OPINIONS OF HOSPITAL DIETITIANS TOWARD UNIONIZATION OF FOOD SERVICE PERSONNEL

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INTRODUCTION

The hospital, influenced by its external environment, is being pressured by labor unions for recognition and the right to represent its workers in collective bargaining. Unions have expanded the boundaries of their organizational activities by their increased interest in service industries, especially the hospital, which is one of the largest industries in the United States.

Dissatisfied personnel within the hospital system, voicing the union philosophy of "more" are attempting to force for the right to be represented by a collective bargaining agent. Although the hospital is protected by federal laws from having to recognize and deal with labor unions, there has been a substantial increase in the number of agreements but the extent of coverage remains small.

Various constraints--technological, economic, and the organizational structure--are apparent in the hospital's effort to achieve its objectives. Even though the hospital has undergone continuous transformation as its boundaries of activities have expanded, the dominant goal has remained centered around the satisfaction of the many and diverse needs of the patient. A subsystem of the organization is the food service department, comprising one of the largest groups of employees in the hospital's work force. The dietary department director is delegated certain responsibilities and authority by the administration and should be prepared to face these demands and the challenges of his position. Dietitians, often more competent in technical than managerial skills, have become increasingly aware of the importance of organizational methods and management techniques in dealing with administrative and supervisory problems. As heads of departments, they have an

increased awareness of the need for more training and expertise in personnel administration. Miller (1960b) found in her study that dietitians recognized their insufficient knowledge in labor relations as one of the matters needing attention in the education of the dietitian.

Information is lacking on dietitians' opinions of labor unions in hospitals. Dietitians generally have opposed, however, unions for food service personnel in hospitals assuming that they interfere with it's work which must place the patient and his needs first. Even though there are indications that hospital administrators may be more willing than dietitians to accept union-management relations, they generally have disapproved and even resisted the entrance of labor unions into the hospital scene.

The purpose of this study was to provide data concerning the opinions of dietitians in a selected group of hospitals toward the unionization of non-supervisory food service personnel. The research was based on several hypotheses:

1. Dietitians have disapproved the unionization of food service personnel in hospitals.
2. Resistance by dietitians to accept the right of hospital food service personnel to be represented in a collective bargaining agreement, has been based on a lack of knowledge about labor unions.
3. Specific areas of the employer-employee relationship need to be evaluated.

REVIEW OF LITERATURE

History of the Hospital

Today's medical center, the hospital, recognized by McGibony (1969) as a phenomenon of the twentieth century, is one of the most complicated models of

human organization evolved by society according to Moss et al. (1966). The hospital as it is known today could hardly be recognized as a descendant of any of the institutions that flourished in ancient times (MacEachern, 1946).

Rosen (1963) pointed out that, sharing the characteristics of its society, the hospital has changed as society itself has been transformed but that providing care and shelter for the sick always has been assumed as a community responsibility. Warner (1937) agreed that these and other great needs were to be met in the hospital created by society for service to society.

Gentle care for the ill was provided in the ancient Egyptian civilizations in crude hospitals. MacEachern (1948) described temples in Greece that were places of refuge where sick people were ministered to in body and soul. Medieval hospitals developed to provide medical care, Rosen (1963) reported, also served as philanthropic and spiritual institutions. When hospitals were regarded as charitable establishments, Lentz (1957) said, it was considered appropriate that employees work for subsistence wages, which in itself was a form of charity. Such employment was considered a way of life, not just a job, according to Burling et al. (1956). Money not spent for wages was available for charity, and there was time and sympathy in greater amounts for patients when it was not spent on employees.

From the seventeenth century on, Rosen (1963) reported, physicians associated with administering to the ill began using the hospital for the study of diseases and for their own practical education. As the scientific and industrial revolutions continued through the nineteenth century, Kast and Rosenzweig (1969) pointed to the transformation of the hospital into a professional health center. Owens (1962) said that many forces of change had

originated outside the hospital itself. But since the early decades of the last century, these institutions have also become increasingly complicated as a result of accommodating more complex functions, additional personnel, facilities, and equipment.

The hospital has had to operate within constraints of present day knowledge and with relative scarcity of appropriate organizational resources. Among the objectives of this institution Georgopolous and Mann (1962) cited its own maintenance and survival, the stability and growth of the organization, its financial solvency, as well as educational and research programs accomplished through collaborative activity.

As in Europe the earlier hospitals established in the United States, McGibony (1969) reported, functioned as custodial institutions for the handicapped, the social unwanted, the pauper, and the sick. Georgopolous and Mann (1962) stressed that providing adequate care and treatment for its patients has remained the chief objective of the hospital through the centuries. The first hospital to open in this country was the Pennsylvania Hospital in Philadelphia in 1751 and it remains in operation today. By 1783, there were 178 hospitals organized and almost half were caring for the insane. About that time great progress and development began so that today, McGibony (1969) recognizes the hospital as an instrument of health. Not only does it devote itself to medical care of patients, it participates in preventive medicine, cooperates with public health and welfare officials, and continues to educate medical personnel.

History of the Dietitian

The profession of dietetics is a development of the twentieth century which as Lipscomb (1966) described, grew from the time of the visiting diet

instructor to the present concept of the science of nutrition and the art of management. MacEachern (1948) cited that in the days of Hippocrates proper diet was stressed, but it was Florence Nightingale, according to Cooper (1967) who by realizing the importance of properly chosen food in the treatment of disease, contributed a great impetus by laying an excellent foundation to the development of this profession.

Lipscomb (1966) stated that in spite of the youth of the profession, it is difficult to determine who first filled a role similar to that of a dietitian. In 1879 Sara Tyson Rorer, whom Barber (1959) called "the first American dietitian", took charge of the cooking in the New Century Club in Philadelphia where she prepared a course on diet suited for the sick. Lipscomb (1966) reported she gave these lectures to students of the Woman's Medical College and the nurses at Woman's Hospital. In those early days, dietitians were hired to teach simple cookery to nurses. But Barber (1959) said the dietitian did not reach stature that justified a distinct professional rating until the art of dietetics was united with the science of nutrition. Full recognition was not received until the profession of dietetics organized in 1917 developed into a strong and well integrated national organization.

The dietitian was described at the Eighth Lake Placid Conference on Home Economics in 1906, Lipscomb (1966) reported, as one who must have great executive ability, an abnormal amount of common sense, infinite patience, tact, a strong personality, and an up to date knowledge of the science of food and service, with the ability to adapt to the needs of the institution.

In educating the dietitian, an understanding of and sympathy with those among whom she works was cited by Lipscomb (1966) along with the possession

of executive ability and business knowledge. The dietitian should have the immediate direction of employees and authority that is required to accomplish the work. If the dietitian was hindered in exercising of this authority or was not capable of exercising it wisely, imperfection would result in the character of the food service.

The development of a profession composed of mostly women would have been rejected before the last century, so Northrup (1960) called dietitians "johnnie-come-latelies" among the professions. The short history of dietetics, Cleveland (1963) said, had been marked by a struggle to establish professional status. Dietitians, he reasoned, did not enjoy the role stability of a long history and the medical hierarchy that had been established for some professional groups but they seemed prepared to face the challenge.

Relations have been significant between unskilled and skilled workers and professionals in the dietary department according to Burling et al. (1957). Introduction of the dietitian into an established system imposed a supervisory level over cooks and chefs who were recognized craftsmen, proud of their competencies and jealous of their independence. Grounds for potential conflict over function and authority were produced when dietitians with high prestige were given formal authority over these artisans.

Georgopolous and Mann (1962) acknowledged that successful integration of non-skilled workers into the hospital system depended somewhat upon the workers' motivation. Greater effort by supervisors was needed to gain acceptance and recognition of their contributions to the hospital's efforts. There has been a trend toward equality, according to Burling et al. (1956), blurring the distinctions between these groups within the dietary department.

Food service was called by McGibony (1969) as one of the most important

activities in any hospital. No other department permeates the entire institution affecting patients and staff as intimately and continuously as the dietary department according to Burling et al. (1956). MacEachern (1957) also regarded food service as being intricately involved in the care of the hospital patient and believed that the dietitian had been permanently placed in the hospital.

In order to render the best possible care and service to patients, the profession of dietetics has contributed its administrative and management skills as well as scientific knowledge necessary to meet daily nutritional needs and to provide diet therapy (American Hospital Association, 1966). Concurring that organization and administration of the department must be entrusted to those adequately prepared by education and experience in the field, West et al. (1966) highly recommended for the dietitian an approved internship built on natural and social sciences.

Lipscomb and Donaldson (1964b) reported that education of dietitians has been directed toward a broad basic background in home economics with emphasis on the science of nutrition and the art of administration enabling them to assume the demands and accept the challenges of hospital dietetics.

History of the Labor Movement

Centuries of stable technology in medieval society have been characterized by an unchanging way of life for the common man (Kuhn, 1967). Most families supported themselves by farming but there were those who had skills in specialized crafts that had been passed from generation to generation with little change.

An early forerunner of today's labor unions was the traders' guild,

development of the eleventh century in England. With the growth of towns and guilds, various crafts formed separate guilds enabling them to hold a monopoly on production and sale of a commodity. The economy was carefully controlled under the combined scrutiny of the local government, the customer, and the guild which Kuhn (1967, p. 9) believed resulted in these relationships:

(1) neither too few nor too many persons would learn and practice a given trade;

(2) quality would be maintained;

(3) prices would be 'fair' and 'just'; and receive a satisfactory income as judged by the standards of the age.

The industrial revolution, beginning in the latter part of the eighteenth century, and its subsequent growth were thought by Kuhn (1967) to have brought important changes in the working man's economic environment. The feudal system, in which everyone had a necessary job to do for the community and the community provided for his needs in return, gave way to the capitalistic system. Another profound change was that production was no longer by individuals but was by enterprises. The worker, who could only produce as a part of an enterprise, was now an employee. He was no longer a manager or owner; specialization and mechanization had destroyed the value of his skills, and he could be replaced easily. Kuhn (1967) pointed out that the worker, in losing his independence because of industrialization, was faced with finding methods of countering this threat. Fear of unemployment was great. Because workers lacked assurance of continued employment, unions emerged as a device for bringing a measure of individual security into the employment relationship according to Beal and Wickersham (1967). Labor unions were considered by Tannebaum (1965) as one means of achieving greater measures of success in the economic realm. Perlman (1936) asserted that unionism, labor's instrument

for collective bargaining, was a technique that enabled an inferior group to carry on the never slackening pressure for a bigger share in the social sovereignty, for more welfare, and for security for its individual members. Unions have helped man to adjust to the problems that involved managers and the managed, and Bakke et al. (1967) believed its existence and growing strength for the past century and a half testifies to the union's survival value.

From the early background of guilds and the changing industrial scene, Estey (1967) noted the American labor movement had developed into a complex institution, the culmination of many years of activity, of expansion and regression, of ebb and flow. He believed it was the resultant of a myriad of economic and social forces, personal influences, and chance events. Aware of changes through the years, Tannenbaum (1965) also acknowledged the sensitivity of unions to the milieu in which they have grown.

At the start of the industrial revolution in Europe, labor was plentiful, according to Kuhn (1967), while land and capital were insufficient. In America, land was plentiful, while labor and capital were comparatively scarce. From the beginning of the settlement of North America, various devices such as higher wages and an opportunity for a higher standard of living even for the unskilled, were used to lure workers. Because demand was so great for his services, each skilled laborer could bargain face to face according to the times. Beal and Wickersham (1967) indicated that there was no need for collective bargaining for any workers until later in the eighteenth century.

As time went by, Beal and Wickersham (1967) declared that members of the same skill or craft who had united together in social clubs, attempted to

reduce and control competition by refusing to work with itinerants. Organized members of a group agreed on shop rules, established standards of daily output and daily wages among themselves and/or with employers, and negotiated with employers through spokesmen.

It was not until the closing years of the eighteenth century, according to Cohen (1970), that trade unions as they are known in this century appeared on the scene. Kuhn (1967) traced strikes and "disturbances" as far back as 1639 but indicated the local organization of unions for the skilled trades did not begin until 1793 when the shoemakers formed a union in Philadelphia. Vulnerable to economic recessions, however, most early unions disintegrated and disappeared.

As immigration increased and cities and the hinterland were linked by development of roads, canals and later railroads, the scene changed (Beal and Wickersham, 1967). The broadened domestic market and increased mobility of labor, Reynolds (1964) said forced competition among skilled craftsmen. The division of labor and increase in size of production units was fostered by this change of the market and contributed to the development of labor unions.

Craft unions continued to thrive following the Civil War, according to Beal and Wickersham (1967), but they were unsuccessful in organizing the factory system which was brought in by the industrial revolution. A significant and lasting breakthrough, it was to be more powerful than its handicraft counterparts. The factories which trained their own apprentices and semi-skilled employees did not seek help in controlling the entrance of workers into the various trades.

More and more workers depended on wage paying jobs, Tannenbaum (1967) said, and enterprises became larger. The employee had less frequent contact

with his employer, and the opportunities for understanding and identifying with each other decreased. So workers who were helpless, discovered through mutual association and experience that they had a common language, which fused them together functionally. This coalescence became the foundation upon which the trade union movement grew.

The American Federation of Labor, Estey (1967) noted, was founded in 1886 and was the first labor organization to survive the rigors of business fluctuations. The autonomy of national unions, exclusive jurisdiction of a union to represent a particular occupation, and the organization of unions by crafts or trades proved to be successful. Their economic power enabled them to bring pressure to bear on employers for their gains. There was an increase in the number of unions but because of continued resistance of employers much expansion was deterred in organizing factories. Hostility of the courts continued through the 1920's so most workers remained unorganized, but by the end of the 1930's, a new social environment and a new government attitude encouraged the unions. This favorable political and economic climate presented the labor movement with what Reynolds (1964) cited as an unprecedented opportunity to penetrate the manufacturing industries. Laws were enacted that provided workers with the right to organize and to bargain collectively free from interference, restraint, and coercion.

Estey (1967) acknowledged that this favorable environment provided for an expansion of unions, and total membership reached an all time high in 1956 of 18,470,000. Even though the country's labor force rose at a vigorous pace, the percentage of workers who were union members then dropped. Cohen (1970) reported that the total union membership in 1968 was less than one fourth of the 80 million persons in the work force. Estey (1967) also pointed out the

lack of expansion in membership and that changes within the labor organization have not been favorable to organized labor. There has been a shift in the work force from the blue-collar to white collar majority. The concentration of membership gains has been among unions in the service industries reflecting losses among the production industries. Ways (1963) noted that because service workers are rarely concentrated in large groups, it has been harder to unionize them than industrial workers.

Technological changes and rising productivity were credited by Estey (1967) for the production of more goods by the same number or fewer workers. Women, long regarded by the unions as difficult to organize, have changed the composition of the work force since their percentage has been rising slowly and steadily. Raskin (1970) recognized a need to accommodate the better educated union membership and considered reconciling the races and restoring labor civil rights coalition a big assignment for today's labor leaders.

Two objectives of American unions, according to Beal and Wickersham (1967), are to raise the standards of living of their members and to protect them from arbitrary employer actions in the course of employment. The individual cannot bargain for changes in his own job or working conditions without affecting others in varying degrees. Individual bargaining is ineffective but Finger (1957) observed that changes in individual employment could be gained by collective pressure on the employer, hence workers formed unions. Beal and Wickersham (1967, pp. 58-59) defined union objectives as follows:

1. To influence the wage and effort bargain; to take labor out of self-competition,
2. To establish a system of individual security; to obtain justice at the workplace.

3. To influence the rules for rule making; by the process of political representation to obtain legislative, executive, and judicial actions which promote the interests of individual unions, unions in general, and the welfare of the constituency of unions, and

4. To obtain power in the state and over the economy; by political means to create an economic and political environment conducive to the welfare of labor.

Tannenbaum (1965) identified conflict and control as by-products of concerns of unions and their members for job security and protection and enhancement of job interest. Various costs to management result from bargaining or union demands producing economic, power, and psychological sources of conflict. Conflicts in the union-management relationship have also been recognized as having constructive consequences. The union as a source of pressure on management has caused it to be alert, stimulated a desire of better and more efficient techniques of production. It also has been influential in improving personnel practices and in upgrading management.

The Union in the Hospital

Labor unionism has been recognized as one of the facts of life in the manufacturing and transportation industries, according to Osterhaus (1966), but not so in the hospital industry. Employees' rights to join unions have been well established but only recently have more employees in hospitals been allowed the privilege of bargaining collectively through their elected union representatives. Gotbaum (1970) also noted a pronounced organization lag in hospitals. Finger (1957) upheld the right of hospital employees to become union members.

History. In 1919 a San Francisco newspaper reported "Five Local State Hospitals' Employees Have Been Organized in California During the Last Two

Years" (Osterhaus, 1966). For the most part, however, the history of unionism in hospitals has dated back to 1936 at which time the American Federation of Labor successfully organized engineers and institutional workers, including the kitchen employees, in three large San Francisco hospitals. More than 50 years after unions began to have collective bargaining agreements with hospitals, only 555 of 7127 hospitals surveyed in 1967 by the American Hospital Association (AHA) had current contracts. There had been a 15% increase in signed contracts in the hospitals Osterhaus (1968) studied. Miller and Shortell (1969) found the increase in the number of agreements was substantial yet the number of employees covered remained small. Of almost 2-1/2 million workers in hospitals in 1969 (Anon, AHA, 1970) the number of employees covered by collective bargaining agreements was not known.

When labor unions began to organize hospitals, Walter (1937) found that hospital personnel management faced a perplexing problem in the formation and recognition of unions and the possibility that employees would strike to enforce their demands. Bluestone (1937) showed concern that workers had a tendency to strike to enforce demands that might or might not be reasonable. He saw a greater responsibility on the part of hospitals toward their workers and speculated that improvements would be made without the influence of the picket. He hoped grievances would disappear but was aware that differences would continue to exist.

Slow unionization of hospital workers was attributed by MacEachern (1957) to lack of interest in unions by professional employees, differences in motivation, and lack of financial resources for salary increases comparable to those provided by profits in industry. Lack of public sympathy with union pressures on charitable institutions also has been a strong influence.

The attitude of the American Hospital Association on collective bargaining was expressed in a statement that voluntary nonprofit health care institutions should be exempt from the provisions of the Labor-Management Relations (Taft-Hartley) Act (Anon, AHA, 1968). It further stated hospitals should be exempt from all legislative acts, federal and state, requiring them to bargain collectively with any unions or professional groups of their employees.

The Catholic Hospital Association adopted a somewhat different statement (Hospital Progress, 1967). It recognized the right of employees to form or join a union or association of their own choosing for representation in bargaining, to be free from reprisal for the exercising of such rights. The association further asserted that the hospital should recognize the right of an individual to choose not to deal with those whom employees elected to represent them.

Osterhaus (1966) substantiated the general belief of administrators that unions have no place in the hospital. The majority, however, were becoming more tolerant toward unions as long as their members did not interfere with hospital operations and management.

Sibson (1965) strongly implied that hospitals could remain nonunion if they chose but they needed the will to win. Raskin (1970) speculated that management would continue opposing the concept of unionism and would resist new union inroads as energetically as ever. The typical employer was recognized by Beal and Wickersham (1967) to prefer managing his business without a union. Unions lose 40 percent of the elections for union certification and they offered possibilities to management for conducting a successful program to beat the union in an election. French and Elbing (1961) presumed that management has become aware of the importance of an environment in which employees could satisfy their needs without a union.

Employees (Husband, 1969) look to their supervisors for leadership and when there is a union organization drive, Cook (1969) stressed that employees had a right to know the disadvantages as well as advantages of union membership. Official silence usually is interpreted by the work force as pro-union or as indifference or fear of the union. Hospital management, Riordan (1968) and Cook (1969) agreed, had a moral and public obligation as well as legal right to participate in such a campaign. It is free to react under the limits of the law and its efforts may have great significance on the outcome of the election (Hepner et al., 1969). Cruikshank (1959) and Riordan (1968) stressed that employees should have adequate opportunity to evaluate all relevant facts. Furthermore before the balloting, a decision on their acceptance or rejection of the union as his representative in collective bargaining should be made, not by the administrator, but by the employees (Davey, 1957; Cruikshank, 1959).

Rate of Unionization. Because of the lack of unionization, the lower economic workers including employees in hospitals have been among the most exploited of all American workers (Raskin, 1970). Holmquist (1953) stated that unionization of hospital workers was inevitable. He found no indications that unionization of this group would diminish; in fact, he believed there would be an acceleration in membership with a corresponding increase in the union's influence on employer-employee relationship.

Riordan (1968) said union leaders looking to new groups for membership have intensified membership drives, which Cook (1969) and Raskin (1970) pointed out would include hospitals. The majority of hospitals, Riordan (1968) noted, have recognized their vulnerability to the union organizer. Schmidt (1964) believed this vast group of unorganized employees was seen by

the organizer as a large and dependable source of membership and dues. Bailey (1954) had earlier recognized that the hospital was one of the almost entirely unworked fields to which labor leaders could turn. Hospital unions were reported by Metzger (1970) to have recruited members at a rate equal to and surpassing the growth of many industrial unions after the enactment of the Wagner Act of 1935.

Loss of workers loyalty has encouraged unionization in the hospital, according to Goodfellow (1966). Some managers have ignored the workers and their wants when making decisions and have downplayed their dissatisfactions. They have continued to introduce changes without explaining them to the work force. Some managers have used pressure tactics to secure high productivity and others have provided workers with only a minimum of information about the operation of the hospital. Such mistakes have encouraged anti-management attitudes that have strengthened the workers feelings of being left out and being ignored in the rush of hospital patients.

Cook (1969) agreed and said that employees joined unions when they lost confidence in their employers because of "confidence gaps." He identified these as lack of communication between employer-employees, unsatisfactory wages and working conditions, lack of priority for seniority, improper handling of grievances, and being stymied for future opportunities. Employers should have an understanding of peoples' problems, show a willingness to listen and communicate as well as maintain good community relations.

Gotbaum (1970) cited one of the primary objectives of the union in the hospital is to eliminate dead-end jobs as well as to improve the working conditions and wages of its workers.

According to Finger (1957) the hospital competes with industry in the

labor market. Hospital authorities have, Owens (1962) added, had to recognize that if working conditions and compensation were not comparable to those in industry, they would lose their workers. Beal and Wickersham (1967) stated that hospital management has had to be aware that in the industrial organization unions have protected the jobs of their workers through seniority and retraining opportunities necessitated by technological changes. Center (1959) reported that wages frequently are not the usual motivator but ranked in his study a poor third behind recognition and security. Finger (1957) pointed out that layoffs have been uncommon in the hospital but seniority represented security if and when layoffs occurred. It generally was conceded by the union that seniority could not be the only criteria used in staffing nursing units or in matters of promotions because the hospital's work depended greatly on the efficiency and ability of its employees. The possibility of emphasis on seniority at the expense of individual merit when a union organized the employees in the hospital was pointed out by Barres (1959). Wood (1959) also cited the union's interest in job tenure for its members.

Among the difficulties encountered in unionization of hospitals have been the size, location and organization of hospitals. Osterhaus (1966) reported that about half of all hospitals had less than 100 beds and were located in small non-industrial communities where it was expensive and difficult to organize. Unionization of the hospital usually has followed unionization of the community. Miller and Shortell (1969) observed that if the larger part of the work force in an area had been organized, hospital employees were more likely to turn to unions for help in gaining additional income and benefits. Public response to union activities was more favorable in larger places, but recently Gershenfeld (1968) noted many traditional union cities had shown little evidence of successful unionization in hospitals.

Schmidt (1964) found in the hospitals' labor force a high preponderance of women who lacked both permanency and labor-consciousness and elderly workers who probably have not understood or accepted the ways of modern unionization. Kochery and Strauss (1960) suggested there were some employees, especially older ones, who were willing to work for lower than union wages for the feeling of security provided by the hospital. Others would not risk joining a union because they knew they could be easily replaced by management.

McKersie and Brown (1963) studied various influences and results of influences on employees in a hospital where some of the workers were out on strike and were trying to force management to recognize their right to union representation. They reported the strong influence of social pressures on individual workers to conform, as well as the cohesiveness of the informal group. A strong moral commitment to the hospital's purpose of caring for the sick was noted in some employees. The cost of participation in the strike meant loss of income which was financial support for himself and his family. Attitudes of families influenced some workers. The "adventure" of a strike had a stronger appeal for younger than for older workers. There was a feminine fear of possible violence. Probably most influential of all were attitudes of management, especially the attitudes of immediate supervisors.

Interest in union organization in hospitals has been weakened by the arousal of community attitudes unfavorable to civil rights activities, according to Gershenfeld (1968). The heavy minority composition of the nonprofessional labor force has weakened organizational drives because objectives of the union and the objectives of civil rights groups have been increasingly at variance.

Kuhn (1967) pointed out that bargaining power for employees, which

resides largely in the strike or the threat to strike, is a potential and dramatic tool used by labor. The strike was identified by Kochery and Strauss (1960) as a by-product of unionism not the objective of its existence. According to Finger (1957) it is generally recognized that hospital employees do not enjoy the right to strike. Schmidt (1964) stated the strike could not be used against the hospital since employees would in essence be striking against the sick and could become involved in a conflict between labor and management. Miller (1967) said since the strike's impact is on the patient and not employees or management, it loses it's usefulness as a tool of collective bargaining in the hospital setting. As an administrator, Barres (1959) said he could have conceded the right of his employees to organize and bargain collectively but he could never accept their right to strike, which would interfere with the vital functioning of the hospital. Hospital workers have interests as employees, however, and Beal and Wickersham (1967) suggested they should be heard. They further stated that a renouncement of the strike for hospital workers could be questioned. Miller and Shortell (1969) noted that the frequency of work stoppages had been relatively low in hospitals and there never has been a complete strike against a hospital. Adequate services always have been provided because of the concern of the community that the hospital not be shut down (Barres, 1959).

Union Participation in Management. Managers always have had to work within restrictions, according to Kuhn (1960), and this included participation in joint decisions with workers and work groups even without a union. The presence of a union required only that the manager act within the limits of established policy, and union participation in establishing policy was not a new limit upon management's power. Rothmann (1966) asserted that hospital

administration must protect its managements rights, and remain aware of the hospital's responsibility for good patient care. Kuhn (1960) further stated that the unique function of management was not its decision making power but its requirement to coordinate and balance the multitudinous demands made upon the organization. As a result of a collective bargaining agreement, the hospital administrator might have an opportunity to exercise his right to manage with greater freedom than ever before. Unions and management generally have decided upon the scope of collective bargaining and the degree of union participation in traditional management areas on the basis of economic realities of their own situations. Miller (1967) questioned the unilateral authority that hospital management must have to make decisions for effective operation of a hospital and the extent of employee representation in decision making.

The overwhelming majority of union leaders and collective bargaining agreements recognize management's right to manage according to Davey (1957). However, unions seek to condition and limit management's rights to manage through contract provisions where the exercise of managerial discretion has a direct impact on the worker on the job. Conner (1966) recommended a positive program of cooperation to make life more tolerable for the hospital administration, the union, and the employees and viewed such a relationship as increasing the stature of management. Allen (1968) advised understanding of the basic characteristics of unions to deal successfully with organized labor but asserted that management really had little to fear from labor.

Labor Legislation Concerning the Hospital

The uniqueness of the voluntary nonprofit hospital, recognized by its exceptions in federal and state laws, was declared by Barres (1959) as

different from enterprises in private industry or even the profit-making proprietary hospitals. Beal and Wickersham (1967) asserted that the exclusion of hospital workers from the basic laws of union recognition had been justified on the basis of protecting employers who could not remain in business if they had to meet union demands. Somers (1969) suggested that hospital labor relations with regard to legislation and the practice of collective bargaining were in primitive stages although hospitals have been increasingly subjected to both federal and state labor laws.

Metzger (1969) found living with unions was a complex and ever changing situation and called attention to the constant need for evaluation of approaches and practices of unions because of the changing context of hospital administration and labor relations. It behooves everyone, Finger (1957) said, to become familiar with the statutes of the state in which he is employed, to determine the status of the hospital in relation to the laws and application of the laws. Metzger (1970) vividly pointed out that the hospital field should direct its efforts toward obtaining maximum legal protection in its dealings with labor unions.

The law has played a significant role in determining union growth according to Schmidt (1964). Gershenfeld (1968) believed the single most important factor accounting for the relatively low level of hospital unionization has been the lack of supportive legislation. Somers (1969) said labor relations laws have been passed in response to pressure however for some machinery to facilitate peaceful and equitable resolution of labor-management conflicts. The Toledo Plan (Bruner, 1959) and the Minnesota Charitable Hospital Act of 1947 (Carlson, 1965) have been cited as examples of such legislation.

The legislative trend at the federal level supported by organized

labor's considerable political power has been toward more and more central control of the economy, according to Carter (1967). At the state level, there is a perceptible trend toward legislation that extends the collective bargaining to public service or quasi-public service employees.

Federal Legislation. The National Labor Relations Board was created in 1935 by the National Labor Relations Act (the Wagner Act) to implement provisions of the law according to Beal and Wickersham (1967). The Board is employed to investigate, to hold hearings, and to issue decisions and orders on matters regarding union recognition, unionization of the enterprise, discrimination by management against union members, and refusal by the interprise to bargain. Hospitals were not included in this Act. The Labor-Management Report and Disclosure Act of 1959 (Taft-Hartly Act) provided protection for the employee from union restraint and coercion, and did not force employers to engage in collective bargaining. According to Cook (1969) the law says an employer must recognize a union as the sole and exclusive bargaining representative for its employees in a specific unit when so designated by the group. If in good faith the enterprise doubts that the majority of the workers desire to be so represented by this union and refuses to recognize the union as such, then a secret ballot election is requested of the National Labor Relations Board. The employer must not engage in unfair labor practices as defined in the law; such as discriminating against or threatening workers with reprisals or even making promises in an attempt to influence them from union activities.

The Taft-Hartley Act and the Landrum-Griffin Law of 1957 excluded employers of nonprofit hospitals and employees of completely nonprofit hospitals from the jurisdiction of the National Labor Relations Board. This meant

to Freeman (1964) that all national regulations of labor-management relations in nonprofit hospitals were withdrawn. Osterhaus (1966) agreed that nonprofit hospitals would not receive federal protection in efforts of workers to organize.

State Statutes. Since voluntary nonprofit hospitals are exempt from federal laws and the National Labor Relations Board declines to take jurisdiction, Hepner et al. (1969) said, control of hospital labor relations has become the responsibility of each state. Osterhaus (1966) summarized the applicable state labor laws.

Fifteen states have labor relations laws similar to the National Labor Relations Act that cover proprietary hospitals. Nonprofit hospitals are covered in only eight of these states, and they are excluded from coverage in the other seven states either through specific statuatory exemption of nonprofit organizations or through court decisions. Kansas and Minnesota are among the eight states with laws that specifically cover nonprofit hospitals. In Minnesota the extent of coverage has been determined by the courts. The seven states in which nonprofit hospitals are not covered include North Dakota, where exclusion is through statutory exemption.

Absence of legislation does not make hospital union activity illegal in these states, but Osterhaus (1966) noted such activity is left unprotected. Union and management disputants may battle freely over acceptance or rejection of collective bargaining. To this extent, the legal status of hospital employees in these states is similar to that of nonprofit hospital employees in states where nonprofit hospitals are exempt from coverage of state labor laws.

In 1939, passage of the Minnesota Labor Relations Act cleared the way

for labor unions to organize hospital employees, and Carlson (1965) recognized that this greatly aided unionization throughout the state. Wood (1959) reported this legislation had made it possible that any working individual was a possible union member in Minnesota. The Charitable Hospitals' Act prohibiting strikes and requiring compulsory arbitration of hospital-labor disputes not settled by conciliation was passed in 1947. This law required charitable hospitals to recognize unions as bargaining agents for their employees. It is apparent, according to Carter (1967) that the organization of Minnesota hospitals has been built to a significant degree upon this arbitration provision.

The "Toledo Plan," established in 1956 to settle hospital labor grievances (Bruner, 1959) was adopted by Seattle in 1958 (Freeman, 1964). A community board of appeals is composed of two members each to represent hospitals, unions, and the public. Policies agreed upon by union leaders and hospital administrators excluded strikes, work stoppages, and slowdowns. The plan gave employees the right to join a union without being subjected to discrimination because of union membership, provided employees with grievance procedures, and required hospitals to pay adequate wages.

Need for Future Legislation. Owens (1962) and later Metzger (1970) and Myers (1970) recommended a study of trends in federal and state legislation. Schmidt (1964) suggested that unions need more favorable legislation to gain national success in hospitals and that hospitals could expect a continued trend toward labor legislation affecting the voluntary hospitals. Metzger (1969) pointed out that there was need for a national labor relations act to protect hospitals' rights and for clear definitions of unfair labor practices for union and management.

Myers (1970) recognized that the hospital industry has become so interlinked with public interest that it requires intense surveilance by local, state, and federal political institutions. Beal and Wickersham (1967) advocated that the right to be or not be represented by a labor union in collective bargaining should be extended to cover those employed in hospitals. Myers (1970) agreed and predicted that organized medicine and organized hospital management would exercise leadership in shaping the framework to accommodate simultaneously the interests of the public, the medical profession, hospital management, and hospital employees. Since present legislation is inadequate, Myers advocated the establishment of an administrative board to determine appropriate bargaining units in hospitals. Miller (1967) said structuring of the bargaining units must consider the employees' interests in representation. Without specific legislation craft or departmental bargaining units such as dietary workers, will develop. Metzger (1969) referred to such a development as balkanization of bargaining units and he foresees proliferation of unions in hospitals. Carter (1967) predicted that with or without protective legislation, hospitals could expect increasingly frequent organizational attempts by unions in the coming years. Hospital administrators and board of trustees, he advised, must become aware of pending legislation and take appropriate action to prepare for the future.

Labor Relations in the Hospital Environment

Expansion of activities and diversification of goals have transformed the hospital's objective from that of individual patient care to the broader concern for total community health services, according to Kast and Rosenzweig (1969). This institution's prime concern remains that of saving lives and

Kochery and Strauss (1960) recognized that this can require quick decisions, instant obedience, and clearly identified authority when a human life is at stake. The Code of Ethics of the American Hospital Association (AHA, 1957) states that the care of the sick is the hospitals' first responsibility and a sacred trust.

The goals of the hospital (Hepner et al., 1969) are far different from those of industry. Cunningham (1960) said a hospital resembles a unit of government more than one of industry because its owners are public and its management is a trusteeship. Georgopolous and Mann (1962) described the hospital as an organization that mobilizes and relies heavily on the skills, motivations, and efforts of many widely divergent groups; Professionals, semi-professionals, and nonprofessionals; provides highly personalized service to individual patients through the attainment and maintenance of adequate coordination of their services. Hospitals provide vital services for public welfare and Strauss and Kochery (1960) emphasized that they are not like products that a consumer can decide to purchase, can elect a substitute, or can do without. People go to hospitals not because they want to go, asserted Kast and Rosenzweig (1969) but because they have to go.

Georgopolous and Mann (1962) indicated that economical efficiency is not entirely compatible with the hospital's traditional humanitarian objective. Barres (1959) defended the hospital against the union's criticism that this service has a high cost for direct labor, has round-the-clock service, keeps a standby service, and invests and maintains equipment that might be used as infrequently as once a month. Any enterprise of moderate size, according to Beal and Wickersham (1967) organizes and integrates its tasks so closely that every job is inter-dependent with all others. But many hospital functions

have not been routinized making it more difficult to establish structured controls for activities that are required for the care and treatment of patients (Kast and Rosenzweig, 1969).

Barriers to Management. Haimann and Scott (1970) recognized that good communications are essential in linking managerial functions in the organization but they are difficult to achieve and maintain. Information has been blurred due to status and role of members in the different echelons of the organization. Owens (1962) stated that human barriers in communications in the hospital were hard to overcome when he recognized the status differences. Kochery and Strauss (1960) noted that these differences made it more difficult for lower status employees to communicate upward in the hospital. The high degree of specialization implied that it was extremely difficult if not impossible for persons to move from one category to another. Kast and Rosenzweig (1969) pointed out the importance of status symbols in the hospitals' social system. The rivalry authorities and incongruent demands of different roles have been recognized as bases for conflict.

Conflict will always be in the work situation, Kruger (1964) predicted. It will be present in an ever changing work situation where employees continuously want more and where someone must manage as well as be managed. The complex employment relationship, recognized as a potential area of conflict, could be further complicated by the entrance of a union. Allen (1968) agreed with Kruger that the needs and desires of men are similar yet they also are varied. He also concurred with Gibb (1959) that empathy was important. Understanding and cooperation in a union-management relationship could result, he stated.

Moss et al. (1966) agreed that each individual in the hospital group has

his own set of values that he brings with him to the workplace and that limit the actions and proposals involving commitments of economic, technical, or human resources. Among individual differences are those in aspiration levels and learning experiences and motivations conditioned by perception. Kast and Rosenzweig (1969) stated that accuracy of role perception was important because of its impact on effectiveness and efficiency in organization.

Scott (1967) stressed that organizations must be concerned with motivation of their workers and must seek an understanding of the inner forces that energize and move individuals into accomplishing organizational goals. Tansiongkun and Ostenso (1968) supported Scott when they said that the individual should be encouraged to develop and utilize voluntarily his capabilities, his skills, his knowledge, and his ingenuity in ways that contribute to the success of the organization.

Flanagan (1964) identified human relations as one of the most vital aspects of management. By knowing his personnel and maintaining a high level of morale and motivation among them, the manager encourages improvement of job performance and is aware of their satisfaction with job and employer.

Five factors were identified by Herzberg (1968) as motivator factors intrinsic to job satisfaction: achievement, recognition, work itself, responsibility, and advancement. Dissatisfaction factors were policy and administration, supervision, interpersonal relationships, working conditions and salary, status, and security. If the motivator factors were absent the worker could be unhappy, but their presence did not make him want to work harder. If there were job enrichment opportunities there would also be economic gain and human satisfaction.

Maslow (1943) stressed that individuals are motivated to satisfy several different kinds of needs, some of which are more prepotent than others. If

any of a person's needs are unsatisfied at any given time the satisfaction of the most prepotent will be more pressing than that of the other needs. The components of the hierarchy of needs that he identified are physiological, safety, love, esteem, and self-actualization. MacEachern (1957) believed that some persons recruited from the labor market accepted hospital employment as a livelihood and not for fulfillment of personal motivation. A majority of unskilled workers in hospitals, however, were believed by Owens (1962) to identify the hospital's objective of helping the distressed, and would accept lower pay than they might receive elsewhere for their services. When basic needs, wants and complaints go unheeded, unheard and unanswered, Goodfellow (1969) said individuals seek help to achieve their needs through unionization.

Grievances. Hahn and Mote (1964) insisted that if management believed its employees were human beings who deserved just treatment, they must devise a method to assure them of this philosophy. Many authors, including Metzger (1967) emphasized the importance of the grievance procedure as a safety valve for the workers. Gershenfeld (1968) was convinced that if employers had unjustly refused to listen to grievances of dissatisfied workers, unions could succeed. Metzger (1967) said that a grievance existed when the employee was discontented whether the complaint was valid or not and as Pollock (1967) stressed, any complaint must be taken seriously because an employee may have felt mistreated. Camerano (1965) noted that if a grievance was ruled out and the difficulty did not cease to exist, it could "snowball" and become a source of increasing discontent. As Pollock (1967) said, every executive had to expect to run into some employee "griping," but he should see each "gripe" as a chance to help an employee, to prove to the worker that his problem was management's problem.

Robins (1959) cited the properly solved grievance as evidence of a climate and atmosphere that encouraged development of the individual and the institution. Management has become more aware, French and Ehling (1961) said, of the importance of the proper atmosphere and environment where employees could satisfy their needs without the help of a union, but management must keep up with the trends of the times or the unions will make gains.

The grievance procedure, Cohen said (1970), has proven a valuable instrument for uncovering causes of worker discontent and has helped labor and management work out various problems.

Clelland (1967) described the grievance procedure as an instrument for interpreting policy, even discovering needs for policy changes, and as a formal expression of upward communication to management. Procedures for grievances are essential to a good personnel program and have been declared the best defense against unionization. Whether a union was on the scene or not the need for a grievance procedure had been clearly established, according to Metzger (1967). The American Hospital Association has approved guidelines for the establishment of a procedure (AHA, 1968) whereby an employees' complaints or grievances can be heard.

The Organizational Structure of the Hospital

In identifying power in the hospital, Perrow (1965) recognized that it has shifted through the years from trustees representing community goals, to doctors representing the interest of the business-profession, and more recently to an administrative staff. When hospitals were regarded as charitable institutions, board members held the highest place in the authority system but this changed when they learned it paid to have a full time representative handle the management of their institution (Lentz, 1957).

The board, the administrator, and the staff have been united in the common task of providing adequate patient care but Burling et al. (1957) stated that each had his own special interest in particular aspects of hospital activity and had initiated changes related to its special interests. None of these three has had complete authority to effect changes, but changes could be carried out through agreement and cooperation of all three.

One obvious difference between hospitals and industry, according to Perrow (1956), is the system of multiple authority or multiple subordination. Lentz (1957) identified the power structure in the hospital as being three pronged; the board members, the medical staff, and the administrator. The hospital employee could find himself responsible to all three sources of authority.

The Board. The supreme authority of the hospital is the board of trustees and accordingly should have full power for its conduct and efficient administration according to the Code of Ethics of the American College of Hospital Administrators, American Hospital Association (1957). Burling et al. (1957) named the board of trustees as the important link between the hospital and the community and which, according to Tappan (1968), is legally responsible to the patient, to the community, and its sponsoring organization. The trustees, as the name implied, are trusted with the responsibility of holding the properties and funds for the public's interest, according to Lapp (1943). They had a duty to keep abreast of modern medical, social and hospital progress enabling them to provide services with a reasonable degree of efficiency and standards of medical care.

This governing board, McGibony (1969) asserted, has legally and morally

the ultimate responsibility for operation of the hospital, including standards of patient care.

MacEachern (1957) recognized that hospital administration was one of the most highly professionalized of the professions. Because the complexity of the hospital entailed a variety of activities and a grave responsibility, only a person with special training and vast experience should be its head. In order for the hospital to operate most effectively Horty (1963) emphasized that the board must set policies and delegate authority. Tappan (1968) stressed that the board must select a competent administrator with specialized training to prepare him to cope with the complex, complicated organization of the hospital.

Insuring permanence of the hospital and its services imposes a responsibility for financial management according to Burling et al. (1957). Owen (1962) agreed that providing the services of the hospital raises unique financial problems. McGibony (1969), in recognizing the everpresent problems of financing the hospital, alledged that every effort must be exerted for efficient and economical utilization of available resources. To get the most for monies spent without compromising patient care means adequate financing and control of expenses. Lentz (1957) and Osterhaus (1966) concurred that the typical nonprofit hospital has tried to maintain itself at or near the breakeven point and that there are no profits under this policy. Carter (1967) considered it a management responsibility to explain to employees the narrow margin involved in the hospital's operation of financial matters.

Burling et al. (1957) cited an early assumption that any good man could learn the rudiments of the job of administration. In those early days the "superintendent" hired personnel, maintained property, and saw that

physicians' orders were carried out. Various developments in the hospital, however, have been changing the administrator's responsibilities, especially the coordination of the diverse activities of the system, according to Owens (1962). The hospital is a highly departmentalized, highly specialized, highly professionalized institution as well as a human system according to Kast and Rosenzweig (1969). The success of any hospital McGibony (1969) stated, is more dependent upon the competency and attitudes of these personnel, from the administrator to the least skilled workers, than upon almost any other factor.

Georgopolous and Mann (1962) asserted that in the hospital, the high degree of specialization and professionalism implies expertness and knowledge. Professionals and specialists cannot perform their functions without supportive personnel and auxiliary services. Much of the work performed in the hospital has been by influential professionals and not the low status workers, which has created administrative and operational problems. Sound personnel organization, written policies and procedures, and competent supervision at all levels have been acknowledged as the best of investments in the maintenance of efficient management, financial stability, and quality care. Tappan (1968) stressed that a sound organization must be established if the administrator is to accomplish the goals of the hospital. Success in managing depends on the stability of the administrator to understand and predict human behavior according to Owens (1962).

The individual transient patient who requires personalized service, Georgopolous and Mann (1962) said, is dependent at every point on his interaction with those who have been entrusted with his care and with the skills, actions, and interactions of many different people. Day-to-day adjustments

must be made to meet demands that lack uniformity, that are variant because the requirements of time, skills, and equipment could not be programmed in advance with automatic precision. This has forced the hospital to take on an autocratic character so maximum efficiency could be achieved and performance could be predicted.

The board, Terenzio (1964) stated, should establish a policy based on an objective appraisal of the labor situation, which should then be explained to supervisors, accepted by the community, and understood by employees.

The Administrator. One responsibility of the board, McGibony (1969) said, is to select as administrator for the hospital, a suitable executive who will act as the sole agency of the board and to whom they delegate corresponding authority and who functions without their undue interference. He is the liason between the board and the medical staff, the board and the employees. Tappan (1968) agreed that the board should delegate the administrator the total business of the hospital. As its manager he is the only one, McGibony (1969) said, who is continuously aware of the total activities of the hospital. Because of his detailed knowledge of hospital affairs, Burling et al. (1957) pointed out the administrator has leverage through which he can influence board decisions. Moss et al. (1966) recognized that even though the administrator is not the final "boss" he is in a position to control the flow of most information going into the decision making process.

The role of the administrator, according to Moss et al. (1966), is a unique juncture of three sets of relationships: (1) relationship with sources of political, legal and financial support, (2) relationship with sources of technical and professional support, and (3) relationship with potential or actual patients.

Duties of the hospital administrator identified by Tappan (1968) include establishing a sound organization, holding leaders together, coordinating activities, making decisions, reviewing existing policies, laying foundations, planning, persuading, managing and delegating work.

The administrator, to perform his duties, must delegate part of his responsibilities to department heads and MacEachern (1957) said the extent of delegation and authority depends upon the size of the facility. Tappan (1968) added that delegated functions must be assigned by the administrator, who chooses the best available persons for their positions and who would be accountable to him. Leaders who have been delegated specific functions to perform are expected to coordinate, direct and even control the activities and working relationships of organizational workers, according to Georgopolous and Mann (1962). Administrative, technical and human relations competencies would enable these department heads to meet the needs of their positions.

The Dietitian. Kirk (1959) recognized the dietitian, as head of the hospital's dietary department, as a professionally trained person with great responsibility and the knowledge to meet the responsibilities with firmness and confidence. If the dietitian's preparation provided opportunity for problem solving, decision making, and all aspects of dealing with personnel, he would be a confident and assured person. To perform effectively the dietitian as a department head must have competencies in several areas and the competencies must be at that management level of the hierarchy in the opinion of Coffman (1956). Competencies he selected as important were ability to apply technical ability to motivate individuals and groups, breadth of perspective necessary to set meaningful objectives, and ability to coordinate and integrate activities in the department and with the larger organization.

The American Dietetic Association (ADA) Standards for Effective Administration of a Hospital Department of Dietetics (1963) states, "The director of dietetics is a member of the American Dietetic Association with leadership ability, vision and appreciation for all phases of department and hospital operations and with varied, progressively responsible dietetic experience." This director selects a qualified staff and then assigns appropriate responsibility and authority to the lowest practical level. In seeking persons to fill the primary department heads in the hospital, one administrator (Ross, 1967) reported he looked for technical competency, people proficiency, problem-solving quotient, and salesmanship.

Lipscomb and Donaldson (1964b) regard executive ability as the most essential qualification for success in the dietetics profession.

Cartmill (1956) visualized the dietitian as a food service executive, a member of a large well knit team whose efforts must be aimed toward the required care for patients and whose prime function is to produce and serve appetizing food on an efficient economical basis.

Dietitians who administer and direct departments, Robins (1959) said, must have professional skills and competence, and these skills must be kept up to date to insure effective functioning of their departments. Difficult problems of supervision are manifested as turnover, promotability, indifferent or sloppy performance, lack of self control and self discipline, and lack of personal responsibility in both employees and supervisors.

Northrup (1960) acknowledged creative thinking as one of the executive characteristics that must be displayed by the dietitian. Favorable characteristics of dietitians were reported by West et al. (1966) as creative and analytical thinking, good judgment in thought and action, initiative, confidence or the ability to act with assurance and vision.

Kallejian (1955) and Cartmill (1956) suggested that the dietetic profession might have neglected the management function in favor of scientific areas and that the hospital needed the food service executive, a management person. Tendencies for dietitians to remain strong in the scientific disciplines could have been based on the history of the profession. In the education and training of dietitians, the emphasis has been on scientific expertise and greater opportunities have been in the scientific areas. Cleveland (1963) concurred that dietetics has offered opportunity for intellectual gratification in a scientific area.

"Dietitian" so defined in 1955 exemplifies the current point of view as to training and experience (Barber, 1959, p. 4). "A dietitian is a member of the profession of dietetics, which deals with the science, the technical aspects and the art of feeding people." A dietitian also was acknowledged as a qualified member of the administrative staff who directs the operation of a dietary department in hospitals and other facilities.

Lipscomb and Donaldson (1964) reported that the hospital dietary department directors perceived their positions as encompassing those of responsibility and authority. Administrators, however believed these department heads were fulfilling the technical aspects of their positions to a greater extent than the managerial aspects. Cartmill (1958) pointed out that the dietitian who can be seen as top management by some, receives authority from and is directly responsible to an administrator who has received his authority through the board of trustees. Seen as the head of his organizational unit, he sets policies, makes decisions; checks policies and results, and provides the environment, tools, and materials used in meeting the objectives.

Hornaday (1963) asserted that dietitians like to direct others, to be in

a position of authority, and to be in situations where it is possible to influence thought and activities of others. A study by Cleveland (1963) also indicated that dietitians were concerned with influencing and manipulating others and appeared more status-conscious and achievement oriented than nurses.

Human relations constitute, Flannagan (1964) said, one of the most important aspects of management at all levels of administration. Gibb (1959), in emphasizing the importance of human relations, cautioned the dietitian that as an administrator he must learn that people are more important than getting the job done, the dietary habits of people or administrative practices or rules. Frequently the dietitian, as do other professionals, becomes more impressed with the "thing-requirements" of the professional job and the importance of technical competency than with the people served. He strongly advocated that the dietitian learn to relate to people as persons not as tools to be used in getting a job done.

Lipscomb and Donaldson (1964a) emphasized that if the functions of the dietary department were to be fulfilled, the director needed the assistance and cooperation of employees. To utilize the abilities of personnel effectively, the dietitian must be able and willing to delegate responsibility and commensurate authority. Their findings revealed that dietary department directors delegated authority to a lesser degree than their assistants estimated this responsibility or authority to be. Also, the assistants believed their authority was less than the responsibility. Rourke (1955) pointed out that proper delegation would improve the operation of the department.

Findings by Hubbard and Donaldson (1968) supported the assumptions that hospital dietitians, regardless of the kind of positions occupied, performed

some administrative activities and that different levels of ability were expected in different positions. Dietitians need technical ability as well as human and conceptual abilities at all organization levels. The proportion of technical ability needed becomes less the higher the position, but this ability is necessary to administrative performance for all types of positions.

The dietitian's ability to educate and train others has become an added requisite for managerial success according to Miller (1960a). The modern administrator must be concerned with the technical problems of organization and of efficiency in production; and he must be an artist in human materials or his effectiveness would be reduced if not nullified. Good personal relationships and morale must be established and maintained between and among workers at every level of management and should be considered a potent determinant of efficient and cooperative productiveness within a whole operation.

PROCEDURE

The scope of the investigation was to include dietitians who were food service directors in hospitals with 200 beds and over in the West North Central district of the United States as defined by the American Hospital Association. Only those facilities classified as general, short term, nonprofit, nonfederal governmental hospitals were studied. Classification data were obtained from the Guidebook, Part 2 of the August 16, 1969 issue of Hospitals, Journal of the American Hospital Association. The seven states in the West North Central district (Region VI) are Iowa, Kansas, Missouri, Minnesota, Nebraska, North Dakota and South Dakota (Figure 1). In this study, the dietitian is a specialist educated for a profession responsible for the nutritional care of individuals and groups, according to The American Dietetic Association (1969).

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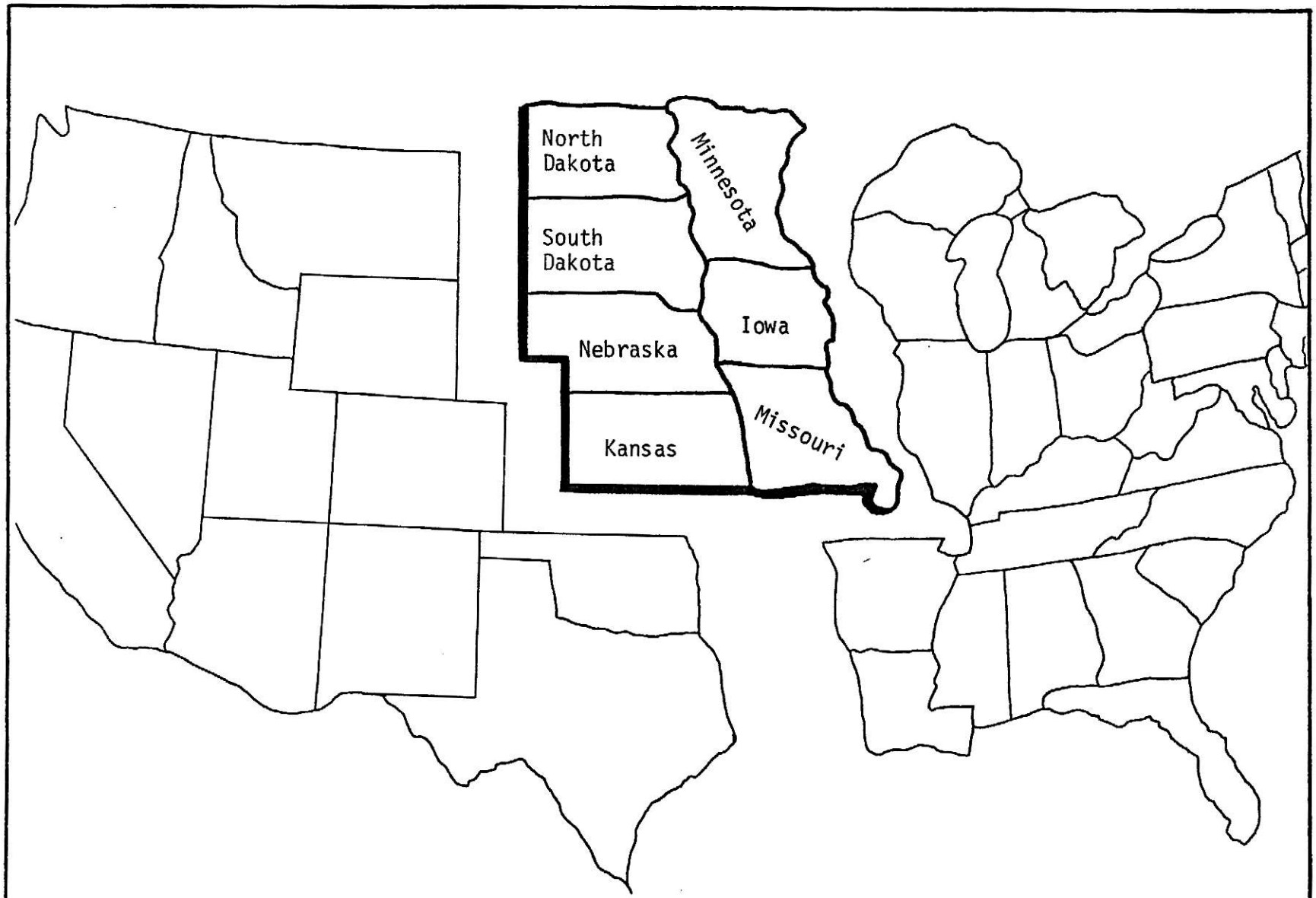

Figure 1. States participating in study.

A mailed questionnaire was selected to secure data for this research. Various studies used in surveying attitudes were reviewed, specifically those related to labor relations and studies in which dietitians participated. Detailed development of the instrument is included in Appendix A. The first part of the questionnaire was related to classification of the food service director and the hospital employing him. The other part was concerned with queries related to the director's opinions of unionization of hospital food service employees. Instructions for completing and returning the questionnaire were included in the cover letter. This letter also gave a brief explanation of the study, requested cooperation in the project, and assured anonymity for the participants. Copies of the cover letter and questionnaire are included in Appendix B.

The research instrument was reviewed at various stages in its development by faculty members from the departments of Institutional Management, Foods and Nutrition, Statistics, and the College of Business Administration.

The questionnaire was pretested for clarity and appropriateness by a selected group of 18 dietitians. All but one were dietitians in hospitals with 200 beds and over and were located outside the West North Central district. Sixteen pretest questionnaires were returned but only 15 (88%) were received in time to be reviewed and have their recommendations incorporated into the tool. Returns represented eight states scattered from the midwest to the east coast. Dietitians from five private, nonprofit hospitals participated in the pretest; also two private nonprofit hospitals with dietetic internships responded. Two dietitians were employed in city hospitals; one of these hospitals was unionized, the other was not. Two other dietitians were in state university hospitals; one facility had an agreement, the other

did not. One federal governmental hospital with a dietetic internship that had a union agreement participated. One long term nonprofit hospital had a contract, another had no formal agreement but some employees were members of a union. One dietitian, a former Head of a Department of Institution Management and college professor, who is now a consultant, cooperated. Pretest responses were tabulated to check the method for tallying the instrument. Comments were studied and recommendations were incorporated into the questionnaire.

Names of dietitians employed as dietary department heads in the hospitals were not available from The American Dietetic Association,[1] or the state hospital associations.[2] Therefore, the letter and questionnaire were addressed to the Food Service Director. This title was used because it was presumed some departments were directed by persons other than dietitians. A self-addressed envelope for easy return of the questionnaire was included.

Two weeks following the initial mailing, a second letter and questionnaire were sent to the entire group being studied. A new cover letter, a copy of which is in Appendix C, restated the importance of the study and encouraged participation. Another self-addressed envelope was included.

Results were tabulated and analyzed by the Kansas State University Statistical Laboratory using the chi-square test of significance, frequency distribution, and percentage data.

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[1]Private communication from Ruth Yakel, Executive Secretary, The American Dietetic Association, August 14, 1970.

[2]Private communication from Stuart Mount, Executive Director, Nebraska Hospital Association, August 7, 1970 and Ted O. Lloyd, Executive Director, Missouri Hospital Association, August 11, 1970.

RESULTS AND DISCUSSION

Of the 105 questionnaires mailed, 91 (86.6%) were returned and 82 were tabulated for analysis. Detailed information regarding returns from the initial and follow up mailings is in Appendix D.

Minnesota and Missouri each had 24 hospitals reporting (Table 1). The hospitals with 200-299 beds accounted for 34.2% of the respondents and there were 24 facilities (29.2%) with 500 beds and over. Forty-four of the hospitals were in cities of 100,000 and over, representing 56.4%, and most of these were in Minnesota and Missouri. Only 15.4% of the hospitals were in cities whose populations were classified as 10,000 - 25,000.

Seventy-two hospitals (87.8%) managed their own food service departments (Table 2). Of the 10 who had contract services one was in a facility with 300-399 beds, another in a hospital with more than 500 beds. The remaining eight contract operations were in hospitals with 200-299 beds. Five were in Missouri but no contract operations were reported in Minnesota or South Dakota. In facilities reporting dietary departments under contract management, no administrative dietitians were employed but there were three therapeutic dietitians.

Although letters and questionnaires were addressed to the food service director, the actual title of the respondents, all employed full time, varied in the different hospitals. Fifty-eight, or 70.7% of the participants (Table 2) were registered dietitians. This compares favorably with a survey made by the ADA (Anon, 1964) in cooperation with the AHA in which 72.4% of the hospitals with more than 200 beds who managed their own food services, had a dietitian in charge. Only 57% of all hospitals in that survey, however, had individuals with college degrees directing the food service.

Table 1. Hospitals participating in study.

State	Bed capacity						Size of cities in thousands					
	200-299	300-399	400-499	500 and over	Total No.	Total %	10 to 25	25 to 50	50 to 100	100 and over	Total No.	Total %
Iowa	4	6	0	2	12	14.7	2	3	4	3	12	15.3
Kansas	5	1	1	3	10	12.2	1	0	2	7	10	7.8
Minnesota	3	4	9	8	24	29.4	2	1	3	17	23[1]	30.0
Missouri	8	5	2	9	24	29.4	4	1	5	11	21[1]	26.9
Nebraska	2	1	1	2	6	7.4	0	0	0	6	6	7.7
North Dakota	2	0	0	0	2	2.4	1	1	0	0	2	2.5
South Dakota	4	0	0	0	4	4.8	2	0	2	0	4	5.0
Total	28	17	13	24	82		12	6	16	44	78[1]	
%	34.2	20.7	15.9	29.2	100.0		15.4	7.7	20.5	56.4		

[1]Information not given on some questionnaires.

Table 2. Distribution of respondents by states.

	Respondents	ADA dietitian[1]		Food service manager		Food service management	
		Administrative No.	Therapeutic No.	With degree No.	With no degree No.	Hospital No.	Contract No.
Iowa	12	7	2	1	2	11	1
Kansas	10	6	1	1	2	8	2
Minnesota	24	22	0	2	0	24	0
Missouri	24	11	0	4	9	19	5
Nebraska	6	3	0	2	1	5	1
North Dakota	2	2	0	0	0	1	1
South Dakota	4	4	0	0	0	4	0
Total	82	55	3	10	14	72	10
%	100.0	67.1	3.7	12.2	17.1	87.8	12.2

[1]Registered members of The American Dietetic Association.

Only three respondents in the present study classified themselves as therapeutic dietitians (Table 2). Minnesota had the greatest representation of dietitians serving as head of the dietary department (22 or 91.7%). Missouri had 11 ADA members, four directors with a baccalaureate degree in some area of food service management, and nine who had no college degree. The greatest number of participants who had earned degrees had bachelor's degrees in dietetics, institutional management, foods and nutrition or restaurant management (Table 3). Ten dietitians had master's degrees, and one held a doctorate. Forty-eight reported having completed a dietetic internship.

Thirty-nine respondents were in the 35-50 age group. Only two were under 25 years. Responses to questions concerning length of time in the profession paralleled the age groups. Over 70% of the respondents were female (Table 3) and, as might be expected in a predominantly female profession, only four (7%) of the ADA dietitians were male. Eight of the 10 managers who were not dietitians were male.

Food service directors were asked to provide information on the number of staff in their departments (Table 4). The numbers of persons in each

Table 4. Numbers of personnel in participating hospitals.

Size of hospital	Personnel					
	Dietitians		Supervisors[1]		Nonsupervisory[1]	
	Ave. No.	Range	Ave. No.	Range	Ave. No.	Range
Beds						
200-299	2.3	1-5	3.1	1-6	44.3	24-90
300-399	4.0	2-7	5.0	1-9	59.5	34-105
400-499	5.8	2-9	4.8	2-8	66.0	37-120
500 and over	11.0	3-28	9.7	1-25	123.5	40-248

[1]Two part-time personnel were counted as 1 full-time person.

Table 3. Characteristics of responding food service directors.

Title	Total No.	Total %	Sex Male	Sex Female	Age under 25	Age 25 to 35	Age 35 to 50	Age 50 and over	Highest degree earned Bachelors	Highest degree earned Masters	Highest degree earned Doctorate
ADA administrative dietitian	55	67.1	3	52	2	9	29	15	44	10	1
ADA therapeutic dietitian	3	3.7	1	2	0	1	1	1	3	0	0
Manager, with degree	10	12.2	8	2	0	4	4	2	10	0	0
Manager, no degree	14	17.0	12	2	0	2	5	7	0	0	0
Total	82	100.0	24	58	2	16	39	25	57	10	1
%			29.3	70.7							

classification probably varied widely because of the differences in qualifications of the professional staff, the supervisory staff and the other personnel. Other factors that would influence the selection of the staff were physical facilities and the objectives of the hospital. Because of his responsibilities of management, the food service director is recognized as a leader who is in a position to influence his group (Peterson, 1954). In the dietary department this is a significant number of employees, according to Ross (1968).

Management Practices

In response to questions concerning management practices, 95% had written policies on file but only 87.7% stated they had written procedures (Table 5). Only 3 reported not having written job descriptions. Even if the organization had sound policies for management of personnel, Chruden and Sherman (1968) indicated that implementation of the policies often fell short of what was supposed to be practiced. Policies and benefits must be established by management, Husband (1969) said, as the first task if it was to deter a unionization attempt.

Among the areas of responsibility assumed by supervisory staff, 98.7% cited on-the-job training but only 61.7% acknowledged having organized training programs (Table 5). Most all reported counseling employees about their work but only 64.2% indicated they counseled about personal matters. Evaluation of job performance of workers was recognized by 95% of the participants as a supervisory responsibility. Meetings to dispense information were held by most food service directors, but only 65 (80.2%) conducted meetings to discuss departmental problems. Intervewing applicants, hiring, discharging

Table 5. Management practices of hospitals studied.

Question		Bed capacity 200-299	300-399	400-499	500 and over	Totals	%
No. 2	Dept. has written policies	27	16	11	24	78	95.1
	written procedures	24	14	10	24	72	87.8
	written job descriptions	27	17	12	23	79	96.3
No. 18	Interview applicants	21	16	11	24	72	88.8
	Hire	17	13	11	20	61	75.3
	Discharge	20	13	11	22	66	81.5
	On-the-job training	27	17	12	24	80	98.7
	Organized training	16	10	10	14	50	61.7
	Counsel employees about work	24	17	12	24	77	95.0
	Counsel about personal matters	13	13	8	18	52	64.2
	Evaluate job performance	24	17	12	24	77	95.0
	Information meetings	24	17	13	21	75	92.6
	Discuss department problems	20	13	12	20	65	80.2
	Write job descriptions	20	16	11	21	68	83.9
	Hear employee complaints	18	16	12	24	70	86.4
No. 14	Have grievance procedure						
	yes	22	14	12	19	67	83.8
	no	6	3	1	3	13	16.2
	total	28	17	13	22	80	100.0
No. 22	Employees assist in decisions						
	yes	12	9	3	8	32	39.5
	sometimes	15	7	9	16	47	58.0
	no	1	1	0	0	2	2.5
	not sure	0	0	0	0	0	0.0
	total	28	17	12	24	81	100.0

Table 5 (concl.)

Question		Bed capacity 200-299	300-399	400-499	500 and over	Totals	%
No. 3	Vacancies filled by:						
	merit	7	4	1	2	14	17.5
	seniority	1	1	3	0	5	6.2
	merit and seniority	18	11	8	18	55	68.8
	tests	0	0	0	1	1	1.3
	merit, seniority, tests	1	1	0	3	5	6.2
	total	27	17	12	24	80	100.0

personnel and preparing job descriptions usually were assumed by supervisory staff members.

The majority of the hospitals confirmed that supervisory personnel are responsible for hearing employees' complaints and that they have guides for employees to use when voicing grievances about their work (Table 5). Larger facilities were more likely to have written grievance procedures than the smaller ones. In the hospitals with 500 beds and over, 22 (92.5%) had such a plan. One respondent in a facility with 200-299 beds reported there was no guide but that "employees know about the 'open door' policy that we have in our department."

When asked about the extent of worker participation in making decisions, (Table 5), one third of the respondents affirmed that employees should assist in those decisions that affect their work, but 57% said they should be involved only some of the time. Work groups, Richards and Greenlaw (1966) reported, tended to identify with and give greater support to decisions which they have participated in making but they did not possess the knowledge and skills which would permit them to contribute effectively to making some decisions.

Vacancies on the food service staff were filled on the basis of merit and seniority in 55 (68%) facilities (Table 5). Only 5 (6%) reported using a test in conjunction with merit and seniority. Another 6% replied that seniority was the only basis for replacing employees.

Participants in this study were asked to rate 10 items that they have recognized as important to their employees (Table 6). Items were ranked from the most important factors to those they considered to be of lesser importance. Good wages were ranked as most important, followed by appreciation

Table 6. Food service directors' ranking items important to employees.

Question		Rank[1] 1 No.	2 No.	3 No.	4 No.	5 No.	6 No.	7 No.	8 No.	9 No.	10 No.
No. 24	Items										
	good wages	25[2]	13	9	6	1	4	4	4	3	1
	appreciation of work	22	10	6	16	12	6	5	3	0	2
	job security	20	18	12	10	5	3	8	4	0	2
	working conditions	19	15	19	6	8	6	3	2	1	3
	"in" on things	11	5	14	14	14	7	7	5	3	2
	interesting work	7	6	7	2	7	7	16	9	11	10
	help on problems	5	1	3	8	7	6	7	10	14	21
	promotion, growth	4	7	8	10	11	15	3	8	10	6
	tactful disciplining	4	0	3	6	8	10	12	14	15	10
	loyalty to workers	3	0	0	5	11	14	7	17	20	5

[1]Rank was from 1 to 10, with 1 the "most important."
Not all respondents rated all ten items.

[2]The number underlined indicates the highest number of respondents ranking the item.

for work done, job security and good working conditions. The satisfaction or dissatisfaction of any factors could influence the employee's attitudes about his work and his employer. Employers have rated elements of job satisfaction differently than their employees, according to Mote and Gehring (1963).

An open end question asked respondents to list the three most urgent demands on their time as department heads. More than a third specifically identified personnel problems as one of the demands. Others mentioned at least one demand associated with human relations. Communications at all levels in the organization but especially those with employees within the department were cited as demanding much time and effort.

When the food service directors were asked the question if they knew what their employees wanted from their jobs, most replied that they did most of the time. Among the comments to this question were:

> Each employee has different reasons, some because they enjoy working, others due to a humanitarian aspect and some to supplement family income or to support themselves.
>
> Satisfaction in doing a good job--also wants compensation for work.
>
> At least what they say they want.
>
> This varies so, particularly among part-time employees, it varies with age and ability of each employee.
>
> I think this varies with the individual and wants have to be satisfied accordingly.
>
> This varies from time to time even with the same individual.
>
> I think!! Think may be the problem--we may think we do when we really don't.
>
> Judging from the rate of turnover of full time employees we have good understanding.

Association with Labor Unions

Many respondents (65.8%) had had no associations with labor unions either through their own membership or through a member of the family (Table 7). Only two participants had been or were union members and just 13 (15.9%) had ever had a member of his family belong to a union.

Dietitians in Minnesota and Missouri apparently were more familiar with labor laws of their states than the other food service directors in the study. Only 45% of the entire group agreed they were familiar with labor legislation affecting hospitals.

The same approximate number of participants (Table 7) were unaware of recent changes in the number of hospital-union agreements as there were those who conjectured that there had been an increase.

Disapproval of labor unions (Table 8) was expressed by 40 (48.8%) of the food service directors who completed the questionnaires. Nineteen did not approve of unions for professionals but did for others; 10 were in favor of unions, and nine said they approved of them but would not join a union.

ADA dietitians expressed disapproval of labor unions (44%) and this opinion is contrasted in Figure 2 with the opinions of the total group of food service directors who participated in this study. Approval of unions by dietitians (13%) is about the same (12%) as that of all respondents. Figure 3 contrasts the opinions of ADA dietitians with the opinions of food service managers with degrees who expressed the strongest disapproval of unions (80%), and with the food service managers who did not have degrees. These opinions were contrasted in Figure 4 with two other studies. Erskine (1962) reported on professional and business persons who had greater acceptance of unions (64%). Vaden's study (1965) showed stronger disapproval of unions than

Table 7. Respondents' knowledge of labor unions.

Question		Iowa	Kans.	Minn.	Mo.	Nebr.	No. Dak.	So. Dak.	Total No.	Total %
No. K	Current, previous union member								2	2.4
	self								13	15.9
	member of family								4	4.9
	self and member of family								54	65.8
	no answer								9	11.0
	total								82	100.0
No. 8	Familiar with labor laws									
	very much	5	6	13	9	3	0	0	36	45.0
	somewhat	7	3	10	15	3	2	3	43	53.7
	not at all	0	1	0	0	0	0	0	1	1.3
	total								80	100.0
No. 10	Recent change in number of hospital union agreements									
	same	0	0	2	1	0	0	0	3	3.8
	ten percent decrease	0	0	0	0	0	0	0	0	0
	ten percent increase	8	5	11	9	3	1	1	38	47.5
	don't know	4	5	9	14	3	1	3	39	48.7
	total								80	100.0

Table 8. Opinions of labor unions.

Respondents	Approve	Approve-not join	Approve-not for professionals	Do not approve	Total	Chi-square
Bed capacity-						
200-299	2	5	7	14	28	7.55
300-399	4	1	2	10	17	9 d.f.
400-499	1	0	4	6	11	n.s.
500 and over	3	3	6	9	21	
total	10	9	19	39	77	
Title						
ADA dietitian-						
administrative	6	7	16	22	51	9.62
therapeutic	1	0	0	2	3	9 d.f.
Manager-						n.s.
with degree	0	1	1	8	10	
no degree	3	1	2	8	14	
total	10	9	19	40	78	
Age						
under 25	0	0	0	2	2	4.06
25 to 35	2	1	5	7	15	9 d.f.
35 to 50	5	5	10	17	37	n.s.
50 and over	3	3	4	14	24	
total	8	9	19	40	78	
Sex						
male	2	2	4	16	24	4.06
female	8	7	15	24	54	9 d.f.
total	10	9	19	40	78	n.s.
Total[1]	10	9	19	40		
%	12.2	11.0	23.2	48.8		

[1]Only 78 (95.2%) of 82 responded.

n.s. = not significant.

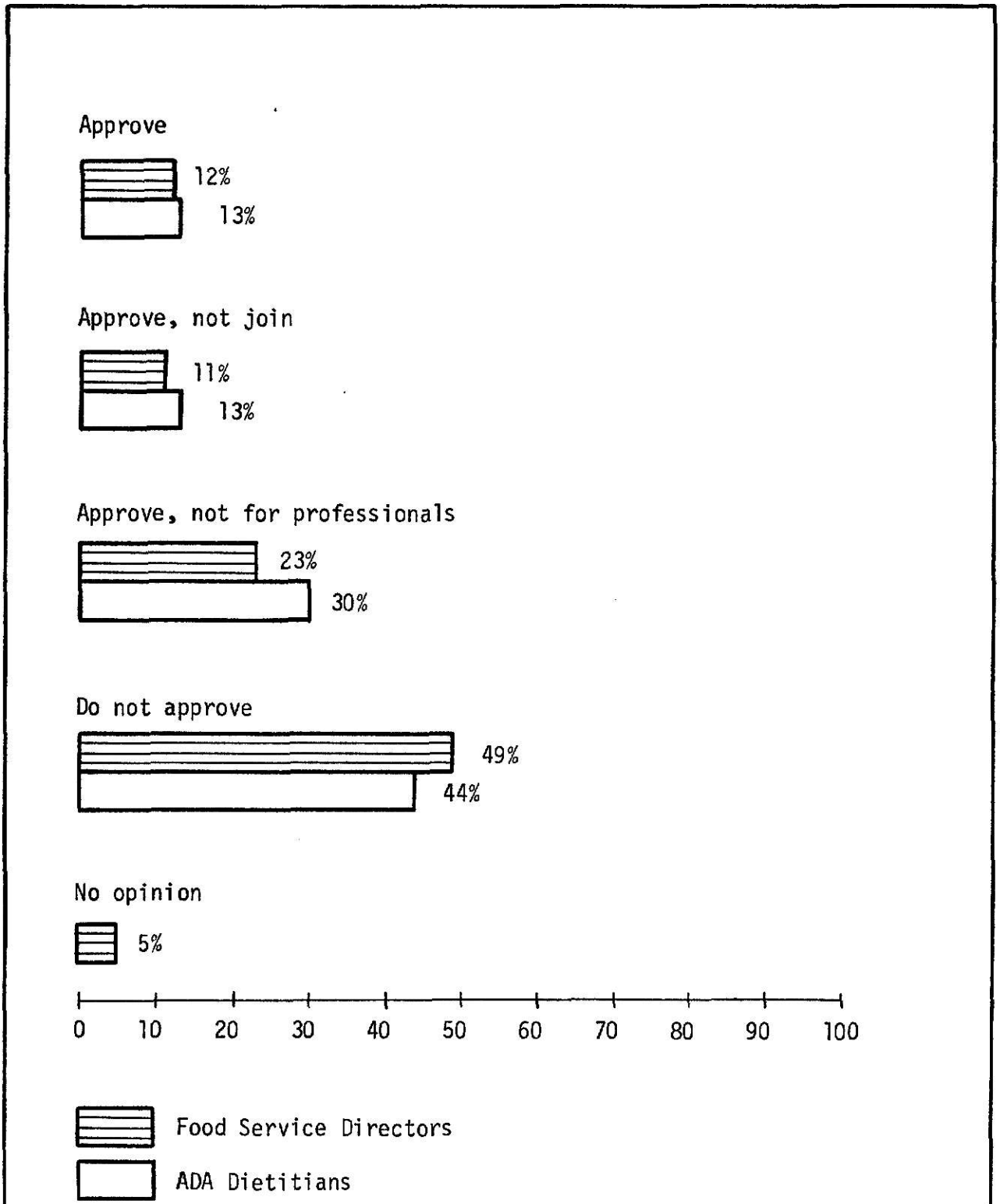

Figure 2. Comparison of opinions of labor unions.

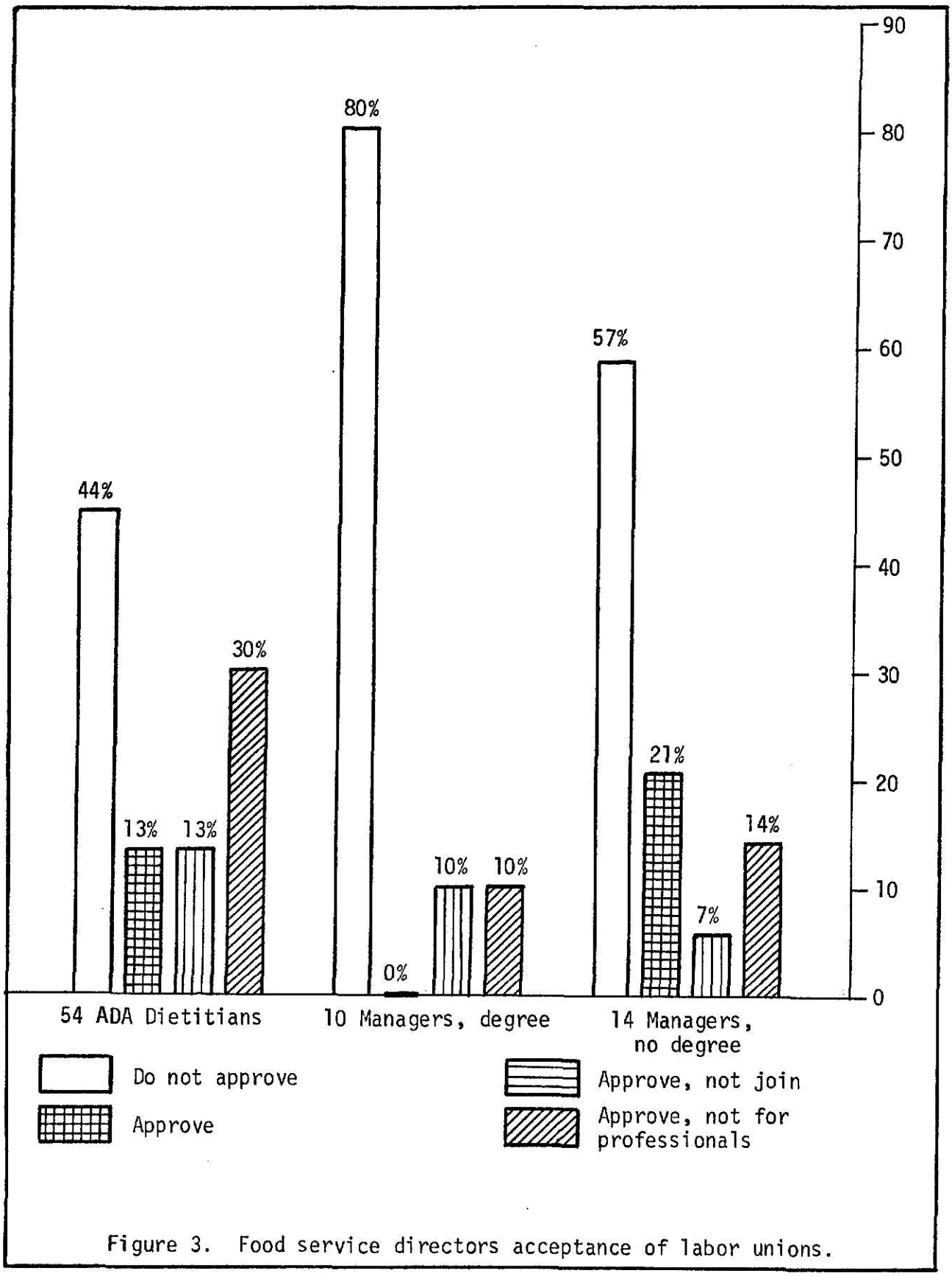

Figure 3. Food service directors acceptance of labor unions.

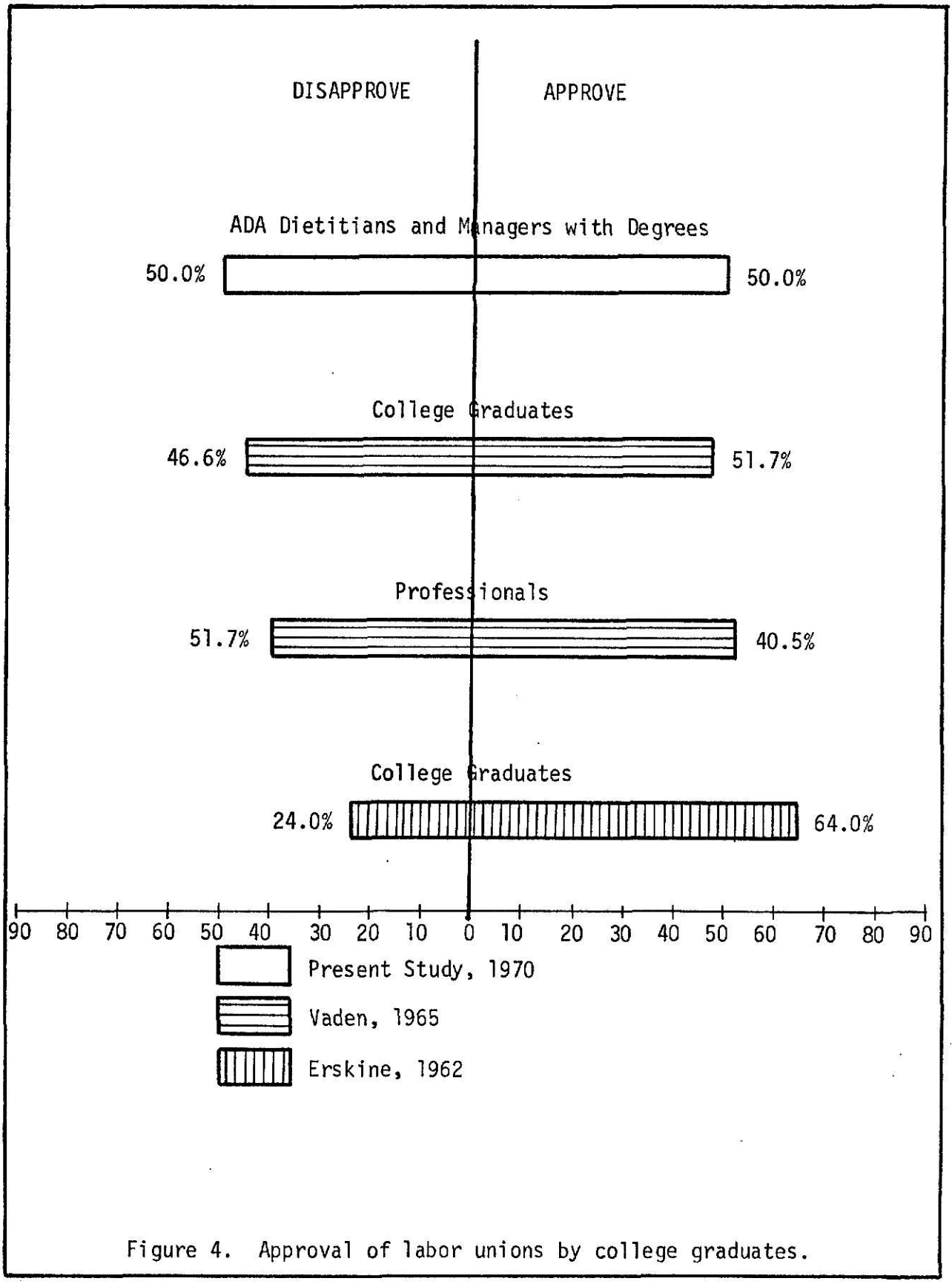

Figure 4. Approval of labor unions by college graduates.

Erskine's but this present study showed expressions similar to Vaden's. That is, 46.6% of the college graduates and 51.7% of the professionals approved.

In the present study there was no significant relationship between bed capacity of the hospital, title of the head of the food service, the age or sex of the respondent and approval of labor unions (Table 8).

Many respondents commented on labor unions in the hospital. One dietitian who approved of unions but not for professionals said that unions at times helped in disciplining employees. Another said the union favored the undesirable employees and put all employees whether good or bad on the same pay scale and demanded no degree of competence. "Union membership could be a hindrance for advancement" asserted another head of a food service department. "Very out of date job titles" was mentioned by another who also complained that the union made many restrictions on the use of personnel within the food service department. A dietitian who disapproved of labor unions commented that "once they had a purpose and improved conditions for the workers; today the only people who profit really are the union leaders." "Unionization has caused a tremendous increase in hospital costs to the patient and though there is need for betterment of hospital workers, unions are not the answer."

Responses to questions concerning associations with unions, opinions of union regulation and relationships of hospital-union were analyzed (Table 9). No significant relationship was found between these opinions and the food service directors approval or disapproval of labor unions.

Opinions of the extent of regulations of labor unions in this study (Table 9) were that there was too little. This attitude was similar to that reported by Vaden (1965). Forty-one (52.6%) hospital food service directors in this study said legislation was insufficient as did 60.1% of the college

Table 9. Food service directors' opinions of labor unions.

Question		Approve	Approve, not join	Approve but not for professionals	Do not approve	Total	Chi-square
No. 12	Association with union						
	self	0	1	1	0	2	8.01
	member of family	1	1	4	6	12	9 d.f.
	both	1	0	0	3	4	n.s.
	neither	6	6	10	29	51	
No. 25	Regulation of unions						
	enough	3	1	2	3	9	7.96
	too much	0	0	0	1	1	9 d.f.
	too little	5	3	9	24	41	n.s.
	not sure	2	5	8	12	12	
No. 20	If union tries to organize						
	present good, bad	5	4	7	23	39	12.21
	take no stand	2	2	5	7	16	9 d.f.
	welcome union	0	0	0	0	0	n.s.
	actively protest	0	0	0	5	5	
	not sure	3	3	3	2	11	
No. 19	Union restricts activities to benefits						
	yes	8	8	15	34	65	6.23
	no	0	1	0	2	3	6 d.f.
	not sure	2	0	4	3	9	n.s.

n.s. = not significant.

Table 9 (concl.)

Question		Approve	Approve, not join	Approve but not for professionals	Do not approve	Total	Chi-square
No. 21	Union has role in setting standards						
	yes	0	1	2	0	3	6.65
	no	9	7	15	38	69	6 d.f.
	not sure	1	1	2	2	6	n.s.

n.s. = not significant.

graduates and 53.4% of the professionals in Vaden's (1965) study. Erskine (1962) noted a different degree of concern among the general public. Laws were not strict enough according to 42% while 22% had no opinion.

Although three fourths of all participants in the present study disapproved of unions, 39 (54.9%) said if a union sought recognition in the hospital they would present the good and bad aspects of union membership to their employees (Table 9). Of this group, 23 (74.3%) stated they disapproved of unions. One dietitian said employees should understand what benefits they do receive but "to discuss bad aspects of unions probably would not only be unwise but not allowed." A food service manager said he would present the good and bad aspects of this association but "would tell them where I stand (actively protest)." A dietitian believed it would be "illegal or even unwise to present good and bad aspects of unions. You would be found guilty of unfair labor practices." One who said he would be willing to discuss the pros and cons of membership admitted he would "resign if a contract was signed."

There were no respondents who would welcome the union or who believed the relationship between management and employees could be improved if the union was on the scene. Five (13.5%) who disapproved of unions admitted they would actively protest hospital recognition of the union (Table 9). Several commented they would take their instructions from hospital administration while 16 (22.5%) signified they would take no stand.

About half of the food service directors speculated that if the employees were union members the relationship would be different but that they could get along satisfactorily in such an environment. As one commented, "clearly the relationship would be altered, whether it would be improved

would depend a great deal on the circumstances." Another admitted that the early days of the union relationship had been difficult but "now we have an excellent rapport." The observation was made by one that "the worker is faced with divided loyalty."

Sixty-five (84.4%) respondents agreed that labor unions should limit their activities to getting fair wages and improving working conditions for the workers and that they should not infringe on the operation of the hospital by its management (Table 9). One dietitian found that the labor union made "many restrictions on the use of personnel within the food service department." Another reflected that "union power has overbalanced management's right" and also that "management has been denied its rightful prerogative as an employer."

When questioned, most participants agreed that the union would have influence on the hospital. Thirty percent said it would interfere, 39% said it would influence some. Approximately the same number who said it would have very little influence said they were not sure of the influence of the union on the management of the hospital.

Only three respondents (3.8%) would accept union participation in setting work standards or changing work methods and procedures (Table 10). One dietitian employed in a non-union hospital who responded negatively, added that she would reject such a role unless the union became "much more cooperative with hospital goals." A food service manager asserted that standards setting was "management's job." One dietitian stated that the establishment of standards was "a function of management with labor's assistance; however, unions should not usurp line authority in any phase of hospital management."

In response to another question, most of the dietary department directors

Table 10. Opinions about satisfaction of employees wants. (Question No. 9)

Question		Wages		Retirement		Holidays		Sick leave		Life insurance	
		Hosp.	Union	Hosp.	Union	Hosp.	Union	Hosp.	Union	Hosp.	Union
No. 11	More concerned for employees										
	hospital	33	14	39	8	36	11	42	5	39	7
	union	0	4	2	2	1	3	1	3	1	3
	concern the same	2	14	8	8	9	7	9	7	10	6
	not sure	3	5	4	4	4	3	5	2	6	2
	chi-square	21.17***		9.21*		6.34		14.19**		8.19*	
	d.f.	3		3		3		3		3	

*Significant at the 5% level.
**Significant at the 1% level.
***Significant at the .1% level.

Table 10 (concl.)

Question		Work week		Training programs		Job security		Working hours	
		Hosp.	Union	Hosp.	Union	Hosp.	Union	Hosp.	Union
No. 11	More concerned for employees								
	hospital	21	24	44	2	43	5	36	13
	union	0	4	2	2	3	1	0	3
	concern the same	1	15	16	1	10	6	10	7
	not sure	2	5	5	3	7	1	4	2
	chi-square	10.95*		14.89***		6.503		11.22*	
	d.f.	3		3		3		3	

*Significant at the 5% level.
**Significant at the 1% level.
***Significant at the .1% level.

agreed that hospital-union contracts should stipulate that an employee should perform work assigned him by a supervisor when it was deemed necessary. One dietitian who agreed stated "the union backs us up." Others commented: "who else would do the job if there was no one to call in?", "this is a must", and "the employee should work as assigned if he is paid comparable wages."

Responses to question no. 11 "Who is more concerned about employees and what they want?" were analyzed in relation to question no. 9 "Who can get more for the personnel, the hospital or the union?". The opinion was that the concern of the hospital was greater than that of the union (Table 10). Relationship of the hospital's concern for employees' needs and who could better provide for them in the areas of wages and training was very highly significant ($P < 0.001$). A high degree of significance ($P < 0.01$) existed in the relationship in the areas of working hours, sick leave and retirement benefits. A significant relationship ($P < 0.05$) was found for insurance and the shorter work week, but there was no significant relationship regarding who could provide for more job security and holidays.

Unions have sought recognition for hospital employees in all seven states represented in this study. Half of the respondents reported attempts to organize their workers but only 29 (35.4%) had agreements (Table 11). In 6 of these facilities food service departments were not included, however. This is considerably higher than the figures reported in a 1967 survey by the American Hospital Association (Figure 5). Miller and Shortell (1969) reported that 2.7% of all hospitals in the West North Central region had had requests for recognition of unions and 9.2% had signed contracts.

As shown in Table 9, Minnesota had the largest number of agreements (21) representing 87.5% of the hospitals from that state. Missouri reported 7

Table 11. Union attempts to seek recognition and number of agreements with hospitals.

Classification	Respondents No.	Attempts to organize: Yes No.	Attempts to organize: No No.	Attempts to organize: Chi-square	Union agreements: Yes No.	Union agreements: No No.	Union agreements: Chi-square
State							
Iowa	12	5	5	33.89***	0	12	45.18***
Kansas	10	2	4	12 d.f.	0[1]	10	6 d.f.
Minnesota	24	21	2		21[2]	3	
Missouri	24	10	8		7	17	
Nebraska	6	2	4		1	5	
North Dakota	2	0	2		0	2	
South Dakota	4	1	3		0	4	
total	82	41	28		29	53	
Beds							
200-299 beds	28	6	15	14.05*	5	23	9.02*
300-399 beds	17	10	4	6 d.f.	6	11	3 d.f.
400-499 beds	12	9	2		8	4	
500 beds and over	24	5	7		9	15	
total	81	40	28		28	53	
Population in thousands							
10 to 25	12	4	6	8.30	2	10	6.69
25 to 50	6	1	4	6 d.f.	1	5	3 d.f.
50 to 100	16	7	6		3	13	
100 and over	44	27	12		20	24	
total	78	39	28		26	52	

[1] One contract does not include food service.

[2] Five contracts do not include food service.

* Significant at the 5% level.

** Highly significant at the 1% level.

*** Very highly significant at the 0.1% level.

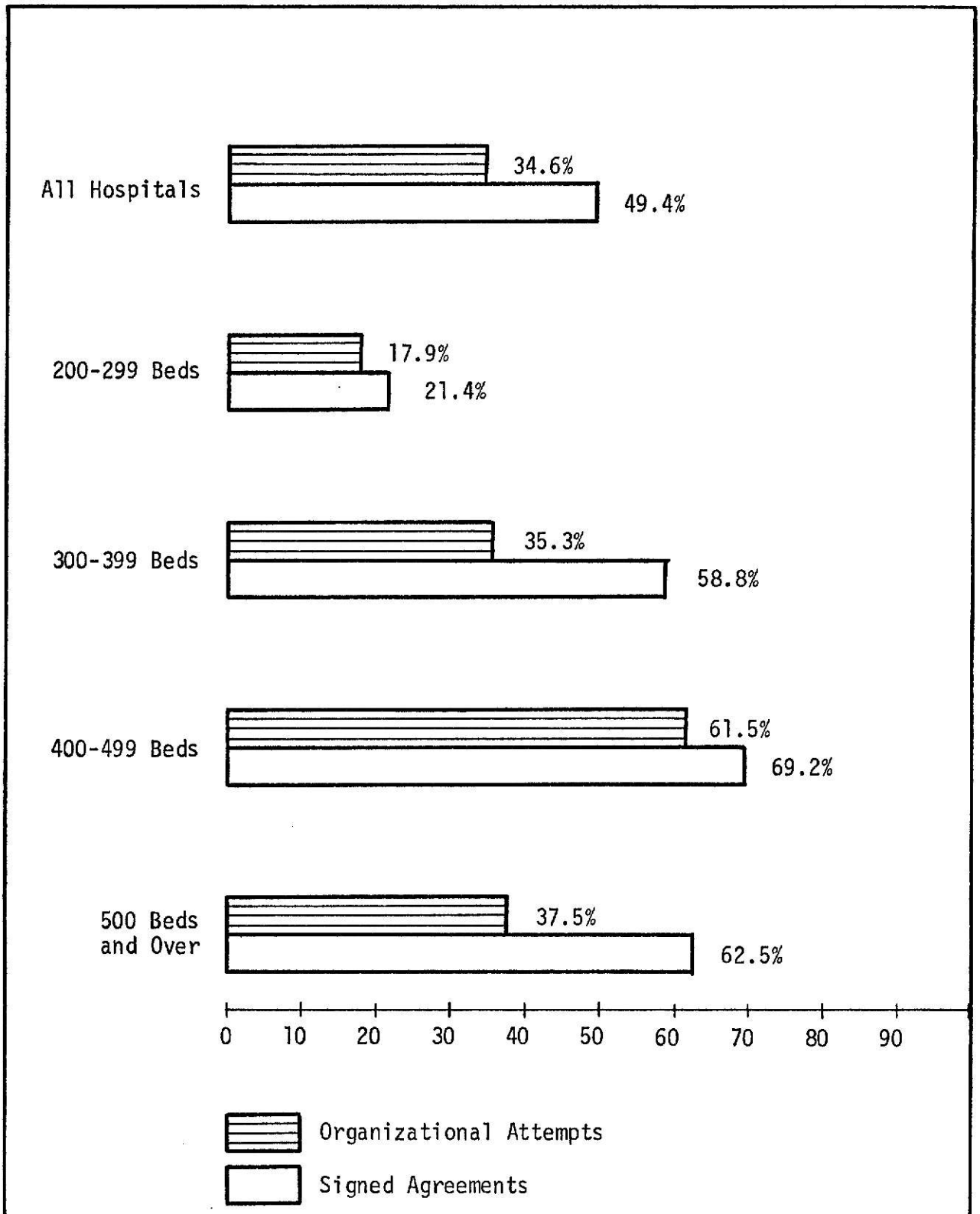

Figure 5. Comparison of organizational attempts and agreements in participating hospitals.

contracts but only 2 of these included food service workers. There was a very highly significant relationship ($P < 0.001$) between the state and the number of organizational campaigns in the hospitals. There was a highly significant relationship ($P < 0.01$) between the bed capacity of the hospital and attempts to unionize as well as the number that signed agreements. Out of 40 attempts to organize, the union attained recognition in 28 (70%) of the elections. There had been fewer attempts to organize employees in the hospitals in the smaller towns than in the larger cities, as might be expected (Table 11).

Hospital participants from Minnesota reported contracts with these unions: The American Federation of State, County, and Municipal Employees, AFL-CIO; Hospital and Nursing Home Employees, AFL-CIO; Hotel and Restaurant Employee and Bartender International Union, AFL-CIO; and the Retail Clerks International Union, AFL-CIO. The Laborers' Union is the authorized union in one of the Missouri hospitals although no formal contract existed.

SUMMARY

The purpose of this study was to assess the opinions of hospital dietitians concerning unionization of nonsupervisory food service personnel. A questionnaire was mailed to food service directors in facilities with 200 beds and over. Only general short term nonprofit nonfederal governmental hospitals in the West North Central district were included. The first part of the instrument was designed to gather classification information, and the second part sought information about practices related to personnel management, and to knowledge and opinions of labor unions. The term "food service director", used to denote the person in charge of the dietary department,

included registered dietitians who are members of The American Dietetic Association.

Analysis of the data indicated that dietitians by admission and inference opposed labor unions. No significance was found in the acceptance of labor unions and whether the individual or a member of his family had ever been a union member.

Most participants admitted they were not well informed about the extent of hospital-union agreements or the labor laws of their states. They believed that there was insufficient legislation regulating labor unions.

Although they opposed unions, the majority of the food service directors agreed that they would discuss union membership with their personnel if there was an organizational campaign in their hospital. They also thought that if their workers were members of a union, the employer-employee relationship would be different but it would be satisfactory.

The dietary department heads seemed confident that they knew what their employees wanted from their jobs and they believed that their hospitals could provide for the satisfaction of these needs better than the union. They selected good wages, appreciation for their work, job security, and good working conditions as most important to their workers. A significant relationship was found between their opinion that the hospital could do more for the employees than the union, and that the hospital, not the union, was more concerned with what employees wanted from their work.

Food service directors believed that unions should limit their activities and not become involved in areas of management, but approved of employees participating some of the time in making decisions which concerned their jobs. Respondents also asserted that employees should work as assigned by their

supervisors. The majority were opposed to union involvement in setting work standards but uncertainty was expressed. A procedure for voicing grievances had been established in most of the hospitals cooperating in this study. Vacancies on the food service department staff were filled on the basis of merit and seniority in the majority of the facilities.

More attempts to unionize hospital employees had been made, according to participants, in cities where the population was over 100,000. When unions had sought to represent the employees they had won 70% of the elections. More than a third of the participating food service directors cited personnel problems as the most urgent demand on their time. All others mentioned some demand that was associated with human inter-relationships.

CONCLUSIONS AND RECOMMENDATIONS

Dietitians in this study did not approve of labor unions. Indications are that dietitians need to be better informed about labor relations, collective bargaining, and they need a better understanding of unionism. This can be accomplished at various levels of education: the undergraduate level, the dietetic internship, the graduate level and through continuing education opportunities.

A second recommendation is that dietitians should improve their comprehension of human behavior to better understand the management-labor-union system. This can be accomplished through continuous development of managerial competencies, especially of human skills.

It is also recommended that dietitians should evaluate their management objectives and practices to maximize their administrative effectiveness.

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APPENDIX A

Selection and Development of the Research Instrument

Selection and Development of the Research Instrument

To obtain adequate information needed for this study, a questionnaire was developed and mailed to hospital food service directors which included ADA dietitians. By using the mail survey technique, the instrument could be administered to a large number of individuals simultaneously (Selltiz et al., 1959) and information could be obtained from a wider geographic area and a larger sampling. Hillway (1964) indicated that questions could be more carefully formulated when using a questionnaire than if the same information were sought through interviews. This specific research technique was also selected to save time and money in the absence of a more satisfactory alternative method for gathering data as suggested by Hillway (1969). The questionnaire, Selltiz et al. (1959) stated, has been used most often in the measurement of attitudes.

Various questionnaires and studies reviewed were by: Bakke et al. (1967), Davis (1962), Davis (1968), Erskine (1962), Graham and Valentine (1967), Menninger and Levinson (1956), Rim and Mannebeim (1964), Schein and Lippitt (1966), Snyder (1966), Zdep (1967), Zweig (1967). Studies reviewed that involved dietitians and their attitudes about management were done by Bloetjes et al. (1962), Miller (1960b), and Shaffer (1955). Unpublished theses by Birt (1966), Messner (1969), and Prideaux (1965) which utilized the questionnaire technique were studied. Other unpublished theses by Vaden (1965) which utilized a questionnaire to study attitudes toward labor unions and by Vaden (1967) which used a questionnaire to study hospital dietitians and administrators were reviewed. Following these evaluations the research tool for this study was developed.

The first part of the questionnaire developed was to gather information about the respondents. The second part contained the queries about attitudes toward unions.

A cover letter should present the title, purpose and brief description of the study according to Rummel and Ballaine (1963) who further advised should be included with the name of the sponsoring educational institution and researchers. The dietitian was asked to cooperate by answering the questions which would provide the data that would be significant and important since it is not available elsewhere. A statement was included establishing the anonymity of the respondents. The identity of the individual responding was not considered particularly important since adequate classification information would be available in the first part of the instrument. Selltiz et al. (1959) cited one of the advantages of the questionnaire as a research tool is that when respondents do not have to identify themselves they often feel freer to express their views. Less pressure is placed on the subject for immediate response should he prefer to consider each point carefully before answering. Borg (1963) reported that those questionnaires which respondents are asked to sign take longer in being returned to the researcher. Selltiz et al. (1959) disclosed that returns would be greater if inducements to reply were offered. Each participant was encouraged to complete and return the questionnaire in the self-addressed envelope which was provided for his use. An offer to send a copy of the findings upon completion of the study as was recommended by Hillway (1969).

The cover letter contained brief, self-explanatory instructions for completing the queries which were as Hillway (1969) pointed out full and clear instructions regarding the manner in which the respondent was to

answer the questions. Dugdale (1967) recommended the researcher estimate the time required for answering the questionnaire.

Because of the relative ease of answering the items, the greater ease in tabulating the results, closed questions were preferred to the open form questions. The closed form, Selltiz et al (1959) called the fixed-alternative question, limits the responses of the subject to stated alternatives. The advantages for such questions is that they are standardizable, simple to administer, quick and relatively inexpensive to analyze.

Rummel and Vallaine (1963) recommended that it might be desirable to include some items which allowed the respondent to express strong personal feelings about certain topics. One open end question and the opportunity to make comments on several other questions was arranged. The inclusion of a "Don't know" alternative, Selltiz et al. (1959) cited, provided an indication of a lack of a crystallized opinion on the part of the respondent. The classification questions in part one were of the closed type for the most part, since this method is considered appropriate for securing actual information.

The reliability and validity of the data obtained Rummel and Ballaine (1963) cited, depended upon the adequacy of the instrument used. A shorter questionnaire stands a better chance of being returned but the length of the questionnaire should be dependent upon the data required.

To facilitate the tabulation of data, Dugdale (1967) recommended that the blanks for the answers be placed immediately preceeding the questions.

The Pretest Questionnaire. Respondents were asked to indicate any difficulties encountered in reading the instructions, the questions and in answering them. The form of the questionnaire they were asked to evaluate

the wordage. Selltiz et al. (1959) and Borg (1963) recommended that the tool be checked for ideas and recommendations with a number of people whose backgrounds were similar to those who were to receive the questionnaire in the study. Critical reactions, Borg (1963) suggested, could be sought of some individuals who are familiar with questionnaire methods and the problems to be studied. The group to be pretested did not need to be large if the subjects were members of a well defined professional group.

Borg (1963) suggested that if the return of the questionnaire during the pretest was less than 75 percent, the researcher would know that major changes could be made in the tool. Those questionnaires which are returned should be studied carefully and the tabulation done to check the proposed method of tallying the results as well as to review the data gathered. Another careful analysis of the instrument must be done to incorporate the recommendations of the pretest group before the mailing of the questionnaire to the study group.

The Mailing to the Study Group. The same procedure for mailing to the group to be studied was repeated with only those adjustments deemed advisable resulting from the pretest.

It is sometimes helpful to send a reminder about two weeks after mailing the initial questionnaire, according to Rummel and Ballaine (1963). A different cover letter with another questionnaire should be sent. The letter again mentioned the importance of the study, the contribution that each person could make in providing data. Another self-addressed stamped envelope should be included. Since a second follow up generally produces little result according to Borg (1963) a third letter was considered inappropriate.

APPENDIX B

Cover Letter and Questionnaire

KANSAS STATE UNIVERSITY *Manhattan, Kansas 66502*

DEPARTMENT OF INSTITUTIONAL MANAGEMENT
JUSTIN HALL

September 4, 1970

Dear Food Service Director:

We are conducting a study at Kansas State University on the opinions of dietitians toward unionization of non supervisory food service personnel in hospitals and we request your assistance. This questionnaire is being sent to the Director of the Food Service Department in hospitals in your state with 200 beds and over.

The general information you are requested to supply will be sufficient so that you are not asked to sign your name or the name of your hospital.

Your answers will be most valuable in this study. Please mark the one answer that Exactly or Most Nearly indicates your opinion concerning your hospital. Please answer every question. If this questionnaire does not adequately express opinions or cover a topic in which you are interested, please feel free to add any comment you have (after you have marked the answer that Exactly or Most Nearly reflects the opinion you hold). It should not take you more than twenty minutes to answer the questions. When you have completed the questionnaire please place it in the enclosed envelope and drop in the mail.

Upon completion of the study we will send you a copy of our findings. Thank you for your cooperation and your time in providing this information.

Sincerely,

(Mrs.) Grace M. Shugart, R.D.
Head, Department of
Institutional Management

Mary Ruth Bedford, R.D.
Graduate Student

1

A. Your hospital has:
____ 200 - 299 beds
____ 300 - 399 beds
____ 400 - 499 beds
____ 500 beds and over

The name of your state:
_____

B. Your hospital is located in a city which has a population of:
____ up to 10,000
____ 10,000 to 25,000
____ 25,000 to 50,000
____ 50,000 to 100,000
____ 100,000 and over

C. Your Title:_____

D. You are employed:
____ Full time (40 hours/week)
____ Other:_____

E. You are employed by:
____ The hospital
____ Contract food company

F. Your age is:
____ under 25 years
____ 25 - 35 years
____ 36 - 50 years
____ over 50 years

G. ____ Male
____ Female

H. Education and/or Training that qualified you for this position:
____ Dietetic Internship
Kind of degree in major area: Bachelors, Masters, Doctorate
____ Degree in Dietetics
____ Degree in Foods and Nutrition
____ Degree in Institutional Management
____ Degree in Hotel and Restaurant Management
_____

I. ____ Current member of The American Dietetic Association
____ Current registered member of The American Dietetic Association
____ If not current member, member previously of The American Dietetic Association
____ Never a member of The American Dietetic Association

J. ____ Employed less than 5 years in the profession
____ Employed 5 to 10 years in the profession
____ Employed 10 to 25 years in the profession
____ Employed more than 25 years in the profession

K. Check if current or previous member of a labor union:
___Self ___Father ___Spouse ___Brother, sister ___Child ___None

1. Number of staff in the Food Service Department:
____ Dietitians, full time and/or part time
____ Non professional Supervisors, full time (40 hours/week)
____ Non professional Supervisors, part time (less than 40 hours/week)
____ All other employees, full time (40 hours/week)
____ All other employees, part time (less than 40 hours/week)

2. Food Service Department has:

Yes	No	
____	____	written Policies
____	____	written Procedures
____	____	written Job Descriptions for all positions

3. Vacancies on Food Service Department staff are filled on basis of:
____ Merit
____ Seniority
____ Merit and Seniority
____ Tests

4. Have there been, and/or there now attempts being made by a labor union to organize employees in your hospital?
____ Yes
____ No
____ Don't know

5. Does your hospital have a signed contract with a labor union now?
____ Yes
____ No
If your answer above was "Yes" and Food Service employees are included, what is the name of the Union:_____
_____

6. Are any Food Service personnel members of a labor union which does not have a signed contract with your hospital?
____ Yes
____ No
____ Don't know

PLEASE MARK THE ONE ANSWER THAT EXACTLY OR MOST NEARLY INDICATES YOUR OPINION.
PLEASE ANSWER EVERY QUESTION.

7. Do you understand what your Food Service employees want from their jobs?
____ Yes
____ No
____ Most of the time
____ Some of the time
Comments:_____

8. Are you familiar with the labor laws of your state?
   ____ Very much
   ____ Somewhat
   ____ Not at all

9. Who do you think could get more for Food Service personnel?

Hospital	Union	
____	____	Wages
____	____	Retirement benefits
____	____	Holidays
____	____	Sick leave benefits
____	____	Life insurance benefits
____	____	Shorter work week
____	____	Training programs
____	____	Job security
____	____	Better working hours

10. Has there been any change nationally in the last five years or so in the number of hospitals having contracts with labor unions?
    ____ About the same
    ____ Ten per cent decrease
    ____ Ten per cent increase
    ____ Don't know

11. Who is more concerned about employees and what they want?
    ____ Hospital administration
    ____ Labor union
    ____ Both concerned about the same
    ____ Not sure

12. What do you think about labor unions?
    ____ Approve of unions
    ____ Approve of unions but would not join
    ____ Do not approve of unions
    ____ Do not approve of unions for professionals but approve for other persons

13. What would be the effect on wages if employees in your hospital were unionized?
    ____ About the same
    ____ Increase a little
    ____ Increase a lot
    ____ Probably be less
    ____ Not sure

14. Does your hospital have a written procedure which each employee is instructed to follow when he has a complaint to make about his work?
    ____ Yes
    ____ No

15. Do you think a union has influence on the management of the hospital?
    ____ Union interferes seriously with the management
    ____ Union has some influence on the management
    ____ Union has very little influence on the management
    ____ Not sure

16. Should a hospital-union contract require an employee to perform work outside his assigned job description when supervisor deems it necessary?
    ____ Yes
    ____ No
    ____ Not sure

17. If wages were higher than they are at present, could you hire any more highly qualified persons for jobs in the Food Service Department?
    ____ Yes
    ____ No
    ____ Not sure

18. Check (✓) areas in which supervisory staff (professional and non professional) have assigned responsibilities:
    ____ Interview applicants, and/or review applications
    ____ Hire workers
    ____ Discharge workers
    ____ Train workers, on-the-job training
    ____ Train workers, organized training programs
    ____ Counsel employees about their work
    ____ Counsel employees about personal matters
    ____ Evaluate job performance of workers
    ____ Conduct employee meetings, give out information
    ____ Conduct employee meetings, discuss department problems
    ____ Write job descriptions
    ____ Hear employee complaints

19. Do you think labor unions should restrict activities to getting fair wages and good working conditions (fringe benefits) and avoid infringing on management's operation of the hospital?
    ____ Yes
    ____ No
    ____ Not sure

20. If a union tried to organize employees in your hospital would you:
    ____ Present what you consider to be good and bad aspects of unions to employees
    ____ Take no stand
    ____ Welcome union entrance
    ____ Actively protest
    ____ Not sure
    Comments: _____

21. As a manager, do you think unions should have a role in setting work standards, changing work methods and procedures?
____ Yes
____ No
____ Not sure

22. Should Food Service employees assist in making decisions that affect their work?
____ Yes
____ Sometimes
____ No
____ Not sure

23. If Food Service workers were members of a union, would employer-employee relations be any different than if employees were not members of a union?
____ Same good relationship
____ Different but we could "get along"
____ Could never "get along" very well
____ Relations would be improved
____ Not sure

24. Please rate these items in order of importance to Food Service employees. Rate from (1) "most important" to (10) "of lesser importance."
____ Good wages
____ Good working conditions
____ Full appreciation of work done
____ Feeling "in" on things
____ Promotion and growth in the organization
____ Personal loyalty to workers
____ Tactful disciplining
____ Sympathetic help on personal problems
____ "Work that keeps you interested"
____ Job security

25. Do you consider regulation of labor unions by state and federal governments to be:
____ Enough
____ Too much
____ Too little
____ Not sure

26. List the three (3) most urgent demands on your time as Director of Food Service:
I. _____
II. _____
III. _____

OTHER COMMENTS: _____

_____

APPENDIX C

Follow up Letter, Mailed with Another

Copy of Questionnaire

KANSAS STATE UNIVERSITY *Manhattan, Kansas 66502*

DEPARTMENT OF INSTITUTIONAL MANAGEMENT
JUSTIN HALL

September 18, 1970

Dear Food Service Director:

Two weeks ago we wrote asking for your assistance in a study which we are conducting at Kansas State University on the opinions of dietitians toward unionization of non supervisory food service personnel in hospitals which have 200 beds or more. If you have completed the questionnaire and have sent it back to us, thank you. If you have not done so, won't you please complete the enclosed questionnaire and return it in the enclosed envelope? Since we did not ask you to identify your hospital we have no way of knowing if you have already returned your questionnaire. If you have returned yours, please do not complete another.

We are anxious to have this data from all the hospitals in your state in the group of hospitals that we have included in this study. We do hope you will participate. Our findings will be more valuable if we have your completed questionnaire.

It should not take you more than twenty minutes to answer the questions. Please mark the one answer that Exactly or Most Nearly indicates your opinion concerning your hospital. Please answer every question. If this questionnaire does not adequately express your opinions or cover a topic in which you are interested, please feel free to add any comment you have (after you have marked the answer that Exactly or Most Nearly reflects the opinion you hold). When you have completed the questionnaire please place it in the enclosed envelope and drop in the mail.

Our response has been that this is a very timely study and we are certain that you want to participate. We will send you a copy of our findings upon completion of our work.

Again, thank you for your cooperation and your time in providing this information.

Sincerely,

(Mrs.) Grace M. Shugart, R.D.
Head, Department of
Institutional Management

Mary Ruth Bedford, R.D.
Graduate Student

APPENDIX D

Response of Food Service Directors to Questionnaire

Response of food service directors to questionnaire.

	Questionnaires mailed					
	Initial mailing		Follow up[1]		Total	
	No.	%	No.	%	No.	%
Questionnaires mailed	105		105		105	100.0
responses	64	61.0	27	25.7	91	86.7
Questionnaires unusable[2]					9	1.0
Questionnaires analyzed					82	79.1
responses - at cut off					88[3]	83.8

[1]Mailed 14 days after initial mailing.

[2]Questionnaires ruled "unusable":

One questionnaire partially completed by the hospital administrator.
One letter from a Personnel Officer, no questionnaire.
One questionnaire mailed from a nonparticipating state, complete except for state identification.
One letter from a Food Service Manager who stated there was no dietitian in the administrative position on the hospital's staff.
Two questionnaires from dubious sources.

[3]Three completed questionnaires received past the tabulation cut-off date (30 days following the initial mailing) and the completion of the study.

OPINIONS OF HOSPITAL DIETITIANS TOWARD UNIONIZATION OF FOOD SERVICE PERSONNEL

by

MARY RUTH BEDFORD

B. S., Madison College, 1943

AN ABSTRACT OF A MASTER'S THESIS

submitted in partial fulfillment of the

requirements for the degree

MASTER OF SCIENCE

Department of Institutional Management

KANSAS STATE UNIVERSITY
Manhattan, Kansas

1971

The hospital is being pressured from its external environment by unions seeking to represent the workers in collective bargaining. Within the system those dissatisfied personnel are attempting to force recognition of a union. This study was made to assess the opinions of dietitians about unionization of food service personnel in the hospital.

A questionnaire was mailed to food service directors in hospitals with 200 beds and over in the seven states in the West North Central region. Only general short term nonprofit nonfederal governmental hospitals were included. The term "food service director" was used to denote the person in charge of the dietary department and included registered dietitians who are members of The American Dietetic Association.

Information about practices related to personnel management and knowledge and opinions of labor unions was obtained. Analysis of the data indicated that dietitians by admission and inference opposed labor unions and that their knowledge of labor relations is inadequate. Most respondents were not sure of the extent of hospital-union agreements, labor laws, and union regulations in their states.

Though the association would be different, most of the department heads believed they could have a satisfactory employer-employee relationship if the food service personnel were members of a union. They shared the opinion that unions should limit their activities and not become involved in areas of management, such as standards setting or procedural changes.

There has been an increase in the number of personnel winning the right to be represented by a union according to the hospitals participating in this study. On the basis of the findings, dietitians should become more knowledgeable about labor relations through education at the various levels. A second

recommendation is that dietitians should improve their comprehension of human behavior to better understand the management-labor-union system, which could be accomplished through a continuous development of managerial competencies, especially of human skills.

It is also recommended that dietitians should evaluate their management objectives and practices to maximize their administrative effectiveness.