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Employment and Labor

Learning Opportunities From The Twin Cities Strike

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On June 10, 2010, an estimated 12,000 nurses in Minneapolis and St. Paul went on strike. The June 10 strike is being called the second largest nursing strike in U.S. history, impacting some 14 hospitals in the Twin Cities. On June 21, 2010, the union, Minnesota Nurses Association (MNA), conducted a strike authorization vote to authorize a strike for an indefinite period of time against the hospitals. MNA in a press release has stated that 84% of Twin Cities nurses voted for the open-ended strike authorization. The parties will have to decide whether and when to return to the bargaining table to attempt to reach a new collective bargaining agreement. Before another strike occurs, a 10-day notice under the National Labor Relations Act (the Act) would need to be issued by the union to the hospitals.

In a series of letters dated June 18, 2010, MNA bargaining representatives informed representatives of the hospitals that the union "will not give a strike notice, under Section 8(g) of the National Labor Relations Act, as long as productive negotiations are continuing." The next paragraph of the union's letter is quoted below to demonstrate the general tone and tenor:

> Your demand to condition a return to bargaining upon the Union signing a no strike/no lockout agreement is clearly a delay tactic and a fraudulent attempt to avoid your obligation to bargain in good faith. You are actively recruiting for and contracting with replacement workers to start the beginning of July, rather than making a good faith attempt to reach a contract settlement. You have been recruiting these replacement workers for months, even on June 11th, as you kept the MNA nurses in holding areas as if they were criminals, delaying their return to patient care.

The Twin Cities experience is clearly a study in adversity for healthcare delivery, for management and labor, and for hospitals, physicians, employees, patients, and the community. While the Twin Cities experience is still very much in flux at the time of this writing, it is perhaps not too early to suggest that some potential learning opportunities may arise from the difficulty. As Winston Churchill said: "A pessimist sees the difficulty in every opportunity; an optimist sees the opportunity in every difficulty."

Triaging the Real Interests

The three main publicly expressed issues in the Twin Cities dispute have been: staffing ratios, pay rates, and pensions. The nurses want to limit nurse/patient ratios and to trigger financial penalties to the hospitals if ratios are not met. This staffing ratio issue is the connection to the union's characterization of the overall dispute as involving "patient safety." The union contends that placing limits on staffing ratios would serve patient safety. The hospitals support safe staffing, but want staffing flexibility and believe the proposed ratios would be economically burdensome. The parties are also at odds over pay increases demanded by the union. Finally, judging from publicly available sources, a major sticking point in the negotiations is how pension benefits will be calculated. Generally speaking, the existing pension formula is calculated by multiplying a base percentage by the employee's compensation and years of service. Currently, the factor used to calculate pension benefits is 1.65% for nurses with less than 13 years of service and 1.75% for nurses who have completed at least 13 years of service. The hospitals have proposed reducing the factor to 1.1% and 1.2% respectively. The union has proposed to increase the factor to 1.85%. Other points of contention include how a year of service is calculated and at what age employees are eligible to retire. (The status of all these proposals may, of course, change.)

Experience in labor/management relations suggests a few observations about the three interests of staffing, pay, and pensions. First, multiple expressed interests are rarely of equal value and importance to their party proponent. Second, interests can, with work, be broken down and triaged for relative importance and priority. Third, interests take on a different shape when they enter the public arena outside the bargaining table. Accordingly, in a press release on June 21, MNA called the strike authorization vote "a historic stand for patient safety." When public opinion is engaged, words such as "patient safety" may or may not reflect a triage of real interests necessary to resolve a labor dispute.

While the point may seem obvious, patient care is the distinguisher between the healthcare industry and most other U.S. industries covered by the Act. Because of patients and their life and death needs and dependency on healthcare, the interests of labor and management are necessarily contingent ones. "What's the patient care impact?" should be the recurring question in the room when labor and management meet. The Twin Cities dispute's impact on patient care at the time of this writing is a story that is still unfolding in anecdotal media reports. For example, the mother of a child being treated for leukemia at one of the hospitals is quoted as saying: "It's not comforting to know I don't have the nurses that know my child to take care of her anymore." Another parent, advised by his doctor to relocate his four premature babies from the neonatal intensive care unit, is reported to have said: "To be stuck in the middle of this stinks."

Healthcare Reform and the Workplace Factor

Labor disputes like the Twin Cities experience is another reminder that, notwithstanding 2,400 pages of new healthcare reform legislation, the healthcare industry still comes down to a dependence on a skilled service delivery workforce. Expanded levels of coverage and service envisioned by the new legislation will only increase the role of this workforce factor. While the new healthcare reform legislation includes some workforce initiatives, suffice it to say that the quality of healthcare is still tied to having an unceasing supply of skilled physicians, nurses, and other healthcare workers.

The 10-day Rule

The Act is an FDR-era law. It needs some updating as it relates to 21st century healthcare. Section 8(g) of the Act requires that unions must give healthcare institutions a 10-day notice of the union's intent to strike or picket. This is the so-called 10-day rule. The Act contains no other dispute resolution procedural mandates between notice and strike. In Minnesota, the one-day strike on June 10 forced the hospitals to spend millions of dollars to pay and fly in 2,800 replacement nurses. Reports indicate that the enormous expense of this staffing emergency has galvanized each side even further.

As evidenced in the letter quoted above, the 10-day notice itself can become a negotiation within a negotiation. The union holds it as a sword and the employer conditions bargaining on not wielding it. The practical overall effect of the Act's 10-day notice is that it subjects patient care continuity to the uncertainties of the dispute without adequate legal protections or procedural safeguards. In effect, it puts patients "in the middle." Our nation's acute care hospitals along with physicians and healthcare workers necessarily navigate a daunting landscape of complexity to deliver care to patients day in and day out. Ten days is insufficient time to ensure true patient care continuity at a busy hospital, or 14 busy hospitals. In this writer's opinion, the Act should be modernized to require a longer notice period plus a series of mandatory dispute resolution steps and procedural safeguards between the issuance of a notice and a strike at an acute care hospital. The modern trend of the law is to seek out ways and means of dispute resolution that are better, less costly, and more just. The rationale for such a change to the Act's 10-day rule is neither pro-management nor pro-union. It is about keeping patients as the first priority of healthcare.

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