly when bargaining in an RN-dominated unit.)

Perhaps the answer to preventing such a situation would be for the state nurses' and anesthetists' associations to draw up some "job equivalency guidelines" for local units which have both RNs and CRNAs in them. The essential concept of such guidelines would be to determine the equivalency (or some uniform ratio) of salaries of CRNAs and a specified class of RNs. Nurse supervisors, head nurses, or RNs with a certain number of years of experience could be chosen as the index group, with all mixed units demanding salaries for their anesthetists which are tied to those of the index group.
Against whom should we bargain?

The mixed units described in the preceding section need not limit themselves to bargaining with a single hospital employer. One can have multi-employer bargaining under the National Labor Relations Act—provided both employers and employees voluntarily agree to this.\(^\text{10}\) Indeed, multi-employer, multi-union bargaining has gone on in this country for more than 80 years.\(^\text{11}\)

Nonetheless, no substantial data exist showing whether or not such multi-employer bargaining shifts the bargaining power balance in either the employers' or unions' favor. Therefore, one suspects that most such bargaining has been more a matter of mutual convenience than the means by which one side or the other can gain extra bargaining leverage.

However, one theoretical footnote is in order for anesthetists in particular. Some have told the author that they would like to try multi-hospital nurse anesthetist bargaining on a regional basis if such bargaining would be legal. They believe that the coalescing of isolated rural anesthetists in particular into one unit would give that unit such professional and economic strength as to more than offset the power their multi-employer bargaining adversary would have.

The experiment would seem to be legal if (1) no other hospital professional group had sought bargaining unit certification at the time the multi-employer anesthetist bargaining starts, and (2) the hospitals consent. Neither the NLRB nor the courts generally will interfere when labor and management agree and other unions are not affected.

How do we form a union?

Any group can call itself a "union" if it bargains with the employer(s) about money, working conditions, and the like. The American Nurses' Association and other professional associations can and do serve as national unions for their members. Or, professional associations can create separate, independent organizations to serve collective bargaining purposes while the parent group restricts its activities to more traditional concerns.

The California Association for Medical Laboratory Technologists, for example, has done both. In the 1940's, it represented its members in collective bargaining with proprietary hospitals. Then, after the 1974 labor law amendments, it created an "Economic Security Assembly" to serve the same purpose.\(^\text{12}\)

There are a number of ways to seek "bargaining unit" certification and thereby "official" union status from the National Labor Relations Board. One way simply is to ask your hospital administrator to submit to the NLRB a petition which claims that your union wishes to be recognized as the bargaining representative defined by the National Labor Relations Act. Or, an individual or group itself can file a petition with the NLRB, describing the bargaining unit and requesting certification. The latter petition must be accompanied by dated authorization cards, signed by at least 30% of the employees who would belong to that unit.\(^\text{13}\)

In either case, a regional director of the board typically would then hold an election by secret ballot. If the proposed unit receives a majority vote and there are no timely filed objections, the regional director would then issue a certification of representative. This certification is valid for at least one year, after which time either the employer or 30% of employees may ask for another election if they claim most bargaining unit members no longer like their representative.\(^\text{14}\)

REFERENCES

(4) Ibid.
(6) 217 NLRB No. 131 (1975).
(7) Trustees of Noble Hospital and Massachusetts Nurses Association, 218 NLRB No. 221 (1975).
(14) Ibid., pp. 162-166, 190.

AUTHOR

Jeffrey A. Brown, MD, JD, MPH, is a graduate of Stanford Medical School, Yale Law School, and the University of California (Berkeley) School of Public Health. He has worked with many professional and legislative groups on medico-legal issues, and has written extensively about legal aspects of health-care delivery. A guest speaker at the AANA's 1976 Annual Meeting and twice a contributor to the AANA Journal (February, 1976 and February, 1977), Dr. Brown has been particularly interested in anesthetist issues. This article is based on a speech which was delivered at the New York State Association of Nurse Anesthetists Annual Meeting held in Albany in April, 1979.