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The NLRB's Proposed Rule for the Determination of Health Care Bargaining Units: Is the AHA Barking Up the Wrong Tree?

Brenda Murphy*

I. INTRODUCTION

Since 1974, the National Labor Relations Act (the "Act" or "NLRA")¹ has extended its protection to the employees in the entire health care industry.² The National Labor Relations Board ("NLRB" or "Board") traditionally has applied a case-by-case approach³ to determining the appropriate bargaining units⁴ in health care representation cases.⁵ Under this approach, unions potentially could be forced to litigate every job category in the health care institution.⁶ In order to eliminate the necessity of protracted

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1. 29 U.S.C. §§ 151, *et seq.* (1935). Section 7 of the Act defines these employee protections as follows: "Employees shall have the right . . . to form, join, or assist labor organization . . . and shall also have the right to refrain from any or all of such activities. . . ." 29 U.S.C. § 157 (as amended 1947). Furthermore, § 10 of the Act gives an administrative agency, the National Labor Relations Board, enforcement powers to protect these rights. "The Board is empowered . . . to prevent any person from engaging in any unfair labor practice . . . affecting commerce." 29 U.S.C. § 160 (1935).

2. Although the employees of not-for-profit hospitals were excluded from the jurisdiction of the Act by the Taft-Hartley Amendments to the Act, the Act's jurisdiction over these employees was restored by the 1974 Amendments to the Act. *See also* J. Stephens, Chairman of the National Labor Relations Board, Remarks before the Southwestern Legal Foundation (October 13, 1988) (available in Daily Labor Report (BNA) No. 206 at D-1, 2 (October 25, 1988)).

3. The Board shall decide *in each case* . . . , in order to assure to employees the fullest freedom in exercising the rights guaranteed by this subchapter, the unit appropriate for the purposes of collective bargaining. . . ." 29 U.S.C. § 159(b) (1935) (emphasis supplied).

4. The group of jobs that serves as the election constituency in an election held to approve or reject union representation is a bargaining unit. If a union wins a representation election, it serves as the exclusive representative of all of the members of the bargaining unit (including those members who voted against representation by that union) in matters affecting terms and conditions of employment. R. GORMAN, BASIC TEXT ON LABOR LAW UNIONIZATION AND COLLECTIVE BARGAINING 66 (1976).

5. Stephens, *supra* note 2, at D-2.

6. *Id.* Prolonged litigation can have an adverse impact on unionization efforts because the delay between the filing of an election petition and the election diminishes the

litigation, the NLRB exercised its rarely used substantive rulemaking powers.⁷ On September 1, 1988, the NLRB published its proposed rule for providing the appropriate bargaining units in the health care industry.⁸ The rule included guidelines for the establishment of as many as eight bargaining units in health care institutions, the largest number proposed since the NLRA was amended to include not-for-profit health care institutions within the scope of its jurisdiction.

This Article will examine the history of the Act in relation to health care institutions and the controversy surrounding the so-called "community-of-interests" and "disparity-of-interests" tests that the NLRB has applied in determining the appropriate bargaining units for health care institutions.⁹ The Article then will explore the NLRB's rule governing the structure of health care bargaining units.¹⁰ Following discussions of the impact of bargaining unit determinations¹¹ and the litigation associated with the proposed rule,¹² the Article will question whether the proposed rule can be amended in order to reduce the number of health care bargaining units and, in turn, reduce the likelihood of interruption of health care that could result from unit fragmentation.¹³ Finally, the Article will explore whether the American Hospital Association ("AHA") should lobby Congress to amend the Act in order to allow the NLRB to certify health care bargaining units containing both technical and professional employees.¹⁴

odds of a union victory. Delaney & Sockell, *Hospital Unit Determination and the Preservation of Employee Free Choice*, 39 LAB. L. J. 259, 261 (1988). See also Roomkin & Block, *Case Processing Time and the Outcome of Representation Elections: Some Empirical Evidence*, 1981 U. ILL. L. REV. 75, 76-77.

7. When the NLRB engages in substantive rulemaking, it utilizes rulemaking procedures to announce substantive law principles. R. GORMAN, *supra* note 3, at 17. Substantive law is "[t]hat part of law which creates, defines, and regulates rights and duties of parties, as opposed to 'adjective, procedural, or remedial law,' which prescribes method of enforcing the rights or obtaining redress for their invasion." BLACK'S LAW DICTIONARY 1429 (6th ed. 1990). Procedural or remedial law "prescribes methods of enforcement of rights or obtaining redress for their invasion." *Id.* at 1203. Thus, in the health care bargaining unit context, the Board's rulemaking has defined the parameters of the bargaining units that health care unions may organize in exercise of the rights accorded to employees under the NLRA.

8. 53 Fed. Reg. 33,900 (1988) (to be codified at 29 C.F.R. § 103) (proposed Sept. 1, 1988).

9. See *infra* notes 46-76 and accompanying text.

10. See *infra* notes 77-101 and accompanying text.

11. See *infra* notes 102-32 and accompanying text.

12. See *infra* notes 133-63 and accompanying text.

13. See *infra* notes 164-75 and accompanying text.

14. See *infra* notes 164-75 and accompanying text.

II. BACKGROUND

A. *The Enactment of the National Labor Relations Act and the Creation of the National Labor Relations Board*

In 1935, Congress enacted the NLRA¹⁵ to alleviate the disruption of commerce that resulted from labor disputes.¹⁶ The Act withstood a constitutional attack in 1937, when the Supreme Court ruled in a landmark decision, *NLRB v. Jones & Laughlin Steel Corp.*,¹⁷ that the commerce clause¹⁸ gave Congress the power to regulate activities that “have such a close and substantial relation to interstate commerce that their control is essential or appropriate to protect that commerce from burdens and obstructions. . . .”¹⁹ The high court examined the congressional purpose of the Act²⁰—to eliminate the burden on the flow of commerce caused by the inequality in bargaining power between employees and employers—and held that Congress has the power to regulate labor activities that affect interstate commerce.²¹ Towards that end, Congress created the NLRB to implement the provisions of the Act.²² Congress delegated to the NLRB both adjudicatory²³ and rulemaking²⁴ powers.

B. *History of Jurisdiction in the Health Care Arena*

Initially, certain categories of employers were excluded from the Act’s definition of “employer.”²⁵ The Act did not specifically include or exclude non-profit health care institutions from coverage.

15. The NLRA also is known as the Wagner Act.

16. R. GORMAN, *supra* note 3, at 21.

17. 301 U.S. 1 (1937).

18. “The Congress shall have the Power . . . To regulate Commerce with foreign Nations, and among the several States, and with the Indian Tribes.” U.S. CONST. art. I, § 8, cl. 3.

19. 301 U.S. at 37.

20. *See* 29 U.S.C. § 151 (1982).

21. *Jones & Laughlin Steel*, 301 U.S. at 43; R. GORMAN, *supra* note 3, at 21.

22. 29 U.S.C. § 153 (1935).

23. “The Board is empowered . . . to prevent any person from engaging in any unfair labor practice . . . affecting commerce.” 29 U.S.C. § 160(a) (1935).

24. “The Board shall have authority from time to time to make, amend, and rescind, in the manner prescribed by [the Administrative Procedure Act], such rules and regulations as may be necessary to carry out the provisions of this subchapter.” 29 U.S.C. § 156 (1947).

25. “The term ‘employer’ . . . shall not include the United States, . . . or any State or political subdivision thereof, or any person subject to the Railway Labor Act, as amended from time to time, or any labor organization (other than when acting as an employer), or anyone acting in the capacity of officer or agent of such labor organization.” 29 U.S.C. § 152(2) (1935).

In 1943, the NLRB interpreted the Act to include non-profit hospitals within its jurisdiction.²⁶ Congress negated this interpretation in 1947, when it enacted the Taft-Hartley amendments to the Act. The amendments altered many aspects of labor law, including the exclusion of non-profit hospitals from the definition of "employer", and the elimination of the NLRB's jurisdiction over these types of institutions.²⁷ Although the Senate Committee on Labor and Public Welfare believed that the amendment was unnecessary because hospitals were not engaged in interstate commerce,²⁸ a floor amendment providing for the exclusion of nonprofit hospitals passed the Senate and House after brief debate.²⁹

During the Senate debate, Senator Tydings, who offered the portion of the amendment excluding not-for-profit hospitals from the Act's jurisdiction, explained that the amendment was intended to "be very helpful [to nonprofit hospitals] in their efforts to serve those who have not the means to pay for hospital service. . . ."³⁰ He further explained that, in his opinion, the amendment would not prevent the employees of not-for-profit hospitals from organizing a union, but that "[t]hey should not have to come to the National Labor Relations Board [to do so]."³¹ By removing the employees of not-for-profit hospitals from the scope of the Act's jurisdiction, however, the amendment eliminated the ability of the NLRB to prevent not-for-profit hospital employers from engaging in unfair labor practices.

After the advent of Taft-Hartley, the NLRB excluded the rest of the health care industry from the NLRA's coverage. The Board considered most proprietary hospitals and nursing homes to be local operations not affecting interstate commerce; therefore, in *Flatbush General Hospital*,³² the Board declined to assert its juris-

26. *Central Dispensary & Emergency Hosp.*, 50 N.L.R.B. 393, 398 n.5 (1943), *enforcement granted*, 145 F.2d 852 (D.C. Cir. 1944), *cert. denied*, 324 U.S. 847 (1945). The Board noted that because the Act made no distinction between for-profit and not-for-profit hospitals, it could be inferred that Congress intended to include not-for-profit hospitals within the Act's jurisdiction.

27. "The term 'employer' . . . shall not include . . . any corporation or association operating a hospital, if no part of the net earnings inures to the benefit of any private shareholder or individual." 29 U.S.C. § 152(2) (1947).

28. 93 CONG. REC. 4996, 4997 (1947). At that time, there is evidence that Congress believed nonprofit hospitals did not affect interstate commerce because they were charitable institutions. 120 CONG. REC. 12,937 (1974) (statement of Mr. Williams).

29. J. ABODEELY, R. HAMMER, & A. SANDLER, *THE NLRB AND THE APPROPRIATE BARGAINING UNIT* 243 (revised ed. 1981) [hereinafter ABODEELY].

30. *Id.* at 242-43.

31. *Id.* at 243.

32. 126 N.L.R.B. 144 (1960).

diction over these health care institutions.³³ In 1967, however, the Board overruled *Flatbush* and adopted jurisdictional standards over proprietary hospitals and nursing homes. In *Butte Medical Properties*³⁴ and *University Nursing Home, Inc.*,³⁵ the NLRB concluded that since the *Flatbush* decision, the impact of the operation of health care institutions on interstate commerce had expanded greatly because of their increasing size and reliance on federal financial support. The increasing effect on interstate commerce and the need for national uniform regulations to engender stable industrial relations convinced the Board to assert its jurisdiction over the proprietary health care industry.

As a result of the Board's new position, employees of not-for-profit health care institutions were denied the same rights³⁶ that employees of proprietary institutions enjoyed. Legal scholars criticized the Board decision as illogical, noting that duties and responsibilities of health care employees were the same whether their employers were not-for-profit or proprietary institutions.³⁷ In 1974, therefore, Congress amended the NLRA to extend its cover-

33. Section 14(c)(1) of the Act grants the Board the discretion to decline jurisdiction when the effect of a labor dispute on commerce "is not sufficiently substantial." 29 U.S.C. § 14(c)(1). Another section of the Act stated that the Board could not decline to assert jurisdiction over any labor dispute under the standards in existence on August 1, 1959. 29 U.S.C. § 164(c)(1) (1959). Under the standards prevailing on August 1, 1959, the NLRB had asserted jurisdiction over proprietary hospitals in the following three situations: when a hospital's operations vitally affected national defense, when the hospital was located in the District of Columbia, and when "the hospital was an integral part of the establishment whose operations met the Board's jurisdictional standards." *Flatbush*, 126 N.L.R.B. at 145. Therefore, the Board concluded that under § 14(c)(1) of the Act, it could decline to assert jurisdiction over all proprietary hospitals that did not meet these criteria. *Id.* at 146.

34. 168 N.L.R.B. 266, 268 (1967) (jurisdiction asserted over proprietary hospitals having annual gross revenues of \$250,000 or more).

35. 168 N.L.R.B. 263, 264 (1967) (jurisdiction asserted over proprietary nursing homes having annual gross revenues of \$100,000 or more).

36. Specifically, these employees were denied their § 7 right to form, join, assist, or refrain from joining labor organizations. In addition, they were not afforded the Act's protection from employer unfair labor practices. It is an unfair labor practice for an employer to interfere with, restrain, or coerce employees in the exercise of § 7 rights.

37. ABODEELY, *supra* note 29, at 244-45. Senator Taft, the son of Senator Robert Taft, co-sponsor of the Taft-Hartley Amendments, remarked: "There is no logical reason why employees engaged in the same industry should be treated differently; employees of nonprofit organizations being deprived of statutory benefits while another segment of employees is accorded rights." 120 CONG. REC. 22,579 (1974). Although the NLRB similarly had declined to assert jurisdiction over nonprofit private colleges and universities, see e.g., *Trustees of Columbia Univ.*, 97 N.L.R.B. 424 (1951), the Board reversed its position in 1970 and brought private nonprofit colleges and universities that met a minimum level of gross annual revenues within its jurisdiction. *Cornell University*, 183 N.L.R.B. 329 (1970). Thereafter, hospitals were the only category of nonprofit private employers completely excluded from the Act's jurisdiction.

age to not-for-profit health care institutions.³⁸ Congress eliminated the nonprofit hospital exemption because it believed that the quality of health care would improve if the protections of the Act were extended to all health care workers.³⁹ Citing the inferior working conditions and high turnover rate in the health care industry,⁴⁰ Congress determined that extending collective bargaining rights to health care workers would alleviate poor conditions and would raise the standard of patient care.⁴¹

During the hearings preceding the enactment of the 1974 amendments, proposals were made to limit the number of appropriate health care bargaining units.⁴² A majority of the Senate Committee on Labor and Public Welfare opposed a statutory limitation on the number of units on the ground that such an approach would eliminate the NLRB's discretion to determine the appropriateness of bargaining units on a case-by-case basis.⁴³ As a compromise, the Committee agreed to try "jawboning," that is, warning the NLRB to avoid undue proliferation in the number of bargaining units approved in health care institutions.⁴⁴ The courts interpreted this congressional admonishment in various ways, causing a controversy over the means the Board should apply to determine appropriate bargaining units in the health care industry.⁴⁵ These interpretations are discussed in turn.

38. 88 Stat. 395 (1974) (amending 29 U.S.C. § 152(2) (1947)).

39. One commentator described the situation this way:

The long hours worked and the small monetary reward received by hospital workers result in a constant turnover with a consequent threat to the maintenance of an adequate standard of medical care Indeed it has been convincingly argued that when hospital employees are unionized . . . the result is better job stability and security than is possible without such collective bargaining arrangements. This will also mean a better job done in terms of the quality of patient care provided. . . .

120 CONG. REC. 12,937-38 (1974) (remarks of Senator Cranston). See also R. Vernon, *Labor Relations in the Health Care Field under the 1974 Amendments to the National Labor Relations Act: An Overview and Analysis*, 70 NW. U. L. REV. 202, 203-04 (1975).

40. 120 CONG. REC. 12,937 (1974).

41. See 120 CONG. REC. 16,899-900 (1974) (remarks of Rep. Thompson).

42. See *Coverage of Nonprofit Hospitals Under National Labor Relations Act: Hearings on S. 794 and S. 2292 Before the Subcomm. on Labor of the Senate Comm. on Labor and Public Welfare*, 93 CONG. REC. 12,934 (1973).

43. See 120 CONG. REC. 12,941, 12,944 (1974); ABODEELY, *supra* note 29, at 248.

44. Warning the Board to prevent proliferation of bargaining units in the health care industry, the Committee cited the following Board decisions with approval and offered them for guidance: Four Seasons Nursing Center, 208 N.L.R.B. No. 50, 85 L.R.R.M. 1093 (1974); Woodland Park Hosp., 205 N.L.R.B. No. 144, 84 L.R.R.M. 1075 (1973); Extencicare of West Virginia, 203 N.L.R.B. No. 170, 83 L.R.R.M. 1242 (1973). 42 S. Rep. No. 93-766, 93rd Cong., 2d Sess. 5 (1974).

45. ABODEELY, *supra* note 29, at 269-76.

C. *St. Francis I: The Community-of-Interests Test*

Before the 1974 Amendments, the Board traditionally had applied the "community-of-interests" test to bargaining unit determinations in all other industries. The Board first articulated this test in *American Cyanamid Co.*⁴⁶ There, the Board based its grant of a separate unit to maintenance employees because they are readily identifiable as a group whose "similarity of function and skills create a community of interest such as would warrant separate representation."⁴⁷ In *Allegheny General Hospital*, the NLRB extended the community-of-interests standard to health care bargaining unit determinations. The Third Circuit Court of Appeals, however, denied enforcement of the Board's unit determination, holding, in effect, that the Board had an obligation to balance the congressional concern for over-proliferation of health care bargaining units against the community-of-interests criteria.⁴⁸

In recognition of the Third Circuit's criticism, the Board established a two-part community-of-interests standard for health care bargaining unit determinations.⁴⁹ Under this standard, the proposed unit had to fit one of the seven classifications of employees that the NLRB established as presumptively appropriate bargaining units.⁵⁰ Only if a proposed unit fit one of the classifications would the second step—the traditional community-of-interests test—be applied to the proposed unit.⁵¹ The Board asserted that

46. 131 N.L.R.B. 909, 910 (1961).

47. In applying the community-of-interests test in non-health related industries, the Board has considered factors such as (1) the similarity in the work done by the employees; (2) similarity in training and skill; (3) similarity in earnings; (4) common supervision; (5) history of relationships in collective bargaining; (6) similarity in terms and conditions of employment; (7) the affected employee's wishes; and, (8) the frequency of contact with other employees. See *Riverside Methodist Hosp.*, 241 N.L.R.B. 1183 (1979); *Allegheny Gen. Hosp.*, 239 N.L.R.B. 872 (1978), *enforcement denied*, 608 F.2d 965 (3d Cir. 1979). See also Bumpass, *Appropriate Bargaining Units in Health Care Institutions: An Analysis of Congressional Intent and Its Implementation by the National Labor Relations Board*, 20 B.C.L. REV. 867, 896 (1979); R. GORMAN, *supra* note 3, at 69.

48. *Allegheny Gen. Hosp.*, 608 F.2d at 966. The court took the Board to task for declining to follow judicial precedent "while conceding applicability of that precedent." *Id.* In an earlier decision, the Third Circuit had ruled that the 1974 Amendments precluded the Board from using the traditional standards (*i.e.*, community-of-interests criteria) in making health care bargaining unit determinations. *St. Vincent's Hospital v. NLRB*, 567 F.2d 588 (3d Cir. 1977).

49. *St. Francis Hosp. ("St. Francis I")*, 265 N.L.R.B. 1025 (1982).

50. *Id.* at 1029. The seven classifications were physicians, registered nurses, other professional employees, technical employees, business office clerical employees, service and maintenance employees, and skilled maintenance employees.

51. *Id.* If the proposed unit does not fit one of the seven presumptively appropriate classifications, it will not be approved by the NLRB.

this two-part community-of-interests standard met its responsibility to avoid undue proliferation in the number of health care bargaining units.⁵²

D. St. Francis II: The Disparity-of-Interests Test

The controversy surrounding the appropriate test for the determination of health care bargaining units did not subside with the *St. Francis I* decision. The Court of Appeals for the Ninth Circuit, in *NLRB v. St. Francis Hospital of Lynwood*,⁵³ urged the application of a disparity-of-interests test, defined as one in which the Board must "focus[] upon the disparity of interest between employee groups which would prohibit or inhibit their representation of employee interests."⁵⁴ In another Ninth Circuit case, *NLRB v. HMO Intern./California Med.*,⁵⁵ the court clarified the meaning of the test: "[s]eparate bargaining units in the health care field must be justified in terms of a disparity that *precludes* combination, not an internal consistency within a class that could *justify* separation."⁵⁶ The same court again advocated a disparity-of-interests test six months before the NLRB rendered the *St. Francis I* decision⁵⁷, and the Tenth Circuit espoused the test two years later.⁵⁸ Both circuits based their opinions on the congressional admonition in the 1974 amendments to avoid undue proliferation of bargaining units.

The *St. Francis I* disparity-of-interests test and unit determinations relying on it never saw "the light of day."⁵⁹ In fact, before the Board issued a single health care unit determination, it reconsidered and overruled *St. Francis I*.⁶⁰ The Board determined, in *St. Francis II*,⁶¹ that the community-of-interests test was contrary to Congress' intent and that the disparity-of-interests test would best effectuate the Board's obligation to avoid undue proliferation of

52. *Id.*

53. 601 F.2d 404 (9th Cir. 1979).

54. *Id.* at 419.

55. 678 F.2d 806 (9th Cir. 1982).

56. *Id.* at 812 n.17 (emphasis in original).

57. *Id.*

58. *Southwest Community Health Servs. v. NLRB*, 726 F.2d 611, 613 (10th Cir. 1984).

59. *St. Francis Hosp. & IBEW* ("St. Francis II"), 271 N.L.R.B. 948, 955 (1984) (Member Zimmerman, dissenting).

60. Comment, *The St. Francis II Disparity of Interests Test: Is it Necessary?*, 9 W. NEW ENG. L. REV. 303, 315 (1987).

61. 271 N.L.R.B. 948 (1984).

health care bargaining units.⁶² This reversal was based in part upon the rulings of the Ninth and Tenth Circuits in favor of the disparity-of-interests test, despite the disagreement of the Second,⁶³ Eighth,⁶⁴ and Eleventh⁶⁵ Circuits.

It must be recognized, however, that the Board's reversal also can be explained on the basis of the change in the membership of the Board in the two years that passed between the two *St. Francis* decisions. NLRB members are appointed by the president and serve five-year terms.⁶⁶ In *St. Francis I*, members Miller, Zimmerman, and Jenkins wrote the majority opinion, adopting the community-of-interest standard. Chairman Van de Water and Member Hunter dissented. Chairman Van de Water argued that in keeping with the congressional admonition against unit proliferation, only two health care units, professional and nonprofessional, were appropriate. Member Jenkins argued that the disparity-of-interests test should be adopted for health care unit determinations. In *St. Francis II*, on the other hand, Chairman Dotson and Member Hunter (who wrote a dissent in *St. Francis I*) wrote the majority opinion, adopting the disparity-of-interests test. Member Diaz-Dennis concurred, but urged the Board to engage in rulemaking on the issue. Member Zimmerman, who had joined in the majority opinion in *St. Francis I*, dissented.⁶⁷

62. *Id.* at 950.

63. See *Trustees of Masonic Hall & Asylum Fund v. NLRB*, 699 F.2d 626 (2d Cir. 1983). In *Masonic Hall*, a nursing home refused to bargain with service and maintenance workers, arguing that the Board improperly had certified their unit rather than a unit of all employees. The Second Circuit stated that the "rigid 'disparity of interests' test is inconsistent with the compromise struck by Congress . . . at the same time, protect[ing] labor and management rights and promot[ing] good health care." *Id.* at 641.

64. *Watowan Memorial Hosp., Inc. v. NLRB*, 711 F.2d 848, 849 (8th Cir. 1983). In *Watowan*, the employer hospital contended that a bargaining unit containing all technical employees was inappropriate. The Eighth Circuit noted that the 1974 amendments do not require the Board to select the largest appropriate bargaining unit, but rather require the Board to certify "an appropriate" bargaining unit. *Id.* at 850 (emphasis in original).

65. *NLRB v. Walker County Medical Center, Inc.*, 722 F.2d 1535 (11th Cir. 1984). In *Walker County*, the employer hospital claimed that the Board, in certifying a unit consisting only of registered nurses, had failed to consider the congressional admonition against the undue proliferation of bargaining units. In rejecting the disparity-of-interests test, the *Walker County* court remarked, "[W]e find it difficult to find where in the legislative history to the 1974 NLRA amendments this 'disparity of interest' standard is stated." *Id.* at 1539, n.4.

66. 29 U.S.C. § 153(a) (1947).

67. Noting a similar reversal in Board policy in the early 1960s, Professor Bernard Meltzer has written that "[These] changes were too rapid to be ascribed to institutional developments or to new insights produced by a maturing expertise; they reflected the different value preferences of new appointees interacting with loose statutory provisions."

In response to numerous criticisms, the NLRB stated that it was “not establishing a rigid disparity-of-interests test that would always result in two broad units.”⁶⁸ Instead, the Board asserted that it would reach unit determinations on a case-by-case basis while focusing on the disparity-of-interests between the petitioned-for unit and other proposed units.⁶⁹ Perhaps the strongest criticism of the disparity-of-interests test came from the Court of Appeals for the District of Columbia Circuit in *International Brotherhood of Electrical Workers, Local Union 474 v. NLRB*.⁷⁰ The *Local 474* court noted that the congressional admonition to avoid undue proliferation of bargaining units merely was a part of the House and Senate Committee Reports of the 1974 Amendments, and “a committee report cannot serve as an *independent statutory source having the force of law*.”⁷¹ In addition, the *Local 474* court noted that Congress had decided against modifying Section 9 of the NLRA⁷² as part of the 1974 amendments, and that the amendments did not, as the Board had ruled in *St. Francis II*, mandate the use of a disparity-of-interests standard.⁷³

More criticism came from within the Board itself. In his dissent in *St. Francis II*, Member Zimmerman suggested that the Board engage in rulemaking to end the controversy over the appropriate test to apply.⁷⁴ In support of this suggestion, he cited the lack of predictability in the sufficiency of evidence to prove a disparity of interests and the increasing litigation surrounding health care bargaining unit determinations.⁷⁵ Although she had concurred in the *St. Francis II* majority opinion, Member Diaz-Dennis likewise urged that the Board exercise its rulemaking authority because it would “provide[] health care labor relations with immediate stabil-

B. Meltzer, *Organizational Picketing and the NLRB: Five on a Seesaw*, 30 U. CHI. L. REV. 78 (1962-63).

68. *St. Francis II*, 271 N.L.R.B. 953, n.39 (emphasis in original). See also *St. Francis I*, 239 N.L.R.B. 872 (Chairman Van de Water, dissenting).

69. 271 N.L.R.B. at 953, n.39.

70. 814 F.2d 697 (D.C. Cir. 1987).

71. *Id.* at 712.

72. 29 U.S.C. § 159 (1982). Section 9 of the NLRA allows the Board broad discretion to determine appropriate bargaining units. See *Allied Chemical & Alkali Workers, Local No. 1 v. Pittsburgh Plate Glass Co.*, 404 U.S. 157, 171 (1971).

73. *Local 474*, 814 F.2d at 712.

74. *St. Francis II*, 271 N.L.R.B. 948, 958 (1984) (Member Zimmerman, dissenting).

75. *Id.* at 956. Member Zimmerman stated that “the continuing lack of definitive guidelines for appropriate units has gradually paralyzed the processing of all Board representation cases in the industry. Consequently, thousands of employees have been denied their right to choose or reject collective-bargaining representation.” *Id.* at 955.

ity and certainty, and obviate[] continued litigation. . . ."⁷⁶

III. THE PROPOSED RULE FOR APPROPRIATE HEALTH CARE BARGAINING UNITS

A. *The Board's Power to Engage in Rulemaking*

In the wake of this powerful disapproval, the Board proposed to amend its rule to specify appropriate bargaining units in the health care industry.⁷⁷ This was considered a dramatic step, for although Congress gave the Board the power to engage in substantive rulemaking pursuant to section 6 of the Act, the Board almost never does so. In the thirteen years following the enactment of the 1974 Amendments, however, neither of the Board's doctrinal formulas for determining the appropriate health care bargaining units generally had been accepted by the courts.⁷⁸ Furthermore, the Board acknowledged⁷⁹ that, for some time, numerous judges and scholars had been urging the Board to engage in bargaining unit rulemaking.⁸⁰ Thus, the dramatic step was a necessary one.

B. *The Hearings*

Following its original Notice of Proposed Rulemaking, the Board conducted hearings at which representatives from numerous health care associations and unions testified.⁸¹ The Board also received written comments from 315 individuals and organizations.⁸² A number of health care employers, including the American Hos-

76. *Id.* at 954-55 (Member Diaz-Dennis, concurring).

77. 52 Fed. Reg. 25,142 (1987) (to be codified at 29 C.F.R. § 103 (proposed July 2, 1987)). Section 9(b) of the Act, 29 U.S.C. § 159(b) (1935), requires the Board to decide the appropriateness of units "in each case," but a leading authority on administrative law has concluded that the Board may decide "in each case" with the help of rules that it establishes. *See* K. DAVIS, ADMINISTRATIVE LAW TEXT 145 (3d ed. 1972) ("The mandate to decide 'in each case' does not prevent the Board from supplanting the original discretionary chaos with some degree of order, and the principal instruments for regularizing the system of deciding 'in each case' are classifications, rules, principles and precedents.")

78. 53 Fed. Reg. at 33,901 (1988).

79. 52 Fed. Reg. 25,145 (1987) (to be codified at 29 C.F.R. § 103 (proposed July 2, 1987)).

80. *See e.g.*, *NLRB v. Res-Care, Inc.*, 705 F.2d 1461, 1466 (7th Cir. 1983) (The NLRB would be entitled to greater judicial deference if it "awakened its dormant rulemaking powers."); Morris, *The NLRB in the Dog House: Can an Old Board Learn New Tricks?* 24 SAN DIEGO L. REV. 9, 27 (1987).

81. 53 Fed. Reg. 33,900, 33,900 (1988) (to be codified at 29 C.F.R. § 103) (proposed September 1, 1988).

82. *Id.*

pital Association, opposed the Board's proposed rulemaking.⁸³ They claimed that the diversity within the health care industry and the need for flexibility in responding to rapid changes in the industry precluded rulemaking.⁸⁴ Further, some employers insisted that if the Board persisted in rulemaking, it should limit appropriate health care units to those composed of professional employees and nonprofessional employees (plus guards).⁸⁵ The employers argued that only two major units were justified because all health care professionals interact on the job and because the distinctions among various classifications of nonprofessionals were not sufficient to support separating or classifying them into distinct units.⁸⁶ Health care industry employers cited further arguments against the establishment of more than two bargaining units. The employers claimed that changes in the health care industry required a team approach; strikes, jurisdictional disputes⁸⁷, and wage whipsawing⁸⁸ might arise from unit proliferation. Further, an increase in the number of bargaining units would result in increased operating costs.⁸⁹

Because lengthy delays and protracted litigation surrounding bargaining unit determinations had made organizing difficult, the unions that participated in the Board hearings supported the Board's rulemaking.⁹⁰ The unions asserted that employers had been able to use delay as a strategy in opposing unionization,⁹¹ and if the Board established a uniform rule, much of the delay would

83. *Id.* at 33,901.

84. *Id.* at 33,901-02.

85. *Id.* at 33,906.

86. *Id.*

87. In a jurisdictional dispute, a labor organization seeks to force an employer "to assign particular work to employees in a particular labor organization. . . ." 29 U.S.C. § 158(b)(4)(D) (1982). Such conduct constitutes an unfair labor practice. Even if health care workers were willing to violate the Act by engaging in jurisdictional disputes, state licensure or certification of health care professionals "make[s] job interchange impossible, or even illegal. . . ." *North Arundel Hosp. & Maryland Nurses Ass'n*, 279 N.L.R.B. 311, 312 (1986).

88. The term whipsaw means "to worst or victimize in two opposite ways at once by a two-phase operation, or by the collusive action of two opponents." WEBSTER'S NINTH NEW COLLEGIATE DICTIONARY 1344 (1989). In the labor context, a union may try to whipsaw an employer into granting wage increases to the members of one unit because the employer granted wage increases to the members of another unit.

89. 53 Fed. Reg. at 33,900, 33,906-10.

90. *Id.* at 33,902.

91. Management consultant Raymond Mickus predicted that "the NLRB rules will spark much more union activity. . . . Under the rules there will be much faster elections [because] employers won't have access to hearings or briefs which used to delay the proceedings. . . ." [Current Developments] *Daily Labor Report* (BNA) No. 162 at A-2 (Aug. 6, 1987).

be eliminated⁹² The unions also argued that the cost pressures under which hospitals operate are not causally related to the organization of the hospital labor force,⁹³ and that there is a lower incidence of strike activity in the health care field than in other industries.⁹⁴ In response to health care employers' argument that the Board should not allow the establishment of more than two bargaining units because it would increase operating costs, some unions questioned whether costs had any relevance to at all.⁹⁵

C. *The Rule*

Although some witnesses had stated that the establishment of multiple units would lead to a parade of horrors, the Board found that these fears were not supported by credible evidence.⁹⁶ In answer to the contention that health care employers could not afford to engage in collective bargaining with their employees, the Board noted that Congress had rejected this rationale when it passed the 1974 amendments out of concern for the low wages and poor working conditions of hospital employees.⁹⁷ The Board concluded that health care employers' costs associated with union organizing were irrelevant to the Board's determination of appropriate bargaining units because unionization might improve health care workers' wages and working conditions.⁹⁸ The Board did not consider the costs that employers could save by avoiding unionization through delay to be a legitimate reason legislating against rulemaking. After the hearings, the Board concluded that rulemaking would actually *reduce* the costs associated with litigation.

After considering the testimony and written comments, the Board published a proposed rule for the appropriate bargaining units in the health care industry.⁹⁹ Instead of restricting the number of units to two¹⁰⁰ (plus a unit for guards)¹⁰¹ as it had in *St.*

92. *Id.*

93. 53 Fed. Reg. at 33,903 (1988).

94. *Id.* at 33,908.

95. *Id.* at 33,909.

96. *Id.* at 33,908.

97. *Id.* at 33,909.

98. *Id.* See also *Beth Israel Hosp. v. NLRB*, 437 U.S. 483, 497-98 (1978) (citing 120 Cong. Rec. 12936-38 (1974)).

99. 53 Fed. Reg. 33,900 (1988) (to be codified at 29 C.F.R. pt. 103) (proposed September 1, 1988). Psychiatric hospitals and nursing homes were excluded from coverage. *Id.* at 33, 932-33.

100. A professional unit and a nonprofessional unit.

101. Section 9(b)(3) of the NLRA requires that guards be placed in a bargaining unit separate from other employees. 29 U.S.C. § 159 (b)(3) (1947).

Francis II, the Board determined that eight units were appropriate for the health care industry: registered nurses, physicians, other professionals, technicals, skilled maintenance, business office clericals, other non-professionals, and guards.

IV. DISCUSSION

A. *The Impact of Bargaining Unit Determinations*

In order for the National Labor Relations Board to direct an election, a union must demonstrate a "showing of interest."¹⁰² Thus, the size of a designated bargaining unit bears a direct correlation with the success rate of hospital union organizing efforts and can determine whether an election will be held.¹⁰³ Unions typically experience difficulty in organizing large units.¹⁰⁴ Because large units may encompass employees who have diverse interests and goals, unions may become entangled in conflicts of interest in attempting to represent fairly all the employees of a large unit.¹⁰⁵ The Board has recognized that "broad units militate against organizing by health care workers."¹⁰⁶ The disparity-of-interests presumption that only two health care bargaining units may be found appropriate frustrates the congressional goal of extending collective bargaining rights to health care workers.¹⁰⁷

The difficulties associated with organizing a professional unit, one of the two units presumed appropriate under the disparity-of-interests test, illustrate the manner in which broad bargaining units interfere with the unionization of health care workers.¹⁰⁸ If a unit encompasses all health care professionals, then physicians, registered nurses, and other professionals would have to reach a consensus on whether they should engage in collective bargaining.¹⁰⁹ Such a consensus is unlikely, however, given that these employees have such varied professional and employment goals.¹¹⁰

In its rule, the NLRB proposed that registered nurses should

102. This "showing of interest" usually is demonstrated with cards signed by at least 30 % of the employees in the bargaining unit designating the union as the desired bargaining representative. R. GORMAN, *supra* note 3, at 41.

103. *Id.* at 67; Delaney, *Union Success in Hospital Representation Elections*, 20 INDUS. REL. 149, 159 (1981).

104. R. GORMAN, *supra* note 3, at 67.

105. *Id.*

106. 53 Fed. Reg. 33,910 (1988) (to be codified at 29 C.F.R. § 103) (proposed September 1, 1988).

107. Comment, *supra* note 60, at 320.

108. Delaney & Sockell, *supra* note 6, at 260.

109. Comment, *supra* note 60, at 320-21.

110. *Id.*

constitute a separate appropriate bargaining unit because of their unique responsibilities and interests.¹¹¹ Registered nurses, unlike other health care professionals, interact continually with patients.¹¹² They also fill out incident reports on mistakes (such as incorrect medication dosages) made by other hospital workers.¹¹³ As the Board noted, nurses' responsibility to report other workers' mistakes may result in antagonism between the RNs and other professionals in a bargaining unit.¹¹⁴ Such antagonism could interfere with collective bargaining by the professionals as a group.¹¹⁵

The Board also found that because of their unique responsibilities and interests, physicians should constitute a separate appropriate bargaining unit.¹¹⁶ Doctors earn considerably more than other professionals and frequently are salaried. Therefore, unlike other health care professionals, they have little concern with hourly wage rates. Furthermore, doctors bear the overall responsibility for the quality of patient care; registered nurses and other health care professionals accept orders from physicians.¹¹⁷

Even though other health care professionals such as social workers, laboratory technologists, and pharmacists might desire to be placed in separate units, the NLRB decided to create a proposed rule providing for a unit including *all* health care professionals (with the exception of physicians and registered nurses).¹¹⁸ The NLRB reasoned that these professionals shared superior education and training.¹¹⁹ The agency also expressed the fear that if it allowed these professionals to form their own distinct bargaining units, there would be the very unit proliferation that Congress wanted to avoid.¹²⁰

In its Notice of Proposed Rulemaking, the NLRB determined that technical employees¹²¹ should constitute another separate appropriate bargaining unit. Technical employees possess higher

111. 53 Fed. Reg. at 33,900, 33,912.

112. *Id.*

113. *Id.*

114. *Id.*

115. *Id.*

116. 53 Fed. Reg. at 33,900, 33,917.

117. The Board stated in its second notice of proposed rulemaking that "to include [physicians] with RNs and other professionals [in a bargaining unit] seems likely to lead to divisiveness and quite possibly to conflicts of interest." *Id.*

118. *Id.* at 33,918.

119. *Id.*

120. *Id.* See also *supra* note 44 and accompanying text (congressional admonition discussed).

121. This category would include medical laboratory, respiratory therapy, radiography, emergency medicine, and medical records technicians. *Id.*

levels of skill and education than other nonprofessionals, and earn substantially more than other health care nonprofessionals.¹²² They experience only minimal contact with other health care workers.¹²³ Because a technical unit encompasses a number of job classifications and constitutes approximately seventeen percent of the health care work force, the NLRB did not believe that a separate technical unit violated the congressional admonition against undue unit proliferation.¹²⁴

The NLRB allowed skilled maintenance workers to form their own bargaining units because unlike unskilled service, maintenance, and clerical employees, skilled maintenance workers operate and repair complex and sophisticated equipment.¹²⁵ Skilled maintenance employees possess distinct bargaining interests such as tool supply allowances and consultation with regard to the subcontracting of work.¹²⁶ Like the technical unit, the skilled maintenance unit encompasses a number of employee classifications.¹²⁷ The NLRB believed, therefore, that it was not allowing undue unit proliferation by creating a separate skilled maintenance unit.¹²⁸

Business office clericals have job duties and functions differing from those of service and maintenance workers, possess a higher level of education than service and maintenance workers¹²⁹, and have health and safety concerns distinct from those of service and maintenance workers.¹³⁰ Consequently, the NLRB approved a separate business office clerical unit as an appropriate health care bargaining unit.¹³¹ In further support of its decision, the NLRB also cited the unique bargaining interests of business office clericals, such as video display terminal distress.¹³²

B. The Injunction Barring Enforcement of the Rule

On April 21, 1989, the Board published its final rule on health care bargaining units.¹³³ The American Hospital Association immediately filed a complaint in the United States District Court for

122. *Id.*

123. *Id.* at 33,919.

124. *Id.* at 33,920.

125. *Id.*

126. *Id.* at 33,922.

127. *Id.*

128. *Id.*

129. *Id.* at 33,924.

130. *Id.* at 32,925.

131. *Id.* at 33,926.

132. *Id.*

133. 54 Fed. Reg. 16,336-48 (1989) (to be codified at 29 C.F.R. § 103).

the Northern District of Illinois, seeking a permanent injunction to prevent the Board from enforcing its new health care bargaining unit rule.¹³⁴ The AHA provided three reasons for invalidating the rule: The rule violated section 9(b) of the Act; the rule violated the congressional admonition against undue proliferation of bargaining units; and the rule was arbitrary and not supported by substantial evidence.¹³⁵ The AHA prevailed, and the district court entered an order permanently enjoining the Board's enforcement of the rule.¹³⁶

Although the court granted the injunction, it did not agree with some of the reasons advanced by the AHA for invalidating the rule. Specifically, the court disagreed with the AHA's assertion that rulemaking was inconsistent with section 9(b)'s requirement that the Board decide unit determinations on a case-by-case basis.¹³⁷ The court did, however, concur with the AHA's claim that the rule violated the congressional admonition against undue proliferation of bargaining units in the health care industry.¹³⁸ The court stated that "when the Board takes action or crafts policy with respect to bargaining units involving health care employees, it must use the means least likely to cause unit proliferation to achieve their objective."¹³⁹ Because the rule established the "automatic fragmentation of the work force into eight units, without regard to the nature and the extent of the health services rendered or the dynamics of a particular health care institution,"¹⁴⁰ the court held that the rule could cause fragmentation.¹⁴¹

The court indicated that the rule would have been more acceptable had it been promulgated as "guidelines" or "rebuttable presumptions" rather than as a mandate that would be modified only if a hospital established the existence of "extraordinary circumstances."¹⁴² In conclusion, the court ruled that the NLRB's

134. AHA v. NLRB, 718 F.Supp. 704 (N.D. Ill. 1989).

135. *Id.* at 705.

136. *Id.* at 716.

137. *Id.* at 713. The court stated that "[i]t would be a misuse of resources to prevent the Board from using fact gathering apparatus to develop principles applicable to recurring scenarios. It defies common sense to believe Congress would entrust unit determination to the Board under section 9 because of its experience and expertise, and then, simultaneously require it to face each contested case *ab initio*." *Id.*

138. Because the court entered an order granting the injunction on this ground, it found that there was no reason to consider the AHA's assertion that the rules were arbitrary and capricious and not supported by substantial evidence. *Id.* at 716 n.17.

139. *Id.* at 714.

140. *Id.* (emphasis in original).

141. *Id.* at 714-16.

142. The Board concluded that none of the arguments raised in the course of the

health-care bargaining unit rule violated the congressional admonition against undue proliferation of health-care bargaining units because they “encourage[], and perhaps coerce[], fragmentation of the labor force within particular health care facilities.”¹⁴³

C. *The Appeal to the Seventh Circuit*

In July 1989, the Board filed a Notice of Appeal with the Seventh Circuit Court of Appeals. The Board argued that its rulemaking did not violate the “in each case” language of section 9(b) because, even if the health care bargaining unit rule took effect, the Board would still have the obligation to decide other representational issues.¹⁴⁴ According to the Board, its obligation to make these determinations in itself fulfilled the “in each case” requirement. In addition, the Board argued that the application of the “extraordinary circumstance” exception—admittedly narrow in scope—when decided on a case-by-case basis, fulfilled the requirement of Section 9(b).

In oral arguments held before the Seventh Circuit Court of Appeals on January 10, 1990, the Board argued that its health care bargaining unit rule did not violate the congressional admonition against undue proliferation of bargaining units.¹⁴⁵ According to the Board, the district court’s notion that the rule violated Congress’ admonition because the rule did not “use the means least likely to cause unit proliferation” ignored the very reason that Congress had enacted the 1974 Health Care Amendments: to im-

rulemaking procedure, including those listed below, alone or in combination, constitutes an “extraordinary circumstance” justifying an exception from the rule. The arguments considered by the Board included:

- (1) Diversity of the industry, such as the sizes of various institutions, the variety of services offered by individual institutions, including the range of outpatient services provided, and differing staffing patterns among facilities (as, for example, a particular facility employing a larger or smaller number of RNs than generally employed as a result of the advent of the multi-competent worker, increased use of “team” care, and cross-training of employees);
- (3) the impact of nationwide hospital “chains”;
- (4) recent changes within traditional employee groupings and professions, e.g., the increase in specialization among RNs;
- (5) the effects of various governmental and private cost-containment measures; and
- (6) single institutions occupying more than one contiguous building.

53 Fed. Reg. at 33,932-33.

143. *AHA v. NLRB*, 718 F.Supp. at 716.

144. These issues included: whether a contract bar existed, whether the hospital was an acute care hospital, and whether certain employees were supervisory or managerial. F. Saubert, *American Hospital Association versus the National Labor Relations Board, an Update* (Presented at the Mid-Winter Meeting of the ABA Committee on the Development of Law Under the National Labor Relations Act, March 5, 1990).

145. Daily Labor Report (BNA) No. 8 at A-9 (Jan. 11, 1990).

prove patient care as well as the wages and working conditions of health care workers.¹⁴⁶ In support of this argument, the Board cited Senator Cranston's remark in the congressional hearings on the 1974 Amendments to the Act that the quality of patient care would be improved if hospital employees were unionized.¹⁴⁷

In addition, the Board contended that the rule did not *mandate* that eight bargaining units be created within each hospital. Instead, eight units would be created within a given hospital only if the employees of the hospital attempted to organize all of the units specified by the rule. Furthermore, the "extraordinary circumstances" exemption would shield an "atypical" hospital from exposure to the possible difficulties associated with the obligation to bargain with all eight units.¹⁴⁸

The court vacated the injunction.¹⁴⁹ Writing for the panel, Judge Posner stated that the term "undue proliferation" as used in the congressional admonition "has always had reference to finer divisions of the health care work force than attempted in the rule under challenge."¹⁵⁰ Furthermore, the court ruled that because the language of the congressional admonition was "cautionary rather than directive," it could not be read to restrict the allowable number of bargaining units in the health care industry to three.¹⁵¹ The Seventh Circuit rejected the AHA's argument that the "in each case" provision of section 9(b) barred the Board's wholesale promulgation of a bargaining unit rule. The court read the "in each case" language differently, holding that a case "can be an industry or (as here) a subset or submarket of an industry." It "need not be a particular dispute between a particular employer and particular union at a particular plant or establishment."¹⁵² In addition, the court noted that because Congress had enacted the section of the National Labor Relations Act giving the Board rulemaking powers at the same time as it enacted the section requiring the Board to make unit determinations "in each case," "it is probable

146. The author attended the oral arguments held before the Seventh Circuit Court of Appeals. The account of the arguments is taken from the notes she made during the arguments.

147. See *supra* note 98 and accompanying text (during rulemaking, Board considered fact that unionization might improve health care workers' wages and working conditions).

148. See *supra* note 142 and accompanying text.

149. *AHA v. NLRB*, 899 F.2d 651 (7th Cir. 1990), *rev'g*, 718 F. Supp. 704 (N.D. Ill. 1989), *aff'd* 59 U.S.L.W. 4331 (April 23, 1991).

150. *Id.* at 659.

151. *Id.* at 658.

152. *Id.* at 656.

that Congress would have made an explicit exception for unit determination if it had wanted to place that determination outside the scope of the Board's rulemaking power."¹⁵³

Finally, the court dismissed the AHA's argument that the rule is arbitrary because it made no differentiation between acute care hospitals on the basis of size or location.¹⁵⁴ Although recognizing that this criticism was important, the court found wholly unacceptable the hospital industry's suggestion that a rule establish a rebuttable presumption that the three unit minimum required by the Act was the appropriate minimum for the health care industry. Because the Seventh Circuit read the Act to imply that "the tilt [among the competing interests of unions and employees] should be in favor of unions," the court found that there was no basis for placing the burden of rebutting a three-unit presumption on unions.¹⁵⁵

D. The Supreme Court's Decision

Writing for a unanimous Court, Justice Stevens delivered a brief opinion affirming the Seventh Circuit.¹⁵⁶ The Court summarily disposed of the three arguments brought by the AHA and essentially tipped its hat to the Board's broad powers. Pronouncing the AHA as having "misread" the "natural meaning of the language read in the context of [section 9(b)]," the Court handily dismissed the argument that the Board lacked the power to engage in rulemaking for an entire industry. Pointing to section 9(b)'s "in each case" language, the Court emphasized that

the ordinary meaning of the statutory language cannot support [the AHA's] construction As a matter of statutory drafting, if Congress had intended to curtail in a particular area the broad rulemaking authority granted in § 6, we would have expected it to do so in language expressly describing an exception from that section or at least referring specifically to the section.¹⁵⁷

Despite the text's sparse legislative history, the meaning of "in each case" seemed crystal clear to the Court, but even if the Court had been unable to glean any meaning from the phrase, it would have deferred to the Board's reasonable interpretation of the

153. *Id.*

154. *Id.* at 659-70.

155. *Id.* at 659.

156. *AHA v. NLRB*, 59 U.S.L.W. 4331 (April 23, 1991), *affirming* 899 F.2d 651 (7th Cir. 1990).

157. *Id.* at 4333.

language.¹⁵⁸

The Court also had no trouble dealing with the argument that the proposed rule violates the congressional admonition against proliferation of bargaining units. First, it emphasized that the Board's rule does not contravene the Board's mandate to determine the appropriate bargaining rule "in each case."¹⁵⁹ Second, the Court found that the Board had given "due consideration" to the special problems that proliferation might create when it promulgated its rule. If it was felt that the Board gave short shrift to the problem of proliferation in the health care industry, "the remedy for noncompliance with the admonition is in the hands of the body that issued it."¹⁶⁰ Thus, any response was left to Congress.

Finally, the Court rejected the AHA's argument that the rule is arbitrary and capricious. In the Supreme Court, the AHA had relied on *St. Francis I* to demonstrate to the Court that "the diverse character of the health care industry precluded generalizations about the appropriateness of any particular bargaining unit."¹⁶¹ The Court concluded that the Board had arrived at this particular rule only after a "reasoned analysis" of an extensive record:

The fact that [the AHA] can point to a hypothetical case in which the rule might lead to an arbitrary result does not render the rule "arbitrary or capricious." This case is a challenge to the validity of the entire rule in all its applications. We consider it likely that presented with the case of an acute care hospital to which its application would be arbitrary, the Board would conclude that "extraordinary circumstances" justified a departure from the rule . . . Even assuming however, that the Board might decline to do so, we cannot conclude that the entire rule is invalid on its face.¹⁶²

Before leaving the matter, the Court cautioned that it had "deliberately avoided any extended comment on the wisdom of the rule, the propriety of the specific unit determinations, or the importance of avoiding work stoppages in acute care hospitals."¹⁶³ Time will tell.

158. *Id.*

159. *Id.* at 4334.

160. *Id.*

161. *Id.*

162. *Id.* at 4335.

163. *Id.*

V. ARE HEALTH CARE EMPLOYERS BARKING UP THE WRONG TREE?

I will leave to the numerous scholars who have written articles either supporting or criticizing the NLRB's proposed rule the issue of whether the number of units established as appropriate by the rule violates the congressional admonition against undue proliferation. Even though the Supreme Court has settled the matter, however, significant problems remain. Because the Court upheld the rule, health-care employers still face many of the same problems that they asserted would result from the "proliferation" in the number of appropriate bargaining units established by the rule.¹⁶⁴ Abolishing the statutory requirement that the Board not certify as appropriate a bargaining unit containing both professional and non-professional employees¹⁶⁵ partially would solve these problems. This is not a remedy, however, that the courts can supply. Rather—as the Court suggests—the solution rests with Congress. If Congress disagrees with the Supreme Court's interpretation of the congressional admonition against undue proliferation of bargaining units, then it may amend the Act in order to reflect its current interpretation of the Taft-Hartley amendments. Health care employers may have wasted their efforts in the courts. Their goals might better be served by lobbying Congress for an amendment to the NLRA that would limit the number of health care bargaining units.

At the very least, Congress should consider amending the Act to facilitate the creation of health care bargaining units that contain some combination of professional, nonprofessional, and technical employees. If health care employers are able to convince Congress to enact such an amendment, they will gain the ability to adapt to a rapidly changing health care work force. Currently there are shortages of so-called "professional" and "technical" health care workers, and there is no indication that this shortage will be alleviated in the foreseeable future. Registered nurses, for example, are in critically short supply throughout the nation.¹⁶⁶ In addition, the

164. For example, strikes, jurisdictional disputes, and wage whipsawing. *See supra* notes 87-89 and accompanying text.

165. In this regard, the NLRA provides that "*the Board shall not (1) decide that any unit is appropriate for such purposes if such unit includes both professional employees and employees who are not professional employees unless a majority of such professional employees vote for inclusion in such unit*" 29 U.S.C. § 159(b) (1988) (emphasis supplied).

166. "RN vacancies at health care institutions have more than doubled between 1983

numbers of medical technologists,¹⁶⁷ radiologic technologists,¹⁶⁸ occupational therapists and physical therapists¹⁶⁹ can no longer meet the demands of American health care employers. All of these health care occupations fall into either the "professional" or "technical" health care units as described by the rule. What will happen when health care employers are forced by severe health care worker shortages to place technical workers¹⁷⁰ in professional job classifications,¹⁷¹ or other non-professionals in technical job classifications? Disputes concerning unit scope surely will follow.¹⁷² This is one of the major objections to the promulgation of the proposed rule that health care employers raised, and with good reason.

In addition, the Board has been unable to establish any clear rules as to whether particular health care occupations fall under the "professional"¹⁷³ or "technical" classifications. For example, although the Board repeatedly has found that medical technologists perform work that qualifies as "professional,"¹⁷⁴ the Board

and 1987, from a rate of 4.4 percent to approximately 12 percent." Colosi & Krupman, *Bargaining Unit Status of Nurses: What Will the Future Bring?*, 40 LAB. L. J. 361 (1989).

167. Chapman, *Programs Target MT Shortage*, CAP TODAY, December, 1989, at 1, col. 2.

168. Appleby, *Running Out: Scarcity of Radiologic Technologists, Who Are Moving to Other Jobs Leaves Hospitals Struggling to Meet Growing Personnel Demands*, HEALTHWEEK, January 8, 1990, at 27.

169. *Id.*

170. *See supra* notes 122-23 and accompanying text (background of technical workers discussed).

171. *See supra* notes 83-86 and accompanying text (recounting how some health care employers need the flexibility to switch personnel in order to meet changing needs). Although it has been argued that state licensure or certification of health care professionals "make[s] job interchange impossible, or even illegal. . .", North Arundel Hosp. & Maryland Nurses Ass'n, 279 N.L.R.B. (1986), this argument applies only to job interchange *among professionals*.

172. The transfer of work out of a bargaining unit is a mandatory subject of bargaining. This is a unit scope issue, rather than an illegal jurisdictional dispute. Sherman, *Collective Bargaining Over Work Assignment Proposals: Differentiating Between Concepts of Jurisdiction and Unit Scope*, 41 LAB. L. J. 3 (1990).

173. The Labor Management Relations Act, 29 U.S.C. § 152(12)(a) defines "professional employee" as:

- (a) any employee engaged in work (i) predominantly intellectual and varied in character as opposed to routine mental, manual, mechanical, or physical work; (ii) involving the consistent exercise of discretion and judgment in its performance; (iii) of such a character that the output produced or the result accomplished cannot be standardized in relation to a given period of time; (iv) requiring knowledge of an advanced type in a field of science or learning customarily acquired by a prolonged course of specialized intellectual instruction and study in an institution of higher learning or a hospital, as distinguished from a general academic education or from an apprenticeship or from training in the performance of routine, mental, manual, or physical processes

174. *See Twin City Hosp.*, 292 N.L.R.B. No. 21 (1988); *Illinois Valley Community*

reached the opposite conclusion with regard to "laboratory technologists."¹⁷⁵ If the Board cannot decide which health care employees are professionals and which are technicals, how are health care employers supposed to decide which tasks to assign to certain groups of employees?

In order to continue to provide quality patient care, health care employers must have the ability to fill job openings as quickly and efficiently as possible. In today's changing health care environment, this may necessitate shifting the less technical job responsibilities to registered nurses from licensed practical nurses in order to maximize the use of the few available registered nurses in the most intellectually demanding aspects of nursing. Similar shifts in job responsibilities throughout health care institutions may become increasingly necessary within other job classifications, such as medical technologists and medical technicians. If Congress amends the National Labor Relations Act to allow the certification of a bargaining units containing both professional and technical employees or technical and non-professional employees, health care employers would have fewer problems in attempting to fill essential positions that can no longer be filled with employees with "traditional" backgrounds.

VI. CONCLUSION

Although a three-unit maximum arguably may not fulfill Congress's intent in enacting the health care amendments, the Board's present rule also fails to fulfill congressional intent in enacting the health care amendments. As the Act currently is written, the Board lacks the discretion to certify a professional-technical health care bargaining unit. In order to ensure that health care employers retain the flexibility to ensure quality patient care while also ensuring health care workers the right to join or refrain from concerted activities under the NLRA, the AHA should lobby Congress to give the Board the legal authority to certify such a unit. The greatest beneficiary would be quality health care.

Hosp., 261 N.L.R.B. 1048, 1049 (1982); Children's Memorial Hosp. of Pittsburgh, 222 N.L.R.B. 588, 590 (1976); Alexian Bros. Hosp., 219 N.L.R.B. 1122 n.6 (1975); Barnert Memorial Hosp. Center, 217 N.L.R.B. 775, 782 (1975).

175. See, e.g., Samaritan Health Servs., 238 N.L.R.B. No. 56 (1978) (blood laboratory technologist not professional because work not predominantly intellectual in character and does not require advanced knowledge or training).