

ARC Issue brief: Collective bargaining for physicians and physicians-in-training

At the 2019 American Medical Association (AMA) Interim Meeting, the House of Delegates adopted Resolution 606-A-19. That resolution asks that the AMA study the risks and benefits of collective bargaining for physicians and physicians-in-training in today's health care environment.*

AMA policy and experience with physician unions

The AMA supports the right of physicians to engage in collective bargaining, and it is AMA policy to work for expansion of the numbers of physicians eligible for that right under federal law (Policy H-385.946; Policy H-385.976). For example, the AMA supports efforts to narrow the definition of supervisors such that more employed physicians are protected under the National Labor Relations Act (NLRA) (Policy D-383.988).

AMA union-related policies contain several caveats. First, physicians should not form workplace alliances with those who do not share physician ethical priorities (Policy E-9.025). Second, physicians should refrain from the use of the strike as a bargaining tactic, although in rare circumstances, individual or grassroots actions, such as brief limitations of personal availability, may be appropriate as a means of calling attention to needed changes in patient care.¹ Physicians are cautioned that some actions may put them or their organizations at risk of violating antitrust laws.²

In 1999, the AMA facilitated, by providing financial support, the establishment of a national labor organization—Physicians for Responsible Negotiation (PRN) – under the NLRA to support the development and operation of local negotiating units as an option for employed physicians and for resident and fellow physicians (Policy H-383.999). In mid-2004, however, after spending a substantial amount of money on the venture that signed up few physicians, the AMA discontinued financial support of the project.

Discussion

The status of physician unions

The number of physicians who are members of unions is small in comparison to the size of the profession. Their numbers, however, are growing. In 1998, the AMA estimated that between 14,000 and 20,000 physicians were union members. In 2014, it appears that this number had grown to 46,689 (5.7 percent of 820,152 actively practicing physicians in the United States).³ In 2019, there were 67,673 physician union members. This represents 7.2 percent of the 938,156 physicians actively practicing in the United States – a roughly 26 percent increase from 2014 in the percentage of physicians belonging to unions.⁴

**The information and guidance provided in this document are not intended as, and should not be construed to be, legal or consulting advice. Physicians should seek legal advice regarding any legal questions.*

Physicians have been successful organizing with the help of certain international unions, including the American Federation of State, County, and Municipal Employees (AFSCME), the Service Employees International Union (SEIU), and the American Association of University Professors (AAUP). AFSCME and SEIU have been successful in affiliating with existing physician unions, while the AAUP has been successful in tapping into academic physician interest in pursuing unionization.

The Union of American Physicians and Dentists, affiliated with AFSCME, is perhaps the largest physician union representing practicing physicians working for the State of California, California counties, non-profit health care clinics, and in private practice. The Federation of Physicians and Dentists, another AFSCME affiliate, is also a union with a history of organizing self-employed physicians in independent practice and challenging established labor and antitrust laws.

SEIU, the largest and fastest growing health care workers union in North America, with over 2.1 million members, is affiliated with the Doctors Council that began representing a group of physicians employed by the Departments of Health and Welfare of the City of New York. Today it negotiates for all attending physicians employed by New York City and the Health and Hospitals Corporation, the public safety net health care system of New York City. Doctors Council has expanded from New York to Illinois, New Jersey and Pennsylvania, where it represents physicians employed by academic medical schools, hospitals, professional corporations, and national corporations. SEIU is also affiliated with the Committee of Interns and Residents (CIR), the oldest and largest house staff union in the country representing more than 22,000 interns, residents, and fellows in California, Florida, Massachusetts, New Jersey, New Mexico, New York, and Washington, D.C.

The AAUP develops and disseminates information and resources in support of the collective bargaining activities of local chapters, including those comprised of academic physicians employed by academic medical centers and clinics. For that purpose, AAUP has established a separate 501(c)(5) organization that provides its services through AAUP staff and through consultants and others with specialized expertise.

The employment status of physicians

The large number of physicians now working as employees has by some reports re-energized the movement for physician collective bargaining.⁵

According to AMA's Physician Practice Benchmark Survey utilizing 2022 data, 49.7 percent of physicians are now employees.⁶ Among employed physicians, 16.9 percent are employed directly by hospitals, 3.4 percent are employed by medical schools, and 6.3 percent are employed by faculty practice plans. Moreover, 13.8 percent of employed physicians work in practices that are wholly owned by other physicians.⁷

Younger physicians are more than twice as likely as older physicians to be employed by hospitals. In fact, 16.4 percent of the under 40 cohort are direct hospital employees compared to only 5.7 percent of physicians over the age of 54.⁸

The basic rights of employed physicians to engage in protected collective bargaining

Employed physicians – who are not supervisors – have the right under the NLRA and other applicable

labor laws, to self-organization, to form, join, or assist labor organizations; to bargain collectively through representatives of their own choosing; and to engage in other concerted activities for the purpose of collective bargaining or other mutual aid or protection. An employer and a union have a legal duty to negotiate any subject that relates to wages, hours and other terms and conditions of employment.

No traditional formal union required for NLRA protections

Physicians are not required to belong to a traditional formal union certified by the National Labor Relations Board (NLRB) to receive the NLRA's protection for employees engaged in concerted activities. Two or more employed physicians have the right to designate a representative and ask their employer to meet with the designated representative and to discuss and negotiate wages and other terms and conditions of their employment. Thus, in *New York Univ. Med. Ctr.*, 324 NLRB 887 (1997), the NLRB decided that the Association of Staff Psychiatrists (the Association), formed by staff psychiatrists at Bellevue Psychiatric Hospital, was a labor organization protected under the NLRA even though it was not a formal union. The NLRB reasoned that the Association was formed for the purpose of dealing with the hospital on such matters as salaries, working hours and conditions, and grievances of its members; had elected officials and dues paying membership; held membership meetings; and had dealt with the hospital through the director of psychiatry. Accordingly, the NLRB ruled that the hospital had violated the NLRA by impliedly threatening its employed physicians with cutbacks, layoffs, and other consequences if they continued to engage in the concerted conduct of protesting the discontinuance of certain Bellevue Hospital physician employment policies.

Physicians-in-training

Residents have organized out of a need to, "create a better and more just healthcare system for patients and healthcare workers and to improve training and quality of life for resident physicians, fellows and their families."⁹

Residents exercise and enjoy collective bargaining rights under the NLRA. Initially the NLRB treated residents as students unable to collectively bargain with the protections of the NLRA. That changed in 1999 when the NLRB held that house staff members are statutory employees with a right to organize under the NLRA. Scholars worried that an ensuing NLRB holding that graduate students had no right to bargain collectively would also apply to house staff. The NLRB, however, has reaffirmed house staff rights to bargain collectively.

Physicians who are supervisors are not protected by the NLRA

Individuals who fit the statutory definition of a supervisor are *not* protected by the National Labor Relations Act. The NLRA defines "supervisor" as:

Any individual having the authority, in the interest of the employer, to hire, transfer, suspend, lay off, recall, promote, discharge, assign, reward, or discipline other employees, or responsibility to direct them, or to adjust their grievances, or effectively to recommend such an 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.¹⁰

Thus, the Supreme Court ruled in *NLRB v. Kentucky River Community Care Inc.*, 532 US 706 (2001), that certain supervising nurses at private hospitals could not join unions because they were "supervisors" as defined by the NLRA.

Although *Kentucky River Community Care* appears to be restrictive in terms of the pool of physicians who would qualify for union membership and the protections of the NLRA, it is not clear that the case has had that impact. Specifically, the NLRB has narrowed the meaning of “effectively to recommend” to be that the supervisor’s recommended action is taken with *no* independent investigation by superiors. *Family Healthcare Inc. and Christine McCallum*, 354 NLRB No 29. (2009). Also, the NLRB has reasoned that to be deemed a statutory supervisor, the employee must be held by the employer to be accountable for the performance of other employees. *Oakwood Healthcare, Inc.*, 348 NLRB No. 37 (2006). In light of these requirements for supervisor status, the NLRB has decided that a physician employed by a physician practice group was not a supervisor of nurse employees. *Family Healthcare Inc. and Christine McCallum*, 354 NLRB No 29. (2009). The physician’s employment contract provided that she was to participate in the supervision of nurses; and she often provided evaluative comments on nursing staff to the practice’s staff director; selected her own primary nurse from among candidates presented by the director; and complained about nurse performance issues to the director. The NLRB held, however, that it was the director and not the employed physician who made the final decisions about performance, termination, and compensation.¹¹

Physicians wishing to avoid supervisory status are advantaged by a rule that places the burden to prove supervisory authority on the party asserting it. Also, the NLRB has generally exercised caution not to construe supervisory status too broadly. the NLRB, however, has indicated that physicians who are medical directors or have significant managerial responsibility are likely to be deemed “supervisors.”¹²

As significant case law has developed surrounding the definition of “supervisors,” physicians should consult with an attorney to determine whether they have the status of a supervisor.

Physicians are also cautioned to consider the professional ramifications of resisting the status of “supervisor.” The AMA supports the use of physician-led team-based care, with care provided by members of the team providing care commensurate with their education and training. Physicians need to ask the question of whether they can be deemed nonsupervisory for purposes of the NLRA and still maintain their positions as the leaders of team-based care.

Academic physicians

Of the unionized academic physicians, most are in public institutions in states that authorize public employees to bargain collectively. That is because a U.S. Supreme Court case, *NLRB v. Yeshiva University*, 444 U.S. 672 (1980), concluded that tenured faculty at Yeshiva were “managerial employees” and thus excluded from the coverage of the NLRA. This seemingly confined physician faculty collective bargaining to the public sector where state collective bargaining law does not necessarily always follow NLRB precedent. A subsequent NLRB decision, however, suggests that many non-tenured faculty members at private institutions do not have enough power to be considered managerial.¹³ This could clear the way for much more unionization under the NLRA of faculty members in private settings, including those who are physicians.

Self-employed physicians

To level the playing field with monopoly health insurers, self-employed physicians have looked for legitimate ways to collectively bargain with health plans without running afoul of the antitrust ban on price fixing. Some have formed a financially or clinically integrated network – a physician joint venture – that is essentially treated like a single firm that is incapable of forming a price-fixing conspiracy and free to negotiate with health plans. Others have lobbied for state or federal legislation that would grant immunity to independent physicians jointly negotiating with insurers.

In the 1990s, some physicians in independent practice hoped that by gaining recognition as a formal union, they could engage in collective bargaining with health plans under the labor exemption from the antitrust laws. Before physicians can engage in collective bargaining under the labor exemption, however, the bargaining process must be part of a labor dispute. For there to be a labor dispute, the collective bargaining must concern the terms and conditions of employment. The physicians, therefore, must be employees. There is no labor dispute for purposes of the labor exemption if the physicians are independent contractors, entrepreneurs, or independent businesses.

While courts are willing to look at the substance of the relationship to determine whether a person is an employee for purposes of the antitrust and labor laws, the concept of an employee is largely restricted to a common-law agency test that differentiates employees from independent contractors. To date, physicians have been unsuccessful in establishing that their contractual relationships with health insurers meet the control test for the NLRA rights afforded employees. Thus, in *AmeriHealth Inc./Amerihealth HMO*, 329 NLRB 76, 4-RC-19260 (1999), the NLRB decided that a group of in-network physicians were independent contractors, reasoning that the HMO did not regulate the patient-physician relationship in a manner comparable to that of an employer. The NLRB determined that the physicians had a “meaningful opportunity” to negotiate the terms of compensation with a health plan. The NLRB expressly held, however, that it was, “not necessarily precluding a finding that physicians under contract to health maintenance organizations may, in other circumstances, be found to be statutory employees.”

More recently, the NLRB signaled a small shift in its definition of “independent contractor.” Specifically, in 2011, the NLRB held that a group of symphony orchestra musicians were statutory employees, not independent contractors.¹⁴ The decision largely hinged on the orchestra’s right to control the manner and means by which the performances of professional musicians were accomplished. This paradigm could reasonably be applied to physicians. In recent years, the emergence of narrow networks, accountable care organizations, and other organizational forms of provider organizations have gained substantial control over the means by which physician services are performed. That development, together with the loss of a “meaningful opportunity” to negotiate compensation (the employee test in *AmeriHealth*), may be opening the door to the availability of NLRA coverage and of the labor exemption from the antitrust laws to an increasing number of physicians.

Bargaining units composed entirely of physicians are presumed appropriate

Like other employees, employed physicians can be in a formal bargaining unit certified by the NLRB. Hospital physicians have been successful in being recognized by the NLRB as an appropriate bargaining unit. Indeed, in 1989 the NLRB promulgated regulations in creating a presumption that in acute care hospitals a separate bargaining unit for physicians (e.g., one that excludes nurses and other types of employees) is appropriate.¹⁵

The advantages and disadvantages of physician unions

The dominant hospital and the case for physician countervailing power

As many physicians have recognized, independently bargaining a second or third contract with a hospital can be a difficult experience. Many hospital markets are highly concentrated and are becoming more so.¹⁶ In a highly concentrated hospital market, a hospital-employed physician may have few hospital employment alternatives. Moreover, covenants-not-to-compete often exist in a physician’s hospital employment contract, and these covenants may further contribute to a bargaining advantage that a hospital employer with market power may possess.

Dominant hospital employers may be under little, if any, competitive pressure to respond to an employed physician's request to renegotiate an equitable agreement that might offer competitive wages and benefits. Nor are hospitals with market power under competitive compulsion to respond to physician practice concerns in the areas of physical plant and equipment, support staff, and other resources it makes available to patients and physicians.

Physicians become upset when they feel that they have no influence or control over key decisions that affect them and their patients or that undermine their autonomy.¹⁷ Additionally, there is the concern that physicians working for dominant hospitals could experience divided loyalties and may feel that the interests of the hospital may not always be consistent with what they believe is in the best interests of the patient.¹⁸ Thus a combination of market conditions and the special organizational behavior needs of physicians may make the countervailing power that can be obtained through collective bargaining seem especially attractive to physicians who are employed by dominant hospitals. This creates a special opportunity for physician unions in the hospital setting.

Need for addressing the physician burnout epidemic

A major driver of physician unionization is physician burnout. Physicians face a burnout epidemic.¹⁹ Physicians vigorously complain that they spend more time than ever on electronic health record (EHR) documentation and bureaucratic administrivia.²⁰ According to a Brookings report, for every hour a primary care physician spends in direct patient care, they spend two hours engaged in administrative functions.²¹ Writing in the *New Yorker*, Eric Topol, MD, observes:

Doctors now face a burnout epidemic: 35% of them show signs of high depersonalization, a type of emotional withdrawal that makes personal connections with their patients difficult. Administrative tasks have become so burdensome that according to one recent report, only 13% of the physicians' day, on average is spent on doctor-patient interaction. Another careful study of doctors' time is shown that, during an average 11-hour workday, six hours are spent at the keyboard, maintaining electronic health records.²²

While many of the administrative burdens and sources of burnout are imposed by health insurers and government regulators and thus, outside the control of organizations employing physicians, physician collective bargaining with employers can certainly result in some relief. After all, one of the major reasons why many physicians have given up independence in exchange for health system employment is to enjoy an ever-larger army of clerical, administrative, and billing staff to help with the onerous requirements for getting paid.²³

Possible loss of physician autonomy and of rewards for individual accomplishments

Detractors of physician unions point out that collective bargaining usually results in an agreement that applies uniformly to all physicians who participate in the collective bargaining. In particular, the level of compensation may be stratified based on seniority or obtainment of certifications, and it may be difficult to write contractual language that differentiates and addresses a significant divergence among physicians in terms of experiences and skills. Proponents of physician unions respond by asserting that their contracts are analogous to those negotiated by the Major League Baseball Players Association, which of course rewards a player's value to the team.

Physician strikes

Physicians regard their responsibility to the patient as paramount. Some physicians may fear that by joining a union they risk harming patients if collective action is taken. There are at least three responses to

this concern. First, physicians in a union need not resort to a strike in order to exercise power in the course of a contract negotiation. As one observer has noted, “[p]hysicians have other means of adjusting their workflow to affect their employer without rejecting all clinical duties. Examples of such adjustments include refusing to perform elective surgeries or neglecting documentation to prevent effective billing.”²⁴

Second and most significantly, there have been very few physician strikes, with most strikes occurring by physicians-in-training. The experience with physician unions going out on strike is that patients have not been harmed. Indeed, one study found that a physician strike by Los Angeles County physicians “was responsible for more deaths *prevented* than lives lost.”²⁵

Finally, the labor laws have been specifically designed to provide healthcare workers, including physicians, with a right to strike that is well tailored to protecting patients. When Congress enacted the 1974 amendments to the NLRA, extending coverage to nonprofit hospitals, it added a new Section 8(g), which requires unions to give ten-day notice before engaging in any strike or other concerted refusal to work at any health care institution. Section 8(g) was added because, in extending the protections of the NLRA to hospital employees, Congress meant to protect the public against undue disruptions in health care services resulting from labor disputes.²⁶ As the Senate committee's report on the measure stated:

In the Committee's deliberations on this measure, it was recognized that the needs of patients in health care institutions required special consideration in the Act including a provision requiring hospitals to have sufficient notice of any strike or picketing to allow for appropriate arrangements to be made for the continuance of patient care in the event of a work stoppage.²⁷

In short, “Congress chose to treat the health care industry uniquely because of its importance to human life.”²⁸ Accordingly, the labor laws have been well-tailored to address physician ethical concerns.

Union formation by medical societies

Some medical societies may wish to consider whether the time has come to organize employed physicians and to provide collective bargaining for them. While it should be possible for a medical society to qualify as a labor organization, various conflicts could arise. Further work is needed by both the AMA and medical societies to determine the exact model necessary to execute successful organizing strategies.

Conclusion

The AMA’s policies supporting a physician’s right to unionize are being achieved. Thus, consistent with existing AMA policy, employed physicians may have the protections of labor law and enjoy an exemption from the antitrust laws when they engage in concerted action concerning the terms and conditions of their employment. Moreover, AMA policy supporting efforts to narrow the definition of supervisors (such that more employed physicians are protected under the NLRA) has received a boost from an NLRB decision finding that a physician was not a supervisor, a case that was decided subsequent to AMA’s discontinuance of its financial support of PRN. Moreover, the NLRB has shown the tendency not to construe supervisory status too broadly and has recently classified certain faculty as nonsupervisory, setting the stage for the unionization of greater numbers of academic physicians. Finally, NLRB regulations create a presumption that it is appropriate for physicians in an acute care hospital to form a separate bargaining unit. This rule is consistent with the caveat contained in AMA policy that physicians should not form workplace alliances with those who do not share physician ethical priorities.

Although the unionized portion of the physician profession remains very small, in the many and growing

number of markets where hospitals have market power and where physicians have few hospital employment alternatives, there is arguably created the need for physician countervailing bargaining power.

A major driver of physician unionization is the physician burnout epidemic. Physicians vigorously complain that they spend more time than ever on EHR documentation and bureaucratic administria. Under these conditions, physician unions present a plausible opportunity to improve physician working conditions in ways that benefit both physician and patients. Unions may also achieve collective bargaining agreements that safeguard the shared interests of employed physicians wanting more control over their practices while also rewarding individual achievement similar to collective bargaining agreements in professional sports.

While physician collective bargaining with hospitals carries the risk of impasse and of a strike, the history of physician unions shows very few physician strikes. Patients are protected by a NLRA requirement that a hospital be given ten-day notice of any strike or picketing to allow for appropriate arrangements to be made for the continuance of patient care in the event of a work stoppage.

Finally, physicians and their medical associations should be aware that unions are highly regulated and present legal issues requiring the assistance of legal counsel familiar with the highly specialized area of labor law and the number of unique legal issues arising in health care, such as whether physicians are supervisors. In making arguments that they are nonsupervisory for the purpose of gaining NLRA protections, physicians should be cautious of undermining their positions as the leaders of team-based care.**

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***This issue brief was prepared by AMA Advocacy Resource Center staff.
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REFERENCES

- ¹ Section 8(g) of the National Labor Relations Act prohibits a labor organization from engaging in a strike, picketing, or other concerted refusal to work at any health care institution without first giving at least 10 days’ notice in writing to the institution and the Federal Mediation and Conciliation Service.
- ² Policy E-9.025
- ³ Hirsh, Barry T and McPherson, David A. 2014 Union Membership and Earnings Data Book. The Bureau of National Affairs, Inc. 2014.
- ⁴ Hirsh, Barry T and McPherson, David A., Union Membership and Database from the 2019 CPS completed February 24, 2020 (Unionstats.com)
- ⁵ Leffell D. The doctor’s office as union shop. Wall Street Journal. January 29, 2013.
- ⁶ Kane, Carol PhD, Policy Research Perspectives. Recent Changes in Physician Practice Arrangements: Shifts Away from Private Practice and Towards Larger Practice Size Continue Through 2022- (2023) available at <https://www.ama-assn.org/system/files/2022-prp-practice-arrangement.pdf>. In addition to the 49.7 % of physicians who are employees, another 6.4% are independent contractors. The rest (44.0%) are owners.
- ⁷ Unpublished estimates based on data from the AMA’s 2022 Physician Practice Benchmark Survey.
- ⁸ *Id.*
- ⁹ See the Mission Statement of the Committee of Interns and Residents, which is affiliated with the Service Employees International Union. The mission statement may be accessed at <http://www.cirseiu.org/who-we-are/>
- ¹⁰ 29 U.S.C. § 152(11),
- ¹¹ Family Healthcare Inc, 354 NLRB 254, 09-CA-044539 (2009).
- ¹² See, Thomas-Davis Med. Ctr. v. Fed’n of Physicians and Dentists, Case 28-RC-5449, N.L.R.B. Region 28 (1996). The physician bargaining unit encompassed “all regular full-time and part-time physicians, including department chairs... excluding all other employees, physician medical directors, assistant medical directors...”
- ¹³ Pacific Lutheran University and Service Employees International Union, 361 NLRB 157, 19-RC-102521 (2014).
- ¹⁴ Lancaster Symphony Orchestra and The Greater Lancaster Federation of Musicians, 357 NLRB 152, 4-RC-21311 (2011).
- ¹⁵ See 29 CFR §103.30 (a) (2). See also American Hospital Association v. NLRB, 499 US 606 (1991) (upholding NLRB’s rulemaking).
- ¹⁶ Gaynor, M and Town, R. (2012) “Competition in Health Care Markets,” in *Handbook of Health Economics*, Vol 2, Pauly, M., Borras, P. and McGuire, T., eds., Amsterdam: Elsevier
- ¹⁷ Friedberg, Mark W., Peggy G. Chen, Chapin White, Olivia Jung, Laura Raaen, Samuel Hirshman, Emily Hoch, Clare Stevens, Paul B. Ginsburg, Lawrence P. Casalino, Michael Tutty, Carol Vargo and Lisa Lipinski. Effects of Health Care Payment Models on Physician Practice in the United States. Santa Monica, CA: RAND Corporation, 2015. http://www.rand.org/pubs/research_reports/RR869. In particular, chapters 8-10 address physicians’ ability to choose colleagues and coworkers, control over business and managerial decisions, the ability to earn desired income, ability to choose hours and schedule, values alignment with practice leadership, balancing leadership initiatives with physician autonomy, and respect from practice leaders. This report may be accessed at www.rand.org/content/dam/rand/pubs/research_reports/RR400/RR439/RAND_RR439.pdf.
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- ¹⁹ (2008). "Resident physician burnout: is there hope?". Family Medicine. 40 (9): 626–632. West, C. P.; Dyrbye, L. N.; Shanafelt, T. D. (March 5, 2018). "Physician burnout: contributors, consequences and solutions". Journal of Internal Medicine. 283 (6): 516–529. Shanafelt, et al (April 2016). "Longitudinal Study Evaluating the Association Between Physician Burnout and Changes in Professional Work Effort". Mayo Clinic Proceedings. 91 (4): 422–431
- ²⁰ *Id.* See also See Gaynor, Mostashari and Ginsberg, “*Making Healthcare Markets Work: Competition Policy for Health Care*”, Carnegie Mellon University/Center for Health Policy, Brookings/USC Schaeffer Center for Health Policy and Economics (April, 2017) (“Brookings Report”) at 12-15, available at: https://www.brookings.edu/research/making-health-care-markets-work-competition-policy-for-health-care/?utm_campaign=Economic%20Studies&utm_source=hs_email&utm_medium=email&utm_content=50778822
- ²¹ *Id.* at 13
- ²² Eric Topal, M.D. ,” Why Doctors Should Organize”, the New Yorker (August 5, 2019) available at <https://www.newyorker.com/culture/annals-of-inquiry/why-doctors-should-organize>
- ²³ Brookings Report at 13.

²⁴ Danielle Howard, MD, "What Should Physicians Consider Prior to Unionizing" *AMA Journal of Ethics*, March 2020.

²⁵ *Id*

²⁶ *Hospital & Health Care Employees District 1199 (United Hospitals of Newark)*, 232 NLRB 443, 444 (1977); *Plumbers Local 630 (Lein-Steenberg)*, 219 NLRB 837, 838-839 (1975), enf. denied on other grounds 567 F.2d 1006 (D.C. Cir. 1977), overruled on other grounds 246 NLRB 970 (1979).

²⁷ S. Rept. 93-766, 93d Cong., 2d Sess. (1974)

²⁸ *Hospital & Health Care Employees District 1199 (United Hospitals of Newark)*, 232 NLRB at 444.